# Psychiatrists in Blue:

## *A Quantitative Analysis of How Police Involvement in Mental Health Crises Affects Social Stigma*

An honours thesis by:

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# Abstract:


## Psychiatrists in Blue:
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This thesis explores the effects of how intertwining police and mental health services in the response to mental health crises contributes to the stigmatization of people with mental illness. The specific research question in focus is: how does having a specialized police response team for mental health crises influence the public's attitudes toward people with mental illness? The prevalence of interactions between police and individuals with mental illness has been well documented, as well as the negative outcomes such as harm or even fatalities. In reaction to this problem, crisis intervention teams were created; these programs bridge a partnership between law enforcement and the health care system. Research up to date has focused on the components, training, and positive outcomes of crisis intervention teams while, negative consequences are not considered. The methodology of this study consisted of 73 undergraduate students as participants who read a vignette completed a quantitative questionnaire. The questionnaire gathered socio-demographic information as well as stigma levels from the Social Distance Scale and Attribution Questionnaire.

Overall, high levels of familiarity with mental illness and low stigma on both the Social Distance Scale and the Attribution Questionnaire was found. There was no significant difference found between the group with the non-police vignette and the group with the police vignette. The highest rated stigma subscales on the Attribution Questionnaire was pity, coercion, and avoidance. For instance, the average scores on the pity subscale for the police ($M$ = 6.50, $n$ = 37, $SD$ = 1.40) and non-police ($M$ = 6.19, $n$ = 36, $SD$ = 1.28). Similarly, the average scores of the coercion subscale for the police ($M$ = 4.40, $n$ = 37, $SD$ = 1.38) and non-police ($M$ =4.51, $n$ = 36, $SD$ = 1.17). With the Social Distance Scale a complementary finding was also discovered. The average rating for the police group was 3.37 ($n$ =37, $SD$ = 0.69) and average rating for the non-police group was 3.30 ($n$ =36, $SD$ = 0.64). In relation to the current study's research question, both groups of the study, the subscales marginally effected in terms of stigma were pity, coercion, and avoidance. In connection to the open-ended question multiple comments mentioned John should be prescribed medication or some sort of treatment hint at the endorsement of coercion. In addition, further exploration showed a small negative correlation was found between level of familiarity with mental illness and social stigma. Through the main finding, that the two groups (Non-Police and Police) are not statistically different shows that these participants did not face high stigma but also that particularly the institutional response (mental health crises response team), police presence, did not influence a labeling that would impact participants social stigma.


Key words: Stigma, Labeling, Mental Illness, Crisis Intervention Teams, Police

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# Section 1: Introduction

Individuals with mental illness are overrepresented within the criminal justice system as well as in interacrtion with police officers (Teplin &Pruett, 1992; Krishan et al., 2014; Morrow & Weisser, 2012; Redlich et al., 2010; Cotton, 2004). Interdisciplinary crisis intervention team programs, combining police and mental health professionals, have become popular and a wide spread phenonenon. The current study's research question in focus follows as: How does having a specialized police response team for mental health crises influence public attitudes toward people with mental illness?

The theoretical framework for this study is Link and colleagues (1989) Modified Labeling Theory. This theoretical perspective will be used to examine the relationship between mental illness-related stigma and police involvement in mental health crises. The Modified Labeling Theory encompasses five stages; the first stage will be the most beneficial and applicable. The first stage describes the socialization of beliefs that individuals with mental illness are discriminated against. This stage is important as this study examines the social stigma influenced by mental health crises response teams. Also to note, the term 'mental illness' will be conceptualized within the theoretical section, as there are various definitions, which are broad, ambiguous, and problematic. Following the theoretical framework is a literature review of research in the area of stigma, mental illness, crisis intervention teams, and police interactions with individuals with mental illness.

The literature review background centers on stigma, both structural and social, then focuses on people with mental illness in the criminal justice system which considers both the prevalence, contributing factors, and police interactions and responses. Three levels of stigma—structural, social, and self-stigma have been examined amongst the

literature. Research has shown overall high rates of negative public attitudes toward people with mental illness (Angermeyer, Matschinger, & Corrigan, 2004; Angermeyer & Matschinger, 1996, 2004; Corrigan & O'Shaughnessy, 2007; Corrigan & Watson, 2002; Cotton, 2004; Kesic & Thomas, 2014; Link, 1999; Schomerus et al., 2012; Nee & Witt, 2013). In addition, high rates of negative portrayals or cases involving individuals with mental illness as been found within media sources, such as news reports (Angermeyer & Matschinger, 1996; Angermeyer & Schulze, 2001; Morgan & Jorm, 2009). Another important note would be an increase in familiarity with mental illness leads to decreased perceptions of dangerousness and a desire for social distance from people with mental illness. Angermeyer, Matschinger and Corrigan (2004) confirmed this correlational relationship between familiarity and dangerousness, as well as with social distance in their study.

Structural stigma, in other words stigma contained within laws, policies, and procedures, through mental health crises response teams can be examined through social stigma and Modified Labeling Theory. One article demonstrated this with a quote: “the policies and institutional practices we create to address social problems are critical for stigma—they can induce it or they can minimize or even block it” (Link, Castille, & Struber, 2011, p. 411). Ultimately, this quote touches on structural stigma as a root issue, which is influenced by the general public who continue to fortify such institutional reactions. As explained by Livingston, Rossiter, and Verdun-Jones (2011), if a person is labeled ‘mentally ill’ or gains a ‘forensic label’ by an institutional response, they then are stigmatized, thereby facing barriers to opportunities and community reintegration.

Research in the field of policing and mental health often refers to police as being on the frontline or acting as gatekeepers the criminal justice system and mental health resources (Hansson & Markstrom, 2014; Watson et al 2010; Livingston et al., 2014). Teplin and Pruett (1992) were the first to use the term 'streetcorner psychiatrist' in relation to police and this has been echoed throughout the literature. Research indicates that approximately 40% of individuals with mental illness have been arrested by police at some time throughout their lifetime (Brink et al., 2011, p. 24). The high prevalence rates are produced by a number of various possible deep-rooted issues. For example, social barriers ranging from homelessness, poverty, inability to access services, tolerance of individuals with mental illness, and community disorganization. Additionally, deinstitutionalization and criminalization of mental illness have been considered throughout the literature.

Ogloff and colleagues (2013) mentioned how police struggle for resources but often hold positive attitudes of people with mental illness although negative attitudes are still present. For this reason police may use their discretion to arrest in order to get treatment for the person thus leading to criminalization of mental illness. Police policy and training can be evaluated with structural stigma, as it may be present either intentionally or unintentionally. As of recent new specialized response teams for mental health crises a situation has been developed, which bridge the health care system and law enforcement. The training has appeared to help and been fairly effective, particularly for police officer attitudes. But police do not work in a vacuum and are influenced by individual factors as well as social and structural stigma and not all police officers are required to have this additional training.

From this point of reviewing the literature it is questionable as to why law enforcement is involved in mental health matters. In addition, often within the current research there is a lack of consideration of the possible effect(s) of police involvement in responding to mental health crises, such as placing or strengthen a label and stigma. Although there is vast research on police training and crisis intervention teams, a significant missing aspect of the literature would be police responses to mental illness rather than a health-focused response and the implications this has on public attitudes and stigma. This is exactly why this research study is significant and has a purpose aimed at unveiling the possible imperceptible consequence of police involvement in mental health crises.

In short, people with mental illness are disproportionately represented with regard to interactions with police officers and often the results in negative or even fatal outcomes. Due to this problem identified within research the creation of crisis intervention teams were developed to address this issue. The majority of the research has been about the program components, implementations, and positive results while hardly any studies consider the possible drawbacks of having police involvement rather than a health focused approach. Following the theoretical framework and literature review the problem statement, research question, and objectives are listed. The current study's methodology is explained, with the results and discussion section following consecutively. Following the conclusion is the appendixes, ethics approval certificate, and finally a list of references to view.

# Section 2: Theoretical Framework

**Conceptualization of Mental Illness**

It is important to note that the terminology regarding mental illness has been unclear and abiguous both in academia as well as within society at large. It is particularly important to consider the conceptualization of mental illness because the definition used can create labels and generate stigma. In short, the way individuals with mental illness are defined relate to how they are percieved, judged, treated, and the services or programs they receive. Mental illness is a difficult term to define or conceptualize because it is broad and socially constructed. Across studies, there are discrepancies with how 'mental illness' is defined and lack of clarification with how it is being conceptualized. Although the Mental Health Commission of Canada definition is open, I chose this definition because it appears adequate and the organization aims to improve the mental health system as well as change attitudes around mental health issues. As defined by Mental Health Commission of Canada, mental health problems and illness are:

> A range of patterns of behavior, thinking or emotions that bring some level of distress, suffering or impairment in areas such as school, work, social and family interactions or the ability to live independently…range from more common mental health problems and illnesses such as anxiety and depression to less common problems and illnesses such as schizophrenia and bipolar disorder. (Mental Health Commission of Canada, 2012, p. 11)

This definition was based on an attempt to define mental health problems and illness without creating labels for those persons defined as having a mental illness. Sometimes when 'mental illness' is discussed or defined, labels or stereotypes accompany the said definition. For example, the aspect of the possibility of dangerousness or threatening

(towards the individual or others) could be considered a part of a certain definition in some instances. As explained in the definition above, there is a varying array of mental health problems and illness, some common while others are less common. As pointed out in the Mental Health Commission of Canada report, this terminology can be summarized as consciously choosing to approach mental health and illness to represent a range of views and aspects. For example, even if an individual develops a mental health problem or illness, they are still able to experience good mental health regardless. Duration is also a factor to be considered, since mental health problems and illnesses can often be a single event or multiple events over a period of time (Mental Health Commission of Canada, 2012, p. 11). This appears to be an adequate definition in terms of being open to cover a wide range of aspects of 'mental illness'.

The Mental Health Mobile Crisis Team (MHMCT) is an integrated team between Capital Health and Halifax Regional Police that respond to mental health crises. The MHMCT differentiates the definition of a mental health crisis and a psychiatric emergency. A mental health crisis is defined as:

> An acute disturbance of thinking, mood, behavior or social relationship that requires an immediate intervention; which involves an element of unpredictability, usually accompanied by a lack of response to social controls; and which may be defined as a crisis by the client, the family or other community members…does not necessarily require a hospital-based assessment. (Mental Health Mobile Crisis Team, 2007, p. 1)

In contrast, a psychiatric emergency is described as a situation in which, "a person is an immediate danger to him/herself due to compromised thinking and/or judgement…requires a hospital based treatment service (Mental Health Mobile Crisis Team, 2007, p. 1). This definition appears to be quite problematic. The definition directly mentions the importance of following social controls and how in addition to a individual in distress, other people (family, community members etcetera) can also just as easily label a person as being in a 'mental health crises' therefore, having a social institution (the emergency crises team) respond. In addition, a unique considerable issue with the Mental Health Mobile Crisis Team definition would be it is too broad. Due to this issue, the definition entails that police in collaboration with mental health agencies are responding to numerous situations, many of which may not be 'mental illness' problems or not require police presence. Lastly, a critique of the definition would be the essential element of danger in the definition, as the individual in psychiatric emergency is considered an immediate danger to himself or herself.

