A Sociological Analysis of Police Interactions with Mentally Ill Youth

by

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ABSTRACT

A SOCIOLOGICAL ANALYSIS OF POLICE INTERACTIONS WITH MENTALLY ILL YOUTH

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The over-representation of youth aged 12-17 with mental illnesses within the Canadian criminal justice system has raised concern among political figures, legal actors and scholars. Although the Ontario Mental Health Act recommends that youth with mental illness should receive specialized treatment, many of these youth continue to be dealt with by the criminal justice system through harsher measures and more punitive sanctions than youth without mental illness. Surprisingly, very little research has been conducted on the decision-making processes of police officers when encountering mentally ill youth despite the fact that they are the first point of contact with the criminal justice system. Using a social constructionist framework, this study employs face-to-face interviews with police officers to explore how they construct mental illness with delinquent youth and how this shapes their use of formal and informal measures. The findings reveal that police officers have developed a construction of mental illness, based on limited information, which they use to create a three-tier response in an effort to protect the safety of the mentally ill youth and the general public.

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Chapter One: Introduction

The over-representation of youth aged 12-17 with mental illnesses within the Canadian criminal justice system has raised concern among political figures, legal actors and scholars (Campbell & Schmidt, 2000; Schulenberg & Warren, 2009; Colwell, Espinosa & Villarreal, 2012; Cheong, Walsh & Yun, 2014). Alarmingly, approximately one in five police interactions involve someone with a mental illness, and this rate increases for youth, especially those of lower socio-economic status, who have the highest overall rates (39-48%) of mental illness in the Canadian population (Ayerst, 1999; Votta & Manion, 2003; Statistics Canada, 2015a). The majority of interactions between police and the mentally ill are relatively uneventful (Engel & Silver, 2001). However, efforts to frame these interactions as problematic has successfully garnished the attention of researchers and the public alike. (Engel & Silver, 2001; Schulenberg & Warren, 2009; Barbaree et al., 2016; Brown et al., 2017; Fisher et al., 2017). Because youth are recognized as a particularly vulnerable population, researchers are beginning to explore the interactions between police officers and mentally ill youth especially (Green, 1997; Campbell & Schmidt, 2000; Hartford et al., 2009; Schulenberg & Warren, 2009; Colwell, Espinosa & Villarreal, 2012; Cheong, Walsh & Yun, 2014).

Research finds that mentally ill youth are often misunderstood by members of the criminal justice system, particularly the police, who often characterize their behaviours as aggressive and uncooperative (Thompson, 2010). Moreover, the police and other actors in the criminal justice system are often inclined to impose punitive sanctions on mentally ill youth (Campbell & Schmidt, 2000; Colwell, Espinosa & Villarreal, 2012; Cheong, Walsh & Yun, 2014). This entangles youth in the web of the criminal justice system (Campbell & Schmidt, 2000; Colwell, Villarreal & Espinosa, 2012; Cheong, Walsh & Yun, 2014). Since police officers

are the first point of contact in the criminal justice system, it is important to better understand

police officer's decision-making with mentally ill youth.

According to the Public Health Agency of Canada (2015), mental illnesses are

characterized by "alterations in thinking, mood or behaviour associated with significant distress

and impaired functioning" (para. 1). However, this definition is not relied upon by police

officers. Instead, research demonstrates that police officers learn many of their definitions of

mental illness through the formal training process, which involves a review of federal and

provincial laws, policies, and protocol (Seagrave, 1997; Schulenberg & Warren, 2009). Two

specific laws and policies relevant to mentally ill youth involved with the law -- the *Youth

Criminal Justice Act* (YCJA) and the *Ontario Mental Health Act* (OMHA) -- both encourage the

use of informal measures (i.e. diversion to a community resource) for youth-related incidents.

However, informal measures are not applied consistently to youth-related incidents by police

officers in differing police services across Canada (Forcese, 1992; Chappell, 2008). Furthermore,

despite these inconsistencies, the Ontario Police College has been reluctant to make changes to

the training process that could result in shared definitions and directions for officers, to better

meet the needs of mentally ill youth (Seagrave, 1996; Black et al., 2007; Chappell, 2008).

In fact, a wealth of research suggests that police officers, upon the completion of training,

encounter confusion in the work force with defining their distinct role (Seagrave, 1996; Cordner

& Sheehan, 1999; Garland & Rowe, 2003; Smith & Stewart, 2004). For example, in some

situations officers focus on the maintenance of public order and safety (law enforcement duties)

while in other situations they perform duties typically performed by health care and social work

professionals (parens patrie or caretaker duty) – such as crisis intervention, diagnosis of mental

health disorders, and counselling (Green, 1997; Borum et al., 1998; Hartford, 2006; Barbaree et

al., 2016; Fulambarker, Watson & Wood, 2017). Regardless of the situation, part of their role is to provide *appropriate* action with youth which should differ from how they respond to adults (Schulenberg & Warren, 2009). Since training does not extensively review the handling of special populations, particularly youth with mental illness, much of what is applied while on the job is a result of post-training experiences – for example on-the-job experiences (Herz, 2001; Smith & Stewart, 2004; Colwell, Espinosa & Villarreal, 2006). The post-training experiences that are more likely to guide officer's decision-making is less known (Schulenberg & Warren, 2009).

Social constructionist theory is a useful framework for understanding the decision-making process of police officers' with mentally ill youth. According to social constructionist theory, whether a behaviour is defined as deviant or abnormal depends on the specific historical, cultural and context specific experiences of members within a particular society (Gergen, 1985; Dewees, 1999; Sahin, 2006). Through this interactive process, particular definitions are constructed; once constructed, these definitions are transmitted to others through the socialization process and become part of individuals' constructions of reality (Sahin, 2006). Police officers are known to be influenced by police and broader cultural influences. A better understanding of the behaviours police officers associate with youth who they believe are mentally ill, as well as how they construct such definitions, could clarify why and how officers choose to react to particular types of young offenders using formal (i.e., court) versus informal (i.e., diverted to community programming) measures. Yet very little research has focused on police discretion from a social constructionist perspective (Campbell et al., 2010; Billette, Charette & Crocker, 2011; Fulambarker, Watson & Wood, 2014). Considering police officers are granted vast discretion as the primary responders to youth crime, this is an important area for

empirical inquiry. After all, these officers ultimately determine the likelihood of a youth's criminal act being processed using formal measures or informal measures (Carrington & Schulenberg, 2008; Schulenberg & Warren, 2009; Cheong, Walsh & Yun, 2014).

1.1 The Current Study

The current study attempts to add to the existing literature by analyzing police officers' discretion with youth they believe are mentally ill, from a social constructionist perspective. Using data gathered through face-to-face interviews with 12 police officers, this study asks: How do police officers from one Police Service in Ontario interact with youth who they reason to believe are mentally ill? The goals of this study are three-fold. First, it will identify what behaviours police officers associate with youth who they believe are mentally ill. Second, this study will attempt to better understand the factors that influence police officers construction of mental illness. Third, this study will determine how the particular schemas used by police officers' impact their decision-making processes with youth who they perceive to have a mental illness. Ultimately, the current study seeks to contribute to our understanding of how officers respond to mentally ill youth through formal and informal responses.

1.2 Chapter Overview

Chapter Two provides a review of past studies conducted on police interactions with mentally ill youth. It begins by illuminating the severity of how frequently mentally ill youth are involved with the criminal justice system. Next, it examines the policies that guide criminal justice actors' decision-making with mentally ill youth in Ontario. Finally, it discusses studies which have focused on the responses of criminal justice actors to mentally ill youth. In doing so,

it becomes apparent that there is a gap in what we know about how police officers' respond to mentally ill youth.

Chapter Three outlines the theoretical perspective employed in this study. First, the theoretical assumptions of social constructionist theory are discussed. Using social constructionist theory, mental illness is broken down to identify its underlying meaning according to Western culture. Lastly, the evolution of police culture and its connection to police officers' views of offenders is reviewed. Chapter Four describes this study's methodology. This chapter reviews the goals that guided the study and discusses the strategy used to recruit participants and describes the sample. Next, this chapter explains the interview process and describes how the data gathered through face-to-face interviews were analyzed; this includes a description of the key measures and concepts. It concludes with an overview of the limitations stemming from the analytic strategy. Chapter Five presents the results of the thematic analysis. Three major themes are discussed which pertain to officers' construction of mental illness, the factors that influence officers' construction of mental illness, and officers' use of formal and informal responses to mentally ill youth. Chapter Six explores the results from this study in connection to prior literature and social constructionist theory. The limitations of this study are discussed and theoretical and policy implications are summarized. This chapter finishes with recommendations for future research on this topic.

Chapter Two: Literature Review

Introduction

This chapter describes the current literature and policies related to the use of discretion by police in their encounters with mentally ill youth. It begins with a presentation of the major policy change – namely the deinstitutionalization movement – that led to the increased prevalence of people with mental illness receiving treatment within the community. From here, it discusses the over-involvement of people with mental illness within the Canadian criminal justice system. It then identifies the policies in Ontario that govern police discretion with mentally ill youth, namely the *Youth Criminal Justice Act* and the *Ontario Mental Health Act*. Finally, it considers how existing research describes police officers' interactions with delinquent youth. This review demonstrates that the current literature leaves important unanswered questions about police officer decision-making with mentally ill youth.

2.1 Mentally Ill Individuals and the Criminal Justice System

The Deinstitutionalization Movement

Throughout the first half of the twentieth century, individuals who were classified as mentally ill were housed in mental institutions and hospitals (French, 1987; Martinez, 2010; Thompson, 2010). Housing the mentally ill in these facilities was considered necessary for two reasons. Firstly, mentally ill individuals were viewed by others as dangerous which suggested that they posed a significant risk to public safety; therefore, locking them up was necessary to maintain a safe and orderly society (Mullaly & Wachholz, 1993; Martinez, 2010). Secondly, society believed that only within the walls of an institution would mentally ill individuals be able to develop a more acceptable sense of self (Goffman, 1961; Martinez, 2010). According to

Goffman (1961), to achieve an acceptable sense of self the individual would be stripped from their previous social roles and identities which would result in a version of self that doctors and clinicians would favour. In most of these cases, mentally ill individuals lost all contact with individuals outside of the institution and were given limited, if any, input into their treatment plan (Goffman, 1961; Martinez, 2010). The power imbalance between clinicians and patients, coupled with the unwarranted restrictions of patient's civil liberties led Goffman (1961) to refer to mental hospitals as *total institutions*, which he claimed were comparable to concentration camps, military organizations, and prisons. Unsurprisingly, Goffman's framing of mental institutions was instrumental in creating societal attention around the treatment of mentally ill persons (French, 1987).

