A STUDY ON THE KNOWLEDGE AND SKILLS OF POLICE OFFICERS IN HANDLING MENTALLY ILL PERSONS IN MDANTSANE IN THE EASTERN CAPE PROVINCE OF SOUTH AFRICA.

BY

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30 November 2009
DECLARATION BY RESEARCHER

I, the undersigned hereby declare the study on the knowledge and skills of police officers in handling mentally ill persons to be my own work and, all references used and quoted have been indicated and acknowledged comprehensively and that I have not previously in its entirety, or in part submitted it at any other university for a degree.

.................................................. ..................................................
Xola Xolani Kolwapi Date

DECLARATION BY SUPERVISORS

In my capacity as supervisor of the candidate’s thesis, I certify that the above statements are true to the best of my knowledge.

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ABSTRACT

Introduction

The dissertation argues that police officers are not trained in handling mentally ill persons.

Purpose

The study explored police officers’ knowledge of mental illness and skills necessary for handling mentally ill people.

Research methods

The descriptive quantitative investigation has been used as a research strategy to identify the knowledge and skills of police officers in handling mentally ill persons. Forty five police officers were randomly selected from a population of 136 police officers. A self administered questionnaire was used for collecting data. Data analysis was done manually and frequency distributions, cross-tabulations and correlations were carried out.

Results

The findings revealed that police officers do not have knowledge and skills to handle mentally ill people.

Recommendations

It is recommended that mental health care practitioners should engage the police in discussions on training in handling mentally ill people.
Limitations

Due to time and budgetary limitations, the study had to settle for a more modest investigation.
ACKNOWLEDGEMENTS

This study is dedicated to my late mother who passed away on the 06 October 2009, for giving me the secret to a person’s blessings. She would say “The greater the number of ‘thank yous’ one gets in a day, the greater the number of one’s blessings”. That is what made me the person and a nurse I am.

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CHAPTER 1 INTRODUCTION TO THE STUDY

1.1 INTRODUCTION

The mentally challenged people form the most disenfranchised group of people in our society. This is so because they are not protected by the agencies that exist to protect the rights of all citizens of the country. The powers that be are negligent when it comes to the rights of people made vulnerable by mental illness. They often argue that the person is not a danger to himself and others (Jaffe, 1994 as cited by Lefley, 2000: 237-241).

Since mental health care was introduced as a component of the primary health care system, patients had been discharged from long term mental health institutions to the community and their families. This came with problems to families who were not mobilised on dealing with the new arrangement in terms of both financial and social resources. This led to families rejecting their mentally ill relatives rendering some homeless and living in the streets without their much needed treatment (Torrey, 1994 as cited by Lefley, 2000: 237).

The South African Police Service, an agency tasked with protecting the rights of the citizens of the republic has not been helping with our mental health care users in the streets of our habitats. They will react when a crime involving a mentally ill person has been committed in the interest of the person calling for their response and not in the interest of the mental health care user. Members of the South African Police Service meet and are greeted by mentally ill people during their patrols on a daily basis with some displaying signs of a need for urgent psychiatric treatment but will ignore
them. Police officers are there to protect citizens and prevent crime but reacting when a crime has been committed is no preventive response. This highlights policemen’s misperceptions and may be attributed to insufficient knowledge about mental illness and lack of training (Psarra, Sestrini, Santa, Petsas et. al, 2008: 77-85).

People begin to want to know why police officers are neglecting the most vulnerable citizens of the country and the answers are hard to find. Is handling mentally ill persons such a mammoth task for the police or does the South African Police Service have the resources and capacity to handle mentally ill persons?

1.2 BACKGROUND INFORMATION.

The study was conducted in Mdantsane Township, the second largest township in South Africa, outside the city of East London, in the Eastern Cape Province. There are three police stations located at strategic positions in the township. One is at the entrance at NU 1 (NU 1 or Mdantsane police station); another in the middle of the township, NU 12 (Vulindlela police station) and the third is at NU 14 (Inyibiba police station) towards the exit and end of the township. A map of Mdantsane exhibiting the three police stations is in appendix F.

The researcher observed that on the streets of Mdantsane, particularly in the shopping zones, there is often a behaviourally disturbed person wandering aimlessly, dressed inappropriately in dirty clothes, with neglected self care, feeding from garbage bins and threatening to harm or eventually hurting other people. Police officers pass by when they see such persons like everything is normal.
They react when the mentally challenged person is involved in a crisis and subsequently the methods they use in apprehending such a person are inhumane. The huge amount of force used is unnecessary and so are their restraining methods.

The most common cause of police officers’ inability to handle mentally ill persons is lack of knowledge and training on dealing with mentally ill individuals. According to captain Nqumashe (personal communication, 11 October, 2007) of the police training college in Bhisho, police officers are not getting trained on how to handle mentally ill individuals, they approach all calls where mentally incapacitated individuals are involved informally using the same skills they use in dealing with criminals.

The police inappropriately use arrest to resolve encounters with mentally ill people. The community call the SAPS in cases of emergency with the mentally ill because they are required to respond around the clock. However, the police service is ill equipped to handle this population. For example, on the 9th of June 2009, 3RD DEGREE on the television channel etv showed a scene of police incompetence in handling a mentally ill person at a small town of Kriel in Mpumalanga province of the Republic of South Africa.

Frederick Brown was suffering from Alzheimer and manifested with loss of memory and confusion. He was at the town’s Shoprite store on the 8th of July 2008, agitated he took a chocolate bar. The store’s security apprehended him and called the police. The police were forceful in their arrest, sprayed him in the face with pepper spray and shoved him out of the door where he was kept at the store.
Mr Brown was taken to the local police station under such inhumane circumstances. The police were informed by Mr Brown’s son-in-law that he was mentally ill but was not allowed to visit him. His family and local business people went to the police to plead for his release. At the time of his release, he was found dead in his cell with a head injury, namely, a big wound on his head that police officers refused to own responsibility for. His mysterious death in a police cell shows clearly how incompetent South African police are when handling mentally ill people (etv, 2009).

Looking at the incompetence of officers in a crisis involving a mentally ill person, it becomes clear that police officers do not get the necessary training to perform such a task.

1.3 RESEARCH PROBLEM STATEMENT

The researcher, during his practice as a psychiatry nurse in a mental health unit observed that the South African Police Service experiences problems when called to attend to a psychiatric crisis. Police officers are despondent when called to attend to a crisis involving a mentally ill person and some end up ignoring such calls rendering such mentally ill people destitute, feeding from garbage bins, homeless and psychotic without the treatment they need.

The mentally ill persons police officers deal with on a daily basis manifest with all or some of the following signs and symptoms: verbal and physical violence directed at family members, neighbours and the community; inappropriate behaviour such as walking in public undressed, swearing and shouting at people for no reason; carrying dangerous objects like spears in public threatening to harm people; suicide attempts that turn violent on police arrival.
Police officers witnessing behaviours like inappropriate dressing and feeding from garbage bins ignore such cries for help. They will only respond when they are called by family members for a psychiatric crisis in a homestead. Police officers are thrust into a service of care for mentally ill people that they are not trained to deliver nor prepared to perform (Ainsworth, 1995; Cherrett, 1995; Green, 1997; and Ruin, 1993 as cited by Patch and Arrigo, 1999: 23).

Families and health care practitioners on the other hand, are not satisfied with the methods police officers use in apprehending mentally ill people and perceive the process as criminalizing mental illness. Families are concerned about the terrors of untreated psychosis and the indignities of forced interventions for their loved ones (Lefley, 2000: 241).

Police departments in the United States that have already embarked on training programmes on handling mentally ill people believe that one way to evaluate a police department is by examining how humanely it treats its most disenfranchised citizens. The programme encourages officers to view the mentally ill from a different perspective which supports humane treatment and creative solutions and promote utilisation of available resources to solve community issues and concerns (Sanchez & Fay, 2005).

The outcry of the community and health care practitioners about criminalization of mental illness led the researcher to recognising the purpose for the study, identifying the objectives and formulating questions for the research.
1.4 PURPOSE OF THE STUDY

The study aims at determining the knowledge and skills needs of police officers with regard to handling mentally challenged individuals. It explores the knowledge and skills of police officers in dealing with mentally ill persons.

Because the Mental Health Care Act, 2002 (Act No 17 of 2002) expects the police service to collaborate with health care workers in the care of, and management of mentally ill people, the police officers’ knowledge and skills base is the point of focus in the study.

After the knowledge and skills have been explored, solutions to the problem will surface.

1.5 RESEARCH OBJECTIVES

The study is designed to:

- Explore the level of knowledge of police officers regarding the management of mentally ill persons.
- Determine the skills police officers have for handling mentally ill persons.
- Describe the understanding of police officers of section 40 of the Mental Health Care Act, 2002 (Act No 17 of 2002).
1.6 RESEARCH QUESTION(S)

- Do police officers have the necessary knowledge about mental illness?
- What is the police officers’ understanding of Section 40 of the Mental Health Care Act, 2002 (Act No. 17 of 2002).
- Do police officers have the necessary skills to handle mentally ill people?

1.7 SIGNIFICANCE OF THE STUDY

The results of the study may help improve police management of mentally ill persons. It will benefit policy makers involved in the development of the police service and its programmes. The visiting of new areas of mental health care in the country by the study will contribute to knowledge.

The study will attempt to close the gap between the police service and mental health care service in an effort to rendering quality and recognizable mental health care.

Finally, the study endeavours to reduce injuries when the police confront a mentally ill person and improve the community living with mentally ill and police relations as mentally ill people will be treated with respect.
1.8 DEFINITION OF CONCEPTS

For the purpose of the report of this study, the following meanings or interpretations will be attached to the indicated key concepts.

1.8.1 A POLICE OFFICER

A police officer is a member of the police force: maintains law and order, prevents crime, investigates offences and preserves the country's internal security. Police officers have to be loyal to the Police Service and to the country and put the safety of the public above their own personal safety.

A police officer should: be emotionally mature and stable; work well under stress; be responsible; be honest and have integrity; be calm and patient; able to give and execute orders; make appropriate decisions quickly; have the desire to help others; able to maintain the highest form of discipline (SAPS poster, 2009).

1.8.2 COMMUNITY POLICING

According to the South African Police Service policy, community policing is a philosophy that guides police management styles and operational strategies and that emphasises the establishment of police-community partnerships and a problem solving approach responsive to the needs of the community (Reyneke 1997: 12 as cited by Morrison and Conradie, 2002).
Stephen Clarke, Westville SAPS communications officer in his presentation of Sector Policing, defines community policing as a philosophy based on partnership between the community and police to ensure a safe and secure environment in the country.

In much broader terms, community policing can be said to be, a joint responsibility of the country’s citizens and the SAPS for community safety through working partnerships and interpersonal relations resulting in a partnership built on trust and respect.

Community policing delivers a new set of policing services and a new approach to crime prevention techniques and control. It is based on the notion that community interaction and support can help control crime and reduce fear, with community members helping to identify suspect and bring problems to the attention of the police.

1.8.3 DEINSTITUTIONALISATION

It is the process that takes place when institutions and long-term institutionalisation are replaced by community-based mental health care services and community support systems in order to promote psychiatric outpatients’ integration and normalisation in the community (Perko & Kreigh, 1988: 506; Rawlins, Williams & Beck, 1993: 902). One approach to deinstitutionalisation which is commonly used is to discharge large numbers of psychiatric patients and primarily expect their families to support them in the community.
1.8.4 DELUSION(S)

An irrational belief which has no basis in reality but cannot be changed by logic or argument. There are many different types of delusions, namely:

- Paranoid delusions or delusions of persecution: the belief that one is being plotted against, spied upon, threatened, interfered with or mistreated by a number of parties joined in conspiracy.
- Delusions of control (delusions of influence): the belief that other people, forces or perhaps extraterrestrial beings are controlling one’s thoughts, feelings and actions often by means of electronic devices which send signals directly to one’s brain.
- Delusions of grandeur: the belief that one is an extremely famous, powerful and important person, for example, God.
- Delusions of reference: the belief that events or stimuli unrelated to the individual are actually referring to the individual.
- Delusions of sin or guilt: the belief that one has committed a terrible sin or inflicted great harm on others.
- Delusions of nihilism: the belief that one, others or the whole world has or have ceased to exist.
- Delusions of hypochondriasis: the unfounded belief that one is suffering from a hideous physical disease or a bizarre physical affliction (Trigoboff as cited in Kneisl and Trigoboff, 2009: 374; Uys and Middleton, 2004: 749-750).
1.8.5 HALLUCINATION(S)

A sensory perception that occurs in the absence of any external stimuli. May occur in any of the five senses and may be mood congruent or mood incongruent.