**Theoretical Framework**

This current study will be framed by labeling theory. This theoretical perspective will be used to examine the relationship between mental illness-related stigma and police involvement in mental health crises. Labeling theory has been discussed for a long time through multiple theorists and has evolved. Herbert Blumer coined 'symbolic interactionism,' to describe how social order is constructed through interactions; therefore, shared meanings, language and symbols are important for symbolic interactionism (Farrington & Murray, 2014, p. 14). In line with the symbolic interactionism paradigm, Charles Horton Cooley used the phrase 'looking glass self' in

reference to social identity and views of individuals reflected back onto them from others (Lanier & Henry, 2010, p. 208). Labeling theories generally ask why particular individuals or groups are labeled and what are the consequences of the label. Amongst the many labeling theorists, Edwin Lemert, Howard Becker, Thomas Scheff and Erving Goffman are important figures when considering this theory. In addition to these theorists, Bruce Link's Modified Labeling Theory will be particularly useful for considering the research question.

With classical labeling theory, Lemert considered the influence of social control in the creation of laws that lead certain behaviors to be viewed as deviant. In the 1950s, Lemert defined primary deviance as temporary behavior not view as deviant by the actor and secondary deviance as the reaction to the initial deviant behavior created through labeling and stereotypes (McLaughlin & Newburn, 2010, p. 141). Primary deviance is most likely non-serious, minor behavior and does not tend to have heavy consequences on the individual's identity or social interactions. If you consider the numerous criminal laws, the majority of people have engaged in primary deviance at one point or another. Secondary deviance has more severe consequences such as stigmatization, segregation, punishment, and changes in the individual's self-identity—all due to the negative reaction to the initial primary behavior (Farrington & Murray, 2014, p. 20). Farrington and Murray (2014) discuss public reaction to social institution actions toward certain individuals or groups as a specifically important factor for labeling. For example, viewing criminal justice system or mental health sector actions, such as witness or hearing about on the news that police involuntarily hospitalizing and individual with mental illness, then labeling the individual.

Howard Becker is well known for his published work ‘Outsiders’ (1963). The focus of Becker’s work centered on how laws influence labeling and the negative consequence of the label. In terms of labeling, Becker defined deviant behavior due to the label as: “deviance is not a quality of the act the person commits but rather a consequence of the application by others of rules and sanctions to an ‘offender’” (Farrington & Murray, 2014, p. 22). Understanding the label and consequence(s) was central to his theory, rather than the common societal view of deviance as stemming from individual characteristics or qualities (Lanier & Henry, 2010, p. 211). For example, based on an individual’s behavior one could gain a label from social institutions such as being labeled deviant, criminal or an outsider as per Becker’s illustration or terminology. According to Becker’s theory, the initial labeling process requires the creation or development of laws and rules. These sets of laws and rules then can be applied to certain behaviors; thus, the creation of a label. Rule enforcers tend to be members within the criminal justice system such as police and judges. Laws and rules are not consistently applied, but rather, selectively imposed, possibly more so aimed at marginalized or minority groups. Lanier and Henry (2010) also mention Becker’s notion of the ‘master status’ where an individual is publically labeled and then becomes vulnerable to experience negative consequences associated with their deviant label.

In addition to Lemert and Becker, Erving Goffman made important contributions within labeling theory in terms of stigma, total institutions and relation of this theory to persons with mental illness. For Goffman, people construct categories as they relate to others during social interactions, some categories may be stigmatizing. Once labeled, the person is treated according to their assigned identity (Lanier & Henry, 2010, p. 213).

Through his research in a mental health hospital, Goffman observed stereotypes, discrimination, rejection, discrediting and hostility between staff and inmates who were persons with mental illness. He stated when a person is released from a total institution, their social status would never return to the previous state before institutionalization, which Goffman referred to as stigmatization (Pescosolido, 2013, p. 1). Goffman set the foundation for stigma being a social phenomenon located within and produced by interactions.

As mentioned by Peggy Thoits' (2011), according to Scheff, once a person is labeled, for example with a mental illness, a stereotype is created and remains in other people's perceptions ultimately influencing stigma and perpetuating the label. Thomas Scheff's claimed that mental illness is entirely a social construct. His theory stated that those who had a "residual rule violation" are stereotyped and negatively labeled, which limits the person to only take on the role as a individual with mental illness (Farrington & Murray, 2014, p. 34). According to Scheff's theory, the identity as 'a person with mental illness' could potentially be a role socialized from a young age and, if accepted, is considered conformity to the socially constituted label. In contrast to Scheff's idea of social labels generating mental illness, Link and colleagues (1989) developed the Modified Labeling Theory to explain how the labeling process can stabilize and deepen deviance and marginalization, rather than cause it.

Modified Labeling Theory expanded the labeling process to five stages (Farrington & Murray, 2014, p. 35). The first stage involves the socialization of beliefs that people with mental illness will be discriminated against and devalued. The stronger this belief, the more a person with mental illness will expect to be discriminated or

devalued. The same occurs with community members; those who hold said strong negative beliefs, are more likely to actually alienate or reject persons with mental illness. The second stage entails social institutions, such as treatment facilities, that apply a mental illness diagnosis and an official label. The third stage consists of how the individual with mental illness responds to the official label applied. Farrington and Murray (2014) explain various possible responses: secrecy, withdrawal, and education. Secrecy would involve, for example, a person refusing to disclose to family, friends, co-workers, and employers that they are receiving mental health treatment. Withdrawal occurs when a person with mental illness becomes confined by their limited social interaction, even with those who accept their mental illness label. Lastly, education of other people would involve sharing information in order to gain understanding and to reduce stigma. The fourth stage involves the negative consequence that a label can produce for the person with mental illness. A few repercussions could include: lowered self-esteem, reduced social networks, and disempowerment (Farrington & Murray, 2014, p. 35). The fifth and final stage involves the vulnerability that is created by labeling and stigma, which causes people with mental illness to fall victim to repeat episodes of mental illness. Therefore, with Modified Labeling Theory, the five stages often act in a circular pattern or cycle for individuals with mental illness.

As shown within Link and colleagues' Modified Labeling Theory, stigma can have detrimental effects on people with mental illness. In addition, the stigma created by labels influences the community in terms of beliefs, support, acceptance, policy, programs, treatment, community cohesion and reintegration. Link's Modified Labeling Theory is applicable to contemporary issues; particularly for answering the question of

whether social stigma is negatively impacted by police presence in mental illness crisis situations.

This current study precisely focuses on the first stage, the socialization of beliefs that people with mental illness will be discriminated against and devalued, of Modified Labeling Theory. This part of Modified Labeling Theory will aid in a better understanding of how social stigma, being community public attitudes, reinforce institutional responses such as structural stigma through mental health crises response teams. One article demonstrated this with a quote: "the policies and institutional practices we create to address social problems are critical for stigma—they can induce it or they can minimize or even block it" (Link, Castille, & Struber, 2011, p. 411). Ultimately, this quote touches on structural stigma as a root issue, which is influenced by the general public who continue to fortify such institutional reactions. As explained by Livingston et al. (2011), if a person is labeled 'mentally ill' or gains a 'forensic label' by an institutional response, they then are stigmatized, thereby facing barriers to opportunities and community reintegration. Due to the label 'mentally ill' and effects mentioned above the labeled individual may be viewed as dangerous or criminal. Modified labeling theory helps with understanding the causal relationship between social conceptions of mental illness and the ensuing institutional response.

Stigma can broadly been explained as "a mark of shame, disgrace or disapproval which results in an individual being rejected, discriminated against, and excluded from participating in a number of different areas of society" (Jorm, Reavley &Ross, 2012, p. 1029). Link and Phelan (2013) conceptualize stigma through five components which include: 1) distinguishing and label differences, 2) Association of differences with

negative attributes or undesirable characteristics, 3) Separation of ‘us’ versus ‘them’ notion, 4) Emotional responses from the standpoint of a stigmatizer, such as pity, fear, irritation, anger, and anxiety, 5) Status loss and discrimination, and 6) a dependence of stigma on power. The first component accounts for the existence of individual differences but noted that certain labeled differences, mental illness for example, are considered too contrasting for what is ‘socially relevant’. The second component is where the label is connected to negatives stereotypes. This third component occurs when the label signifies a differentiation or estrangement between oneself and the group labeled (e.g. people with mental illness). The fourth component considers the importance of emotions, as emotions not only influence how those stigmatized feel but also can influence community members’ actions towards the stigmatized individual. The fifth component on status loss and discrimination is a devaluing process when the labeled individual(s) is connected to abhorrent characteristics. The last component describes how stigma relies on social, economical, cultural, and political power. Additionally, within these social aspects there are low-power (e.g. other psychiatric patients) and high-power groups (e.g. authorities within health care system) hold certain perceptions and influence the label in various ways (Link & Phelan, 2013, p. 531). These components allow for the incorporation of various possible connective aspects such as the relationship between stigma and labeling, discrimination, and stereotyping.

Researchers have investigated the existence of stigma on three levels: self, social, and structural (Livingston, 2013, p. 7). Self-stigma occurs on an individual level and encompasses the experiences, emotions and perceptions of a stigmatized individual. For example, a stigmatized individual may internalize harmful stereotypes and then suffer

from low self-esteem and feelings of worthlessness or alienation (Livingston, Rossiter, & Verdun-Jones, 2011, p.115; Angermeyer, Matschinger, Link, & Schomerus, 2014). Social stigma is concentrated at the public or community level. It is a set of collective beliefs of the majority, or powerful communal influences. Social stigma can be defined as an encompassing judgment of certain traits that are inconsistent with the community norms (Livingston, 2013, p. 7). For instance, public attitudes around desire for social distance, perceived dangerousness of people with mental illness, or preferences to use coercive measures against people with mental illnesses are examples of social stigma. Social stigma is comprised by public attitudes that can, through various social processes, create or perpetuate structural stigma. Social stigma would be connected to structural stigma via the development and enactment of laws or policies to respond to dominant beliefs about how to address social problems or to control particular social groups.

The third level of stigma, structural stigma, concentrates on the institutional arrangement of society. Structural stigma can be defined as stigma engrained within law, regulations, policy, and procedures of private and public institutions causing constraints on rights, treatment, programs and other opportunities for people with mental illness (Livingston, 2013, p. 9). There are two types of structural stigma, intentional and unintentional. Intentional structural stigma would be planned, purposeful, hidden, premeditated inequality within rules, laws, policies and procedures. Unintentional structural stigma creates unfair treatment through accidental or unexpected policy, law or procedures. Examples provided by Livingston (2013) of intentional structural stigma would refusing health care to a person because they have a mental illness (p. 9) and an example of unintentional would be a policy such as ‘tough on crime’ as those with mental

illness are disproportionately represented (p. 9). Structural stigma can also involve the way in which societal institutions and their representatives, such as police officers or mental health service providers, respond to people with mental illness.

# Section 3: Literature Review

## Literature Review

In this literature review, I will provide a description of empirical literature related to social stigma, structural stigma, involvement of people with mental illnesses in the criminal justice system specifically, with police interactions, and mental health response models. Commonly, in research on social stigma negative results are often discovered. Social stigma is an important concept for this current study and in relation to labeling theory. Research on social stigma and the influence of the news media will be discussed. Dangerousness, social distance, and coercion are three common themes under social stigma and will be consecutively discussed and reviewed in further detail. Structural stigma is another concept related to social stigma, labeling, and policing. Research in the area of structural stigma will be highlighted followed by a section on the prevalence of persons with mental illness interaction with the police and contributing factors of overrepresentation throughout the literature is highlighted. Finally the issue and literature on police interactions with individuals with mental illness and mental health response models will be reviewed.