It was not long after Goffman released his essays on institutionalism that mental institutions and hospitals were facing extreme over-crowding (French, 1987; Martinez, 2010). At the same time, advancements pharmacologically suggested that treatment of mentally ill persons within the community setting was achievable (French, 1987). The community treatment model would mainstream treatment processes by producing more accessible clinical services which would focus on preventing hospitalization, providing support and reducing the symptoms that accompany mental illness (French, 1987; Engel & Silver, 2001). Ultimately, the shift in societal perceptions surrounding the treatment of persons with mental illness resulted in the release of thousands of patients into the community and the closure of several psychiatric facilities (Herman & Smith, 1989; Green, 1997; Engel & Silver, 2001; Martinez, 2010).

Despite the objectives of deinstitutionalization, community mental health services failed to increase as individuals were deinstitutionalized (Teplin, 1983; French, 1987; Mullaly & Wachholz, 1993). This left mentally ill people of all ages to reside in communities without

proper medical support and resources, creating issues involving poverty, unemployment, victimization and homelessness (French, 1987; Herman & Smith, 1989; Engel & Silver, 2001; Commission on the Future of Health Care in Canada, 2002; Public Health Agency of Canada, 2006; Marcussen et al., 2011). Eventually, this resulted in the re-institutionalization of mentally ill individuals within the walls of the criminal justice system (Martinez, 2010). This historical event has been termed the deinstitutionalization movement. Although the majority of research on the Canadian deinstitutionalization movement focuses on mentally ill adults, it is likely that a similar process occurred for mentally ill youth who were institutionalized, with the notable exception that youth were released into the care of foster homes, group homes, parent's who reside in low-income housing and/or shelters prior to becoming homeless.

The deinstitutionalization movement placed mentally ill individuals in a unique position as they were, and continue to be, dealt with through the criminal justice system despite having needs that require assistance from the mental health system (French, 1987; Thompson, 2010). More specifically, research demonstrates that this movement has resulted in the over-representation of mentally ill individuals within the justice system for two key reasons. First, community organizations that specialize in the treatment of mentally ill individuals are underfunded (French, 1987; Engel & Silver, 2001). Secondly, the needs of mentally ill persons are misunderstood by criminal justice actors (French, 1987; Engel & Silver, 2001; Martinez, 2010; Thompson, 2010; Statistics Canada, 2015a; Fulambarker, Watson & Wood, 2017).

The Results of Deinstitutionalization for Youth

Deinstitutionalization had specific affects on mentally ill youth which included rendering thousands of North American mentally ill youth into foster care, group homes, shelters or into

the care of their families who often resided in low-income housing (French, 1987; Herman &

Smith, 1989; Martinez, 2010). It is possible that limited parental support and medical resources

led some mentally ill youth to drift into subcultures, that were tolerant of their symptomatic

behaviour (French, 1987; Engel & Silver, 2001; Marcussen et al., 2011). From here these youth

began engaging in poor coping mechanisms which often included committing crimes (Wilton,

2004) which required police officers to patrol (Engel & Silver, 2001; Wilton, 2004).

Traditionally, police officers focus on their duty to protect the public which involves

physically removing individuals who pose a danger to society (Engel & Silver, 2001). However,

during interactions between police and mentally ill youth, officers act in the capacity of parens

patrie which requires them to help citizens who are unable to help themselves (Engel & Silver,

2001; Fulambarker, Watson & Wood, 2017). Although the duty of parens patrie was not an

entirely new concept, it did complicate officers' decision-making as to when to arrest a mentally

ill person (Engel & Silver, 2001). Essentially, officers' duty to maintain public safety

outweighed their duty to care for the helpless which meant arresting any youth, regardless of

their mental capacity, who posed a danger to society (Engel & Silver, 2001). Since a great

majority of police contact with youth was when the youth was under the influence of drugs or

alcohol (Engel & Silver, 2001) or during a time of distress, most of the youth were arrested to

ensure protection and order within society, leaving prisons to be the largest treatment setting for

the mentally ill (Borum et al., 1998; Lurigio, 2011; Fulambarker, Watson & Wood, 2017). This

over-representation of people with mental illness in the criminal justice system has been

explained using the criminalization hypothesis (Abramson, 1972). The criminalization

hypothesis assumes that police officers unsuitably rely on arrest to resolve situations with

mentally ill individuals (Abramson, 1972). Yet, the challenges faced by mentally ill individuals,

which include court actors imposing punitive sanctions on individuals with complex needs, are equally important contributors to their involvement in the criminal justice system.

Challenges Faced by Mentally Ill Individuals

Mental illnesses are a complex phenomenon. Research demonstrates that a large majority of individuals who are diagnosed with a mental illness actually have co-occurring – more than one – mental illnesses (Lurigio, 2011). In some instances, the mental illness is coupled with a substance abuse disorder (Borum et al., 1998; Lurigio, 2011), while in others it co-occurs with other mental illnesses (Lurigio, 2011). Research conducted with individuals involved in the criminal justice system finds that individuals with co-occurring mental illnesses are most likely to receive diagnoses for at least two of the following mental illnesses: schizophrenia and psychotic disorders, bipolar disorders, depression, anxiety, post-traumatic stress disorder and substance disorders (Lurigio, 2011). In fact, within the criminal justice system, the estimated prevalence of co-occurring mental illnesses is 75 percent (Fulambarker, Watson & Wood, 2017). Mentally ill individuals present their symptoms differently (Lurigio, 2011) which further complicates the diagnosis of their condition (Fulambarker, Watson & Wood, 2017).

To further complicate matters, mental illnesses are often coupled with homelessness (Wilton, 2004; Farrell & Marshall, 2007; Lurigio, 2011). Homeless individuals, specifically youth, have the highest prevalence of mental illness within the Canadian population (Wilton, 2004; Statistics Canada, 2015b). These youth face difficulties obtaining safe and secure housing and they have limited access to mental health resources (Wilton, 2004). In Canada, access to mental health resources, such as counselling or pharmaceutical drugs, requires the youth or youth's parent(s) to have benefits which can cover the costs of such resources. (Wilton, 2004).

Since homeless youth rarely secure employment or have access to parental benefits, their means for coping with their mental illnesses are constrained.

When youth or adults with mental illness are unable to obtain treatment for their disorder(s), their mental illnesses may become exacerbated leading to: diminished self-esteem, additional mental illnesses, loss of familial support, an inability to maintain social relationships, and they may become withdrawn and isolate themselves, or take their lives (Erdner & Piskator, 2013; Brown et al., 2017). Ultimately, the complicated web of needs confronted by people with mental illness, coupled with limited access to mental health treatment make them particularly vulnerable to increased contact with the criminal justice system (Erdner & Piskator, 2013).

Abundant research on court actors has focused on their decision-making with mentally ill young offenders. Studies have estimated that in Canada, 50-70 percent of youth who serve custodial sentences suffer from at least one mental illness (Charette, 2011). These youth often exhibit behavioural issues, anti-social attitudes and the inability to understand the consequences of their actions. To court personnel, these behaviours are often incorrectly characterized as low self-control, which is correlated with delinquent behaviour (Cheong, Walsh & Yun, 2014). This often propels youth with mental illnesses further into the justice system, increasing their likelihood of recidivism upon release (Campbell & Schmidt, 2000; Colwell et al., 2012; Cheong, Walsh & Yun, 2014) and hinders the reintegration process (Carrington & Schulenberg, 2008; Schulenberg & Warren, 2009; Cheong, Walsh & Yun, 2014). With the realization that a large majority of the youth who were being arrested and housed within correctional facilities had a mental illness, police as the first point of contact with the justice system, came under scrutiny (Fulambarker, Watson & Wood, 2017) and policy makers attempted to construct policies that could better direct officers' decision-making.

2.2 Policies

The increase in contact between mentally ill youth and the Canadian criminal justice system suggested that new policies were necessary to combat issues related to their over-representation. In Ontario, there are two key policies that guide police officers' decision-making with mentally ill young offenders. These policies include the *Youth Criminal Justice Act* (YCJA) of 2002 and the *Ontario Mental Health Act* (OMHA) of 1990. The YCJA is a piece of federal legislation that is administered by criminal justice personnel at the provincial level (Carrington & Schulenberg, 2008). The principle objectives of this act include fair and proportionate responses to youth crime, a greater reliance on rehabilitative and reintegrative measures, and timely responses to youthful offending (Government of Canada, 2015). This legislation also grants police officers a considerable amount of discretion by allowing them to exercise their autonomy and power when deciding how to respond to young offenders (Carrington & Schulenberg, 2008; Schulenberg & Warren, 2009; Yun, Cheong & Walsh, 2014). Specifically, the YCJA provides police officers with the authority to decide whether to respond to young offenders with formal or informal measures (Schulenberg & Warren, 2009). Formal measures include the laying of a charge whereas informal measures include diverting youth to an external agency, known as an extra-judicial measure. The YCJA "requires police officers to consider the use of extra-judicial measures before deciding to charge a young person" (Department of Justice, 2015), meaning the decision about when to charge ultimately rests with each individual officer.