- Auditory hallucinations: false perceptions of sound, usually voices.
- Gustatory hallucinations: false perceptions of taste such as unpleasant taste.
- Olfactory hallucinations: false perceptions of smell.
- Somatic hallucinations: false sensations of things occurring in or on the body, for example, snakes crawling inside the stomach.
- Tactile hallucinations: false perceptions of touch or surface sensations, for example, a crawling sensation on or under the skin (Trigoboff as cited in Kneisl and Trigoboff, 2009: 374; Uys and Middleton, 2004: 751).

1.9 OVERVIEW OF CHAPTERS

The first chapter of the study is the introduction. It dwells on the reasons for the study, background description of the study area, purpose of the study, objectives and research questions and significance. Chapter 2 is the literature review. The literature is presented in an organised and structured manner. Chapter 3 documents the design and methodology followed in the process of the research. The chapter also provides information about the study population, study sample, measurement and ethical issues. The fourth chapter is the presentation and discussion of the results of the study. In this chapter, the results are analysed using manual and statistical techniques. The
fifth chapter is conclusion and recommendations. The chapter deals with the meaning of the results to the study area and other areas that it will impact. It further entails suggestions for the application of the results of the study and suggestions for dissemination of the results.

1.10 CONCLUSION

It is perceptible that police officers do not have the necessary knowledge and skills to manage mentally ill individuals. This has put fuel on psychiatric crises as families and mental health care practitioners saw violation of the rights of mentally ill people by the police when police had been called to assist.

The study will attempt to address the knowledge and skills of police officers in handling mentally ill individuals. It will be conducted in a quantitative paradigm and a survey design will be used. Sampling will be done randomly, data will be collected using a questionnaire and analysis will be done manually. The research report will be disseminated to the departments of health and police for their perusal with the hope that the recommendations will be utilised to improve the management of mentally ill people by the police.
CHAPTER 2 LITERATURE REVIEW

2.1 INTRODUCTION

This chapter covers literature on community management and policing the mentally ill in the Republic of South Africa and overseas.

Most of the work done and that is accessible on law enforcement approach to the mentally ill as well as policing the mentally ill was done in the United States. Studies that have been conducted in policing and mental illness, were guided by societal perceptions of the mentally ill as seen by scholars there. Society is intolerant of mentally ill persons and as evidenced by the stereotype of mentally ill persons as dangerous (Teplin, 2000).

In the Republic of South Africa there are no scholarly articles on the management of mentally ill people by the police service. The media has shown numerous incidents of police brutality to the mentally ill yet no expert saw how policemen handle mentally challenged persons worth studying, it may be assumed. The police service continues to be first line managers in psychiatric crises in the country regardless of criticisms of their methods therefore it is essential to look at what is happening in the community regarding the mentally ill.

The topics that will be consulted in this section are the following: A mentally ill person; Deinstitutionalisation of the mentally ill; Care of community based mentally ill persons; Legislation and care of mentally ill persons; Engagement by the departments of Health and Police in kwa Zulu Natal and; Policing the mentally ill.
2.2 A MENTALLY ILL PERSON

A mentally ill person is a person suffering from a mental disorder. Uys and Middleton (2004: 753) define a mental disorder as a clinically significant behavioural or psychological syndrome or pattern that occurs within a person and is associated with distress or disability.

Kneisl and Trigoboff (2009: 6) perceive mental illness and mental health as outgrowths of interpersonal processes and state that determining that a person is mentally ill is a matter of judgement, therefore, the appropriateness of behaviour depends on whether it is judged reasonably or not according to a set of social, ethical and legal rules that define the limits of appropriate behaviour and reality. A mental disorder is a psychological group of symptoms such as a pattern or a syndrome in which the individual experiences distress, disability or a significant risk of suffering pain, loss of freedom or death (Kneisl and trigoboff, 2009: 6).

A mentally ill person is characterised by psychosis, that is, a state in which a person’s mental capacity to recognise reality, to remember, think, communicate with others, respond emotionally and behave appropriately is impaired, aggressive and disruptive behaviour and suicidal ideations thus interfering with the person’s capacity to deal with life’s demands, for example, schizophrenia, bipolar depression and paranoia (Kneisl and trigoboff, 2009: 5-8; Uys and Middleton, 2004: 756).

A Bipolar mood disordered person(s) (manic episode) has a distinct period in which the predominant mood is either elevated, expansive or irritable and the disturbance is sufficiently severe to cause marked impairment in occupational functioning or usual social activities or relationships with others (Jarvis and Middleton as cited in Uys and Middleton, 2004: 356). The person appears colourful and flamboyant with very high energy levels. His or her speech is loud, rapid and
uncontrollably exuberant with the use of puns. There is pressure of speech and flight of ideas accompanying this disorder. His or her mood is labile and the patient is easily susceptible to distracting stimuli; the patient is intrusive, domineering and demanding. He or she is grandiose and often sexually inappropriate, that is, promiscuous and hypersexual (Jarvis and Middleton as cited in Uys and Middleton, 2004: 356).

**Schizophrenias:** the term schizophrenia is used to describe a group of complex, severe conditions that are the most chronic and disabling of the mental illnesses. The conditions are characterised by patients experiencing a different reality from that of the people around them. Their reality is distorted, changeable and often frightening. Their sensory perceptions may be distorted by hallucinations and their thought processes are often confused so that they find it difficult to think straight or to focus on or engage in problem solving. Their thought content is also abnormal, delusions being common and their emotional expression is usually limited or inappropriate (Trigoboff as cited in Kneisl and Trigoboff, 2009: 373; Uys as cited in Uys and Middleton, 2004: 366).

Though **epilepsy** is not a mental illness, it is important to note that psychiatric conditions and epilepsy may share the same aetiology, for example, head injury. Ictal states, be it pre-ictal, ictal, inter-ictal and post-ictal state, usually manifest as irritability, agitation, aggression and sometimes depression. Ictal psychosis may present with visual, gustatory and auditory hallucinations that are not well defined (East London Mental Health Unit clinical guidelines and protocols, 2008).

**Substance related disorders** are self explanatory, that is, they are mental disorders that are induced by the use of one or more of the following substances: alcohol, illegal drugs like dagga, mandrax,
cocaine and other drugs that bring about impairment of mood, altered level of perception and impaired brain function. Police officers should be able to differentiate between substance induced disorder and substance intoxication (East London Mental Health Unit clinical guidelines and protocols, 2008).

Police officers should be made aware of such persons as they will be summoned to assist families of persons suffering from disorders like bipolar mood disorder; schizophrenia; pre-ictal, ictal, inter-ictal or post-ictal confusion; and substance induced psychosis. The hallucinations and delusions with schizophrenics make such people more dangerous to handle and need a knowledgeable and skilled person to succeed.

The discharging of mentally ill people from long term institutions which came with the integration of mental health care to the primary health care system came with a load of work to communities with mentally ill people.

2.3 DEINSTITUTIONALISATION OF THE MENTALLY ILL

According to the South African government’s primary health care approach, mental health institutions have to discharge as many psychiatric patients as possible from long-term psychiatric hospitals (ANC, 1994: 44). This process, called deinstitutionalisation, puts greater responsibility for people with mental illness on their families. Families are expected to support them towards integration and normalisation in the community.
Deinstitutionalisation replaces long-term mental health institutions by community-based mental health services and community support systems in order to promote the psychiatric outpatient’s integration and normalisation into the community. In South Africa, deinstitutionalisation was proposed as part of the attempt to correct fragmented and centralised mental health care services (Uys, 1997:64; ANC, 1994: 44). A primary health care approach was suggested, in which clinics, health centres and independent practitioners were the primary areas of first contact with the health system in contrast with the hospital as first contact (ANC, 1994: 19).

Although deinstitutionalisation is not fully employed, a great number of mental health care institutions have started reducing the stays of mental health care users in such facilities and thus leaving persons who should be cared for as inpatients in the care of their families. This brings the burden to the police service as uncared for mentally ill persons usually go astray.

The deinstitutionalization of the mentally ill in the United States of America released a lot of non-violent patients to their families leaving mentally ill people without appropriate social services and support systems. The families of the mentally ill were not mobilized to effectively carry out the responsibility (Hanson & Rapp, 1992:182). Unprepared families were emotionally and financially drained and mentally ill persons were rejected and rendered unemployed and homeless. When people became psychotic, the police were most commonly called and were serving as frontline mental health workers though they were not formerly trained (Teplin, 2000).

The law enforcement agencies were taken by surprise as they were not prepared for their new or additional roles. Concerned mental health care practitioners in the United States decided to study the new roles of police officers, particularly that of apprehending mentally ill persons. The
Deinstitutionalisation and shift of mentally ill people to the community lead police to playing an important role in the management of acute psychiatric states (Psarra, Sestrini et al., 2008: 77-85).

In Britain, deinstitutionalisation took place with more caution, as the possible isolation, rejection and neglect of patients by unprepared families were anticipated (Reed, 1984: 83).

A more successful approach was followed, namely, big psychiatric hospitals were replaced with smaller community based facilities, necessitating the development of a community based mental health care system (Culhane, 1996: 25).

Deinstitutionalisation necessitated an effective community based mental health service. Families of people with mental illness need to be mobilised so that they can provide the patients with material resources, to give attention to their emotional and spiritual needs.

2.4 CARE OF COMMUNITY BASED MENTALLY ILL PERSONS

Mental health services in South Africa have been integrated in the general health services and are intended to be available at all levels of care, that is, primary mental health care, secondary mental health care and tertiary mental health care. Primary mental health care is part of primary health care services and nurses and doctors are trained on early detection, diagnosis, treatment and appropriate referral to other levels of care. District hospitals form part of the primary health care system and are used depending on the severity of the condition and facilities available (Rita Thom as cited in Bauman, 2007: 4-5).
Secondary and tertiary level mental health services are provided by a limited number of specialist mental health care practitioners who work in the public sector including acute psychiatric units in general hospitals, in psychiatric hospitals and specialised community psychiatric services (Rita Thom as cited in Bauman, 2007: 5).

Mental health care services available at community level are rendered by clinics that are expected to give a comprehensive service, including diagnosing and treating the most common conditions, community based rehabilitation, preventive and promotive services (Uys as cited in Uys and Middleton, 2004: 61). The clinics have the community health centres and the district hospital to refer to when they cannot handle a problem involving a mentally ill person. The district hospital is fully equipped with the necessary human resources that form a multi-disciplinary team like clinical psychologists, occupational therapists, mental health nurses and psychiatric social workers, and psychiatrists (Uys as cited in Uys and Middleton, 2004: 61).

A mental health team (multi-disciplinary team) is made up of the psychiatric health nurse as an integral and important part involved in mental health care and is the most likely to have a overall view of the mentally ill person’s situation. The mental health nurse plans and shares with others to deliver maximum mental health services to clients and families; and the purpose of partnering and collaborating with others is to make the best of different abilities of mental health team members to give the client and family the most effective service available (Kneisl as cited in Kneisl and Trigoboff, 2009: 22).

In the community, it is the families of the people with mental illness that shoulder the greatest part of the burden of caring for them and the burden this creates for them is significant (Uys as cited in
Uys and Middleton, 2004: 77). The family is the main resource of the person suffering from mental illness and families act as care givers and they support other families with similar problems (Uys as cited in Uys and Middleton, 2004: 77). According to Kneisl as cited in Kneisl and Trigoboff (2009: 24), family and friends are a central influence in each person’s life. It is therefore important to include clients and their significant others in the collaborative process of the mental health care team whenever it is possible. Mental health care users’ participation in their own health care assures nurses that their clients are informed consumers of mental health care services (Kneisl as cited in Kneisl and Trigoboff, 2009: 24). Clients and families can also be invited to participate in case conferences that have an important place in the functioning of the mental health service or in case conferences involving collaboration among several agencies or several mental health care practitioners moving towards similar goals (Kneisl as cited in Kneisl and Trigoboff, 2009: 24).

Families living with a family member who is mentally ill have three pillars that can guide them in caring for their members with a serious mental illness. They must create an environment low in stress, manage disturbing behaviour successfully and promote social integration and rehabilitation (Uys as cited in Uys and Middleton, 2004: 79-82).