### Social Stigma Research

Research has shown overall high rates of negative public attitudes toward people with mental illness (Angermeyer, Matschinger, & Corrigan, 2004; Angermeyer & Matschinger, 1996, 2004; Corrigan & O'Shaughnessy, 2007; Corrigan & Watson, 2002; Cotton, 2004; Kesic & Thomas, 2014; Link, 1999; Schomerus et al., 2012; Nee & Witt, 2013). In addition, high rates of negative portrayals or cases involving individuals with mental illness has been found within media sources, such as news reports (Angermeyer & Matschinger, 1996; Angermeyer & Schulze, 2001; Morgan & Jorm, 2009). If a person with mental illness is labeled by the criminal justice system, the news media, or the

health care system, the label could contribute to the strengthening negative perceptions. If an institution, such as a psychiatric facility, officially labels an individual they could appear more dangerous, violent or criminal in the eyes of the public, even though this stereotype may not be true. This exemplifies how stigma, particularly structural and social stigma, encompasses labeling and discrimination towards devaluing individual(s).

Furthermore, news media often present or places labels on individuals, which in turn influence the community members viewing the news stories. Another illustration of news media portraying dangerousness would be a study that discovered after a year and a half of news media coverage of a specific violent attack perpetrated by a individual with schizophrenia, 83.2% of people recalled the offender had a mental illness (Angermeyer & Matschinger, 1996, p. 1727). Another evaluation of an Australian newspaper found the most common stories of police interaction with people who have mental illness was in connection to violence or police use for in a threatening situation (Kesic & Thomas, 2014, p. 410).

Morgan and Jorm (2009) mentioned how news from all over the world often portrays negative imagery of people with mental illness as dangerous, criminal, vulnerable and unpredictable. Also discussed was the fact that media is capable of worsening attitudes on top of reinforcing stereotypes. Corrigan and Watson (2002) found social stigma is widely supported in Westernized areas; while Jorm and Reavley (2012) came to a similar conclusion of high levels of dangerousness perceptions of individuals with mental illness in America compared to other Western countries. With media so important in today's society Slate, Buffington-Vollum, and Johnson (2013) make the point the predominant depiction is of persons with mental illness acting violently; the

public never hears stories about people with mental illness who are doing well or going to work.

When considering social stigma and mental illness, the theme of dangerousness is important to examine, as it is a prominent stereotype faced by individuals with mental illness. In addition, an example of further research conducted on social sigma would be a public survey on the comparison between drugs or alcohol and mental illness. In a General Social Survey, although alcohol dependence and cocaine use were the most associated with violence, 61% of respondents mentioned a higher possibility of violence associated with those diagnosed with schizophrenia (Link et. al., 1999, p. 1332). When discussing how attitudes have not improved over time, Cotton (2004) referenced numerous studies that showed greater public fear concerning the dangerousness posed by people with mental illness in the 1990s than decades before (p. 137). Angermeyer and Matschinger (2004) found the public attitudes in Germany had worsened between 1991 and 2001.

In addition to dangerousness, social distance is another variable that is commonly studied in relation to public attitudes. Social distance refers to a desire for separation or a division from people with mental illness. For example, individuals may not want to be neighbors or work with a person with mental illness. Unfortunately, high levels of social distance towards people with mental illness are still prevalent amongst the general public. Social distance can be thought of with the common phrase ‘not in my backyard’ which is a community reaction that causes resistance, alienation rather than reintegration, and barriers for those with mental illness (Link, Phelan, Bresnahan, Stueve & Pescosolido, 1999, p. 1328). A meta-analysis conducted on literature in this field demonstrated most

studies on social stigma that used a social distance scale have found discrimination and rejection of persons with mental illness (Schomerus et al., 2012).

The third and final theme under social stigma is the acceptance of coercion for people with mental illness. Part of social stigma and discrimination is the public belief that there needs to be an institutional response to mental health crises with the use of coercion (Corrigan & O'Shaughnessy, 2007, p. 91). Coercion can be defined as forced service use and compliance involving mandatory treatment or hospitalization against a person's will. Use of force still occurs and is one of the harms associated with policing minority groups and is a possible negative consequence of social stigma. If a police officer holds pre-existing perceptions that individuals with mental illness are dangerous then they may be at a greater likelihood of using force (Coleman & Cotton, 2014, p. 64).

Two types of coercion identified by Pescosolido, Bernice, Gardner, Brooks and Lubell (1998) are legal coercion and extra-legal coercion. Legal coercion involves formal measures such as court orders or enforced by police officers, while extra-legal coercion would include pressure from family members or friends for the person with mental illness to receive treatment. One study showed that 45.9% of participants with mental illness indicated they received treatment via their own decision, while 22.9% actively resisted a push for treatment (Pescosolido et al., 1998, p. 280). Public views of dangerousness or criminality in regards to persons with mental illness influence the public's belief about the use or need for coercion. One study examined the extent of public willingness to advocate coercive measures. It was found that 78.1% of the participants agreed the for the need of forced coercion if the individual with mental illness were a danger to themselves, while 82.8% of participants agreed to coercion if the individual was a threat to others

(Pescosolido et al., 1999, p. 1342). The topic of coercion in addition to public attitudes can be connected to structural stigma, such as within the criminal justice system in policing procedures or health care policies.

**Structural Stigma Research**

As an example of the influence of public attitudes on structural stigma, a compelling study by Angermeyer, Matschinger, Link and Schomerus (2014) administered a survey in 2001 and 2011 that asked community members to choose three health conditions in which medical funding should be cut. The options included medical conditions (i.e., cancer, cardiovascular disease, diabetes, rheumatism, AIDS) and mental health conditions (i.e., Alzheimer's, schizophrenia, depression, alcohol dependence). At both points in time, community members were more supporting of cutting funding for mental health conditions compared to physical health conditions. This study sheds light on the connection between public attitudes and social structures (e.g., healthcare funding) affecting people with mental illness. Furthermore, research suggests that social institutions can influence and reinforce public attitudes. For instance, a study by Phelan and Link (1998) tested how public attitude about mental illness are shaped by the dangerousness criteria contained involuntary commitment legislation in the US. They found that, coinciding with an increased focus on issues of dangerousness within involuntary commitment legislation between 1950 and 1996, there was an increased reference to violence when members of the US public described people with mental illness (Phelan & Link, 1998, p. 10).

## People with Mental Illness and the Police

### Prevalence

People with mental illness are overrepresented in the criminal justice system, both within institutions and interactions with police officers (Teplin, 1992; Krishan et al., 2014; Morrow and Weisser, 2012; Redlich et al., 2010; Cotton, 2004). It is estimated police aided in roughly 30% of transport or referral to health care services involving people with mental illness (Brink et. al., 2011, p. 26). People with mental illness often face social and structural barriers that not only affect their health, but also contact with the criminal justice system, including frequent contact with police officers. Brink et al. (2011) conducted an in depth literature review and found that 2 in 5 interactions between police and individuals with mental illness were unrelated to criminal acts (p. 31), a quarter of interactions were initiated by police officers (p. 32), and 1 out of 7 interactions will consequently ended with the individual with mental illness being arrested (p. 33). It is clear an excessive amount of individuals with mental illness face numerous interactions with the police.

Run-ins with police officers or the court systems can lead to labeling or stigmatization. It is known that within correction facilities there are limited services to help individuals with mental illness or even worsens mental health (Langille, 2014). With such high proportions of individuals with mental illness overrepresented within the criminal justice system, the questioned asked is why? Interestingly, the president of Mental Health Commission of Canada has stated: “The bottom line is that we need to stop viewing this as a policing problem or mental health problem—and start seeing it for

what it is: a societal problem" (Langille, 2014). This speaks to the fact that the problem is engraved within societal institutions.

**Contributing Factors**

Multiple complicated factors contribute to both the overrepresentation of individuals with mental illness in the criminal justice system as well as stigmatization. A review of the literature has suggested multiple major themes influencing the overrepresentation of persons with mental illness within interactions with police officers. Often cited as contributing factors are social and structural barriers, such as: homelessness, poverty, inability to access services, tolerance of persons with mental illness, and community disorganization.

Deinstitutionalization is also a reason frequently discussed. Deinstitutionalization is the push away from total institutions, such as psychiatric hospitals, towards reintegration and community care which was occurring by 1965—a time when arrest rates of persons with mental illness started to increase (Patch & Arrigo, 1999, p. 25). The reasons for increase encounters between police and individuals with mental illness after deinstitutionalization are not quite clear. However, it stated that the increased presence of people with mental illness within the community there would generally produce greater contact with police. In addition, research has shown individuals with mental illness are more likely to be victimized and vulnerable (Cotton, 2004, p. 135). Deinstitutionalization also led to an increase in criminalization of mental illness.

Criminalization is another aspect to consider when assessing contributing factors. Criminalization of mental illness means shifting persons with mental illness into the criminal justice system for reasons other than increased criminality, while moving them

away from treatment or mental health programs (Stuart, Florez, & Sartorius, 2012). For instance, as described by Cotton (2004), police may decide to criminalize situations involving a persons with mental illness who is not acting criminally, which occurs with police officers who would arrest a person with mental illness in the hopes they will better receive mental health services. Slate, Buffington-Vollum, and Johnson (2013) use the term 'mercy bookings' in reference to an arrest may appear more beneficial than the alterative mental health care resources for the individual with mental illness.

Lastly, aspects of social stigma and structural stigma, such as within police organizations, have been considered strong contributing factors plus can be connected to the prevalence of interactions between people with mental illness and the police. Interactions between persons with mental illness and police officers are often impacted by influential factors, such as police discrimination and the actions of the individuals with mental illness which result in an influx of police attention (Kesic & Thomas, 2014, p. 410). Social stigma, particularly perceptions of dangerousness, social distance, and coercion may influence community members to turn to police during a mental health crisis. Secondly, social stigma can influence the actions of individual police officers (Coleman & Cotton, 2014, p. 57). For instance, police officers who hold negative stereotypes about mental illness are at an increase risk of using coercive methods (e.g., mandatory hospitalization) and force when responding to situations involving individuals with mental illness (Coleman & Cotton, 2014, p. 58).

Research in the field of policing and mental health often refers to police as being on the frontline or acting as gatekeepers to the criminal justice system and mental health treatment (Hansson & Markstrom, 2014; Watson et al 2010; Livingston et al., 2014).

Teplin and Pruett (1992) were the first to use the term ‘streetcorner psychiatrist’ in relation to police and this has been echoed throughout the literature. Compton et al. (2011) bring to light the lack of questioning or focus on why persons with mental illness are overrepresented within the criminal justice system and experience frequent contact with police. Research has comprehensively shown roughly 40% of people with mental illness have been arrested by police at some point (Brink et al., 2011, p. 24). From here it is questionable as to why law enforcement is involved in mental health matters.

The reason it is questionable is due to the prevalence of individuals within the criminal justice system, interactions with police in particular. It is well documented that there are various consequences and negative outcomes, such as labeling, associated with high frequency interactions between police and individuals with mental illness. One more consideration would be that if the majority of individuals with mental illness are harmless and a mental health crisis could happen to anyone for a stressful event, then why are police present in crises situations.

From a labeling perspective, there may be unintended effects of having police involved in responding to mental health crises. For instance, it could possibly strengthen the stigma that is experienced by people with mental illnesses. One study that examined interactions between police and persons with mental illness found that persons with mental illness feared and felt vulnerable in regards to the possibility of police brutality or being wrongly arrested (Watson, Angell, Morabito & Robinson, 2008, p. 452). This is an example of how interactions with police may be viewed negatively from the perspective of individuals with mental illness. It has been found that 76% of people with mental illness respect the police, but 33% do not trust the police and 44% reported non-

respectful treatment (Brink et al., 2011, p. 42). It is important to be aware police perceptions of interactions with mentally ill persons can truly influence the outcome, as police have a large amount of discretion. Although there is vast research on police training and crisis intervention teams, a missing aspect of the literature is how police responses to mental illness influences stigma.