The OMHA, on the other hand, governs police discretion when dealing specifically with mentally ill persons. Implemented in 1990, the OMHA provides police officers with the ability to exercise discretion with any persons with mental illness with whom they come into contact at a first-responder level. Section 17 of this act allows police officers who have reasonable grounds,

to arrest any person who presents a harm to themselves or to others (Ontario Mental Health Act, 1990). Section 17 thus implies that police officers possess mechanisms to appropriately characterize and identify mental illness. Neither the YCJA nor the OMHA provide guidance on how to identify a mental illness, nor do they outline effective ways to respond to a youth who possesses a mental illness. They also do not require police officers to record the mental health status of the youth with whom they come into contact for future reference. Despite attempts at creating policies that could assist officers in their decision-making with mentally ill youth, several researchers demonstrate that youth with mental illness are dealt with by the criminal justice system through harsher measures and more punitive sanctions – such as longer prison sentences and more stringent probation terms – than youth without mental illness (Campbell & Schmidt, 2000; Colwell et al., 2012; Cheong, Walsh & Yun., 2014).

Numerous studies have attempted to understand the decision-making processes of court personnel, including judges, lawyers and juries, in dealing with mentally-ill youth under these policies (Campbell & Schmidt, 2000; Colwell et al., 2012; Cheong, Walsh & Yun., 2014); yet, very little research has been conducted on the decision-making processes of police officers who come into contact with mentally ill youth (Hartford et al., 2009; Bohrman et al., 2014). Few studies have assessed the impact of the OMHA and the YCJA on police officers' use of discretion with youth who are suspected to have mental illness (notable exception is Hartford et al. (2009)). Nevertheless, research suggests that administrative policies do influence police officers' decision-making when they make decisions pertaining to situations which require the enforcement of laws (Wilson, 1968) but administrative policies do not influence officers' decision-making when they are responding to situations which require them to care for helpless individuals, such as people with mental illness (Bittner, 1967; Wilson, 1968; Engel & Silver,

2001). Instead officers are more likely to rely on the extralegal and situational factors present at the situations in making their decisions and on how they have come to construct and view these complex situations (Bittner, 1967; Engel & Silver, 2001; Schulenburg & Warren, 2009).

2.3 Police Officers and Delinquent Youth

Police officers are awarded a considerable amount of discretion with youth and are the primary decision-makers regarding whether to deal with young offenders through formal or informal measures. Research demonstrates that a police officer's response to criminally involved youth is influenced by the following extralegal and situational factors: the seriousness of the offense committed, the youth's prior involvement with the criminal justice system, the youth's race, age, education, substance abuse, socio-economic background and attitude towards the officer or situation (Campbell & Schmidt, 2000; Kakar & Potter, 2002; Hannah-Moffit & Maurutto, 2007; Schulenberg & Warren, 2009; Cheong & Walsh & Yun, 2014). Although very little research has been conducted on the extent to which mental illness influences police discretion (Engel & Silver, 2001), studies indicate a strong correlation between the characteristics associated with mental illness to that of low self-control (Cheong, Walsh & Yun, 2014). These characteristics include: unwillingness to cooperate or follow directions, the inability to understand the consequences of one's behaviour, and the presentation of a hostile demeanour. This research has suggested that police officers may incorrectly assume the characteristics of a mental illness to be those associated with low self-control, consequently leading to a greater use of formal measures when dealing with youth (Cheong, Walsh & Yun, 2014).

In fact, research conducted on police discretion with persons with mental illness has revealed that police often act as frontline workers in deciding the outcome of mental health crisis calls. Officers generally feel confident in their ability to identify a mental illness (Green, 1997; Watson et al., 2014), though their ability to identify a mental illness relies on the type of scenario with which they are presented over their patrol car radio communication system, which triggers particular schemas about mental illness (Watson et al., 2014). Upon identifying what they consider to be a mental illness, officers justify their use of discretion in terms of how cooperative the individual is and whether or not the person has or is threatening the use of a weapon (Green, 1997; Watson et al., 2014). The exercise of evaluating a person's behaviour and deciding if it mirrors that of a mental illness or just delinquent behaviour has been described by researchers as the response-and-enforcement model (Martinez, 2010).

Due to recent criticisms of the response-and-enforcement model, officers have begun to employ additional response models with mentally ill individuals which enlist the help of specialized mental health workers (Martinez, 2010). These new models include: Crisis Intervention Teams (CIS), Mobile Crisis Teams (MCT) Community Service Officers (CSO) and TEMPO. In the CIS model, police services train a unit of police officers in identifying the signs and symptoms congruent with various mental illnesses (Martinez, 2010). This unit also has access to various mental health services to which they can connect the mentally ill individual. In contrast, the MCT model enlists the help of mental health experts who, upon the request of the officer, can respond to the scene to assist the mentally ill person (Martinez, 2010). The CSO model relies on individuals with prior social work experience to assist during mental health calls (Martinez, 2010). The officers selected for participation in this model are required to complete a training program prior to employment. Finally, the TEMPO model was developed by the Mental

Health Commission of Canada and builds on existing models that fail to adequately address the challenges faced by Police Services in Canada (Coleman & Cotton, 2014). TEMPO stresses anti-stigma and human rights, the inclusion of persons with mental illness as educators, context to which interactions or learning occurs and it challenges traditional views officers hold about people with mental illness (Coleman & Cotton, 2014). According to Coleman & Cotton (2014), the major advantage to TEMPO is its ability to be easily integrated into existing police frameworks. Very few studies have assessed these new models within a Canadian context (Schulenberg & Warren, 2009).

Overall, and in line with the assumptions of parens patrie, officers suggest that they reserve arrest for the most violent and disruptive persons with mental illness. Officers generally feel more compelled to refer the mentally ill to psychiatric hospitals with the expectation that the individual will receive specialized care that will prevent future illness related incidents (Green, 1997). Because most research on police decision-making has been conducted with mentally ill adults, it is unclear if the above statement holds for police responses to mentally ill youth. Since the implementation of the YCJA, evidence suggests that the overall number of youth charged by police officers has decreased substantially, while the number of referrals to extra-judicial measures programs has grown substantially (Carrington & Schulenburg, 2008). Nevertheless, youth who possess a mental illness continue to be over-represented (65-75 percent) within all aspects of the criminal justice system (Carey, Hartford & Mendonca, 2006; Colwell, Espinosa & Villarreal, 2012).

2.4 Conclusion

This chapter summarized the prevalence of mentally ill persons in the criminal justice system. It explored the effects that the deinstitutionalization movement had on mentally ill individuals and reviewed the policies that exist in Ontario to guide police officers' decision-making with mentally ill youth. Finally, it assessed the current research on police officers' decision-making with young offenders. In short, this chapter suggests that there is limited existing research that has been conducted on police decision-making with mentally ill youth within a Canadian context. Moreover, few studies consider the extent to which factors such as police training or post-training experiences, influence police officers' working definitions of mental illness and their subsequent response patterns. The following chapter will provide the theoretical framework employed in the current study which will attempt to bridge the gaps in the current literature.

Chapter Three: Theoretical Framework

Introduction

Studies suggest that the ways in which a society identifies mental illness are largely due to their construction of the behaviours that constitute deviancy and abnormality (Collins & Furman, 2005; Galanek, 2013). According to social constructionist theory, the way a behaviour is defined as deviant and abnormal depends on the specific historical, cultural and context specific interactions that members within a particular society have experienced (Gergen, 2015; Dewees, 1999; Sahin, 2006). Through this interactive process, particular definitions are constructed; once constructed, these definitions are transmitted to others through the socialization process and become part of individual's constructions of reality (Sahin, 2006). This construction of reality includes the individual's ideologies, values, and beliefs about the world which allows for the organization and understanding of situations they will encounter ultimately shaping individual's responses (Houston, 2001).

Understanding the meaning of mental illness is a key example of the construction process. Interactions in which an individual emits pathological symptoms that deviate from the norms of society are framed and constructed as abnormal (Gaines, 1992). Once defined as abnormal, society assumes medical attention is necessary to modify the individual's behaviour to bring the mentally ill individual back to a state of normalness (Farone, 2002). Different cultures have different social norms that influence what the society defines as abnormal, including a mental illness (Gaines, 1992). Western culture has defined mental illness scientifically with reference to the *Diagnostic and Statistical Manual of Mental Disorders*. This construction of mental illness and its treatment carries over into the criminal justice system in the work of the courts (Campbell & Schmidt, 2000; Thompson, 2010; Colwell et al., 2012; Cheong, Walsh &

Yun, 2014) and activities of frontline workers such as social workers (Furman & Collins, 2005; Sahin, 2006) and police (Paoline, 2003; Hartford et al., 2009; Bohrman et al., 2014).

As previously discussed, police officers possess considerable discretion as the first point of contact between youth and the criminal justice system. Initial contact with mentally ill youth tends to be due to minor infractions such as trespassing, vandalism and minor thefts/assaults (Michailakis & Schirmer, 2014). Mentally ill youth may be the victim of the crime, the suspect of the crime or in need of escort to psychiatric care (Michailakis & Schirmer, 2014). These interactions with mentally ill youth have shaped how police officers construct mental illness and influence their decision-making (Hartford et al., 2009; Michailakis & Schirmer, 2014; Bohrman et al., 2014).

3.1 Historical Context of Social Constructionism

Social constructionist theory focuses on the processes individuals use to describe and explain their reality. Historically, philosophers Spinoza, Kant, and Nietzsche believed that individuals think, categorize and process information as a way to organize their knowledge about their world (Gergen, 1985). This knowledge is influenced by the ways members of particular cultures interpret and construct their reality. Through interactions with different members of a society, individuals' construction of reality becomes a construction of shared norms and values that exist within a particular culture and time period (Collins & Furman, 2005). The current understanding of social constructionism can be divided into three waves of thought, described below.

Wave I

Social constructionist theory is deeply rooted in cognitive constructivism, cognitive psychology, and the philosophy of human experience (Sahin, 2006). In the 1920's-1930's theorists such as Jean Piaget were concerned with how individuals' frameworks and internal structures related to an individual's social surroundings (Hruby, 2001). Piaget predicted that these frameworks occur unconsciously and help to structure our responses to our environment (Hruby, 2001). At the time, some sociologists argued that Piaget's predictions focused too much on the formation of knowledge as an unconscious phenomenon. Those sociologists acknowledged that psychology and biology played a role in the construction of reality (Houston, 2001), but the social world is manufactured through human interaction thus culture, historical time periods and context is important to analyze (Sahin, 2006). The first wave of Social Constructionist Theory was termed the sociology of knowledge (Hruby, 2001).