Creating an environment with low stress entails keeping a predictable schedule. This decreases decisions and adjustment; developing appropriate expectations. Expectations should be pitched low with the patient’s tolerance tested gradually; mentally ill people should be spoken to simply; there must be a plan for stressful situations; over-involvement must be avoided and family members must deal effectively with their own stress (Uys as cited in Uys and Middleton, 2004: 79-80).

Persistent inactivity, refusal of treatment and aggressive behaviour are the most common disturbing behaviours of people with mental illness. To manage inactivity successfully, a schedule of a few simple activities should be planned and others added later as he manages to keep the schedule. A
discussion with the treatment team is useful since they may be able to initiate and maintain medication taking through home visits. They may also change oral treatment to intramuscular treatment.

Aggressive behaviour is the most difficult to manage and disrupts family life. People attending to a mentally ill person with aggressive behaviour must first analyse the circumstances of the violence. Listening to what he says to find out what the anger is about helps. If the violence is a result of relapse, intervention with medication or hospitalisation is indicated (Uys as cited in Uys and Middleton, 2004: 81).

Aggression used by the patient to get his or her way usually intimidates people to give in to his or her demands and this makes things worse. Uys as cited in Uys and Middleton (2004: 81-82) mentions steps that should be followed in managing such a patient:

- A meeting should be convened with health care workers to decide which demands will no longer be accepted.
- The patient should be told in a calm way what will not be tolerated and what the consequences will be if he acts violently. Have telephone numbers of help handy when doing so and later, evaluate how the plan worked.

If the mentally ill person loses control over himself or herself and lashes out when cornered, carers must learn to identify the signs which show that he/she is beginning to lose control. He or she must be given space and have the discussion postponed. The family must at all times preserve their own safety by phoning for help (police) or call neighbours (Uys as cited in Uys and Middleton, 2004: 81-82).
The police are another major resource in the care of, and management of mentally ill persons in the community. They therefore should have the skills necessary to effectively manage mentally ill people preventing harm in the process, for example, identifying a mentally ill person and management of an aggressive patient.

The legislations that oversee the care of the mentally ill are interpreted differently by the people they are made to guide. The Mental Health Care Act, 2002 (Act No. 17 of 2002) incorporates the South African Police Service in the care of the mentally ill yet the South African Police Services Act, 1995 (Act No. 68 of 1995) does not mention care of, and management of mentally ill persons as part of policing duties therefore the police do not get trained on the management of mentally ill persons.

2.5 LEGISLATION AND THE CARE OF MENTALLY ILL PERSONS IN THE COMMUNITY

The government’s failure to ensure accountability for security forces’ (South African Police Service/ SAPS) violations of human rights remains a very serious problem with regard to handling of mentally ill people.

In terms of the constitution of the Republic of South Africa, South African Amendment Act, 1996 (Act No. 108 of 1996) and the South African Police Strategic Plan (South African Police Service Strategic Plan 2004 B, 2007), one of the objectives of the SAPS is to maintain public order, yet lack of professional conduct and discipline in the police force is rampant as evidenced by the use of excessive force against mentally ill persons by police officers.
The Mental Health Review Board, another sphere of the government of the Republic of South Africa, in Section 40 of the Mental Health Care Act, 2002 (Act No. 17 of 2002), states that, if a member of the South African Police Service (SAPS) has reason to believe, from personal observation or from information obtained from a mental health care practitioner, that a person due to his or her mental illness or severe or profound intellectual disability is likely to inflict serious harm to himself or herself or others. The SAPS member must apprehend that person and arrange for that person to be taken to an appropriate health establishment administered under the auspices of the state for assessment of the mental health status of that person and handed over into the custody of the head of the health establishment or any other person designated by the head of the health establishment to receive such persons (Madela-Mntla as cited in Uys and Middleton, 2004: 96).

The Mental Health Care Act, 2002 (Act No. 17 of 2002) aims to protect the rights of mentally ill people and these include the right to dignified and human treatment, freedom from discrimination in terms of access to all forms of treatment, the right to privacy and confidentiality, the right to protection from physical or psychological abuse and the right to adequate information about their clinical status (Sean Kaliski as cited in Bauman, 2007: 573). Mentally ill people have the right to be treated under the same professional and ethical standards as other ill people and this must include efforts to promote the greatest degree of self determination and personal responsibility in the part of the mentally ill persons. Admissions and discharges are always carried out in the mentally ill person’s best interests in the least restrictive environment. The Mental Health Care Act protects mentally ill persons from exploitation and abuse. Any person witnessing any form of abuse against a mentally ill person is encouraged to report that to the Mental Health Review Board or lay a charge with the South African Police Service (Sean Kaliski as cited in Bauman, 2007: 573).
If the police service is to collaborate with the mental health care service, police officers need to be aware of the kind of person they will be dealing with. Following the incorporation of the South African Police Service in the care of mentally ill people, some provinces have taken the necessary steps in ensuring that a collaborative process is put in place between the mental health care system and the police.

2.6 ENGAGEMENT OF THE HEALTH AND POLICE DEPARTMENTS IN KWAZULU NATAL

Responding to the enactment of section 40 of the Mental Health Care Act, 2002 (Act No. 17 of 2002), some provincial health departments became proactive in finding ways of including the police service in the care of, and handling of mentally ill people. On the 26 of February 2009, the Kwa-Zulu Natal Department of Health hosted a workshop with the South African Police Service to share ideas and expertise in caring for, and handling of mentally ill persons (Kwa-Zulu Natal Department of Health, 2009). The workshop sought to:

a) Brief the SAPS on the Mental Health Care Act, 2002 (Act No. 17 OF 2002).

b) Define Roles and Responsibilities of policemen, and to

c) Adopt an action plan that would enhance cooperation in caring for and handling of mentally ill persons.

The workshop was addressed by specialists in the field of psychiatry from health institutions, the University of Kwa Zulu Natal and the Mental Health Review Board. Further meetings were
indicated and would follow the workshop on a continuous basis to ensure the cooperation between the two departments in handling mentally ill persons.

In view of the policing landscape of the country, community policing does not embrace the safety of mentally ill people. The constitution puts down that the South African Police Service has the responsibility to prevent, combat and investigate crime, to maintain public order, to protect and secure inhabitants of the country and their property, and to bring the perpetrators to justice. Police officers are trained on preventing violence against women and children and special teams are formed therefore, claims the South African Amendment Act, 1996 (Act No. 108 of 1996) but nothing has been done to protect mentally ill people.

It is in the United States that scholars took turns in studying the policing of mentally ill people bringing to the fore various programmes they felt suited the task. Some came with recommendations that became popular throughout the United States and Europe and were used and are still used in the management of mentally ill people by the police in the subcontinents (Vickers, 2000; Teplin, 2000; Watson, Morabito et. al, 2008; Williamson, 2004; Sanchez and Fay, 2005; and Cordener, 2006).
2.7 POLICING THE MENTALLY ILL

The deinstitutionalization of the mentally ill led to the formation of a crisis intervention team and the first police department in the United States to invest in the crisis intervention team for handling crises involving mentally ill persons was Memphis, Tennessee Police Department (Vickers, 2000). It came after a shooting incident of a black man with a history of mental illness in September 1989. The mentally ill young man was cutting himself with a knife threatening suicide when the police were called. The police confronted the man demanding that he drop his weapon. The commands upset him and he charged the officers who in fear of their own safety, shot and killed him. The death’s racial overtones catalysed the creation of the crisis intervention team a year later (Vickers, 2000).

The team is staffed by police officers with special training in mental health issues. The officers learn about mental illness, substance abuse, psychotropic medication, treatment modalities, patient’s rights, civil commitment law and techniques for intervening in crisis. The training promotes a philosophy of responsibility and accountability to consumers of mental health services, their relatives and the community (Vickers, 2000). The benefits of having the crisis intervention team include immediate crisis response, decreased use of force and arrest, and officers are better trained and educated in verbal de-escalation techniques increasing officers’ recognition and appreciation by the community (Vickers, 2000; Watson, Morabito, Draine and Orrati, 2008: 359-368).

The partnership between the police department and the medical centre’s psychiatric emergency department is a key element in the programme’s effectiveness in which procedures were developed jointly (Vickers, 2000). Programmes based on the Memphis policing model have been adopted and
developed by cities throughout the United States. The model is a shift from a traditional law enforcement model to a community policing model (Vickers, 2000).

Elizabeth Williamson (2004) relate of an approach used by Frederick Police Department in west Maryland in the United States to train police officers in handling mentally ill people. Frederick city police wear earphones and listen to sounds of schizophrenia so as to understand why people who suffer from the illness sometimes respond badly to commands from police officers or ignore them entirely. The sessions are part of an effort to better serve Frederick residents with mental illness. Frederick police officers who have undergone training on mental illness believe that most people with mental disabilities pose no danger and they need people who know how to talk to them (Williamson, 2004).

Linda Teplin (2000) suggested a change in the criminal justice and health policies for the police to have a clear judgement on their new task. The findings from a study to determine the high prevalence rates of mental disorders in male and female jail detainees suggested that mentally ill people were criminalised. A number of mental health professionals commented on that, some claiming it is “criminalization of mentally disordered behaviour” (Teplin, 2000).

The findings suggested a need for several changes in both the criminal justice and mental health systems. Linda Teplin (2000) suggested the following policy changes:

- The public mental health system must evolve to meet the challenges of deinstitutionalization. Policy makers must recognise the need for significant increases in funding for mental health services in the community. The public mental health system and
the criminal justice system must collaborate, not just arrest or hospitalise when handling mentally ill persons in the community.

- A more integrated system of care-giving must be designed to reduce the number of persons falling through the cracks into the criminal justice net and to provide effective community services to persons who are arrested and released.
- The least restrictive alternative should be used and whenever possible, mentally ill persons with misdemeanour charges pending should be treated in a mental health facility. In this way, mentally ill individuals would not become victims of their own disorder unless they commit serious crimes.
- Police officers must receive adequate training in recognising and handling mentally ill citizens so that individuals who are more disordered than disorderly are referred to the appropriate system. The police must have a clear set of procedures on handling mentally ill people.

A person with mental illness may harm other citizens by committing personal or property crimes or disruptive behaviour. Alternatively, a person with mental illness may be harmed as a crime victim, as an abused family member or patient, as a person whose mental health problem has left him or her erroneously subjected to criminal charges and jail confinement. It is important therefore to keep the concept of harm in mind when addressing this particular problem because there is a tendency to simply define people with mental illness as the problem and getting them out of sight as the solution. Police have to be careful not to blame people with mental illness but instead focus on the behaviour that causes harm to self or others (Cordener, 2006).
Encounters with police are likely to be dangerous for people with mental illness than for the police. It is estimated that people with severe mental illness are four times more likely to be killed by police. Serious injuries and death of people with mental illness at the hands of the police are tragic and reduction of such injuries and deaths should be a high priority objective for every police agency (Cordener, 2006).

A new approach by Cam Sanchez, the chief of police of the City of San Rafael in County Marin in San Francisco and Joel Fay, a mental health liaison officer with the police department ensures that police officers responding to calls regarding a mentally ill person will be better equipped to evaluate their entire situation, including whether or not there is a crime involved and to identify appropriate solutions.

According to Sanchez and Fay (2005), law enforcement traditionally deals with people who cause problems by determining if the problem is a crime and if so, arresting that person for that crime. The belief is that as a person is in jail, there is no problem and the arrest will deter the person from repeating the crime. The approach does not work for people with psychiatric disorders, addictions or dual diagnoses (Sanchez and Fay, 2005).

The San Rafael Police Department repeatedly arrest these offenders with little change to show for their efforts. The lack of results occurs primarily because people with psychiatric disorders have very little control over them and secondarily because psychiatric disorders do not go away because a person is in jail. When a mentally ill person is incarcerated, the Marin County Sheriff’s department employs a crisis specialist and a part-time psychiatrist at the county jail to provide mental health treatment (Sanchez and Fay, 2005).
The Sheriff’s department needed to find alternative and creative methods for handling calls for service with the mentally ill. The community oriented policing model provided a framework for the task. In becoming a part of a team that addresses the issues of the mentally ill, the San Rafael police department took the opportunity to become a pioneer in an area that has been ignored. They are committed to utilising the community oriented policing model in order to bring multidisciplinary team approach to handling of cases involving the mentally ill (Sanchez and Fay, 2005).