**Police/Mental Health Response Models**

Police work is based on a paramilitary style with strong authoritative and forceful approaches, which influence police perceptions and actions. Traditional policing tactics are not beneficial in certain situations and may escalate the interactions between police and individuals with mental illness; such interactions can occasionally lead to tragedy (Slate, Buffington-Vollum, & Johnson, 2013, p. 181). Interestingly, Cotton (2004) found high characteristics of benevolence compared to authoritarianism suggesting police have become more positive but also found a perceived pressure for the police to act or do something in mental health situations. This is a conflicting perception and can be frustrating if there are not many resources or options for people with mental illness. Ogloff and colleagues (2013) mentioned how police struggle for resources but often hold positive attitudes of individuals with mental illness although negative attitudes are still present. For this reason police may use their discretion to arrest in order to get treatment for the person—hence, the criminalization of mental illness. This was demonstrated in Cotton and Coleman's (2010) article as they found that once a person with mental illness is charged, they are more likely to spend time in custody. There is a strong general belief in the literature that police attitudes are related or effects police behavior.

Police training influences not only the police officer's behavior and the outcome but also the police officer's perceptions and understanding of when to use force. Training and protocols for police officers has the potential to contain intentional or unintentional structural stigma. In relation to responding to situations deemed mental health crises, recently police have started working in a team with health care professionals to focus on de-escalation, recovery, treatment and diversion from the criminal justice system. Connected to the concept of criminalization, police have the discretion to refer or transfer a person to treatment rather than arrest. Compton, Bahora, Watson, and Oliva (2008) state that if there are no available resource options then mental health crisis intervention teams are not able to divert the individual with mental illness from the criminal justice system. If there is a lack of resources then there will be higher chances of criminalization in order for to police to act in a situation. The need for better and specialized police training came up in research as being an important improvement in relation to handling situations involving people with mental illness. Borum, Deane, Steadman and Morrissey (1998) describe three programs: police based specialized police response, police based specialized mental health response, and mental health based specialized mental health response. Crisis intervention teams are interdisciplinary in nature comprised of police and various health care workers. Various programs adopted in areas could be any of the three listed or a hybrid of these programs.

The first is police based specialized response consists of police officers who have received specialized mental health training and act as a bridge between law enforcement and the formal mental health system. An example would be the original Memphis Crisis Intervention Team or the Toronto Mobile Crisis Intervention Team. The Memphis model

of crisis intervention team is one of the most popular programs. Police on the Crisis Intervention Team receive an extra training course of 40 hours conducted of a few days and is assumed to enhance police officers' knowledge, skills, understanding, increase confidence, use of force and interactions (Compton, Bahora, Watson & Oliva, 2008, p. 47). Dr. Randolph Dupont and Major Sam Conchran at the University of Tennessee created the Memphis model in 1988 after a shooting incident involving a person with a mental illness. The idea behind the initial program creation was to bridge a connection between law enforcement, mental health professionals, and advocates to prevent such terrible instances. The goal is to reduce arrests of persons with mental illness and rather, divert them to community services. At the center of this response team is the education for providing further knowledge about mental illness to police officers so they gain a better understanding as well as compassion. Police officers interested in the training volunteer to be part of the program and once trained are called upon for situation when they are needed (Bonfine, Ritter, & Munetz, 2014, p. 341).

With the Memphis model after the training, police officers still are on their own and have discretion plus individual attitudes influencing their actions. The training has appeared to help and been fairly effective, particularly for police officer attitudes, confidences, preparedness and safety (Bonfine, Ritter, & Munetz, 2014, p. 347). But police officers do not work in a vacuum; they are influenced by individual factors as well as impacted by social and structural stigma. Additionally, it is important to note that not all police officers are required to have this supplementary crisis intervention team-training course. The research centered on the Memphis Crisis Intervention Training is on the outcomes at the police officers level and there is a need for more research on the

outcomes or perspectives of the public and persons with mental illness (Compton, Bahora, Watson & Oliva, 2008, p. 53).

Police officers who are trained in crisis intervention teams have been found to not use force in escalated situations compared to non-crisis intervention trained police officers (Bonfine, Ritter, & Munetz, 2014, p. 343). Crisis Intervention Training does have a beneficial influence as it has been found police who do have such training use decreased amount of physical force compared to their non-CIT trained co-workers (Compton et al., 2011, p. 742). Research on use of force is limited as it is based on documents or self report and is difficult to measure, particularly in connection with stigma and training. In the closing of Compton et al. (2011) article is the mention of further research to consider the high frequencies of police interaction with mental illness. The reason of such high interaction frequency appears to be important and has yet to be adequately studied. Additionally, among the research literature public reaction to police measures, such as use of force, directed at individuals with mental illness have not been examined.

The second program is police based specialized mental health response consists of mental health professionals hired by police departments to provide support such as over the telephone or attending situational calls with police officers. Borum, Williams, Deane, Steadman and Morrissey (1989) provide the example of Birmingham Community Service Officers. This model consists of hired, trained mental health professionals who work directly with police officers in police departments and on calls, as well as aiding via telephone (Borum, Williams, Deane, Steadman, & Morrissey, 1989, p. 395). The goal of this response program was to approach it from a ‘problem solving’ angle and utilize

community partnerships (Borum, Williams, Deane, Steadman, & Morrissey, 1989, p. 395).

The third model is the mental health based specialized mental health response which encompasses the traditional model of the partnership between police and mobile mental health crisis teams grounded in the community and separate from police organizations. This model is different in the aspect that it is a mobile team organized by the health care sector that communicates with the police department but works separately (Borum, Williams, Deane, Steadman, & Morrissey, 1989, p. 395). The police are not an active or consistent role in this crisis model although, will be called if their assistance is needed. This means that the response team is primarily community based which translates to community programs or mental health trained individuals as well as one police officer. The police officer usually stands back, unless there is a problem or threat, while the community services attempt to help the individual in the crises situation.

In Halifax, a Mental Health Mobile Crisis Team has been established to respond to mental health crises. It consists of mental health nurses and a police officer in plain clothing. The Mental Health Mobile Crisis team response to crises locally with the police officer present on the team or they can work over the phone providing advice anywhere in Nova Scotia to individuals in crisis or other police officers (Mental Health Mobile Crisis Team, 2007). The Halifax Mental Health Mobile Crisis Team is best explained as a hybrid of models two and three because, although unlike the tradition third model a police officer is always present on the crisis team but it is predominantly lead by the mental health agency.

Due to the nature of their work, in addition to other personal and societal contributing factors, police officers have continual numerous interactions with people with mental illness. Individual personal experience and social stigma also influences police officers perceptions and actions toward people with mental illness. These interactions could have many negative consequences for the individuals with mental illness such as labeling, use of force resulting in harm or fatalities. Based on the negative consequences of interactions with persons with mental illness specialized crisis intervention teams were established to address this issue. Research on the crisis intervention teams are limited and focused on the positive benefits, very few studies examine the possible drawbacks of the program.

# Section 4: Problem Statement, Research Question & Research Objectives

## Problem Statement

Persons with mental illness are disproportionately present within the criminal justice system and commonly interact with police officer (Teplin & Pruett, 1992; Krishan et al., 2014; Morrow and Weisser, 2012; Redlich et al., 2010; Cotton, 2004). It is estimated that 30% of the time police involvement with people with mental illness entails transport or referrals to services (Brinks et. al., 2011, 26). Also noteworthy is that 1 out of 7 interactions will consequently ended with an individual with mental illness being arrested (Brinks et. al., 2011, p. 33). Negative outcomes can result from frequent interactions between police officers and persons with mental illness. For instance, if individuals with mental illness are swept up into the criminal justice system and have numerous interacts with police officers the negative consequences, such as death or serious injury could occur. Treating individuals with mental illness as criminal can result in negative effects of their health, liberty, and wellbeing (Brink et al, 2011, p. 11). Numerous approaches have been designed to address the problem of police officers use of violence and force against persons with mental illness. Specifically the creation of crisis intervention teams began to address fatalities of individuals with mental illness. The goal was that bridging a partnership between police officers and mental health professionals would decrease both the prevalence of individuals with mental illness within the criminal justice system and the harms associated with interacting with the police.

The majority of research has focused on the success or positive effects of these models; however, from a labeling theory perspective, negative consequences could be expected from these models. One of the possible negative consequences could be the

aggravation of mental illness-related social stigma. This would occur by the reinforcement of the relationship between mental illness and crime, dangerousness, and coercive state intervention. In terms of such negative stereotypes about mental illness, social stigma configures societal responses to people with mental illness, which in turn continue to influence social stigma. Although there is vast research on police training and crisis intervention teams, a significant missing aspect of the literature is concerning a police response to mental illness crises rather than a health-focused response and the potential implications this has on social stigma.

## Research Question

This study's research question follows as: how does having a specialized police response team for mental health crises influence the public's attitudes toward people with mental illness? This study will explore the effects of how intertwining police and mental health services in the response to mental health crises contributes to the stigmatization of people with mental illness.

## Research Objectives

This current study seeks to examine the degree to which police presence in forma responses to mental health crises influences social stigma. In particular, the study examines whether the involvement of police officers in responding to mental health crises affects the publics desire for social distance from people with mental illness and their endorsement of stereotypes about mental illness, such as the perceived level of dangerousness posed by people with mental illness. The specific hypotheses are as follows: (a) People who are exposed to a hypothetical story about a mental health crisis in which the police responded will express a greater desire for social distance from persons

with mental illness, compared to people exposed to a story in which only mental health service providers responded to a mental health crisis; and (b) People who are exposed to a hypothetical story about a mental health crisis in which the police responded will endorse more negative stereotypes about mental illness, such as dangerousness or need for coercion, compared to people exposed to a story in which only mental health service providers responded to a mental health crisis.

# Section 5: Research Methodology

## Methodology

### Participants

The sample for the current study was comprised of undergraduate students. Inclusion criteria for the participants included the following: 19 years of age or older, current and actively enrolled undergraduate students at Saint Mary's University, ability to speak and read English for the purpose of completing the questionnaire, and enrolled in the selected criminology/sociology classes during the winter (January-April 2015) semester. All participants were recruited from two classes being instructed by Dr. Jamie Livingston, and a bonus point was given toward the students' final grade as an incentive to complete the questionnaire. The sampling method used was convenient sampling, which consists of participant selection based on the level of ease for accessibility and practicality purposes (Caulfield & Hill, 2014, 128). In total, 73 participants were recruited for this study.

### Materials

The study conducted used self-report as the mechanism for collecting data through the use of a questionnaire containing 42 questions. The questionnaire took approximately 25-30 minutes to complete. There were 41 closed-ended questions and one open-ended question at the end of the questionnaire. The questionnaire (see Appendix E) contained established scales that measured different dimensions of stigma. The single open-ended question asked, 'is there anything in the vignette that you would change in order to improve the response to John's situation?', allowing any addition comments from the participants. Additionally, the questionnaire asked participants about their

gender, age, number of years of university education, majors, and level of familiarity with mental illness. Finally, the study included two vignettes, which are described below.

**Familiarity Scale**

The familiarity scale was based on Angermeyer, Matthias, Matchinger, & Corrigan (2004) study, which rates the participants' level of personal experience with mental illness or familiarity of persons with mental illness. This scale inquires if the participants themselves or anyone they know has experience with mental illness or undergone psychiatric treatment. There are four hierarchical categories for this scale: no experience with mental illness, knows friends/co-workers/neighbours with mental illness, knows family member(s) with mental illness, or have had individual personal experiences with mental illness. The purpose of gathering this particular data of familiarity is so that the two groups could be ensured to be equal with respect to level of familiarity, which is known to be correlated with social stigma.