The sociology of knowledge was influenced by Erving Goffman's *The Presentation of Self in Everyday Life* (1959) and Berger and Luckmann's *The Social Construction of Reality* (1966). Goffman (1959) suggested that individuals derive meaning and construct a sense of self through the interactions they have with one another. During these interactions, especially the initial interactions individuals have with one another, individuals convey a view of themselves they believe others will find acceptable (Goffman, 1959). As interactions among individuals progress, individuals will add or modify the initial sense of self they once portrayed to create a more favourable sense of self (Goffman, 1959). Therefore, interactions between members of a society are crucial as they provide meaning to everyday life. Social interactions are further acknowledged in the work of Berger and Luckmann who focused on the use of language to assist in the creation of themes and social meaning. They argued that language allows for the transfer

of subjective meaning to objective meaning which then leads to social meaning and themes (Hruby, 2001). Language assists in the creation of symbols and themes which society actively works to construct; these symbols and themes help society and the individual to organize and construct their environment and reality (Hruby, 2001). Therefore, reality exists because individuals construct it.

Goffman (1959) and Berger and Luckmann (1966) laid the foundation for later predictions around the way theorists understand the world to be a product of social interaction and negotiation (Sahin, 2006). These contributions emphasized the importance of language in regulating social life and its influence on the generation of reality (Sahin, 2006).

Wave II

By the 1970's – 1980's, social constructionists began to focus on the role of culture and history in societies' constructions of reality. Of particular importance during this time period, Michael Foucalt, stressed the importance of power for understanding the social construction of reality. He predicted that the more dominant and powerful a particular theme or construct is, the greater chance it will have to become part of the social reality (Houston, 2001). Adding to the work of Foucault was Kenneth Gergen who emphasized that reality was a social construct that is transmitted and reconstructed from generation to generation (Gergen, 1985). What is thought of as reality is dependent on what elements are reinforced through social sanctions (Gergen, 1985). Reality is contingent upon the experiences and interactions between individuals in a given society. Therefore, reality is dependent on context and culture (Gergen, 1985; Houston, 2001; Sahin, 2006). With regard to mental illness, Gergen made the following four assumptions:

Assumption 1. "What we take to be experience of the world does not in itself dictate the terms by which the world is understood." (Gergen, 1985, p. 266)

Gergen (1985) suggested that knowledge about the world is not a product of hypothesis testing or induction. Instead, how the world is understood was a direct result of negotiated, re-negotiated and generated social interactions (Dewees, 1999). These interactions are culturally and historically dependent and continuously changing over time (Gergen, 1985; Dewees, 1999). Gergen related this assumption to persons within the mental health system. He suggested that the criteria used to determine one's risk for suicide and the classification scheme used to identify schizophrenia and psychological disorders is circumscribed by the social context, history and culture (Gergen, 1985). Therefore, what may be viewed as a disorder in one society may not be viewed similarly in another. This led Gergen (1985) to question conventional knowledge and commonly accepted categories of mental illness.

Assumption 2. "The terms in which the world is understood are social artifacts, products of historically situated interchanges among people." (Gergen, 1985, p. 267)

The way the world is understood is a result of active interactions between persons in relationships; however, these relationships will change over time (Gergen, 1985). These changes are a result of historically and culturally contingent factors which is why the way the world is understood differs from one culture to the next (Gergen, 1985). Of particular importance are the economic, moral, political and social institutions that shape the culture and history (Gergen, 1985). This led Gergen (1985) to assume that the construction of mental illness was a result of the historical and cultural events happening during a particular time period and that this construction will change over time.

Assumption 3. "The degree to which a given form of understanding prevails or is sustained across time is not fundamentally dependent on the empirical validity of the perspective in question, but on the vicissitudes of social processes." (Gergen, 1985, p. 268)

Gergen (1985) stressed the role of communication, rhetoric, negotiation, and conflict in shaping perspectives within a community. In particular, language allowed for the sharing of human experiences and stories upon which consensual understandings of the world are based (Dewees, 1999). Despite the validity of experiences and stories, particular understandings would prevail if they continued to go without challenge.

Assumption 4. "Forms of negotiated understanding are of critical significance in social life, as they are integrally connected with many other activities in which people engage." (Gergen, 1985, p. 468)

Descriptions and explanations of reality are intertwined with human activities (Gergen, 1985). Specifically, certain descriptions and explanations are differentially valued which makes some more salient than others (Gergen, 1985; Dewees, 1999). Although one understanding is not more accurate than another, the dominant understandings force the powerless to accept the views of the powerful (Dewees, 1999). For example, Gergen (1985) noted that current research on mental illnesses, such as schizophrenia, demonstrated that the narratives of clients are marginalized and the views of doctors became more dominant. While the narratives provided by the mentally ill were not incorrect, they were less valued than those of the dominant culture. This was shaped by the way in which individuals engaged with one another during the historical time period.

While Foucault's prediction is less recognized, it is equally important as Gergen's main assumptions about social constructionism. Foucault and Gergen's assumptions have been criticized by current social constructionists.

Wave III

Recent advancements in social constructionist theory have come to recognize the role that biology, evolution and labelling have on individuals' constructions of reality (Gaines, 1992). Social constructionists, however, often fail to recognize that their explanatory frameworks are themselves analytic constructs (Gaines, 1992). Critics have accordingly sought to emphasize the context of the construction of reality and influence of individuals' conflicting occupational requirements (Hruby, 2001). Constructionists have recognized the need to incorporate power differences into their analysis as the dominant shapes the norms of a society (Gaines, 1992). Social constructionist theory can thus be used to deconstruct social issues, one of which is the construction of mental illness and accepted treatment options.

3.2 The Construction of Mental Illness

The construction of mental illness and treatment options have evolved throughout history (Farone, 2002). What constitutes a deviation from normalness and reality is context, culturally and historically-dependent. The suggestion that mental illness is socially constructed does not mean that there are not psychological or physiological components that impact an individual's abilities; however, as Foucault argued, mental illness only becomes a reality when and if the particular culture recognizes it as such (Farone, 2002). The idea that certain behaviours should be viewed as an illness, as opposed to criminal behaviour, has been termed the *medicalization of deviance* (Farone, 2002). Once a behaviour becomes defined as an illness, individuals within society view the ill individual as being in need of treatment which would allow them to return to a state of normalness (Farone, 2002). Depending on the society's construction of appropriate treatment and response options, dominant forces within society are able to hold and withhold

treatment through the creation of laws, regulations and medical coverage criteria. Mental illness is a social construct, often codified with reference to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Since court actors rely heavily on clinicians' evaluations of offenders, the DSM has become highly influential in determining perceptions of normal versus mentally ill offenders.

Disease as a Social Construct

Mental illness is a complex construct. The term itself suggests that the individual has departed from the norms deemed appropriate in a particular society (Farone, 2002). While practitioners assert accepted clinical criteria, sociologists have argued that illnesses of the mind are culturally constructed, deriving their existence from what society defines as abnormal within a medical context (Gaines, 1992). From a critical perspective, mental illness subsumes all behaviours outside the realm of normal. The actual classification of such diseases "are created out of perceptions, which are simultaneously interpretations of the experiences of self, other and of culturally constructed instances of abnormality" (Gaines, 1992, p. 4). Individuals who demonstrate abnormal behaviours that align with the construction of a particular mental illness are defined as mentally ill to secure medical treatment to bring the individual back to a state of normal (Farone, 2002). Despite the lack of consensus among clinicians about symptoms, constructions of mental illness determine how society responds (Gaines, 1992).

Gergen's work on ethnomedicines and ethnopsychiatries has been particularly useful in understanding the social construction of mental disease and illnesses (Farone, 2002). Gergen (1985) noted that professional medicine is grounded in culture, history and cultural artifacts. Without consideration of these elements, approaches to diseases cannot be fully understood.

Since culture and history are constantly changing and influencing medical realities, medical

systems are incomplete cultural constructs (Gergen, 1985). Medical systems are shaped through

letters, texts, books, histories and/or speech. These interactions tend to be focussed on pain,

suffering, relief, frustration, joy, loss and anger (Gergen, 1985). Therefore, it is essential to

consider disease as a constantly changing phenomenon dependent on the ever-changing

construction of the social reality (Gergen, 1985). The specific changes Gergen warns against can

be seen in the evolution of the construction of mental illness as defined within the DSM.

Diagnostic and Statistical Manual of Mental Disorders

In 1840, the United States government established the first psychiatric classification

manual titled the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (Gaines, 1992).

At the time, mental illness was a single term used by health professionals to describe all patients

they believed to display symptoms of insanity and idiocy. By 1880 the DSM had evolved to

include seven categories of mental illness: mania, melancholia, paresis, dementia, epilepsy,

monomania and dipsomania (Gaines, 1992). Despite this being the first psychiatric classification

manual created, the illnesses outlined were primarily of Northern Germanic ethnic origin – for

males and adults (Gaines, 1992). Therefore, the manual was not particularly useful in cultures

that did not experience the same cultural and historical experiences.

By the 1940's, military personnel began to return home from World War II which posed

significant strains on the health care system. It was during this time that the DSM was once again

revised to allow clinicians to better identify the disorders encountered with military personnel

and the appropriate treatments for these illnesses (Gaines, 1992). Arguably, this particular time

period in history created a shift in the construction of what constituted a mental illness. That is,

the returning home of military personnel, some of whom exhibited symptoms that strayed from the agreed upon normal symptoms, caused the medical profession and society to reconstruct mental illness. In particular, these shifts included the construction of post-traumatic stress disorder. This rapid proliferation of diseases has been recognized as being derived from invidious distinctions, not clinical reality (Gaines, 1992). Menninger proposed that mental illnesses, as described by the DSM, are not a result of medical science but instead actions or behaviours that the larger society perceived as being a major deviation from the norms (Gaines, 1992).