The San Rafael police department has also established a law enforcement mental health liaison officer resource team comprised of officers from each department in the county and the Marin County sheriff’s office. Marin community mental health has provided a mental health specialist to serve as a resource person in the team. It intended to address the mentally ill person brought to their attention by shifting their focus from the person to the problem. The problem will become the target of their efforts and not the person. By modifying their approach, they hoped to find alternative solutions and to engage the person in solving the problem responsibly. It is in their belief that one way to evaluate a police department is by examining how humanely it treats its most disenfranchised citizens. The programme encourages officers to view the mentally ill from a different perspective which supports humane treatment and creative solutions and promote utilisation of available resources to solve community issues and concerns (Sanchez & Fay, 2005).

The San Rafael police department committed itself to playing a key role as a problem solver and community resource in cases involving the mentally ill.
2.8 CONCLUSION

The community policing models used in the United States embrace adoption of a problem solving orientation to operational problems and the use of community partnerships to accomplish operational objectives. Policing agencies are applying these principles in developing initiatives to improve the effectiveness of their response to mental health crises in the community. Police officers are provided with specialised training with a curriculum developed by local mental health care professionals often in collaboration with family groups and law enforcement personnel. The programmes appear to hold promise for diverting mentally ill people from jail, keeping them in the community and facilitating access to treatment.

All the literature available on relations between the police and the mentally ill in a crisis situation shows a significant need for training of police officers in identifying and recognising disorderly behaviour that is indicative of mental illness so that they do not confuse mentally ill people with criminals.

Collaboration and partnerships of the police service and the community mental health service in the care of mentally ill persons is the core to the success of such specialized training facility and resources.

As indicated by Cordener (2006), the majority of the mentally ill population is also a victim of homelessness, alcohol and drug abuse and it is imperative that all social service agencies be fulltime partners in all strategic endeavours and policy formulations in the interests of the mentally ill.
The scholars of the studies that were reviewed utilised descriptive and exploratory designs for their studies and the most common methods used were surveys with their tools of choice questionnaires and interviews. The studies reviewed were useful in identifying the design and the measurement tool for this study.
CHAPTER 3 RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter contains links regarding the methodological issues in the study. It focuses primarily on the research method, research design, tools and techniques used in the research process. It begins with a discussion of the research method, research design followed by details of the population selected for the study, a description of the respondents, sampling procedures, instrumentation used, data collection methods and the treatment and analyses of the data.

3.2 RESEARCH METHOD

The study was conducted in the quantitative paradigm. According to Kumar (2005: 12), the quantitative approach is structured. In the structured approach, everything that forms part of the research process, that is, objectives, design, sample and the questions, is predetermined. Quantitative research gathers empirical evidence, that is, evidence that is rooted in objective reality gathered directly and indirectly through the senses rather than through personal beliefs or hunches; the evidence is gathered systematically using formal instruments to gather the needed information (Polit and Beck, 2006: 15-16).
The quantitative method was chosen for the study because in the quantitative paradigm, data can be collected in a highly structured manner; the same information is gathered from all participants in a comparable, pre-specified way. Data will be gathered in such a way that it can be quantified and a structured instrument was used to collect data. Polit and Beck (2006: 16) affirm that in a total structural instrument, respondents are asked to respond to same questions in the same order, and are given the same set of options for their responses. The research design for the study is discussed below.

3.3 RESEARCH DESIGN

In order to attain the objectives of the study, a descriptive design was utilized. Burns and Grove (2005: 232) depict a descriptive design as designed to gain more information about characteristics within a particular field of study, its purpose being to provide a picture of situations as they naturally happen.

A descriptive design may be used for the purpose of developing theory, identifying problems with current practice, justifying current practice, making judgements or determining what others are doing in similar situations (Waltz and Bausell, 1991 as cited in Burns and Grove, 2005: 232). A survey was selected for the study because, the study aims at establishing what people (police officers) are thinking, doing, anticipating and will assist in gaining insight into the present life of the police force in relation to their response to people with mental illness and also reveal their problems therewith. According to Polit and Hungler (1995) as cited in Parahoo (2006: 323) state that a survey
is appropriate for descriptive studies as it is designed to obtain information from populations, the prevalence, distribution and interrelationship of variables within those populations.

Taking from the above scholars, it is apparent that a descriptive type of research is primarily concerned with describing the nature or conditions and degree in detail of the present situation. The emphasis is on “describe” rather than on “judge” or “interpret”. Researchers who use this method for their research usually aim at:

- Demarcating the population by means of perceiving accurately research parameters; and
- Recording in the form of a written report of that which has been perceived.

Because the total population during a specific investigation cannot be contemplated as a whole, demarcation of the population or of the selection of a representative test sample will be utilized. Sampling therefore forms an integral part of descriptive design.

### 3.4 POPULATION

The population for the study is the police force in Mdantsane, that is, all police officers employed in the three police stations in the township. Parahoo (2006: 256) defines a population as the total number of units from which data can potentially be collected and this is a theoretical population. Parahoo (2006: 257) further states that in theory all the units in the population could potentially take part in the study but in practice that is impossible as there may be a need to exclude some units to get the required results. In stipulating the inclusion and exclusion criteria, the researcher has defined
the target population or study population (Parahoo, 2006: 257). For the study the inclusion and exclusion criteria that define the study population are as follows:

**3.4.1 INCLUSION CRITERIA**

The study population comprises the South African Police Service in Mdantsane, particularly, the police officers working at the Community Service Centres of the three police stations. The Community Service Centre commonly known as the Charge Office is the department of a police station that receives calls for assistance from the community and responds as such. They are the most active part of the entire police force as they work directly with the community and are first line managers of community problems.

**3.4.2 EXCLUSION CRITERIA**

- Office bearers not actively involved in the management of mentally ill people are excluded from the population.
- Police reservists and volunteers are excluded because they have not undergone all the necessary education and training to be fully ranked police officers.
3.4.3 STUDY POPULATION

The Community Service Centre police force of Mdantsane (all three police stations) is comprised of 136 fully fledged police officers, that is, seventy two at Mdantsane police station, thirty at Vulindlela police station and 34 at Inyibiba police station. Table 1 presents the Community Service Centre police force of Mdantsane per rank, race and gender.

Table 1: Mdantsane South African Police Service, Community Service Centre (CSC) profile as per rank, race and gender

<table>
<thead>
<tr>
<th>RACE, RANK AND GENDER</th>
<th>BLACK</th>
<th>COLOURED</th>
<th>WHITE</th>
<th>OTHER (Specify):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
<td>Males</td>
<td>Females</td>
</tr>
<tr>
<td>Student constables</td>
<td>14</td>
<td>10</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Constables</td>
<td>50</td>
<td>21</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Sergeants</td>
<td>12</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Inspectors</td>
<td>22</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>98</td>
<td>37</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

The vast majority, namely, ninety eight (72 %) of police officers in the Community Service Centre are male and only 37 (28 %) are female. The distribution of the population per gender is portrayed in Figure 1.
Out of the population, twenty four (18%) are student constables, seventy two (53%) are constables, fourteen (10%) are sergeants and 26 (19%) are inspectors. Figure 2 displays the ratio of police officers by rank.

Figure 2: Distribution of the population by ranks.
3.5 SAMPLING METHOD

Sampling was done randomly. A simple random sampling technique was used for the task. According to Parahoo (2006: 261), simple random sampling is the most common form and is one in which each unit in the sampling frame is given a number; these are then put into the proverbial hat and numbers are drawn one at a time until the size of the sample is reached.

Burns and Grove (2005: 223) claim that random or probability sampling requires less time and is cheap; is more likely to be representative of the population; there is less systematic bias if subjects are selected randomly; and it increases the probability that subjects with various levels of an extraneous variable are included and are randomly dispersed throughout the groups within the study.

The deliberations by Parahoo (2006: 261) and Burns and Grove (2005: 223) led the researcher to choosing random sampling as the correct sampling method for the study.

3.6 STUDY SAMPLE

The budget and time determined the size of the sample. The researcher is aware that, the greater the sample size the more accurate the results would reflect the true picture of the population but because of time and budgetary constraints that could not be aimed at.

The study is a mini dissertation and the university requirements for such a study are met in terms of sample size. Thirty three percent of the policemen and policewomen working for the Community
Service Centre were selected for data collection and were sampled in all three stations. The simple random sampling of the population accessible in each police station was done proportionally, that is, a bigger number of respondents was selected from a bigger police station with a larger police force and vice versa. All police officers that had reported for duty on the days of data collection were given numbers, the numbers were put in a bowl (bowl shaken) and forty five numbers were selected. The study sample is 45 police officers, twenty four from Mdantsane police station, ten from Vulindlela police station and eleven from Inyibiba police station. Thirty three percent was chosen to be the correct sample to be studied considering the time and financial constraints. The characteristics of the sample in the form of a table are found in Appendix A. Having attained the study sample, data were collected.

3.7 DATA COLLECTION

Data collection is the process of gathering data from the subjects; the actual steps are dependent on the research design and are specific to each study (Burns and Grove, 2005:430). After selecting the subjects, the data are collected in a consistent way maintaining research controls and solving problems that may threaten to disrupt the study (Burns and Grove, 2005: 430).

The data collection was done in a sequence; the process was timed, that is, time was allocated for explaining the study to the participants, obtaining consent and completing questionnaires. The data collection plan in the next section summarises the events.
3.7.1 DATA COLLECTION PLAN

Preparing for data collection was done following the approach of Polit and Beck (2008: 374). According to Polit and Beck (2008: 374), data collection plans for quantitative studies should yield accurate, valid and meaningful data that are maximally effective in answering research questions. The steps followed in developing the data collection plan are as follows:

- Identifying the data needs for addressing the research questions, that is, describing sample characteristics, interpreting results and obtaining administrative information (dates of actual data collection and where data collection takes place).
- Selecting and developing an instrument for collecting data. In selecting the instrument, resources were considered (Data collection costs), population appropriateness (literacy level) and administration issues (conditions regarding time of administration and privacy of the setting).
- Pre-testing the instrument (pilot study).
- Developing collection forms (informed consent forms, forms for recording data and information sheets, data capture sheet and code sheet) (Polit and Beck, 2008: 374).

Polit and Beck (2008: 381) further state that the quality of data is affected by both the data collection plan and how the plan is implemented and mentioned the following steps in implementing a data collection plan: Selecting research personnel and training data collectors. For the study, the researcher collected the data as it is of a smaller scale; and after the data collection plan was developed, it was employed starting with the population and sampling, data were collected using a questionnaire.
3.7.2 RESEARCH INSTRUMENT

A Questionnaire was used to measure the level of knowledge and skills of police officers regarding handling of mentally ill persons in the three Mdantsane police stations. It was done in August 2009 and the researcher consequently performed the measurement.

According to Parahoo (2006: 282-284), the questionnaire is the most common method of data collection in social and health sciences and is most frequently used in survey designs.

The choice of the measurement tool, the questionnaire, was guided by its relative simplicity. A questionnaire is cheap to construct and to distribute especially when it is going to be self administered and is the most rapid and efficient method of gathering data. It is also suitable for the study because of its ability to ensure that respondents remain anonymous (Polit and Beck, 2008: 426-427).

Polit and Beck (2008: 426-427) mention four important considerations researchers should keep when constructing their questionnaires:

1. Clarity; questions should be clearly worded and unambiguous.
2. Ability of respondents to give information: respondents must be able to answer the questions.
3. Bias: the wording of the questions should minimize the risk of response bias.
4. Sensitivity: questions must not ask things that are sensitive to the respondents (private in nature).
In developing the questionnaire used, the following were added to Polit and Beck (2008: 426-427) s’ considerations:

- Good questions were asked.
- Both closed-ended and open-ended questions were used.
- It was ensured that questions were logical, not misleading and
- The questions are answerable, neat and not too lengthy.

On completion of developing the questionnaire, it was pre-tested with a smaller group of subjects.

### 3.7.3 PILOT STUDY

Polit and Beck (2008: 213) define a pilot study as a small-scale version or trial run, designed to test the methods to be used in the larger study and are sometimes referred to as feasibility studies. Pilot studies are significant in planning the larger study including the evaluation of the following: adequacy of study methods and procedures, likely success of a participant recruitment strategy, appropriateness and quality of instruments, potential problems such as loss of participants during the course of the study and extent to which the preliminary evidence justifies subsequent larger scale research (Polit and Beck, 2008: 214).