**Social Distance Scale**

The second scale, originally used by Reavley and Jorm (2011), is designed to measure desire for social distance. Social distance can be defined as and individual's aversion to developing and engaging in social relationships or interactions with a stigmatized individual; in this case, persons with mental illness (Angermeyer, Matschinger, Link, & Schomeris, 2014, p. 63). If an individual holds stigmatizing beliefs about persons with mental illness, particularly of fear or danger, there can be a desire for social distance. The modified version of the social distance scale, developed by Reavley and Jorm (2011) was used, as the situations were relatable to university students. This scale used a five-point Likert scale, ranging from 'strongly disagree' (1) to 'strongly

agree' (5). These following five social distance were asked: I would go out with John on the weekend, I would work on a project with John, I would invite John to my house, I would develop a close friendship with John, and I would go to John's house. The social distance scale was calculated by running the compare means function in SPSS to find the social distance average mean for both the non-police vignette group and the police vignette group. The average mean for each group allowed a comparison, where the higher the score meant the greater the level of stigma or wish for social distance.

**Attribution Questionnaire Scale**

The third measure is designed to assess attributions associated with mental illness. The Attribution Questionnaire, developed by Corrigan (2012), assesses the degree to which respondents endorsed nine common stereotypes about mental illness, including blame, anger, pity, help, dangerousness, fear, avoidance, segregation, and coercion (Corrigan, 2012, p. 9). The stereotype 'blame' has to do with how much perceived control or blame for the mental illness is placed on the individual with mental illness. 'Anger' relates to how agitated or irritated participants are because people are to blame for their mental illnesses. 'Pity' entails the level of sympathy for individuals with mental illness. 'Help' concerns the willingness to assist an individual with mental illness. The 'dangerousness' stereotype is that individuals with mental illness are not safe while the 'fear' stereotype is a dismay or frightened feeling that an individual with mental illness are dangerous. The 'avoidance' stereotype is similar to social distance and it consists of keep away from individuals with mental illness. 'Segregation' is the push of individuals with mental illness out of the community into an institution. Lastly, the stereotype of

'coercion' means forcing individuals with mental illness to take medication or attend certain treatments.

The Attribution Questionnaire contained 27 questions, broken down into three questions per each of the nine stereotypes about mental illness. The Attribution Questionnaire used a nine-point Likert scale, ranging from not at all (1) to very much/absolutely (9). The higher the scores on the nine stereotypes of mental illness, the more the stereotypes were endorsed by participants. The Attribution Questionnaire score was calculated by using the compare means function in SPSS in order to find the average mean for the Attribution Questionnaire for each group (Non-Police vignette and Police vignette). The average mean for each group was then contrasted. The higher the number of the average mean determined a greater level of stigma.

**Vignettes**

To elicit responses from participants, vignettes were used. Vignettes can be described as: "a short summary of a scenario that is designed in such a way as to invite comment…often followed by some questions designed to draw out the participants' views" (Caulfield & Hill, 2014, 116). Two vignettes depicted the same mental health crisis but varied as to whether the police were involved in the crisis response. Vignette A described a mental health crisis without police involvement and Vignette B illustrated a mental health crisis with police involvement (See Appendix C). In the vignettes, the character (John), depicted behavior and particular situation was based on a vignette from a previous study by Jorm and Wright (2008). The second part of the vignette detailing the response to John's mental health crisis was based off similar aspects of the Halifax Mental Health Mobile Crisis Team.

**Procedures**

I approached the two criminology and sociology classes 30 minutes before the schedule class time ended to inform the potential participants about the study. Once the professor left class, for reasons of anonymity, the recruitment script was read and any questions answered. Following this, two copies of consent forms were then distributed so those students who choose to participate in the study could carefully read and sign the consent forms. Once the students signed and submitted the consent forms, the questionnaires were passed out and students began to read the vignette then fill out. Questionnaires were distributed to the participants with half receiving the package that contained a questionnaire with Vignette A (Non-Police) and the other half received the package that contained a questionnaire with Vignette B (Police). An ABAB approach was used to randomize participants into the two study groups (Police Vignette or Non-Police Vignette). Students were instructed to read the vignettes and then fill out the questionnaire. Anonymity was maintained by asking participants to not write personal information (name or student number) on the questionnaires.

The consent forms and questionnaires were kept separated in two different file folders and were store safely in locked filing cabinet in the faculty supervisor's office in the Department of Sociology and Criminology. The unidentifiable data was entered into SPSS (Statistical Package for the Social Sciences) and stored on the secure, password-protected network of Saint Mary's University. The study procedures were reviewed and approved by the Saint Mary's University Research Ethics Board.

**Data Analysis**

Descriptive statistics and frequencies were used to describe the sample, including the demographics, Familiarity Scale, Social Distance Scale, and Attribution Questionnaire scale. Chi-square tests were run to compare the non-police vignette group and police vignette group on socio-demographic characteristics including gender, number of years of university education, major(s), and level of familiarity with mental illness. An independent sample *t*-test was performed to compare the two groups on age. Independent samples *t*-test were used to compare the average scores on the social stigma scales, including the nine subscales of the Attribution Questionnaire and the total Social Distance Scale, between the two groups (Police and Non-Police Vignettes). Further exploratory analysis was conducted to examine relationships between participant characteristics and stigma. Independent samples *t*-tests were used to analyze the relationship between gender and scores on the Attribution Questionnaire and Social Distance Scale. Additionally, the Pearson product-moment correlation coefficient was calculated to explore the relationships between two participant characteristics (age and level of familiarity with mental illness) and scores on the Attribution Questionnaire and Social Distance Scale.

# Section 6: Results

# Results

## Participant Characteristics

Presented in Table 1 (See Appendix F) are the percentage or average, chi-square test results and independent samples *t*-test results on various participant characteristics. Overall, the two study groups (non-police and police) can be described as a statistically similar ($p > 0.05$) on selected socio-demographics, including gender, age, education level, major discipline, and level of familiarity with mental illness. Survey respondents were, on average 22 years of age ($n = 73$, $SD = 3.56$). Almost two-thirds of the sample ($n = 24$, 64.9%) were women. Survey respondents tended to be in either second ($n = 22$, 30.4%), third ($n = 26$, 35.6%) or fourth ($n = 18$, 24.7%) year of university. They were predominantly majoring in Criminology ($n = 52$, 71.2%) or Sociology ($n = 26$, 34.6%). Interestingly, a high number of participants had some type of familiarity or experience with mental illness, with only 8.2% ($n = 6$) having no experience with mental illness. The greatest level of familiarity for about a third of participants ($n = 26$, 35.6%) was in relation to knowing someone, such as a friend, co-worker, or neighbor, who had mental illness. More than one-fifth ($n = 16$, 21.9%) indicated that they had experience with family member(s) with mental illness, while 34.3% ($n = 25$) reported personally having experience with mental illness which may have included seeking health treatment.

## Attribution Questionnaire

Table 2 (See Appendix F) outlines the average scores across nine subscales of the Attribution Questionnaire. For most subscales, average ratings fell below the mid-point of the nine-point scale, suggesting the participants did not strongly endorse most stereotypes about mental illness. For instance, the overall average rating on the

dangerousness subscale was 2.92 ($n$ = 73, $SD$ = 1.27), indicating a weak endorsement of the stereotype that people with mental illnesses are dangerous. The highest rated subscales on the Attribution Questionnaire were pity ($M$ = 6.34, $n$ = 73, $SD$ = 1.35), coercion ($M$ = 4.45, $n$ = 73, $SD$ = 1.27), and avoidance ($M$ = 4.44, $n$= 42, $SD$ = 1.71). The lowest rated subscales on the Attribution Questionnaire were segregation ($M$ = 2.11, $n$ = 73, $SD$ = 1.14), fear ($M$ = 2.37, $n$ = 73, $SD$ = 1.37), and anger ($M$ = 2.46, $n$ =73, $SD$ = 1.17). Low ratings on these subscales suggests low stigma in participants emotions (e.g., anger, irritation, annoyance) towards people with mental illness. Participants do not appear to express fear in relation to persons with mental illness. Moreover, participants do not hold a strong view of sending persons with mental illness away from the community into institutions.

For the nine subscales of the Attribution Questionnaire, it was hypothesized that the group of participants exposed to the police vignette would express higher average scores—indicating greater levels of social stigma—compared to the group of participants exposed to the non-police vignette. Independent samples $t$-tests were run to compare average scores of the nine subscales between the non-police and police study groups, testing for the null hypothesis—that there would be no statistically significant differences between the two groups. As shown in Table 2, the two study groups had similar average scores on each of the nine subscales. For instance, the average scores on the pity subscale for the police ($M$ = 6.50, $n$ = 37, $SD$ = 1.40) and non-police ($M$ = 6.19, $n$ = 36, $SD$ = 1.28) groups were statistically similar, $t(71) = -0.99$, $p > 0.05$. Similarly, the average scores of the coercion subscale for the police ($M$ = 4.40, $n$ = 37, $SD$ = 1.38) and non-police ($M$ =4.51, $n$ = 36, $SD$ = 1.17) again were statistically similar, $t(71) = 0.38$, $p > 0.05$. None of

the between-group differences were statistically significant; that is, the *p*-values were all greater than 0.05. As such, the null hypothesis concerning the Attribution Questionnaire could not be rejected.

**Social Distance**

Table 2 (See Appendix F) outlines the average scores on the Social Distance Scale. Overall, the average ratings were around the mid-point of the five-point scale ($M$ = 3.34, $n$ = 73). The mid-point average responses suggest neutral feelings of social distance or sitting on the fence; responses in the middle of the scale neither agreed nor disagreed with the statements. An independent samples *t*-test was used for testing the null hypothesis that there will be no significant difference of desire for social distance between the two study groups. It was hypothesized that was the sample group who had the non-police vignette would experience less social distance than the sample group who received the police vignette. The analysis revealed that two study groups had similar average scores on the Social Distance Scale. The average rating for the police group was 3.37 ($n$ =37, $SD$ = 0.69) and average rating for the non-police group was 3.30 ($n$ =36, $SD$ = 0.64 ). It was found that the groups were statistically similar, $t(71) = -0.47$, $p > 0.05$. The *p*-value was greater than 0.05 and, as such, the null hypothesis concerning the Social Distance Scale could not be rejected.

**Relationship Between Participant Characteristics and Stigma**

Overall, the average means for the Attribution Questionnaire subscales did not vary much by gender. To illustrate, the subscale of blame was 2.51 ($n$ = 29, $SD$ = 1.01) for men and 2.52 ($n$ = 44, $SD$ = 1.33), for women, $t(71) = -0.031$, $p > 0.05$. No significant differences between men and women were found on any subscale of the Attribution

Questionnaire. The same was found in regards to gender and the Social Distance Scale scores, with an average of 3.39 for men ($n$ = 29, $SD$ = 0.59) and 3.30 for women ($n$ = 44, $SD$ = 1.32) $t(71) = 0.58$, $p > 0.05$.

As for evaluating relationships between age and the social stigma scales, there were no strong or significant correlations ($p > 0.05$). There appeared to be somewhat stronger correlations found between study participant's level of familiarity with mental illness and the social stigma scales. Negative correlations in this case would mean high levels of familiarity with mental illness correlate with low levels of social stigma. Statistically significant, negative correlations were found between levels of familiarity and two Attributional Questionnaire subscales: coercion ($r$ = -0.28, $p$ = 0.02) and fear ($r$ = -0.27, $p$ = 0.02). This suggests that the more familiar someone is with mental illness, the less likely they will be to fear people with mental illnesses or express a desire to respond to them with coercive measures.