In addition to the critiques made by Menninger, theorist Sigmund Freud contended that the creation of the DSM commonly included notions of neurosis, defense mechanisms and neurotic conflict (Gaines, 1992). These inclusions, appeared in the DSM-I, at a time which these abnormalities were particularly apparent (Gaines, 1992). Despite there being no universal and discrete symptoms associated with each illness (Farone, 2002), the construction of different disorders has had a major impact on the ways in which those classified as having a disorder are treated. As the construction of the DSM has changed throughout history, the treatment covered by health insurance companies has also been impacted, often disadvantaging the poor who cannot afford health insurance, resulting in their over-representation in the mental health system (Michailakis & Schirmer, 2014). Furthermore, the evolution of the DSM coupled with the construction of appropriate behaviours based on race and gender, has played an influential role in the treatments provided to criminal offenders. Unlike police officers, court actors are provided with psychiatric assessments of each medium to high-risk offender with whom they deal with. These psychiatric assessments are based on DSM criteria. Changes in the DSM thus influence court actors' construction of mentally ill offenders.

Normal Offenders

Decision-making in the criminal justice system often conforms to patterned responses based on categories of normal and abnormal behaviour (Thompson, 2010). In the 1970's, Alfred Schutz coined these socially constructed categories as typifications (Schutz, 1970). Typifications are a result of social interactions in which individuals process new information and interactions by comparing it to past information and interactions; this allows for the creation of person schemas which differentiate a normal versus abnormal offender (Schutz, 1970; Thompson, 2010; Bohrman et al., 2014) and event schemas which allow for the prediction of how particular situations will unfold (Bohrman et al., 2014). Typifications result in a more predictable and manageable reality, (Schutz, 1970) highly valued by police who face highly stressful and unpredictable situations on the job. Since limited research exists on officers use of typifications, court actors typifications will be explored.

Court actors classify offenders into gender and race based typifications based on the behaviour an offender displays while in the court room. Typically, females are viewed as passive and submissive, whereas males are viewed as being assertive and dominant within Western cultures (Thompson, 2010). The stereotypes of what constitutes female behaviour and male behaviour become gender expectations in society which are then transferred into court room typifications. When these typifications are broken, criminal actors tend to label female offenders as mentally ill and males as rational actors, responsible for their bad behaviours (Thompson, 2010). The view that female offenders are *mad* whereas male offenders are *bad* has been coined the medicalization of female deviance (Thompson, 2010). Research shows that females tend to have higher rates of classified depression and anxiety, as compared to males who tend to have higher rates of substance abuse and antisocial disorders. These differences by gender are less

pronounced within the general population (Thompson, 2010). The construction of gender

typifications in the court room lead to higher rates of mental health placements for female

offenders than male offenders upon sentencing.

Individuals are also typified based on racial characteristics, particularly Blacks versus

Whites. Since the time of slavery, African Americans and Caucasians have experienced unique

social interactions. African American men have often been constructed as violent criminals,

causing society to view crime as a normal behaviour for them (Thompson, 2010). African

American male offenders are less likely to be perceived congruent with mental illness

typifications and more likely to be viewed as criminal (Thompson, 2010). In contrast, Caucasian

males receive more treatment for mental illness than their African American counterparts

(Thompson, 2010).

Culture, context and history play a major role in the construction of a typical offender.

Through the reliance on past experiences, social interactions and adhering to social norms, the

idea of what a typical offender consists of leads decision-makers to presume that women are not

criminals (Thompson, 2010). Assumptions of gendered behaviour support a typification

associated with mental illness as opposed to criminal behaviour. African American males in

particular, have been over-represented in the criminal justice system as crime among Blacks has

become normalized (Thompson, 2010). Past experiences and typifications of their behaviour are

more consistent with the construction of a criminal. These assumptions have resulted in

disproportionate punitive sanctions for Black male offenders and mental hospitalization for

female offenders (Thompson, 2010), despite there being little evidence to suggest that gender or

race is associated with the rate of mental illness.

This section describes the construction of mental illness and its relation to court actors' decision-making processes. Unfortunately, little research exists to assess whether police officers hold the same constructions of normal offenders and mental illness as court actors do and whether these constructions extend to interactions with youth. Nevertheless, the existing literature presents convincing research on the role of police culture in shaping police officers' decision-making.

3.3 Police Culture

It has long been recognized that police services are part of a distinctive culture. In the 1960's and 1970's the phenomenon known to dictate police behaviour and responses was referred to as the 'blue curtain' or 'code of silence' (Campeau, 2015). Also referred to as a para-military organization because of its similarity to the military sub-culture, this uniting brotherhood works to protect police officers from isolating and threatening occupational conditions (Campeau, 2015). According to Robert Reiner, there are six core characteristics that define this brotherhood: conservatism, mission-oriented, masculinity, pessimism, suspiciousness, and isolation (Campeau, 2015). The historically monolithic blue curtain culture shapes police values and attitudes and police officers' behaviour while on the job. This section will demonstrate how police culture extends to police officers' construction of offenders.

The Blue Curtain

Police officers fill a variety of roles. Police culture occupies two main environments: the occupational and the organizational environment (Paoline, 2003). The occupational environment

consists of situations and problems officers must respond to; these problems are often

characterized by the potential for danger and the coercive power and authority officers possess

(Myers, Paoline & Worden, 2000; Paoline, 2003; Woody, 2005; Ingram, Paoline & Terril, 2013;

Campeau, 2015). The potential for danger is an essential variable influencing attitudes and

interactions with the public (Myers, Paoline & Worden, 2000; Paoline, 2003; Woody, 2005).

Maintaining distance from outsiders is a strategy police use for 'maintaining the edge' (Paoline,

Myers & Worden, 2000). Maintaining the edge involves taking charge of situations and

maintaining authority over outsiders (Myers, Paoline & Worden, 2000; Paoline, 2003). Once

citizens are characterized as outsiders, it further solidifies the 'us versus them' mentality among

officers. The us versus them mentality works to bring together members of the force which

allows officers to act as an internal support system to their fellow officers. If an officer's

authority or safety becomes threatened by outsiders, fellow officers are there to protect and

support the decisions of the officer being threatened. Therefore, the overall demands of the

occupational environment assist in the creation of strong internal solidarity amongst police

officers (Woody, 2005; Ingram, Paoline & Terril, 2013; Campeau, 2015).

The organizational environment consists of police officers' relationships to the formal

organization (Paoline, 2013). Within the organizational environment, officers are subjected to

supervisory oversight often leading to a sense of ambiguity as to what their role actually is

(Paoline, 2003; Woody, 2005). For example, officers report difficulty with enforcing laws while

following appropriate procedural regulations (Paoline, 2003; Ingram, Paoline & Terril, 2013).

This is particularly true in situations involving the use of force. Officers often feel that their

supervisors are working to identify situations in which they have inappropriately used force,

opposed to supporting them in their decision to use force. This results in negative attitudes

towards the formal organization (Ingram, Paoline & Terril, 2013) and the need for a unified

culture that facilitates shared support, values and beliefs amongst police officers (Paoline, 2003;

Woody, 2005). Officers are socialized to protect the police culture as an authority above that of

their supervisors, further reinforcing the 'us versus them' mentality (Woody, 2005).

The expectations of supervisors are often contradictory to that of the police subculture

(Woody, 2005). Preserving the blue curtain is dependent on uniformity (Woody, 2005). The

inclusion of new officers in the force represents the potential for breakdown in group cohesion

(Paoline, 2003). This requires officers to instill the construction of police culture during the

initial stages of training with new officers. In addition to social interactions while on the job, this

culture and training exerts a powerful influence on police officers' behaviour.

The Influence of Social Interactions on Police Behaviour

The types of interactions police officers have with citizens can result in positive or

negative constructions of civilians (Myers, Paoline & Worden, 2000). These interactions are

largely contingent on the training processes officers experience as well as the cultural forces to

which officers are exposed. The training process provides the initial introduction of police

language, (Woody, 2005) which is of particular importance in the creation of themes and social

meaning that allow for the transfer of subjective meaning to objective meaning (Hruby, 2001).

Police language allows officers to express the rules and cultural perspectives to new members to

instill group cohesion and loyalty (Paoline, 2003).

Cultural forces shape their perceptions of the problems and behaviours of citizens and the

response officers have to these citizens (Myers, Paoline & Worden, 2000). To manage these

social interactions with citizens, officers use typifications to categorize citizens based on their

potential for danger - such as high, medium and low risk offenders (Paoline, 2003). Officers assigned to the same workgroups are more likely to experience similar workgroup environments – including interactions with supervisors and the public – resulting in similar constructions of reality (Ingram, Paoline & Terril, 2013). These social constructions of reality are often structured around similar tasks and goals relating to how to cope with organizational and occupational environments. Because officers working in the same group share the same interactions on a regular basis, social constructionists believe it is more likely that shared attitudes will emerge (Ingram, Paoline & Terril, 2013). However, recent inclusions of female and minority officers may influence the uniformity of police culture.

Changes to Police Culture

Research on police culture has stressed the importance of recognizing the historically and culturally changing environment for frontline workers. With the move towards demographic diversity on the police force, changing constructions of reality may cause changes and disturbances to the unified police culture (Myers, Paoline & Worden, 2000). Police culture differs depending on the officer attitude, style and rank (Paoline, 2003). Myers, Paoline & Worden (2000) found that law enforcement officers who held values in line with the traditional police culture engaged in more coercive practices than law enforcement officers with non-traditional attitudes. Furthermore, the introduction of community policing has meant greater contact between police officers and citizens (Myers, Paoline & Worden, 2000). Depending on the successfulness of these interactions, the construction of what constitutes an outsider and appropriate responses to them may have shifted. Despite these predictions, limited research exists to support these claims, warranting expansion of research on this topic.