For the study, the questionnaire was pretested among a smaller group of target respondents (fifteen subjects) to check its accuracy in capturing the intended information, its reliability and validity, the time it takes to complete it as well as the understandability of the questions. The questionnaire used is displayed in appendix B.
The findings of the pilot study gave the following interpretation:

- The information obtained from the study will be valid, reliable and trustworthy;
- Potential participants were willing to be part of the study;
- The questionnaire is understandable and accurate in capturing the intended information; and
- The length of the questionnaire was acceptable to participants.

On completion of the analysis and perusal of the findings of the pilot study, the larger scale data collection was conducted.

3.7.4 DATA COLLECTION PROCESS

Data were collected in accordance with the approach of Polit and Beck (2008: 371). “Research data for quantitative studies are collected according to a structured plan that indicates what information is to be gathered and how to gather it, for example, most self administered questionnaires are highly structured: they include a fixed set of questions to be answered in a specified sequence and with pre-designated response options” (Polit and Beck, 2008: 371).

A major and central procedural challenge in the data collection process of the study was the question of gaining access to the police stations and respondents. The South African Police Service does not have a tradition of openness to researchers and much of the functioning of the organisation is veiled by secrecy and training has been a particularly sensitive area. It took the researcher a measurable amount of time to gain access to the respondents and the station commissioners made the task less daunting. There was always the fear of media involvement in the study and their
anxieties were allayed by being reassured of no media involvement and the importance of the study to the police and health departments.

To obtain empirical data for the study, the researcher was assisted by the station commissioners of the relevant police stations in identifying key role players for the study, namely, police officers employed in the Community Service Centre of the police stations.

On receipt of the letters of approval from the provincial departments of health and police, the researcher met with the Cluster Commissioner of Mdantsane who also approved of the study and acted above expectation by including in the approval letter, a statement ensuring cooperation by the station commissioners of the three Mdantsane police stations and had copies delivered to them. Approval letters can be viewed in appendix H and appendix I.

The researcher organised appointments with the three station commissioners at dates and times convenient to them so as to inform them about the study and make arrangements for collecting data.

Data were collected from the Community Service Centre members of the three police stations at different dates. Data collection dates were decided with the police commissioners of the relevant police stations. On the 3rd of August 2009 to the 7th August 2009 data was collected at Inyibiba police station; on the 10th to the 14th of August 2009 at Vulindlela police station; and on the 17th to the 21st of August 2009 at Mdantsane police station. A data collection sheet is available in appendix E.
The Community Service Centre police force of each police station is divided into four relief groups and work two shifts (day and night). The four groups take turns rotating the two shifts and that made it easy for the researcher to access all four teams of each police station during their day shift.

After obtaining consent from all members on duty on the days of data collection, sampling was done randomly to get 33 % from the numbers reported for duty. Cards with numbers and the fishbowl technique were used to achieve the required sample.

At Inyibiba police station, thirty four policemen and women comprised the Community Service Centre. After sampling all four teams proportionally (33% of available officers), eleven police officers were given questionnaires to complete. The questionnaires were distributed by the team leader of each shift and completed questionnaires were returned to the station commissioner’s office.

At Vulindlela police station, the Community Service Centre is made up of 30 police officers. After sampling the four relief groups, ten officers received questionnaires and completed questionnaires were handed to the team leaders of the relevant groups.

At Mdantsane police station, out of 72 police officers, twenty four were sampled and given questionnaires. Completed questionnaires were given to the police superintendent in charge of the department.

The researcher collected the completed questionnaires from the relevant persons at the end of each shift. The response rate was 100 % and that was made possible by the loyalty and obedience of
police officers to their supervisors or authority. After collection, the data were cleaned and analysed as discussed in the next section.

3.8 DATA CAPTURING AND EDITING

For the purpose of data analysis, a code sheet was developed. A code book provides a set of rules for assigning numerical values to answers obtained from the respondents (Kumar, 2005: 224). Coded data can be analysed manually or with the help of a computer. If the number of respondents is reasonable small, there are not many variables to analyse, and the researcher is neither familiar with a relevant computer programme nor wishes to learn one, one can manually analyse data (Kumar, 2005: 244). Because the study is of a smaller scale, a code sheet was developed. A code sheet is made available in Appendix C.

The coded data were then put in a data grid and data analysis took place. A data grid is available in Appendix D.
3.9 DATA ANALYSIS

Data were analysed in compliance with the descriptions of Mouton (2001:108).

Mouton describes data analysis as involving breaking up the data into manageable themes, patterns, trends and relationships. Mouton (2001: 108) further states that, data analysis is aimed at understanding the various constitutive elements of one’s data through an inspection of the relationship between concepts, constructs or variables, and to see whether there are any trends or patterns that can be identified or isolated or to establish themes in the data.

The first step in the data analysis process was to obtain an overview of the involvement of mentally ill persons in the daily work of police officers and the knowledge and skills of police officers in handling mentally ill persons. All the completed questionnaires were read to obtain a holistic understanding of the information and the subjects’ view points. The researcher then grouped the questionnaires together based on apparent themes relating to the police officers’ duties with mentally ill people and the knowledge and skills of police officers in handling mentally ill people.

Data analysis was done manually and the types of analysis of variables carried out are frequency distributions and cross-tabulations/comparisons and correlations. After analysing the data quantitatively by hand for different patterns or themes, four themes were identified, namely:

- Daily work of police officers at the Community Service Centre involves handling mentally ill persons.
- Police officers are not educated and trained on handling mentally ill persons.
• Police officers are not aware of the do’s and don’ts when handling a mentally ill person.
• Police officers see a need for education and training on handling of mentally ill persons.

Quantitative analysis techniques were used to examine, evaluate and interpret the police officers’ responses in the questionnaires. These included tables and graphs to allow comparisons, correlations and frequency of occurrence. The variables will be discussed with much emphasis put on major variables of the study.

In the overall research process ethical considerations were observed with the highest level of standards maintained throughout.

3.10 ETHICAL CONSIDERATIONS

In conducting the study, the ethical considerations that were observed are those listed in the memorandum defining the ethical standards for nursing research published by the South African Society for Nurse Researchers in 1990 (Uys and Basson, 2000: 97).

The researcher applied the highest possible standards in respect of the planning and implementation of the project.

Firstly, permission was obtained from the relevant authorities to conduct the study. The provincial commissioner of the South African Police service approved conducting the study and so did the
Mdantsane police commissioner after studying the research protocols delivered to them in request of permission and letters of approval were received to that effect.

Before the study was commenced, permission requirements to the participants (police officers) were met, that is, the officers were informed about the research in such a way that they thoroughly understood it. The information comprised the purpose of the research, the method to be followed, the duration of the study, the nature of the participation expected from them, how the results will be published and the identity and qualifications of the researcher.

Anonymity and confidentiality were maintained as the researcher ensured that the data is not related to a particular police officer or police station. No person, not even the researcher can trace the data of a specific subject and the researcher ensured at all times that the anonymity of the participants was not threatened.

The privacy of the police officers was ensured. The researcher collected no more data than is absolutely necessary for achieving the objectives of the study and no data of private nature were collected. The officers participating in the study were given the questionnaires to complete in their free time and the researcher did not interrupt or invade their private space (self administered).

Lastly, the participants were informed of the termination of the participation in the study if an individual chooses to withdraw, regardless of the fact that he or she initially agreed to participate and if the project was no longer proceeding in accordance with the standards set during its planning (Uys and Basson, 2000: 97).
To complement the above, the original of the questionnaire used went through an ethical committee for approval and received the approval by the university ethical committee (Ethics committee letter in Appendix G), the Provincial Department of Health and the Provincial police Department.

3.11 CONCLUSION

Data collection was conducted successfully in a quantitative paradigm. A descriptive survey design was employed and a self administered questionnaire was used to collect data. Ethical decisions were properly made in the data collection process and data analysis was done manually. The collected data will be presented, analysed and discussed in the next section.
CHAPTER 4 RESULTS: PRESENTATION AND DISCUSSION

4.1 INTRODUCTION

After all the questionnaires were collected from all three police stations, they were counted and checked for completeness, correctness and errors. The results as displayed in the completed questionnaires are presented in summary form in this section followed by analysis of the findings, and conclusion on the results. The results section of a research report summarises the key findings accompanied by more detailed tables and contain basic descriptive information for the variables using simple statistics including a description of participants (for example, average age, percentage of males and females) (Polit and Beck, 2008: 72).

The discussion section draws conclusions about the meaning and implications of the findings. It tries to sort out the meaning of the results, why things turned out the way they did and how the results can be used in practice (Polit and Beck, 2008: 73).

4.2 BIOGRAPHIC DATA OF THE RESPONDENTS

The following biographical data have been derived from the questionnaires:
4.2.1 AGE DISTRIBUTION

A total of 45 subjects (police officers) participated in the study and all submitted completed questionnaires. The participants have a mean age of 36 years, a range of 34 (ranging from 23 to 57 years); a median of 35 years and a mode of 33 years. They range from student constables to inspectors in terms of ranks. Constables dominate the police force making up 52% of the population. The difference between the mean and the median was brought about by the sensitivity of the mean to extreme values or outliers especially in small samples but in larger samples outliers do not have a significant effect. In this case, the outlier is the 57 years of age. Figure 3 is a diagrammatic presentation of sample (police) distribution by age.

Figure 3: A graphic presentation of age distribution of the respondents.

[Key: x-axis: Age in years; y-axis: Number of police officers]
4.2.2 GENDER AND RANK DISTRIBUTION

In the 45 policemen and women sample, thirty two (71%) police officers are male and 13 (29%) are female. Of the 32 males, twenty three (72%) are constables, six (19%) are inspectors, two (6%) are sergeants and one (3%) is a student constable. Of the 13 females, ten (77%) are constables and 3 (23%) are student constables. Table 3 compares gender and rank distribution of the respondents.

<table>
<thead>
<tr>
<th>OFFICERS</th>
<th>RANK</th>
</tr>
</thead>
<tbody>
<tr>
<td>GENDER</td>
<td>STUDENT</td>
</tr>
<tr>
<td></td>
<td>CONSTABLES</td>
</tr>
<tr>
<td>MALE</td>
<td>1</td>
</tr>
<tr>
<td>FEMALE</td>
<td>3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>4</td>
</tr>
</tbody>
</table>

The statistics in Table 3 show that the majority of police officers in senior positions or high ranks are male. All police inspectors, all sergeants and 70% of constables in the study sample are male.
4.2.3 DISTRIBUTION PER EXPERIENCE

The participants have a **mean** experience in the police service of 6 years, ranging from 5 months to 33 years (**range** of 32 years 7 months), a **mode** of 5 years and a **median** of 5 years. The difference between the mean and median was brought about by the extreme value of 33 years. The effect of the outlier is not that significant because of the big size of the sample. Figure 4 is a schematic presentation of respondents by experience.

*Figure 4: Schematic presentation of distribution by experience.*

[**Key:** y-axis: Number of police officers; x-axis: Experience in years]
4.2.4 EDUCATIONAL QUALIFICATIONS

Concerning their educational qualifications, all 45 have matric or grade 12 as their highest level of education.

4.3 POPULATION AND SAMPLE CHARACTERISTICS

Looking at the population and the sample statistics, the study population has 72 constables and the study sample has 23 constables; out of four female inspectors in the population, none was sampled; of two female sergeants, none was selected; of twenty one female constables ten (48%) were selected for the study; and out of ten female student constables in the population three (30%) participated in the study. Generally, out of a population of 37 female police officers 13 (35%) made it to the study sample.

From a male population of 99 police officers, 32 (32%) policemen took to the sample and sampling went as follows: Out of a population of 51 male constables, twenty three (45%) were selected to the sample; of twenty two male inspectors, six (27%) were selected; of twelve male sergeants, two (17%) got to the sample; and out of fourteen male student constables, one (7%) made it to the study sample.
4.4 PRESENTATION OF RESULTS

This section describes and summarises the main results that were obtained using tables. Research results are usually ordered in terms of overall importance and if research questions or hypotheses have been numbered in the introduction, the analyses addressing them should be ordered in the same sequence (Polit and Beck, 2008: 695).

The questions on the views of the respondents regarding the knowledge and skills of police officers in handling mentally ill people include the following:

- Police officers’ training in handling mentally ill persons.
- Police officers’ awareness of the Mental Health Care Act, 2002 (Act No. 17 of 2002) which requires cooperation of health care workers with the police service in care of, and treatment of mentally ill persons.
- Police officers’ ability to identify a mentally ill person and act accordingly and
- The relationship between police incompetence and lack of knowledge and skills.