**Recommendations for Improving Response to Mental Health Crisis**

At the end of the questionnaire, the respondents were invited to suggest changes to the vignette that they though would improve the response to John`s situation. Of the total number of study participants, 57.5% ($n$ = 42) wrote a response to this question, including 59.5% ($n$ = 25) from the non-police vignette group and 40.5% ($n$ = 17) from the police vignette group.

The most common comments ($n$ = 13) indicated that the vignette scenarios were either handled very well or that nothing could be changed to improve the response to the crises. For example, a few study participant responses include: "Not at all, all the medical health practitioners responded appropriately," "No, I think they handled the situation very

well," "I think it was an appropriate response," or "No, it was safe to call 911 and find him some sort of help before something bad happened". Another frequent response ($n$ = 7) concerned the prescription of medications or mentioning John should be or should have treatment. Participants either recommended that he be prescribed medications or requested clarification about whether he had been prescribed medication previously. For instance, a few comments were: "I would prescribe appropriate medication and regular weekly meetings for check-ups," "He should see a psychologist and possible receive medication for schizophrenia because he's having auditory hallucinations," and "I'd recommend he go to therapy and take medication".

In contrast, one respondent indicated that medications would not be a desirable response to the situation presented in the vignette: "John should actively be seeing a psychologist to find the root stressor in his life. Numbing him with meds and locking him away is not what is best for John." This was the only response that referred to medication in a negative or coercive manner. A number of responses ($n$ = 8) recommended that John`s situation could be improved with the help of mental health professionals (e.g. monitoring, medications, or providing counseling). Only one participant referenced police officers in relation to improvements that could be made to how the crisis in the vignettes was handled: "I think the vignette went about getting John the attention he needed in a stress free environment. I think the fact that the police officer was not in uniform was beneficial to John`s situation." The reference to the police officer was in a positive reaction as the participant considered the subtle police presence as beneficial for John.

# Section 7: Discussion, Study Limitations, and Future Research

## Discussion

This study intended to explore the potential effects of having a crisis response team, with police, on social stigma. To attain this objective, a quantitative questionnaire with one open ended question was used to measure social stigma among participants who were either exposed to a story about a mental health crisis that was resolved either by a joint police-mental health response team or by mental health professionals only. The findings from the study's results will be briefly summarized followed by a comparison to Modified Labeling Theory and previous literature on the topic.

It was fascinating to note that the majority of participants had some level of familiarity with mental illness, either knowing someone with mental illness personally or have had own person experience with mental illness. Together, the stigma measured by using the Attribution Questionnaire and Social Distance Scale was very low, suggesting a weak endorsement of stereotypes about mental illness. In terms of the Attribution Questionnaire the average subscales of pity, coercion, and then avoidance had the greatest endorsement of the stereotype. The lowest endorsed stereotype subscales was segregation, fear, and anger. In relation to the current study's research question, both a mental health crises team and a integrated team of mental health and police, marginally effect pity, coercion, and avoidance. Coercion and social distance are common themes in social stigma research. The finding of the coercion subscale as the second highest indicates a fairly strong belief amongst participants that there needs to be a institutional response in mental health crises situations and potentially coercive actions such as involuntary hospitalization or medication, this relates to high support of coercive means (Pescosolido et al., 1999; Pescosolido et al., 1998). Avoidance was another compelling

subscale with the third highest stigma score, that related to social distance in the desire for space away from individuals with mental illness.

The study hypothesized that participants who had the police vignette would have higher social stigma and those who had the non-police vignette would experience lower stigma, on both the Attribution Questionnaire and Social Distance Scale. This was not the case. The mean average stigma scores were very similar between the two groups of participants, there was no statistical difference found—this is the main finding of the study. In addition, further exploration showed a small negative correlation was found between level of familiarity with mental illness and social stigma. Angermeyer, Matschinger and Corrigan (2004) previously found with increased familiarity with mental illness there is a decrease desire for social distance plus less of a dangerousness perception associated with mental illness.

The theoretical framework of this study is Modified Labeling Theory, with a focus on the first stage—involving the socialization of beliefs that people with mental illness will be discriminated against and devalued. The more intense this belief about persons with mental illness, the more an individual will expect to be discriminated against. This aspect occurs on a communal level, not just on an individual basis. This explanation also aids in better understanding the reinforcement of institutional responses. Through the main finding, that the two groups (Non-Police and Police) are not statistically different connects to stigma and labeling. This result shows that these participants did not face high stigma but also that particularly the institutional response (mental health crises response team), police presence, did not influence a labeling that would impact participants social stigma.

In additional the exploratory analysis was statistically significant, negative correlations were found between levels of familiarity with mental illness and the common social stigma aspects of dangerous perceptions and fear. When level of familiarity with mental illness increased then the level of social stigma decreased. This finding coincides with previous research on social distance and dangerousness. Angermeyer, Matschinger and Corrigan (2004) previously found with increased familiarity with mental illness there is a decrease desire for social distance plus less of a dangerousness perception associated with mental illness.

Lastly, there were a number of participants who took the time to fill out the open-ended questionnaire concerned with if the vignette situation could be improved. The most common remarks were that the situation in the vignette was dealt with very well and there is not much to change. Multiple comments mentioned John should be prescribed medication or some sort of treatment, another hint at the endorsement of coercion. Only one individual expressed medication in a negative light. The third common improvement listed would be that John should receive help from professionals such as psychiatrist and attend counseling.

Two types of coercion have been defined—Legal coercion involves formal measures such as court orders or enforced by police officers, while extra-legal coercion would include pressure from family members or friends for the person with mental illness to receive treatment (Pescosolido et al., 1998, p. 276). This relates to the open-ended recommendations on the questionnaire and multiple participants listed medication as an improvement to the vignette situation. The vignette example would be legal coercion, a crisis team (with or without a police officer present). The social stigma in this case would

be supporting medication treatment, which is echoed within structural stigma by the individuals on the mobile crisis team as well as their actions. Although, participants did not find the police presence in vignettes or avocation for medication as problematic, harsh or as labeling.

## Limitations

One of the most important limitations of this study is the sample. The technique used was convenient sampling which was beneficial for the scope and timeline of this study but created limitations. It was a contributing factor to the homogeneity of variance between the two study groups (police vignette and non-police vignette). As shown in the participant characteristics data, there was similar variance on aspects such as age, educational background and year of study to mention a few examples. Therefore, the findings cannot be considered generalizable to a larger societal representation. Another important similarity to consider would be the fact that most of all the participants were criminology or sociology students learning about inequalities, mental illness, and stigma within their course work. Ultimately, this could be why the levels of stigma were so low compared to what was hypothesized and previously found throughout the literature. Another aspect of a sampling consisting of criminology and sociology students would be the greater possibility of increase level of familiarity within work or volunteer experience, such as at a homeless shelter as a student. In addition to hypothesis driven analysis there was an exploratory nature to an aspect of some analysis, which considered problematic as going into the study there was no set plan of statistical tests to use.

Another limitation would be the wording on the first statement of the Familiarity Scale. The question was negatively worded (you have no experience with mental illness,

rather than have you have any experience with mental illness), this caused slight confusion amongst participants. Lastly, using a five-point Likert scale for the social distance scale as it allowed participants to circle the center option of neither agree nor disagree. It a larger, perhaps a nine-point scale, or even numbered Likert scale had been used it would have reduced participants sitting on the fence with these scale statements.

## Future Research

Further research recommendations would include evaluating the similar topic, as it has not directly or extensively been studied, but with different sample groups. Using a larger, more diverse sample will be beneficial. For example, it the sample consisted of undergraduate students from different majors, a goal would be to get a sample that is more generalizable to the wider community. Finally, it would be beneficial for researchers to examine the effect that police-mental health response teams have on the perceptions of stigma among people with mental illness who receive such services.

# Section 8: Conclusion

## Conclusion

Individuals with mental illness are disporportionately represented within the crimnal justcice system and with police interactions, which leads into negative police outcomes such as violence. Programs, such as crisis intervention teams, have been created to address this issue. There is only a focus in emprical research on the positivies of such progams rather than consdiering the potential negative consequences. Therefore, this study aimed to find how a specialized police response team for mental health crises influences the public's attitudes toward people with mental illness. The hypotheses were (a) out of both study groups (Non-Police and Police vignette groups), police vignettes will cause participants to express a greater desire for social distance and (b) the police vignette group will endorse more negative stereotypes about mental illness, such as dangerousness or need for coercion.

In conclusion the results of this study show no statistical difference between the study groups (Non-Police and Police) in terms of the level of endorsement for the nine stereotypes of the Attribution Scale and the Social Distance Scale. For this reason, the theoretical framework of Modified Labeling Theory does not sufficiently support the findings well, as police presence in the vignette did not influence a stronger label that would influence social stigma.

# Section 9: Appendix

## A. Sample Recruitment Script

Format: Verbally, Face to Face

**Public Attitudes towards Mental Illness**
**Study: Vignette & Questionnaire**
**Recruitment Script**

My name is Samantha and I am conducting a research study for my honours thesis, under the supervision of Dr. Jamie Livingston. I am here to tell you about the study and to invite you to be involved in.

The purpose of this study is to gain an understanding of public attitudes towards mental illness.

Participation in this study will involve reading a short vignette and then filling out a questionnaire. This study is a one-time event during second half of your class and the study will last approximately 25-30 minutes. You will receive one bonus point to go towards your final grade for participating. You do not have to sign up for the study and if you do sign-up, you can decide to stop participating at any time. If you choose not to take part in the study, it will have no impact or consequence on the assessment of your performance in this course

I, as the student principal investigator, will answer questions and be available during the course of the study. The faculty supervisor, Dr. Jamie Livingston, will be absent during the in-class recruitment of participants and during the administration of the questionnaire. In addition, Dr. Jamie Livingston will be unaware of students who participated in this study until the completion of the course. I will have the list of students who will be receiving a bonus point on a Saint Mary's password protected computer account until the completion of this course.

The eligibility for participation in this study is:
-19 years old or older
-A current and actively enrolled undergraduate student at Saint Mary's University
-Able to speak and read English for the purpose of completing the questionnaire
-In the selected criminology/sociology class
-In addition if you have participated in this study in another criminology/sociology class at Saint Mary's you will be excluded as you cannot participate in the same study twice.
If you are interested in hearing more about the study or participating, you can stay here and those who do not wish to participate may leave class.

Do you have any questions?
Thank you for your time

## B. Sample Informed Consent Form

**INFORMED CONSENT FORM**

**Public Attitudes Towards Persons with Mental Illness**
**SMU REB #15-170 (SMU REB File Number)**

**Principal Investigator:**
Samantha Banfield
Saint Mary's University
Department of Sociology & Criminology
923 Robie Street, Halifax, NS B3H 3C3
902-435-2075
samantha.banfield93@gmail.com

**Faculty Supervisor:**
Dr. Jamie Livingston
Saint Mary's University
Department of Sociology & Criminology
923 Robie Street, Halifax, NS B3H 3C3
902-491-6258
jamie.livingston@smu.ca

**INTRODUCTION**

You are invited to take part in a study being conducted as part of an honours thesis under the supervision of Dr. Jamie Livingston. Taking part of this study is voluntary and you can decide whether or not to participate. Refusing to participate in this study will have no impact or consequence on the assessment of your performance in this course. Before you decide, you need to understand what this study is for, what risks you might take and what benefits you might receive. This consent form explains the study. Please read this carefully and ask questions about anything that is unclear.

**PURPOSE OF THIS RESEARCH**
The purpose of this study is to gain an understanding of public attitudes towards mental illness.