3.4 Conclusion

In summary, this section described social constructionist theory as related to mental illness. A historical review of social constructionism demonstrated the importance of culture, context, and history in the construction of deviant and abnormal behaviours. In Western culture, mental illness has been codified through the creation of the DSM; this document has been influential in the processing of offenders by court actors through the criminal justice system. Although the DSM has been less influential in the decision-making of police officers, research on police culture suggests that the blue curtain, instilled in officers during initial training stages, as well as interactions with offender's shape, officers' perceptions and subsequent decision-making.

Drawing on assumptions of social constructionist theory, this study attempts to answer: How do police officers from one Police Service in Ontario interact with youth who they reason to believe are mentally ill? More specifically, what behaviours do police officers associate with youth who they believe are mentally ill? What factors influence police officers construction of mental illness? How does this construction of mental illness impact officers' decision-making about how to process young offenders with whom they interact? I turn now to describing the methodology employed to answer the above research questions.

Chapter Four: Methodology

Introduction

This chapter outlines the data, sample, analytic strategy and key measures used to examine police interactions with what are considered to be mentally ill youth. It begins with an explanation of the recruitment strategy used to collect the data followed by an overview of the resulting sample. This chapter then discusses the survey instrument used in the face-to-face interviews and the thematic analytic used to analyze the data. The methodological limitations are also discussed.

4.1 Recruitment Strategy

This study used convenience sampling to recruit police officers on active-duty. Convenience sampling is a technique whereby participants are selected based on their ability to be easily accessed. Although this technique limits the generalizability of the study findings, it is useful in cases where the sample is difficult to access, which police officers are known to be. To cope with the scrutiny that often accompanies their involvement in high conflict situations (Arieli & Cohen, 2011), officers tend to maintain a code of silence and strong group cohesion which may impact the responses obtained by the researcher (Myers, Paoline & Worden, 2000; Paoline, 2003). Researchers are often viewed by police officers as outsiders who pose a threat to group cohesion and are therefore deemed to be suspicious and untrustworthy (Arieli & Cohen, 2011). As such, researchers face difficulty gaining cooperation and participation from police officers (Arieli & Cohen, 2011).

Convenience sampling can mediate the reluctance police officers feel towards participating in the researcher's study through the introduction of trusted social networks. For

instance, once a researcher makes contact and develops trust with one officer, that officer serves

as a first link to a larger group of officers (Arieli & Cohen, 2011). This larger group of officers is

referred to as a trusted social network since the trust that was built between the first officer and

the researcher becomes dispersed throughout the officer's social network, allowing the

researcher to gain access to additional potential participants (Arieli & Cohen, 2011).

Officers were recruited from a local Police Service in Southern Ontario. This Service was

targeted because of the willingness of the Police Chief to participate in the research project.

Having secured the Chief's commitment to the project, and upon gaining approval from the

Chief and from the University of Guelph's Research Ethic Board (the University of Guelph's

Research Ethic Board did not permit the use of direct quotes in the final write-up of the thesis),

the researcher was connected with a member of the data resource unit at the Police Service. The

researcher provided her contact at the data resource unit with a study overview (Appendix A)

and a recruitment email (Appendix B) so that details of the study could be posted throughout the

Service, such as the Service's kitchen and lounge area. The recruitment email was also sent to

some of the police officers employed by the Service. These recruitment procedures provided

police officers with the option to contact the researcher via email if they were interested in

participating in the study. At no point in the study did the researcher initiate contact with

participants.

Once an interested participant emailed the researcher, she corresponded with the

participant to identify a mutually convenient time and place for an interview to occur.

Participants were provided the opportunity to request the location for their interview in order to

foster open dialogue about potentially sensitive information pertaining to their job. This was

done to ensure that the officers felt comfortable participating and were not worried about facing

negative repercussions from their superiors because of their answers. All of the interviews took place in private rooms at the police Service or at local coffee shops. Participation in the study was voluntary and there was no incentive offered for participation.

4.2 Sample

A dominant expectation within the police culture is that officers maintain uniformity and strong internal solidarity (Woody, 2005). Indeed, some social constructionists hypothesize that police officers will respond to mentally ill youth in similar ways given the strong occupational culture (Myers, Paoline & Worden, 2000; Paoline, 2003; Woody, 2005; Ingram, Paoline & Terril, 2013; Campeau, 2015). However, empirical studies provide only weak support for this prediction and instead reveal variation in how police officers respond to mentally ill youth (Forcese, 1992; Chappell, 2008; Schulenberg & Warren, 2009). This seems to be particularly true for officers who differ in gender, rank, years of service and training (Chappell, 2008). Due to the existing contradictions, the goal for this study is to include a sample of officers who differ in gender, rank, years of service, and training to determine if variations in responses to mentally ill youth are influenced by these factors.

The data collection process generated a final sample of twelve participants. Table 4.1 provides a summary of the key characteristics collected from the sample. Of the 12 participants, five were female and seven were male. Participants ranged in their years of service from four to twenty-three years with the average years of service being eleven and a half years. Prior to becoming a police officer, five (42%) participants had completed a college program whereas seven (58%) had completed a university program. Although all of the participants were employed by the Service at the time of the interview, they differed in their rank and held a

variety of jobs at the police Service including: Sergeant, Community Resource Officer, School

Resource Officer, Patrol Officer and Detective. Convenience sampling does not always produce

a diverse sample; however, in this study the ideal sample which included officers who differ in in

gender, rank, years of service, and training was achieved.

Table 4.1 Sample Characteristics (n=12)

Variable		
Years of Service	Range: 4-23 years	
	Mean: 11.5 years	
Variable	**N**	**Percentage (%)**
Gender		
Female	5	42
Male	7	58
Job Title		
Sergeant	2	17
Community Resource Officer	2	17
School Resource Officer	3	25
Patrol	4	33
Detective	1	8
Education		
College	5	42
University	7	58

4.3 Interview Instrument

Face-to-face interviews were used to gather information from police officers about their

interactions with mentally ill youth. A major benefit of this approach is the rapport generated

between the researchers and the participants, which allowed them to identify several prominent

themes and latent schemas that may not have been identified through use of other

methodological approaches (Bohrman et al., 2014). For instance, Bohrman and colleagues

(2014) were able to clarify the factors used by the officers to determine if the individual had a mental illness and encourage further discussion regarding the appropriateness of their response to the individual. In this study, face-to-face interviews were particularly useful because they allowed for the building of rapport between the researcher and the participant in a short period of time. This allowed the researcher to ask about sensitive information and to probe deeper into the participant's answers which fostered richer data.

Prior to beginning the interview, a consent form was read to the participant (Appendix C). The participant was told the purpose, goals, and potential benefits of the study, as well as the potential risks associated with participation. To ensure confidentiality, the researcher took several precautions, including referring to participants and their data using an identification code. Participants were also reminded of their right to withdraw from the study at any time throughout the interview. All the participants signed consent forms without hesitation and none of them asked to withdraw from the study.

Given the paucity of information about the nature of interactions between police officers and mentally ill youth within Ontario, this study is exploratory in nature. As such, the interviews were semi-structured, and remained flexible to allow for new questions to emerge. The interview guide included both open-ended (nine) and close-ended (seven) questions (Appendix D) and attempted to tap into officers' perceptions of mental illness and decision-making. Although the interview began with a relatively small number of questions (sixteen), follow-up probes and questions were used where appropriate. For example, officers were asked to describe an instance in which they encountered a youth whom they believed had a mental illness. From here, they were asked to clarify the factors used to assist them in determining that the youth was mentally ill. After the officer had clarified the factors he/she used, the researcher read a non-mutually

exclusive list of other possible factors associated with mental illness. Some of these factors included: assaultive/ violent, loud/ obnoxious, confused, intoxicated, and injuries to self. The officer was then asked to instruct the researcher on which factors they believed the youth was exhibiting during the situation. Additionally, the officer was asked to specify how they responded to the youth and whether they felt it was an appropriate response.

To protect the identity of youth about whom the officers were referring in their responses to the interview questions, the officers were read a disclaimer which directed them *not* to reveal the name of any individual protected under the YCJA, a court order, or a protected investigative technique or procedure. During the interviews, participants' responses were recorded by the researcher using an encrypted laptop. Interviews ranged from approximately half an hour to an hour and a half and took place between the months of November 2016 and January 2017. By January 2017, similar themes were emerging in the interviews with officers which suggested that theoretical saturation had been met; therefore, no additional participants were recruited or interviewed.

4.4 Analytic Strategy

Sample Characteristics

As previously stated, the interviews consisted of open- and closed-ended questions. The data pertaining to the closed-ended questions was analyzed using basic descriptive statistics (see Table 4.1).

Thematic Analysis

The data gathered through the open-ended questions were analyzed using thematic analysis. Thematic analysis is a technique that allows the researcher to formulate themes –

patterned responses to the study's research question – which assists in the identification of common words, phrases, and ideas that relate to the study's focus (Bohrman et al., 2014). In this case, thematic analysis allowed the researcher to tap into the personal experiences, perceptions, and views of police officers who interact with mentally ill young offenders. This study followed Attride-Stirling's (2001) step-by-step guide to thematically analyze the interview data.

The first step involved the creation of charts. Responses were dissected by survey question and placed in the corresponding survey question chart. A total of nine questions were coded, meaning nine charts were created. During the second step, each chart was reread and codes were created. Codes were given a corresponding colour and words or phrases associated with that code were highlighted accordingly. For example, the Ontario Mental Health Act (OMHA) corresponded to the colour yellow and included words or phrases that mentioned the word apprehension, threshold and risk of harm to self or others. In another example, area of city (AOC) was highlighted blue and encompassed phrases pertaining to housing developments characterized by their low socio-economic status, the city's downtown core, high schools and 'hang-out' areas such as malls or youth drop-in centres. This process was completed for all nine charts. The third step included the organization of the codes into larger thematic networks (Attride-Stirling, 2001). These thematic networks were derived from the study's three sub-research questions. They included: police officer *construction* of mental illness, *influential factors* in officers' construction of mental illness, and *decision-making* with mentally ill youth. Construction referred to the behaviours officers believed to constitute a mental illness. Influential factors referred to the historical, cultural, and context-specific factors that influenced the officers' definition of mental illness. Decision-making referred to the responses officers' take with mentally ill youth. The fourth step involved exploring the thematic network, or returning to

the original text to explore and interpret the underlying meaning of the extracted codes. In the fifth step, themes were finalized and clear definitions were created. During the final step, the themes were interpreted in terms of their connection to past literature, which will be discussed in the next chapter.

i) Key Measures & Concepts

Since the current study is exploratory and reflexive, key measures were developed through a close examination of the data once it was collected. More specifically, key measures were identified if they were deemed to be important or relevant to the construction of mental illness by police officers.