4.4.1 TRAINING ON MENTAL ILLNESS AND HANDLING OF MENTALLY ILL PERSONS

The research subjects were questioned about their training on handling mentally ill people. Their responses reveal that 39 (87 %) are not trained in handling mentally ill persons and 6 (13 %) claim they are. This is the main variable in the study. Again, the participants were asked if the police training curriculum includes management of mentally ill persons and all (100%) claim it does not.
Further to determine their level of knowledge, they were asked if there is in-service training in their work stations and only 6 (13 %) of the 45 subjects claimed presence of in-service education in their work places.

In an attempt to further discover the training of police officers in handling mentally ill people, the respondents were asked if education and training was necessary for their competence in the task. All forty five (100 %) believe that further education and training is necessary in handling mentally ill people.

To further determine police officers’ knowledge of mental illness, the subjects were asked if they know the signs of mental illness and all (100%) claim they do. The respondents were tasked to identify a mentally ill person given five common signs or symptoms and 34 (76%) got high scores which denote that they can identify a mentally ill person and 11 (24%) got low scores and that signify that they cannot successfully recognise a mentally ill person.

4.4.2 NECESSARY SKILLS FOR HANDLING MENTALLY ILL PERSONS

When the researcher attempted to find out if the respondents knew what to do when confronted by a mentally ill person in distress, it was uncovered that 43 (96%) can act accordingly when in confrontation with a mentally ill person and 2 (4%) cannot. A majority of respondents have scored high in the test of their capacity to act accordingly when they are confronted by a mentally ill person.
Further to determine their skills level, they were asked for the do’s and don’ts in a psychiatric crisis and all do not know.

4.4.3 AWARENESS ABOUT SECTION 40 OF THE MENTAL HEALTH CARE ACT, 2002 (ACT NO. 17 OF 2002)

When the researcher was investigating police officers’ awareness or knowledge of the Mental Health Care Act, it became apparent that 22 (49 %) are aware of section 40 of the Mental Health Care Act, 2002 (Act No 17 of 2002). The Mental Health Care Act, 2002 (Act 17 of 200), section 40 in particular, expects the South African Police Service to collaborate with the mental health care system in the management of mentally ill people.

4.4.4 CONSEQUENCE OF POLICE OFFICERS’ LACK OF KNOWLEDGE AND SKILLS

Lastly, the researcher wanted to know if the participants’ lack of knowledge is related to their incompetence in the management of mentally ill persons. All the respondents believe that lack of knowledge makes it difficult for them to manage mentally ill persons. They unanimously link their incompetence in handling mentally ill persons to lack of knowledge and skills.

In conclusion, the respondents were given an open ended question to express their own views on the knowledge and skills of police officers in handling mentally ill people; a majority sees a need for more education and training. A multitude of minorities have different views on the matter, some are
convinced that police officers do not know how to handle mentally ill people. Others simply believe strongly that if mentally ill people are treated with the respect and dignity they deserve, it would be easy for peace officers to handle them.

The findings are further presented and analysed using cross tabulations, comparisons and correlations.

### 4.4.5 RELATIONSHIP BETWEEN EXPERIENCE AND TRAINING

Table 4 illustrates the relationship between experience and training on handling mentally ill people.

<table>
<thead>
<tr>
<th>EXPERIENCE IN YEARS</th>
<th>TRAINED ON MENTAL ILLNESS</th>
<th>NOT TRAINED ON MENTAL ILLNESS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 months – 1 year</td>
<td>0</td>
<td>5 (100%)</td>
<td>5</td>
</tr>
<tr>
<td>2 years – 5 years</td>
<td>5 (19% of 26)</td>
<td>21 (81% of 26)</td>
<td>26</td>
</tr>
<tr>
<td>6 years – 10 years</td>
<td>0</td>
<td>6 (100%)</td>
<td>6</td>
</tr>
<tr>
<td>11 years – 20 years</td>
<td>0</td>
<td>7 (100%)</td>
<td>7</td>
</tr>
<tr>
<td>21 years – 33 years</td>
<td>1 (100%)</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>6 (13%)</td>
<td>39 (87%)</td>
<td>45</td>
</tr>
</tbody>
</table>
4.4.6 RELATIONSHIP BETWEEN EXPERIENCE AND AWARENESS OF THE MENTAL HEALTH CARE ACT, 2002 (ACT NO 17 OF 2002)

Table 5 illustrates the relationship between experience and awareness section 40 of the Mental Health Care Act, 2002 (Act No 17 of 2002).

<table>
<thead>
<tr>
<th>EXPERIENCE IN YEARS</th>
<th>AWARE OF MHCA (Section 40)</th>
<th>LACK AWARENESS OF MHCA(Section 40)</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 months – 1 year</td>
<td>1 (20% of 5)</td>
<td>4 (80% of 5)</td>
<td>5</td>
</tr>
<tr>
<td>2 years – 5 years</td>
<td>13 (50% of 5)</td>
<td>13 (50% of 5)</td>
<td>26</td>
</tr>
<tr>
<td>6 years – 10 years</td>
<td>3 (50% of 6)</td>
<td>3 (50% of 6)</td>
<td>6</td>
</tr>
<tr>
<td>11 years – 20 years</td>
<td>4 (57% of 7)</td>
<td>3 (43% of 7)</td>
<td>7</td>
</tr>
<tr>
<td>21 years – 33 years</td>
<td>1 (100%)</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>22 (49%)</td>
<td>23 (51%)</td>
<td>45</td>
</tr>
</tbody>
</table>

In Tables 4 and 5, there are minimum numbers in some cells which are too small and do not meet the requirements for statistical tests. For statistical tests, the minimum number should be more than 5 or 7. For statistical reasons the cells with smaller numbers will be collapsed to make a 2×2 table. Tables 6 and 8 are collapsed versions of Tables 4 and Table 5.
Table 6: Relationship between years of experience and awareness of the Mental Health Care Act (Section 40)

<table>
<thead>
<tr>
<th>EXPERIENCE IN YEARS</th>
<th>AWARE OF MHCA (Section 40)</th>
<th>LACK AWARENESS OF MHCA (Section 40)</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 months – 5 years</td>
<td>14</td>
<td>17</td>
<td>31</td>
</tr>
<tr>
<td>6 years – 33 years</td>
<td>8</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>22</strong></td>
<td><strong>23</strong></td>
<td><strong>45</strong></td>
</tr>
</tbody>
</table>

Using the chi-square test to determine whether there is an association (or relationship) between years of experience and awareness of section 40 of the mental health care act and if that association will affect the association between the two in the population, it went as follows:

\[ X^2 = \frac{[(14\times6)-(17\times8)]^2(14+17+8+6)}{(31\times14\times23\times22)} \]

\[ = \frac{(84-136)^2}{(45)} \div 219604 \]

\[ = \frac{(-52)^2}{(45)} \div 219606 \]

\[ = 121680 \div 219604 \]

\[ = 0.554 \]

The results are, a chi square statistic \(X^2 = 0.554\), a predetermined alpha level of 0.05 or 5% and a degree of freedom of 1 (df = 1). Entering the chi square distribution table with 1 degree of freedom and reading along the row we find that our value of \(X^2 (0.554)\) lies between 0.455 and 2.706. The corresponding probability is 0.5 <P< 0.1. This is far below the conventionally accepted significance level of 0.05 or 5%, it can therefore be accepted that the two distributions are the same, that is, the
awareness of section 40 of the mental health care act is not associated with the years of experience of the police officers. Table 7 is the chi square distribution table.

Probability level (alpha)

<table>
<thead>
<tr>
<th>Df</th>
<th>0.5</th>
<th>0.1</th>
<th>0.05</th>
<th>0.02</th>
<th>0.01</th>
<th>0.001</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.455</td>
<td>2.706</td>
<td>3.841</td>
<td>5.412</td>
<td>6.635</td>
<td>10.827</td>
</tr>
<tr>
<td>2</td>
<td>1.386</td>
<td>4.605</td>
<td>5.991</td>
<td>7.824</td>
<td>9.210</td>
<td>13.815</td>
</tr>
</tbody>
</table>

Table 8: Relationship between years of experience and training on mental illness and handling mentally ill people

<table>
<thead>
<tr>
<th>EXPERIENCE IN YEARS</th>
<th>TRAINED ON MENTAL ILLNESS</th>
<th>NOT TRAINED ON MENTAL ILLNESS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 months – 5 years</td>
<td>5 (16% of 31)</td>
<td>26 (84% of 31)</td>
<td>31</td>
</tr>
<tr>
<td>6 years – 33 years</td>
<td>1 (7% of 14)</td>
<td>13 (93% of 14)</td>
<td>14</td>
</tr>
<tr>
<td>TOTAL</td>
<td>6</td>
<td>39</td>
<td>45</td>
</tr>
</tbody>
</table>
4.4.7 RELATIONSHIP BETWEEN GENDER AND AWARENESS OF SECTION 40 OF THE MENTAL HEALTH CARE ACT, 2002 (ACT NO 17 OF 2002)

Table 9 demonstrates that, a majority of male police officers are aware of section 40 of the mental health care act as opposed to a minority of female police officers.

<table>
<thead>
<tr>
<th>OFFICERS</th>
<th>AWARE OF SEC 40 OF MHCA</th>
<th>UNAWARE OF SEC 40 OF MHCA</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>MALES</td>
<td>17 (53% of 32)</td>
<td>15 (47% of 32)</td>
<td>32</td>
</tr>
<tr>
<td>FEMALES</td>
<td>5 (38% of 13)</td>
<td>8 (62% of 13)</td>
<td>13</td>
</tr>
<tr>
<td>TOTAL</td>
<td>22 (49%)</td>
<td>23 (51%)</td>
<td>45</td>
</tr>
</tbody>
</table>

The chi-square test was used to determine whether there is an association (or relationship) between gender and awareness of section 40 of the mental health care act and if that association will affect the association between the two in the population. The chi square statistic compares the tallies of the categorical responses between the two variables as follows:

\[
X^2 = \frac{\left[(17 \times 8) - (15 \times 5)\right]^2}{(17+15+5+8) \div (32 \times 13 \times 23 \times 22)}
\]

\[
= \frac{(136-75)^2}{(45) \div 210496}
\]

\[
= \frac{(61)^2}{210496}
\]

\[
= \frac{167445}{210496}
\]
The results are, a chi square statistic ($X^2 = 0.8$), a predetermined alpha level of 0.05 or 5% and a degree of freedom of 1 ($df = 1$). Entering the chi square distribution table with 1 degree of freedom and reading along the row we find that our value of $X^2 (0.8)$ lies between 0.455 and 2.706. The corresponding probability is $0.5 < P < 0.1$. This is far below the conventionally accepted significance level of 0.05 or 5%, it can therefore be accepted that the two distributions are the same, that is, the awareness of section 40 of the mental health care act is not associated with the gender of the police officers. Table 7 is the chi square distribution table.