WHO IS ELIGIBLE TO TAKE PART?

Who can?
You can participate if you are 19 years of age or older, a current and actively enrolled undergraduate student at Saint Mary's University, able to speak and read English for the purpose of completing the questionnaire, and enrolled in selected criminology/sociology classes during the winter (January-April 2015) semester.

Who can't?
Individuals will be excluded from the study if they are under the age of 19, cannot speak or read English or are not a student registered in the two criminology/sociology classes selected for the study. In addition if you have participated in this study in another criminology/sociology class at Saint Mary's you will be excluded as you cannot participate in the same study twice.

**WHAT DOES PARTICIPATING MEAN?**

If you choose to take part in this study, during the end of class, the student principal investigator will instruct you to read a vignette story and then answer a questionnaire containing 42 questions. All the questions will be short, close-ended questions with the exception of the last question, which is open-ended. There are no right or wrong answers to these questions; the study just wants your perspective and opinions about various issues about mental illness. Once the study is complete, a feedback letter and debrief will be provided to you. In regards to how long the study is, the process is expected to last 25-30 minutes in total participant time. This study is a one-time event. There will be no subsequent research sessions.

**WHAT ARE THE POTENTIAL BENEFITS OF THIS RESEARCH?**
Benefits to society include gaining insight on public attitudes of mental illness as well as filling a knowledge gap.

**WHAT ARE THE POTENTIAL RISKS FOR PARTICIPANTS?**

This is a very low risk study with no foreseeable risks. Be assured the study is completely voluntary, and you can withdraw from the study at any time. In the unlikely event you experience distress or adverse effects stemming from participation in this study, you are encourage to contact the Faculty Supervisor Dr. Jamie Livingston and/or the Saint Mary's Counseling Centre. The Counseling Centre's phone number is 902-420-5615 or 1-855-649-8641 for an emergency or crisis call after business hours [this number is 24/7, confidential phone counseling to SMU students, call and inform them you need immediate assistance]. Although you are encouraged to answer all of the questions, please feel free to skip any questions that you do not want to answer.

WHAT WILL BE DONE WITH MY INFORMATION?

Types of Information:
This study will directly identify public attitudes about mental illness. All of the data and answers provided will be completely anonymous and untraceable to your identity. Demographic information collected will be age, gender, field of undergraduate major, number of years educated as well as level of familiarity with mental illness.

Will the data be kept confidential?

The only people who will have access to the information collect will be the student principal investigator and the faculty supervisor. Signed consent forms will be kept separate from questionnaires and securely stored in a locked filing cabinet within an office in Department of Sociology and Criminology. De-identifiable data will be electronically entered into a program for analysis on a password-secure computer account at Saint Mary's University. De-identified data and documents will be stored for 5-years after the study has been completed, after which time it will be permanently destroyed.

How will data be kept secure?

Your privacy will be protected by the student principal investigator and faculty supervisor. The information will not be travelled or moved a lot as it will be locked in a filing cabinet. In addition, de-identified data will be stored on a password-secure computer account at Saint Mary's University. Upon study completion (March 2015) paper documents of the questionnaires will be destroyed and discarded, while the consent forms and de-identifiable computer data will be stored on a password protected computer account at Saint Mary's University for 5-years.

Dissemination of research results:

Once all the data is collected and analyzed for this study, the student principal investigator plans on sharing the information with the Saint Mary's University research community in the Department of Sociology and Criminology as presented through a conference at the end of March 2015. If you are interested in receiving more information regarding the results of this study, or if you have any questions or concerns, please contact the principal investigator or faculty supervisor, at either the phone number or email address listed on the first page of this document.

WHAT TYPE OF COMPENSATION IS AVAILABLE FOR PARTICIPATION?

This study's incentive for participation includes one bonus point toward your final class grade, as permission was granted from the professor Dr. Jamie Livingston.

**HOW CAN I WITHDRAW FROM THIS STUDY?**

Participants are free to withdraw from the research study at any time without penalty. Participants who withdraw from the study will have the option of allowing the use of the data in the study or withdrawing the data provided. There are no consequences from withdrawing from the study. If you choose to participate and later change your mind, you are able to stop participating and leave the study. If you choose to withdraw your consent from the study, please inform the student principal researcher who will be present while the questionnaires are completed.

HOW CAN I GET MORE INFORMATION?

Participants can discuss the study with the principal investigator or the faculty supervisor at any time. The student principal investigator will answer questions and be available during the course of the study. The faculty supervisor will be absent during the in-class recruitment of participants and during the administration of the questionnaire. In addition, Dr. Jamie Livingston will not see the list of students who will gain a bonus point for participation in this study until the course is completed. The student principal investigator will have the list of students eligible for a bonus point on a secure password protected Saint Mary's computer account until the completion of the class, in which case Dr. Jamie Livingston will be notified of students receiving a bonus point. Contact for the student

principal investigator and the faculty supervisor is listed at the top on the first page of this consent form.

**Certification:**
The Saint Mary's University Research Ethics Board has reviewed this research. If you have any questions or concerns about ethical matters or would like to discuss your rights as a research participant, you may contact the Chair of the Research Ethics Board at ethics@smu.ca or 902-420-5728.

**Signature of Agreement:**

**Public Attitudes Towards Persons with Mental Illness**

I understand what this study is about, appreciate the risks and benefits, and that by consenting I agree to take part in this research study and do not waive any rights to legal recourse in the event of research-related harm.
I understand that my participation is voluntary and that I can end my participation at any time without penalty.
I have had adequate time to think about the research study and have had the opportunity to ask questions.

Participant

Signature : _____ Name (Printed) :_____
Date :_____

(Day/Month/Year)

Principal Investigator

Signature : _____ Name (Printed) :_____
Date :_____

(Day/Month/Year)

Please keep one copy of this form for your own records.

## C. Sample Feedback Letter

**FEEDBACK LETTER**

**Public Attitudes Towards Persons with Mental Illness**
**SMU REB File # 15-170**

**Principal Investigator:**
Samantha Banfield
Saint Mary's University
Department of Sociology & Criminology
923 Robie Street, Halifax, NS B3H 3C3
902-435-2075
samantha.banfield93@gmail.com

**Faculty Supervisor:**
Dr. Jamie Livingston
Saint Mary's University
Department of Sociology & Criminology
923 Robie Street, Halifax, NS B3H 3C3
902-491-6258
jamie.livingston@smu.ca

Date March 24th 2015

Dear Participant,

I would like to thank you for participating in this study.

As a reminder, the purpose of this study is to gain a better understanding of public attitudes towards persons with mental illness. The data collected from the questionnaires will contribute to a better understanding of the differences in public attitudes when police are part of a health services. As well as the possible consequences of labeling associated with such programs.

For the purpose of this study deception was involved. The deception in this study consisted of participants initially being unaware there were two different vignettes. Vignette A described a mental health crisis without police involvement and Vignette B illustrated a mental health crisis with police involvement. The study's objective is to measure the difference in public attitudes between police presence and police absence in mental health crises; therefore, deception in this case is important to achieve the goals of this study.

Please remember that any data pertaining to you as an individual participant will be kept confidential. Once all the data is collected and analyzed for this project, I plan on sharing this information through a presentation to department faculty, honours students as well as any other Saint Mary's students who attend the conference in the end of March.

If you are interested in receiving more information regarding the results of this study, or if you have any questions or concerns, please contact myself or my faculty supervisor, at either the phone numbers or email address listed at the top of the page.

If you would like a summary of the results, please let me know by contacting or emailing my Faculty Supervisor, Dr. Jamie Livingston. The study is expected to be completed by March 2015.

As with all Saint Mary's University projects involving human participants, this project was reviewed by the Saint Mary's University Research Ethics Board. Should you have any comments or concerns about ethical matters or would like to discuss your rights as a research participant, please contact the Chair of the Research Ethics Board at 902-420-5728 or ethics@smu.ca.

## D. Vignettes

**<u>Vignette A</u> (No Police Presence)**

John is a 20-year-old who lives at home with his parents. Up until a year ago, life was pretty okay for John. But then, things started to change. He has been attending university irregularly over the past year and has recently stopped attending altogether. Over the past 6 months, he has stopped seeing his friends and begun locking himself in his bedroom and refusing to eat with the family or to bathe. John's emotions have changed as well. He often feels an extreme amount of stress, he finds himself crying uncontrollably, feels a sense of panic and anxiousness as well as feelings of loneliness and a sense of being unloved. In addition, John has lately become preoccupied with hearing voices.

One evening John became very emotional, frantic and distraught. During the crisis situation, John's parents were concerned for his well-being and health so they called 9-1-1 for help. A mental health mobile crisis team, consisting of two experienced mental health nurses, responded to help John. The nurses actively listened to John, administered a mental health assessment, and offered brief counseling and support. In addition, the nurses taught some skills on dealing with stress and provided John and his parents information about community services. Lastly, they assigned John a mental health team who called John to follow up the next day.

**<u>Vignette B</u> (Police Presence)**

John is a 20-year-old who lives at home with his parents. Up until a year ago, life was pretty okay for John. But then, things started to change. He has been attending university irregularly over the past year and has recently stopped attending altogether. Over the past 6 months, he has stopped seeing his friends and begun locking himself in his bedroom and refusing to eat with the family or to bathe. John's emotions have changed as well. He often feels an extreme amount of stress, he finds himself crying uncontrollably, feels a sense of panic and anxiousness as well as feelings of loneliness and a sense of being unloved. In addition, John has lately become preoccupied with hearing voices.

One evening John became very emotional, frantic and distraught. During the crisis situation, John's parents were concerned for his well-being and health so they called 9-1-1 for help. A mental health mobile crisis team, consisting of two experienced mental health nurses and a police officer in plainclothes, all who arrive together in a unmarked police car, responded to help John. The police officer was present to ensure everyone's safety and to detain John for involuntarily hospitalization if the need arose. The nurses actively listened to John, administered a mental health assessment, and offered brief counseling and support. In addition, the nurses taught some skills on dealing with stress, and provided John and his parents information about community services. Lastly, they assigned John a mental health team who called John to follow up the next day.

* Note: The only variable changed in the vignette was whether the police were present or not present.

## E. Sample Questionnaire

**Questionnaire**

1) Gender ☐Male ☐ Female ☐ Transgender

2) Age _____

3) Number of years of university education (check one)

☐1st year ☐2nd year ☐3rd year ☐4th year ☐≥ 5 years

4) Major(s) (check all that apply)

☐Criminology ☐Sociology ☐Psychology ☐Other _____

**Please read each of the following statements carefully. After you have read all of the statements below, place a check by every statement that represents your experience with persons with a mental illness. A mental illness is a pattern of behavior, thinking or emotions that bring a person some level of distress, suffering or impairment. Commonly known mental illnesses include, but are not limited to, anxiety, depression, schizophrenia and bipolar disorder.**

5) You have no personal experience with mental illness.
**Yes _____ No_____**

6) You know someone, work or volunteer with someone (friend, co-worker, neighbor etcetera) who has mental illness.
**Yes _____ No_____**

7) You know a family member(s) who has a mental illness or is/was treated for a mental illness.
**Yes _____ No_____**

8) You personally have experience and/or have sought help or treatment for a mental illness.
**Yes _____ No_____**

**Based on the vignette, please answer each of the following questions about John. Circle ONE number per statement or question.**

9) I would go out with John on the weekend.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| **strongly disagree** | **disagree** | **neither agree or disagree** | **agree** | **strongly agree** |

10) I would work on a project with John.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| **strongly disagree** | **disagree** | **neither agree or disagree** | **agree** | **strongly agree** |

11) I would invite John to my house.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| **strongly disagree** | **disagree** | **neither agree or disagree** | **agree** | **strongly agree** |

12) I would develop a close friendship with John

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| **strongly disagree** | **disagree** | **neither agree or disagree** | **agree** | **strongly agree** |

13) I would go to John's house

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| **strongly disagree** | **disagree** | **neither agree or disagree** | **agree** | **strongly agree** |

14) I would feel aggravated by John.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---|---|---|---|---|---|---|---|---|
| **not at all** | | | | | | | | **very much** |

15) I would feel unsafe around John.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---|---|---|---|---|---|---|---|---|
| **no, not at all** | | | | | | | | **yes, very much** |

16) John would terrify me.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---|---|---|---|---|---|---|---|---|
| **not at all** | | | | | | | | **very much** |

17) How angry would you feel at John?