Severity of Mental Illness. Because officers' construction of mental illness remains relatively understudied, past literature was not relied upon for coding. Throughout the analysis severe mental illness and non-severe mental illness were coded. Severe mental illness included the phrases: "violent", "disruptive", "crisis", "suicidal", "erratic", "paranoid", "disconnected", "low social interactions", "danger to self or others", "bipolar disorder" and "schizophrenia." In contrast, non-severe mental illnesses were discussed and the phrases coded as such were: "rational", "calm", "eye contact", "tantrum", "moody", "developmental issues", "distressed", "anxiety" and "depression."

Influential Factors. The second thematic network involved historical, cultural or contextual factors that influence officers' construction of mental illness. Consistent with earlier theoretical predictions made by Kenneth Gergen (1985), the current literature cites several factors as influential in police officers' construction of mental illness. For instance, Marcussen et al. (2011) find that dispatch plays a crucial role in the relaying of information pertaining to a

youth's mental health behaviours. In fact, officers reported relying on this information in deciding whether the youth had a mental illness (Marcussen et al., 2011). Based on this finding, a code was created for dispatch. The second code included in this network is training. Several studies cite the importance of training in officers' construction of mental illness (Green, 1997; Bohrman, 2014; Barbaree et al., 2016). Training assists officers' in identifying dangerous situations such as when a mentally ill individual is a safety risk (Bohrman, 2014; Babaree et al., 2016). Based on this, statements related to "use of force", "de-escalation" and "training course/days" were coded as training. Next, a code was created for area of city. This code was based on prior research which suggests a link between areas of low socio-economic status or hang-out areas and higher prevalence of mental illness (Wilton, 2004; Lurigio, 2011; Crocker et al., 2016). As such, the code area of city included "low socio-economic status" and "hang-out areas." The fourth and fifth codes refer to previous experience and known adults. Bittner (1967) finds that officers rely on their past interactions with mentally ill individuals or members of the individuals' inner circle to assist them in classifying mental illness. To assess whether these factors had differing affects on the officer's construction of mental illness, these two factors were kept separate. Previous experience included phrases where the officer recalled their past experiences with the youth. In contrast, known adults included "family", "teachers", "social worker" and "friends."

Officer Decision Making. The final thematic network concerned officers' decision-making. According to the *Youth Criminal Justice Act* and the *Ontario Mental Health Act*, officers are permitted to formally charge a delinquent youth, utilize an Extra-Judicial Measure with a youth or referral, apprehend the youth to a hospital for a psychiatric assessment, take no action with the youth or attempt to de-escalate the youth (Government of Canada, 2015; Ontario

Mental Health Act, R.S.O. 1990, c.M.7). Because of these restrictions, decision-making was

coded as follows: charge, EJM/referral, apprehend, no action and de-escalation. In order for a

phrase to be included in this thematic network, the officer had to specifically mention one of

these five codes.

4.5 Limitations

Face-to-face interviews were the most appropriate method for addressing the study's

research questions as they allowed the researcher to probe deeper into a highly sensitive topic,

generating rich and detailed data. However, this strategy does pose several limitations. Most

notably, convenience sampling creates several problems pertaining to sample bias,

representativeness, and generalizability (Arieli & Cohen, 2011). In general, individuals who

work with each other or have similar interests are most likely to associate with one another. This

is especially true for police officers who work in the same unit or on the same rotation as other

officers. Therefore, one must be aware that the individuals volunteering to participate in the

study may be friends and share the same opinions of the officer who referred them to the study.

It should also be acknowledged that the pressure officers feel by the police culture (Woody,

2005; Ingram, Paoline & Terril, 2013; Campeau, 2015) could have lead to uniformity in the

responses obtained from the participants.

Additionally, participation in this study was purely voluntary. Individuals who feel more

educated about, or interested in, the topic may have been more inclined to participate. As such,

the study did not seek to produce a random sample. The total sample consisted of twelve

individuals, five of which were females. According to data collected by Statistics Canada

(2015b), the number of females serving as police officers in Canada has grown steadily over the

years. In fact, in 2014, 20.6 percent of police officers were female (Statistics Canada, 2015b). Despite these increases, females are over-represented in the sample (42%), suggesting a bias with volunteering. Moreover, seven of the participants in this study possess a University degree whereas five hold a College diploma. According to a Police Administration Survey administered across Canada in 2014, 51 percent of newly recruited officers had completed college, 29 percent had a University degree, and 19 percent had a high school diploma prior to becoming an officer (Statistics Canada, 2015b). As such, officers with University degrees are over-represented in the sample (58%). It is possible that females and officers with University degrees may have been more sympathetic towards youth who they perceive to be mentally ill. Even with these limitations, a goal of the study was to access a dynamic and difficult to reach population to answer some initial questions and open the door for future research on this topic.

4.6 Conclusion

This chapter reviewed the methodological approach used to assess police interactions with mentally ill youth. Convenience sampling was used to generate a sample of twelve police officers. Upon gaining consent, these officers participated in face-to-face interviews in which they were asked about their experiences, views, and decision-making with youth they deemed mentally ill. Thematic analysis was used to identify key themes that emerged from the interviews. Despite the limitations of the analytic approach, the methodology outlined in this chapter was used to successfully address the research questions guiding this study. I turn now to discussing the findings.

Chapter Five: Results

Introduction

This chapter presents the results from my thematic analysis of police officers interactions with mentally ill youth. Taken together, the themes discussed in this chapter support the study's main finding; namely, that police officers have developed a construction of mental illness, based on limited information, which they use to create a three-tier response in an effort to protect the safety of the mentally ill youth and the general public.

5.1 Thematic Analysis

Perhaps not surprisingly, all twelve of the officers interviewed for this study reported that the Ontario Police College, a mandatory requirement for all newly appointed police officers in Ontario, did little to assist them in their identification and decision-making with youth who have a mental illness. The Ontario Police College focuses on physical fitness, self-defence, firearms operations, and the legal processes and procedures associated with the law; none of this training focuses on youth with mental illnesses specifically. In fact, throughout the interviews, all of the officers repeatedly expressed frustration with the minimal training they receive relating to mentally ill persons. For example, one officer (ID 107) stated that the one or two days of training they receive a year on mental health is geared toward adults and is not necessarily relevant to youth. Despite recent efforts by the Service to include more applicable training, such as the *Road to Mental Readiness* training which includes a simulation exercise with a mentally ill adult in crisis, all twelve officers reported it does little to advance their knowledge or prepare them for real-life situations involving mentally ill youth. More specifically, this training does not

differentiate decision-making with mentally ill persons based on age or gender which limits the

applicability of the training to youth who differ in needs.

To complicate matters, the officers (12/12) reported having contact with anywhere from

one to one hundred youth they presumed to be mentally ill, within a given month with the

highest contact (30-100 interactions) being reported by Community Resource Officers and

School Resource Officers. When describing the gender of mentally ill youth, seven of the

officers reported that the youth was equally likely to be male or female, three of the officers

believed the majority to be female and two of the officers believed it to be mainly males.

Noticeably absent in officers (12/12) description of mentally ill youth was the identification of

their race. When asked to describe the factors they use to identify whether youth have a mental

illness, officers reported relying on youth's behaviours, previous experience, adults who know

the youth in question (trusted adults) and zone of city to develop a simplified system for

categorizing the severity of mental illness with which youth suffer. In the absence of applicable

training, this categorization system allows the officers to provide specialized assistance to youth

with differing mental health needs.

Theme One - Mental Disorders: the DSM-V versus Police Officer Categorization

The first major theme to emerge from this study is the apparent disconnect in the way

police officers classify mental disorders compared to the way mental disorders are outlined in the

Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-V). The DSM-V is used

by health care professionals throughout Canada as a tool for classifying and diagnosing mental

disorders. According to the DSM-V,

> "a mental disorder is a syndrome characterized by a clinically significant disturbance in
> an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in

the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities." (American Psychiatric Association, 2013, p. 20)

There are currently 297 mental disorders classified in this document, each of which is comprised of specific and unique behaviours. The severity to which someone presents these behaviours ranges from mild to severe. Instead of categorizing disorders according to overall severity, the DSM-V uses a linear structure to group together disorders that share similar symptoms based on neuroscience. For example, the chapter on depressive disorders is placed directly after the chapter on bipolar and related disorders. In another example, the chapter on disruptive, impulse-control, and conduct disorders are placed beside the chapter on substance-related and addictive disorders. This linear sequence indicates that depressive disorders and bipolar and related disorders share common symptoms and features whereas disruptive, impulse-control and conduct disorders share common symptoms and features with substance-related and addictive disorders. This linear structure allows clinicians to better identify patterns in the individual's symptoms, leading to a better treatment plan for the mentally ill individual (American Psychiatric Association, 2013). In order to be diagnosed, individuals must undergo an extensive interview process and assessment testing administered by a clinician (who has been trained) such as a psychologist and/or a psychiatrist.

While psychologists and psychiatrists receive extensive training in assessing mental health disorders and devote a majority of their professional role doing so, police officers rely primarily on the behaviours youth present at the scene of a disturbance to determine whether they are mentally ill. Not surprising, contrary to the complex classification system of the DSM-V, police officers reported grouping individuals into one of three categories: 'severely' mentally

ill with abnormal behaviours, 'severely' mentally ill without abnormal behaviours or 'non-

severely' mentally ill. Each of these categories are comprised of a distinct set of characteristics

and are associated with certain mental disorders.