Probability level (alpha)

<table>
<thead>
<tr>
<th>Df</th>
<th>0.5</th>
<th>0.1</th>
<th>0.05</th>
<th>0.02</th>
<th>0.01</th>
<th>0.001</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.455</td>
<td>2.706</td>
<td>3.841</td>
<td>5.412</td>
<td>6.635</td>
<td>10.827</td>
</tr>
<tr>
<td>2</td>
<td>1.386</td>
<td>4.605</td>
<td>5.991</td>
<td>7.824</td>
<td>9.210</td>
<td>13.815</td>
</tr>
</tbody>
</table>

4.4.8 RELATIONSHIP BETWEEN RANK AND AWARENESS OF SECTION 40 OF THE MENTAL HEALTH CARE ACT, 2002 (ACT NO 17 OF 2002)

Table 10 illustrates that the majority of junior police officers are not aware of section 40 of the mental health care act as opposed to senior police officers.
### Table 10: Relationship between rank and awareness of section 40 of the MHCA

<table>
<thead>
<tr>
<th>OFFICERS</th>
<th>AWARE OF SEC 40 OF MHCA</th>
<th>UNAWARE FO SEC 40 OF MHCA</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>STUDENT CONSTABLES</td>
<td>1 (25%)</td>
<td>3 (75%)</td>
<td>4</td>
</tr>
<tr>
<td>CONSTABLES</td>
<td>14 (42% of 33)</td>
<td>19 (58% of 33)</td>
<td>33</td>
</tr>
<tr>
<td>SERGEANTS</td>
<td>2 (100%)</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>INSPECTORS</td>
<td>4 (67% of 6)</td>
<td>2 (33% of 6)</td>
<td>6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>21 (47%)</td>
<td>24 (53%)</td>
<td>45</td>
</tr>
</tbody>
</table>

#### 4.4.9 RELATIONSHIP BETWEEN RANK AND TRAINING ON HANDLING MENTALLY ILL PERSONS

The statistics in Table 11 reveal that, all student constables, namely, the lowest rank in the police force, those who just got out of police training college did not receive training on the handling of mentally ill people. The majority of other ranks are also not trained on handling mentally ill people, that is, 85% police constables, all police sergeants and 83% of police inspectors.
Table 11: Relationship between rank and training in handling mentally ill persons

<table>
<thead>
<tr>
<th>OFFICERS</th>
<th>RECEIVED TRAINING</th>
<th>DID NOT RECEIVE TRAINING</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>STUDENT CONSTABLES</td>
<td>0</td>
<td>4 (100%)</td>
<td>4</td>
</tr>
<tr>
<td>CONSTABLES</td>
<td>5 (15% of 33)</td>
<td>28 (85% of 33)</td>
<td>33</td>
</tr>
<tr>
<td>SERGEANTS</td>
<td>0</td>
<td>2 (100%)</td>
<td>2</td>
</tr>
<tr>
<td>INSPECTORS</td>
<td>1 (17% of 6)</td>
<td>5 (83% of 6)</td>
<td>6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>6 (13%)</td>
<td>39 (87%)</td>
<td>45</td>
</tr>
</tbody>
</table>

4.4.10 RELATIONSHIP BETWEEN GENDER AND TRAINING ON HANDLING MENTALLY ILL PEOPLE

Table 12 compares training on handling of mentally ill people with gender of the police officers sample. These statistics show that the majority of male and female police officers did not receive training in handling mentally ill persons.

Table 12: Relationship between gender and training in handling mentally ill persons

<table>
<thead>
<tr>
<th>OFFICERS</th>
<th>RECEIVED TRAINING</th>
<th>DID NOT RECEIVE TRAINING</th>
<th>TOTAL</th>
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<tr>
<td>MALES</td>
<td>4 (13% of 32)</td>
<td>28 (87% of 32)</td>
<td>32</td>
</tr>
<tr>
<td>FEMALES</td>
<td>2 (15% of 13)</td>
<td>11 (85% of 13)</td>
<td>13</td>
</tr>
<tr>
<td>TOTAL</td>
<td>6 (13%)</td>
<td>39 (87%)</td>
<td>45</td>
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</table>
4.5 DISCUSSION

This section is devoted to a thoughtful analysis of the findings, leading to a discussion of their clinical and theoretical utility. A typical discussion session addresses the following questions: What were the main findings? What do the findings mean? What evidence is there that the results and interpretations are valid? What limitations might threaten validity? How do the results compare with prior knowledge on the topic? What can be concluded about their findings, their use in nursing practice, in nursing theory and in future research? (Polit and Beck, 2008: 697-698).

The main objective of this research is to describe the level of knowledge and skills of police officers in handling mentally ill persons. Formulated in more detail: To describe if police officers are educated and trained regarding mental illness and handling of mentally ill people and whether police officers are aware of section 40 of the Mental Health Care Act, 2002 (Act No. 17 of 2002) that requires their cooperation with health care workers in the care of, and handling of mentally ill persons.

Subordinate to the above objectives, the research intended to further determine if lack of knowledge and skills are related to police officers’ incompetence in handling mentally ill persons.

Firstly, the findings show that the daily duties of the police officers in the community service centres of our police stations involve an average of two mentally ill persons. This tells that responses from the respondents are reliable and valid because the subjects are suitable for the study and that makes their responses accurate.
The findings reveal that the student constables or newly qualified police officers straight from police training college did not receive training on mental illness and handling of mentally ill persons. This is evident of the fact that the current police training curriculum does not include mental illness and handling of mentally ill people.

This clearly shows without doubt that police officers are not educated or trained on mental illness and handling of mentally ill persons; and the police training curriculum does not include the management of mentally ill persons. This further translates to saying that they do not have the knowledge and skills required for handling mentally ill persons though they are first line managers of psychiatric crises. All police officers, be it male or female are equally not knowledgeable about mental illness and handling of mentally ill persons. They are neither trained nor prepared for the task (Ainsworth, 1995; Cherrett, 1995; Green, 1997; Ruiz, 1993 as cited by Patch and Arrigo, 1999: 23-35).

The findings indicate that police officers are partially aware of the Mental Health Care Act, 2002 (Act No 17 of 2002) and the section 40 involving them directly in the management of mentally ill persons. However, their awareness does not make them better equipped for handling mentally ill persons as they do not have the knowledge and skills needed.

As they do not have the generic knowledge about mental illness and handling of mentally ill persons, police officers see a need for education and training programmes and services to improve their skills base and morale for working with mentally ill people. Lastly it became clear that the lack of knowledge and skills is related to police incompetence in the management of mentally ill people. In the city of Reno, Nevada in the United States of America, after establishing a training
course for responding to mentally ill and suicidal people, Reno police have seen a dramatic improvement in their handling of those in mental distress. “Training helps police officers recognise the signs and symptoms of mental illness and to get people help from Reno’s mental health centres (Voyles, 2004). According to Sanchez and Fay (2005), police officers who lack the appropriate resources and training for the task of handling mentally ill people are left with fewer options to address the situation.

In the literature studied, other researchers studying policing of mentally ill persons and similar topics found the same results, namely, a need for resources, that is, education and training for police officers to be able to handle mentally ill persons. All the scholars, namely, Bunch (2001); Cochran, Deane and Borum (2000); Cordener (2006); Moore (2006); Teplin (2000); Vickers (2000); and Steadman, Morrisey, Deanne and Borum, (2000) whose works on policing the mentally ill were studied informed of a need for training of police officers in handling of mentally ill people. All the data agree with the researcher’s expectations. The similarities in the findings imply that the findings are reliable and can be generalized.

The findings have opened a point of debate and may be a platform for engagements and deliberations on the management of mentally ill people by all the relevant stakeholders, namely, the department of health, police, community and experts in the fields of psychiatry and policing. The findings are an eye opener to the stereotypes who believe the police and health care workers cannot work harmoniously because of their differences in beliefs and values. Nursing personnel can enter into a collaborative relationship with police officers in an endeavour to look at the needs of mental health care users.
Further to enhancing quality care and management of mentally ill persons in the community, the partnership and collaboration with families, friends and the community is paramount and that is supported by Kneisl and Trigoboff (2009: 24). Uys as cited in Uys and Middleton (2004: 77) views the family as the major resource in the care of a mentally ill person.

The findings are valuable to nursing theory as through engagements with the police department an evolution of a nurse-police team is possible. The findings have paved way for future studies in the fields of mental health and policing. It is through further research at a larger scale that the validity of the findings can be improved; the size of the study threatened the validity of the findings as the study was of a smaller scale. Further research can be done in the qualitative paradigm, or incorporate the quantitative and qualitative approaches so as to get all views of participants.

The study had its limitations, however, the limitations did not deter its successful completion.

4.6 LIMITATIONS

The following limitations were identified during and after the process of collecting data:

- This study will not deal with police officers perceptions and feelings about their training programmes and services because of its size, though that could be a good finding.
- This work will not consider police officers working in departments outside the Community Service Centre as they are not involved in the care of, and handling of mentally ill persons though their views and opinions would enrich the study.
Due to budgetary and time limitations, the study had to settle for a more modest investigation. The researcher funded the study and time was limited due to the delays in screening the protocol by the university ethics committee and the return of approval letters by the relevant authorities. Finance and time were not available for a large scale study.

Though the response rate was 100%, the responses were stereotyped. Police officers are known to work in groups and due to that habit their responses to some questions are more or less the same. The majority of responses appear to having been rehearsed or done in a group and a few are more informative and individual.

The majority of the questions in the questionnaire are closed questions to keep the study focussed but that suppressed a lot of information that could have been obtained had open-ended questions been used.

Police officers have a busy work schedule and could not think through all the answers before completing the questionnaires. They had to attend to complaints, make required dockets while trying to complete the questionnaires. The quality of their responses is debatable.

Various cultural groups were not represented in the sample as there are few white or coloured police officers in Mdantsane. The few that are available are high ranked and work in offices therefore not actively involved in handling mentally ill people. Due to their absence, their knowledge and skills in handling mental illness and their perceptions about mental illness could not be investigated. The information might have enriched the study.
4.7 CONCLUSION

The evidence supports the theory that police officers need comprehensive training to be able to handle people with mental difficulties, however, the police service cannot function alone to achieve such a huge task. Police officers must be prepared to view the mentally ill from a different perspective which supports humane treatment and creative solutions and promote utilisation of available resources to solve community issues and concerns (Sanchez & Fay, 2005).

Whether called collaborative, interdisciplinary, inter-professional or trans-disciplinary, practice and education involving members of more than one profession or discipline has become increasingly popular and necessary. The police service should therefore collaborate with the mental health care service with their major focus being care of the mentally disabled population. There must be collaborative seminars that are an educational effort to prepare health care practitioners and police officers for collaborative practice. The community should not be excluded in such endeavours as their input is also valuable.

The final chapter in the research project endeavours to give a conclusive statement of the whole process. It gives meaning and value to the findings detailing how they can be made use of.
CHAPTER 5  CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

This section entails things that have been deduced from the study as a whole and answers the research statement (Hostee, 2006: 157). “Conclusions must always link back clearly and explicitly to your thesis statement” (Hofstee, 2006: 157). Hofstee’s interpretation of a conclusion will be implemented in concluding on the study.

Recommendations, also called suggestions for application of research tell how the results of the study are intended to be applied. The recommendations must be feasible to implement and clearly useful (Hofstee, 2006: 159).

The recommendations will be explained including where and how they could be implemented and the benefits of doing so, as advised by Hofstee (2006: 159-160).

5.2 CONCLUSION

Having analysed the data on the knowledge and skills of police officers in handling mentally ill persons, it is evident that police officers are not trained in handling mentally ill persons. Most of the respondents indicated that they were of the opinion that there is a dire need for education and training on mental illness and handling of mentally ill persons. To enhance competence in police officers’ handling mentally ill people, an injection of resources, education and training is indicated.
The results of the study strongly suggest that, a partnership between the department of health, the police service and the community can help in efforts to assist people who are experiencing a mental illness crisis to gain access to the treatment system where they will best be attended to.

It can be concluded therefore that, police officers in Mdantsane in the Eastern Cape Province of South Africa do not have the knowledge and skills for handling mentally ill people and therefore require education and training on mental illness and handling of mentally ill people for them to be competent in the task. The results are generalizable as they are similar to results by other scholars from different countries. Above all, police officers in South Africa undergo the same form of training and this means therefore, that all police officers in South Africa do not have the knowledge and skills for handling mentally ill people unless of course there are some who underwent training elsewhere.

5.3 RECOMMENDATIONS

For the recommendations to be applicable and resourceful to the two fields, that is, the mental health care system and the police, psychiatric nurses should organise workshops, seminars and conferences with the police to look at the following suggestions on the same platform.

Mental health nurses should volunteer to give in-service training to police officers in their districts on the management of mentally ill persons so as to improve police officer’s competence in the management of mentally ill people.
Following the enactment of section 40 of the Mental Health Care Act, 2002 (Act No. 17 of 2002) that requires cooperation between mental health care practitioners and the police in the management of people with mental illness, a new police training curriculum is suggested and should incorporate basic education on mental illness and skills for handling mentally ill people in times of psychiatric crises as is already the case in the United States. The idea can be discerned in a new programme to train police recruits with its goal being implementation of a modernised recruit training and professionalising the service and changing its culture. This will make police officers more open minded and enlightened.

Mental health care practitioners, the Mental Health Review Board and authorities in the mental health care system should engage with policy makers in the Department of Police in discussions on improving police response to psychiatric crises and the required resources. Health care professionals will help police gain a better understanding of the people they are dealing with. This means providing them with training and tools to deal with the problems they face when dealing with mentally ill persons.