**1 2 3 4 5 6 7 8 9**
**not at all very much**

18) If I were in charge of John's treatment, I would require him to take his medication.

**1 2 3 4 5 6 7 8 9**
**not at all very much**

19) I think John poses a risk to his neighbours unless he is hospitalized.

**1 2 3 4 5 6 7 8 9**
**not at all very much**

20) If I were an employer, I would interview John for a job.

**1 2 3 4 5 6 7 8 9**
**not likely very likely**

21) I would be willing to talk to John about his problems.

**1 2 3 4 5 6 7 8 9**
**not at all very much**

22) I would feel pity for John.

**1 2 3 4 5 6 7 8 9**
**none at all very much**

23) I would think that it was John's own fault that he is in the present condition.

**1 2 3 4 5 6 7 8 9**
**no, not at all yes, absolutely so**

24) How controllable, do you think, is the cause of John's present condition?

**1 2 3 4 5 6 7 8 9**
**not at all under personal control completely under personal control**

25) How irritated would you feel by John?

**1 2 3 4 5 6 7 8 9**
**not at all very much**

26) How dangerous would you feel John is?

**1 2 3 4 5 6 7 8 9**
**not at all very much**

27) How much do you agree that John should be forced into treatment with his doctor even if he does not want to?

**1 2 3 4 5 6 7 8 9**
**not at all very much**

28) I think it would be best for John's community if he were put away in a psychiatric hospital.

**1 2 3 4 5 6 7 8 9**
**not at all very much**

29) I would share a car pool with John every day.

**1 2 3 4 5 6 7 8 9**
**not likely very likely**

30) How much do you think an asylum, where John can be kept away from his neighbours, is the best place for him?

**1 2 3 4 5 6 7 8 9**
**not at all very much**

31) I would feel threatened by John.

**1 2 3 4 5 6 7 8 9**
**no, not at all yes, very much**

32) How scared of John would you feel?

**1 2 3 4 5 6 7 8 9**
**not at all very much**

33) How likely is it that you would help John?

**1 2 3 4 5 6 7 8 9**
**definitely definitely**
**would not help would help**

34) How certain would you feel that you would help John?

**1 2 3 4 5 6 7 8 9**
**not at all certain absolutely certain**

35) How much sympathy would you feel for John?

**1 2 3 4 5 6 7 8 9**
**none at all very much**

36) How responsible, do you think, is John for his present condition?

**1 2 3 4 5 6 7 8 9**
**not at all very much**
**responsible responsible**

37) How frightened of John would you feel?

**1 2 3 4 5 6 7 8 9**
**not at all very much**

38) If I were in charge of John's treatment, I would force him to live in a group home.

**1 2 3 4 5 6 7 8 9**
**not at all very much**

39) If I were a landlord, I probably would rent an apartment to John.

**1 2 3 4 5 6 7 8 9**
**not likely very likely**

40) How much concern would you feel for John?

**1 2 3 4 5 6 7 8 9**
**not at all very much**

41) Did you think the response to the mental health crisis that was presented in the vignette was appropriate?

**1 2 3 4 5 6 7 8 9**

**not at all very much so**

42) Is there anything in the vignette that you would change in order to improve the response to John's situation?

_____

_____

## F. Data Tables

**Table 1: Participant Characteristics**

| Participant Characteristics | Vignette Exposure: Non-Police (*n*=36) *n*(% or *M*) | Police (*n*=37) *n*(% or *M*) | Total (*N*=73) *n*(% or *M*) | Chi-square $\chi^2$ *(df), p* | Independent Samples *t*-test *t (df), p* |
|---|---|---|---|---|---|
| Gender | | | | $\chi^2$ (1)= 0.66, *p*= 0.42 | |
| Men | 16 (44.4%) | 13 (35.1%) | 29 (39.7%) | | |
| Women | 20 (55.6%) | 24 (64.9%) | 44 (60.3%) | | |
| Transgender | 0 | 0 | 0 | | |
| Age (Years) | 36 (21.81) | 37 (21.84) | 73 (21.83) | | *t*(71)= -0.04, *p*= 0.80 |
| Number of Years of University Education | | | | $\chi^2$ (3)= 2.47, *p* =0.48 | |
| 1st year | 0 | 0 | 0 | | |
| 2nd year | 12 (33.3%) | 10 (27.0%) | 22 (30.4%) | | |
| 3rd year | 14 (38.9%) | 12 (32.4%) | 26 (35.6%) | | |
| 4th year | 6 (16.7%) | 12 (32.4) | 18 (24.7%) | | |
| ≥5th year | 4 (11.1%) | 3 (8.1%) | 7 (9.6%) | | |
| Major(s) | | | | | |
| Criminology | 25 (69.4%) | 27 (73.0%) | 52 (71.2%) | $\chi^2$(1)= 0.11, *p*= 0.74 | |
| Sociology | 10 (27.8%) | 16 (43.2%) | 26 (35.6%) | $\chi^2$ (1)= 1.90, *p*= 0.17 | |
| Psychology | 6 (16.7%) | 7 (9.6%) | 13 (17.8) | $\chi^2$(1)= 0.06, *p*= 0.80 | |
| Other | 3 (8.3%) | 5 (13.5%) | 8 (11.0%) | $\chi^2$ (1)= 0.50, *p*= 0.48 | |
| Level of Familiarity | | | | $\chi^2$ (3)=0.94, *p*= 0.82 | |
| No Experience | 4 (5.6%) | 2 (5.4%) | 6 (8.2%) | | |
| Friend, Co-worker, Neighbour Etc. | 13 (36.1%) | 13 (35.1%) | 26 (35.6%) | | |
| Family | 7 (19.4%) | 9 (24.3%) | 16 (21.9%) | | |

| | | | | | |
|---|---|---|---|---|---|
| Members | | | | | |
| Personal Experience | 12 (33.3%) | 13 (35.1%) | 25 (34.3%) | | |

The level of familiarity aspect is based from Angermeyer, Matschinger & Corrigan (2004), the purpose is to gather data of participant's familiarity with mental illness therefore, it can be taken into account and contrasted with the levels of social stigma or social distance.

**Table 2: Social Stigma Measured Results**

| Social Stigma Scales | Vignette Exposure: Non-Police (*n*=36) | | | Police (*n*=37) | | | Total (*N*=73) | | | Independent sample *t*-test |
|---|---|---|---|---|---|---|---|---|---|---|
| | *n* | *M* | *SD* | *n* | *M* | *SD* | *N Total* | *M* | *SD* | *t (df), p* |
| Attribution Questionnaire | | | | | | | | | | |
| Pity | 36 | 6.19 | 1.28 | 37 | 6.50 | 1.40 | 73 | 6.34 | 1.35 | *t* (71) -0.99, *p*= 0.54 |
| Coercion | 36 | 4.51 | 1.17 | 37 | 4.40 | 1.38 | 73 | 4.45 | 1.27 | *t*(71) 0.38, *p*= 0.15 |
| Avoidance | 36 | 4.44 | 1.68 | 36 | 4.44 | 1.76 | 72 | 4.44 | 1.71 | *t*(70) 0.02, *p*= 0.95 |
| Dangerousness | 36 | 2.97 | 1.34 | 37 | 2.87 | 1.21 | 73 | 2.92 | 1.27 | *t*(71) 0.36, *p*= 0.59 |
| Help | 36 | 2.91 | 1.55 | 37 | 2.73 | 1.37 | 73 | 2.82 | 1.45 | *t*(71) 0.52, *p*= 0.93 |
| Blame | 36 | 2.44 | 1.39 | 37 | 2.59 | 1.15 | 73 | 2.51 | 1.27 | *t*(71) -0.50, *p*= 0.16 |
| Anger | 36 | 2.48 | 1.23 | 37 | 2.44 | 1.12 | 73 | 2.46 | 1.17 | *t*(71) 0.15, *p*= 0.63 |
| Fear | 36 | 2.31 | 1.30 | 37 | 2.43 | 1.45 | 73 | 2.37 | 1.37 | *t*(71) -0.39, *p*= 0.77 |
| Segregation | 36 | 2.25 | 1.36 | 37 | 1.98 | 0.89 | 73 | 2.11 | 1.14 | *t*(71) 1.00, *p*= 0.13 |
| Social Distance Scale | 36 | 3.30 | 0.64 | 37 | 3.37 | 0.69 | 73 | 3.34 | 0.66 | *t*(71) -0.47, *p*= 0.57 |

Attribution Questionnaire rated on a 9 point-scale ranging from 1 (low stigma) to 9 (high stigma).
Social Distance scale rated on a 5-point likert scale ranging from 1 (low desire for social distance) to 5 (high desire for social distance).

# Section 10: Ethics Approval

# A. Saint Mary's Research Ethics Review Board

## Certificate of Ethical Acceptability for Research Involving Humans

This is to certify that the Research Ethics Board has examined the research proposal:

| | |
|---|---|
| **SMU REB File Number:** | 15-170 |
| **Title of Research Project:** | Public Attitude Towards Persons with Mental Illness. |
| **Faculty, Department:** | Arts, Sociology & Criminology |
| **Faculty Supervisor:** | Dr. Jamie Livingston |
| **Student Investigator:** | Samantha Banfield |

and concludes that in all respects the proposed project meets appropriate standards of ethical acceptability and is in accordance with the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans (TCPS 2) and Saint Mary's University relevant policies.

Approval Period: March 16, 2015 – March 16, 2016*

**Continuing Review Reporting Requirements**

**ADVERSE EVENT**
Adverse Event Report: http://www.smu.ca/academic/reb/forms.html
Adverse events must be immediately reported (no later than 1 business day).
SMU REB Adverse Event Policy: http://www.smu.ca/academic/reb/policies.html

**MODIFICATION**
FORM 2: http://www.smu.ca/academic/reb/forms.html
Research ethics approval must be requested and obtained prior to implementing any changes or additions to the initial submission, consent form/script or supporting documents.

**YEARLY RENEWAL***
FORM 3: http://www.smu.ca/academic/reb/forms.html
Research ethics approval is granted for **one year only**. If the research continues, researchers can request an extension one month before ethics approval expires.
FORM 4: http://www.smu.ca/academic/reb/forms.html
Research ethics approval for course projects is granted for **one year only**. If the course project is continuing, instructors can request an extension one month before ethics approval expires.

**CLOSURE**
FORM 5: http://www.smu.ca/academic/reb/forms.html
The completion of the research must be reported and the master file for the research project will be closed.

*Please note that if your research approval expires, no activity on the project is permitted until research ethics approval is renewed. Failure to hold a valid SMU REB Certificate of Ethical Acceptability or Continuation may result in the delay, suspension or loss of funding as required by the federal granting Councils.

On behalf of the Saint Mary's University Research Ethics Board, I wish you success in your research.

Dr. Jim Cameron
Chair, Research Ethics Board, Saint Mary's University

# Section 11: References

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