Currently, police officers are trained to talk loudly, perhaps appear physically threatening in order to be authoritative. The approach may be sound generally, but when dealing with mentally ill people, these tactics have the opposite result. They make a mentally ill person more aggressive than calming him or her. Traditional police practices do not work the way they are meant to when dealing with people who are mentally ill. Police officers must therefore be trained to recognise the signs of mental illness quickly and respond accordingly.
Police officers in our community also deal with people taking alcohol and drugs. These cases pose a challenge to a police officer not trained in mental illness as the use of drugs and alcohol can exacerbate or mask the signs that a person is mentally ill. Clear guidelines and training are therefore necessary for police officers who have to make such difficult decisions.

The suggested collaboration between the department of health and the police service in endeavouring to design police in-service training programmes that include handling mentally ill people should entail the following suggestions:

- Training on signs and symptoms of mental illness and how to identify a mentally ill person.
- Handling of people with different manifestations of mental illness.
- Training on speaking in a non-authoritative voice instead of demanding people to follow police commands.
- Safer constraining methods.
- Use and understanding of the Mental Health Care Act, 2002 (Act 17 of 2002).

A partnership between the police service, the mental health system and the community will help in getting mentally ill people in crisis to health care facilities and will enlighten police officers and give them access to knowledgeable professionals so they can respond properly to calls involving persons with mental health problems.

Collaboration between the justice, mental health and social service systems is the key to success in the care of mentally ill persons and in ensuring continuity of care (Grudzinskas et. al, 2005 as cited by Sly, Sharples, Lewin and Bench, 2009: 92-100).
Psychiatric nurses should ensure through in-service education that police officers responding to emergencies involving a mentally ill person should look at applying the following suggestions when responding to such emergencies:

1. Have a documented report of the call for the response, the presenting problem and the required response.
2. Must engage with both the alleged disorderly person and his/her family or neighbours to make an unbiased judgement.
3. Must take the person for assessment to an institution if his behaviour warrants, accompanied by a relative or neighbour (who reported the emergency) with his/ her medication and clinic book.
4. The alleged disorderly person must not be physically restrained in the transfer journey.
5. Chemical restraining is preferable; a mental health care practitioner can be called in to administer a chemical restraining agent.

It is further suggested that for the community safety agency (police), to perform these duties competently, the community, families and neighbours of the person disabled by mental illness must give the assistance expected of them. In community policing forum meetings, such issues can be discussed and expectations from community members when calling for a police response may be written as follows:

- They must give true and complete information to the police officer receiving the call.
- They must assist the police officers in getting their relative to the transportation vehicle.
- They must have his/her medication and / or clinic book handy on arrival of police officers.
• A relative closest to the mentally challenged person must accompany police officers when transferring him to an institution so as to give all information needed by the institution.

Future research is recommended to look intensely into the needs of police officers in handling mentally ill people and it must be done in a qualitative paradigm or a combination of both quantitative and qualitative research methods to get all views in the matter.

5.4 CONCLUSION

Research to date has very effectively highlighted the fact that the mentally ill are vulnerable to systematic criminalization and the reasons for this range from decreasing mental health resources to restrictive civil commitment statutes, to increased number of mentally ill citizens in the community as a result of deinstitutionalization (Patch & Arrigo, 1999: 33).

The study has addressed the role expected of police officers in handling mentally ill people and ways of improving their performance in the task. Adequate training should be provided to policemen and women concerning mental health issues, for better management of crisis situations with people in acute psychiatric states. Communication between police, the mental health community and social service providers should improve and specialised crisis teams need to be established.

Continuous deliberation meetings between heads of departments, namely, police service and mental health care service at both local, districts, provincial and national levels for progress on handling of mentally ill persons are essential. Community organisations, organisations representing people with
mental illness and their families, for example, families of people with bipolar mood disorder, and the Mental Health Review Board must be part of such meetings.

The report will be disseminated to the department of police and the department of health and it is suggested that policy makers in both departments act on the findings. It is their input that will change the policing landscape of the country in terms of the protection of the rights of people with mental defects.
6. BIBLIOGRAPHY


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## 7. APPENDICES

### Appendix A

Table 2: Characteristics of the sample in terms of age, race, gender, highest level of education, rank and years experience in the police service.

<table>
<thead>
<tr>
<th>PARTICIPANT(S)</th>
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<th>RANK</th>
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Appendix B: Questionnaire

QUESTIONNAIRE FOR POLICE OFFICERS PARTICIPATING IN THE STUDY ON KNOWLEDGE AND SKILLS OF POLICE OFFICERS IN HANDLING MENTALLY ILL PERSONS

Please indicate by a tick where it is applicable

SECTION A

PERSONNAL AND PROFESSIONAL DETAILS
<table>
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<tr>
<th>RANK</th>
<th>Student constable</th>
<th>Constable</th>
<th>Sergeant</th>
<th>Inspector</th>
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<td>GENDER</td>
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</tr>
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<td>EXPERIENCE IN THE POLICE SERVICE (in years)</td>
<td></td>
<td></td>
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</table>
THE STUDY WILL HAVE AN INVALUABLE INPUT TO SERVICE DELIVERY IN THE POLICE SERVICE AND MENTAL HEALTH CARE, THEREFORE YOUR PARTICIPATION WILL BE APPRECIATED.....

SECTION B

1. Does your daily work involve handling mentally ill persons?
   Yes  No

2. On average, how many mentally ill persons do you encounter in a day's work .............

3. Did you get training on handling mentally ill persons?
   Yes  No

4. Does the police training curriculum include education and training in handling mentally ill persons?
   Yes  No
5. Are you aware of section 40 of the Mental Health Care Act (Act 17 of 2002) which requires cooperation of health care workers with the police service in care of, and handling of mentally ill people?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

6. Are police officers getting in-service training (in their work centres) on the management of mentally ill people?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

7. In your opinion, is education and training on mental illness and handling mentally ill people necessary in the police service?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

8. Do you know the signs of mental illness?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>
9. Would you consider the following persons mentally ill?
   1. Dirty, wearing torn and dirty clothes.
   2. Carrying a knife/metal bar/stick and swearing at people.
   3. Shouting and screaming in the street, restless and pacing up and down.
   4. Sleeping on the roadside naked.
   5. Telling you he is mentally ill.

10. Are you aware of the Do's and Don'ts when in confrontation with a mentally ill person?
11. A person is wandering at the Highway taxi/bus rank carrying a broken bottle and a metal bar; he is dirty in person and wearing dirty clothes. He talks to himself, shouts at people looking at him and threatens to kill them. You happen to be in the vicinity. What would you do?

a. Apprehend him, handcuff him and take him to the police station and charge him.  
Yes  No  

b. Leave him alone.  
Yes  No  

c. Tell people not to look at him.  
Yes  No  

d. Talk quietly to him, with respect, explaining the situation.  
Yes  No  

e. Start a conversation with him, talk about the situation and his feelings.  
Yes  No  

f. Persuade him to calm down and talk about the situation.  
Yes  No  

g. Ask him about his doctor and where he collects his treatment.  
Yes  No  

h. Call for reinforcements and a police negotiator.  
Yes  No  

i. Take out your firearm and tell him to drop the knife and metal bar.  
Yes  No  

j. If he refuses, shoot him down.  
Yes  No  

12. What, in your opinion, makes it difficult to handle mentally ill persons?...........................  
Yes  No  

13. Is it lack of knowledge and skills that makes it difficult to manage mentally ill persons?  
Yes  No  

14. Is there anything else you wish to say about the knowledge and skills of police officers in handling mentally ill persons?.............................................................................................................

THANK YOU FOR ANSWERING ALL THE QUESTIONS
Appendix C: Coding sheet.

CODE SHEET

The code sheet has been specially designed for the purpose of data presentation and analysis for the study. It contains the variables that are paramount in the study as found in the questionnaire. Each answer to the questions in the questionnaire is given a numeric code for simpler presentation and analysis.

The codes for the subject characteristics have not been utilized in the data presentation and analysis as that was not necessary. Each numeric code is consistent throughout the study, for example, Yes is given a code = 1 and No = 2 throughout the study.

SUBJECT CHARACTERISTICS

RANK(S)

Student constable = 40
Constable = 41
Sergeant = 42
Inspector = 43
Male = 50
Female = 51

QUESTIONS

1. Yes = 1
   No = 2
2. 1 =7
   2 = 8
   3 = 9
4 = 10
5 = 11
6 = 12
7 = 13
0 = 14
3. Yes = 1
   No = 2

4. Yes = 1
   No = 2
5. Yes = 1
   No = 2
6. Yes = 1
   No = 2
7. Yes = 1
   No = 2
8. Yes = 1
   No = 2
9. A score of 3/5 – 5/5 means Good = 20
    and a score of 0/5 – 2/5 means Bad = 21
10. Yes = 1
    No = 2
11. A score of 5/10 -10/10 means Good = 20
    and a score of 0/10 – 4/10 means Bad = 21
12. Lack of knowledge and skills = 18
13. Yes = 1
    No = 2
14. Police officers need training in handling mentally ill people = 28
    Police officers need to treat mentally ill people with respect and dignity = 30
Working with community members = 31
Police officers can handle mentally ill people successfully = 26
Police officers do not know how to handle mentally ill people = 27
No response = 29
Use minimum force = 32
Be careful and alert at all times = 3

Appendix D: Data grid

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Appendix E: Data collection sheet

DATA CAPTURE SHEET

POLICE STATION:

POPULATION PER RACE AND RANK

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POPULATION PER GENDER AND RANK

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SAMPLING AND DATA COLLECTION SCHEDULE

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SAMPLE PER GENDER AND RANK

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Appendix F: A map of Mdantsane showing the 3 police stations studied. Source: Buffalo City Municipality.
Appendix G: University of Fort Hare Ethics committee approval letter
Application for clearance from the University of Fort Hare’s Ethics Committee

Project Title: A study on the knowledge and skills of police officers in handling mentally ill persons in Mdantsane in the Eastern Cape Province of South Africa.

Chief Researcher: Mr. Xola Kolwapi
Supervisor/co-supervisor: Mrs. NIN Magadla/Dr Tshotso
Date of application: 29 May 2009

Having consulted the Dean of Research, I hereby grant permission to conduct the research.

Professor J R Midgley
Deputy Vice-Chancellor
Chairperson of the interim Ethics Committee

30 August, 2009
Appendix H: Permission to conduct the study from the provincial/national department of police.
Mr Xola Kolwapi
East London Mental Health Unit
Cecilia Makiwane Hospital
Private Bag X 13003
Cambridge
5206

RE: RESEARCH PROPOSAL: A DESCRIPTIVE STUDY INTO THE NEEDS OF POLICE OFFICERS IN HANDLING MENTALLY CHALLENGED INDIVIDUALS; M CUR DEGREE, UNIVERSITY OF FORT HARE; RESEARCHER: XX KOLWAPI

1. Your request to conduct research on the above mentioned topic was approved by the Provincial Commissioner: Eastern Cape. (See attached letter from Div Comm Eastern Cape)

2. Your attention is drawn to par 6.2(e) of the National Instruction on Research in the SAPS that states that the final research report must be submitted to the SAPS for perusal before it is published or communicated.

3. Approval is granted provided that you sign the attached undertaking to comply with the conditions of approval. Please fax a copy of your signed undertaking to comply with the conditions of approval. Please fax a copy of your signed undertaking to Supi GJ Joubert at 012 393 3178.

4. Further arrangements can be made with the station commissioners of the relevant police stations.

Kind regards

ASST COMMISSIONER
HEAD STRATEGIC MANAGEMENT
GÉ MOORCROFT
Appendix I: Permission to conduct the study from the Mdantsane police commissioner.
RESEARCH PROPOSAL FOR MCUR DEGREE BY XOLA X KOLWAPI: TITLE: THE NEEDS OF POLICE OFFICERS IN HANDLING MENTALLY ILL PERSONS: MDANTSANE TOWNSHIP: EAST LONDON: EASTERN CAPE

"A" (1) This is to inform you that this office is allowing you to conduct your research within the above mentioned stations, personnel as requested.

(2) Photo copying of any document is not allowed unless that is authorised by this office.

(3) This office is also requesting you to respect all ethical issues during your research, it means answers to your targeted groups must not put this organisation to a disgrace situation.

(4) Hoping that you will honour these instructions and respect your studies.

"B-C" (1) Copy for information and co-operation.

Kind Regards,

................................. Asst Comm

CLUSTER COMMANDER: MDANTSANE CLUSTER

W.M.MBALISO