The officers unanimously reported that the 'severely' mentally ill *with* abnormal

behaviours category is the most worrisome of the three categories of mental illnesses because

youth in this category present extremely abnormal and harmful behaviours at the time the officer

arrives at the scene. Two-thirds of the officers (ID 100-104 & 109-111) explained that youth who

fit this diagnosis exhibit signs of deliria, extreme distress, a disconnect from reality and paranoia.

The youth's actions at the scene are often violent, erratic and present a risk of harm to

themselves, others or the community at large. During the interviews (Appendix E), officers

described youth in this category as assaultive (9/12), crying/tearful (9/12) loud/obnoxious (8/12),

uncooperative (8/12), agitated (8/12) and depressed (8/12). Less than half of the officers

associated scared (5/12), confused (4/12) or passive (4/12) with a severe mental illness. Most

surprisingly, and in stark contrast to the DSM-V, only three of the twelve officers associated

intoxication with a mental illness. In some examples provided by officers (ID 104, 108, 110 &

111), youth within this category were described as foaming at the mouth and unable to engage

with the responding officer. Others were described as engaging in extremely risky behaviour

which included eating glass (ID 106), drinking bleach (ID 104) and jumping in front of moving

cars (ID 109 & 111). In the officers' views, these youths are either at or approaching a redline

crisis and were at a heightened risk for suicide. The officers unanimously speculated that youth

who fit this category most likely suffer from, and would be expected to have a confirmed

diagnosis of, bipolar disorder or schizophrenia. The officers (12/12) speculated that very few

youth they encounter on the job meet the criteria to be categorized as 'severely' mentally ill *with* abnormal behaviours.

Youth categorized as 'severely' mentally ill *without* abnormal behaviours, suffer from the same behaviours and diagnoses as youth in the first category of mental illness, yet they do not present the abnormal behaviours and diagnoses when the officer arrives at the scene. Since these behaviours are not present at the officer's time of arrival, officers must make the 'severe' mental illness assessment based on previous experience with the youth, information gathered through trusted adults, and the zone of city that the youth frequents or lives in (these factors are discussed in greater detail under *Theme* II). Officers unanimously report categorizing a higher percentage of youth within this category than they categorize in the first category of mental illness.

'Non-severe' mental illnesses were defined by officers as involving issues with impulse control, tantrums and attention seeking behaviour. Three-quarters of the sample attribute these behaviours to delays in the developmental process and an inability for the youth to rationalize the outcome of their words or actions. For instance, five officers (ID 100, 102, 104, 110 & 111) suggested that between the ages of 12-17, youths' brains are developing which may cause them to be moody, dramatic and overly expressive. This may cause them to quote common phrases such as "I want to kill myself" without thinking of the seriousness of the phrase (ID 106 & 109). Officers (ID 103, 106, 108, 109 & 111) also report that after speaking with the youth and engaging in de-escalation strategies, the youth presents themselves as calm and rational. The crimes committed by youth with mental illnesses categorized by police as non-severe are non-violent, victimless crimes that are spur of the moment – typically property offenses (ID 100-101, 103-105, 107-108 & 111). All of the officers in the sample agreed that youth in this category

most likely suffer from, or have a confirmed diagnosis of, anxiety or depression. The majority of

mentally ill youth that officers come into contact to were placed in this category.

In sum, the disconnect between the detailed categorization of mental illness in the DSM-

V and police officer categorization of youth into 'severe' (bipolar and schizophrenia) and 'non-

severe' (anxiety and depression) is evident. Unlike the officer's categorization, the DSM-V

maintains that these four disorders are separate and distinct. Therefore, these disorders fall under

the sections: Schizophrenia Spectrum and Other Psychotic Disorders, Bipolar and Related

Disorders, Depressive Disorders, and Anxiety Disorders. The construction of only three

categories, severe with abnormal behaviours, severe without abnormal behaviours and non-

severe, instead of four, suggests that officers rely on a quantitative process of categorizing

mental disorders to make sense of the plethora of potential disorders that the youth could be

exhibiting. By categorizing the youth, the officers can create responses which allow them to

more easily manage the high-risk and unknown situations which they encounter. These responses

will be discussed in more detail later in this chapter.

Theme Two - Identifying Severe Mental Illness in the Absence of Abnormal Behaviours

The second major theme to emerge in this study is the identification of 'severe' mental

illness without abnormal behaviours. A vast majority of officers (10/12) reported attending

situations in which the youth involved does not present a direct harm to themselves or others; in

other words, the youth does not overtly manifest any symptoms of a 'severe' mental illness. In

such situations, when the youth does not demonstrate abnormal behaviours such as harm to self

or others, officers reported the need to rely on (1) their own previous experience with youth, (2)

information provided by trusted adults and (3) the zone of the city to which they were called as indicators of the youth being 'severely' mentally ill.

i) Previous Experience with Mentally-ill Youth

Receiving information about youth through police databases or through personal experience was key to identifying 'severely' mentally-ill youth without abnormal behaviours. The Police Service surveyed in the current study uses two databases to store information about youth: the Canadian Police Information Centre (CPIC) and Niche RMS. CPIC is a national database used by all police services across Canada. All cases, youth or adult, regardless of conviction or acquittal, are placed in this system for law enforcement officers across the country to access. Due to ethical concerns, CPIC does not store mental health records. Nevertheless, CPIC does record behaviours related to the offender's risk for violence.

Niche RMS is an internal database that can only be accessed by police officers and dispatch at each individual service which governs the information stored in the internal database. These mental health records include: 911 calls pertaining to crisis intervention, calls involving concern for a family member or friend, doctors' orders for individuals to be transported to the hospital for a psychiatric assessment, abnormal behaviours displayed by the individual during police encounters, pre-existing mental illness diagnoses by medical professionals and if the individual is apprehended. Although youths CPIC and Niche RMS records are more limiting than adults records, due to privacy regulations that prohibit life-long access, half of the officers reported receiving valuable information pertaining to potential mental illnesses the youth suffers from (NICHE) or crimes the youth has committed (CPIC).

Half the officers (ID 101-103 & 106-108) in the sample cited police databases as a useful tool for assisting them in the identification of a severe mental illness in youth with whom they interact. Police databases were used by dispatch to provide information to the officer prior to arrival at the scene, or by the responding officer upon arriving at a scene. For example, one officer (ID 108) described attending a 911 call that was flagged by dispatch as including a youth with a severe mental illness, only to be surprised by the youth's calm, rational and respectful behaviour. Because of the negligible abnormal behaviour presented at the time the officer arrived at the scene, he initially categorized the youth as having a non-severe mental illness. However, upon investigating the youth further in Niche RMS, the officer discovered that there was a history of 911 calls to the youth's home address and notes made by previously responding officers regarding the youth's mental well-being. Essentially, this youth had been described by previous officers in Niche RMS as displaying abnormal behaviours congruent with a severe mental illness, including being aggressive, violent and out of control. After reading the data recorded by officers in Niche RMS, the responding officer re-categorized the youth as 'severely' mentally ill despite his calm and rational demeanour at the time.

Information regarding a youth's record in police databases can be provided to officers through dispatch. One officer (ID 108) recalled a situation where he responded to a 911 call made by a youth's father who was being threatened. On the way to the call, dispatch informed the officer that data stored in NICHE indicated there was a possibility that the youth suffered from bipolar disorder. Although the youth did not present any aggressive or assaultive behaviours upon arrival of the officer at the scene of the disturbance, the information provided by dispatch led the officer to categorize this youth being 'severely' mentally ill and to apprehend and transport him to the hospital for a full psychiatric assessment.

Previous experience can also refer to the personal experience an officer has had with a youth. Indeed, three-quarters of officers reported relying on their previous interactions with youth in the absence of abnormal behaviours to categorize the youth with a severe mental illness. One example of this comes from an interview with a Community Resource Officer (ID 103) who had several encounters with a male youth who displayed behaviour that was consistent with 'severe' mental illness. More specifically, he would drop to the floor and shake and as the months progressed he became extremely socially withdrawn from all areas of his life. A Community Resource Officer often fulfills duties outside of the traditional police officer role which involves maintaining order and security; Community Resource officers perform duties consistent with a social worker's role which involves follow-up visits with youth to ensure they are receiving access to mental health resources, attending school and remaining socially active. The officer explained that during follow-up visits, the youth's behaviour did not always mimic that of a severe mental illness. In fact, during most of these visits the youth's behaviour mirrored that of a non-severe mental illness. Despite the absence of abnormal behaviours that the officer had previously experienced with the youth, she remained cautious in future interactions with this youth, knowing that he had a 'severe' mental illness and could at any moment display behaviours consistent with such categorization.

ii) Trusted Adults

In the absence of abnormal behaviours or prior experience with youth, officers may identify youth as being mentally ill using information they gather from trusted adults. Three quarters of the officers reported relying on the following trusted adults: parents of the youth and the youth's school guidance counsellors, teachers or social workers. Roughly half the officers

(ID 100-101, 105-106 & 111) suggested that the relationship shared between trusted adults and mentally ill youth allows the trusted adult to gain a valuable understanding of the youth's mental health history and to witness the abnormal behaviours that the youth exhibits during regular social interactions. Some of the notable abnormal behaviours reported to officers (ID 100-101, 103, 105-106 & 111) by trusted adults included: violent or assaultive, loud or obnoxious, threatening, delirious, paranoia and disconnection from reality. Trusted adults also mentioned bipolar disorder, schizophrenia and obsessive-compulsive disorder as mental illnesses related to the youths' mental health histories (ID 100-101, 105 & 111).

With the exception of obsessive-compulsive disorder, the behaviours and mental health history described by trusted adults aligns with the symptoms that officers have categorized as a 'severe' mental illness. Therefore, when officers are presented with the information from trusted adults, they categorize the youth with a 'severe' mental illness despite limited abnormal behaviours present at the time of the officer's arrival. Since officers are placed in zones, Patrol Officers (ID 101, 105 & 106) are more likely to rely on a youth's parents for information whereas School Resource Officers (ID 111) are more likely to rely on the youth's teachers, counsellors and social workers for information. Community Resource Officers (ID 100 & 103) spend their time at schools and within the community; they (ID 100 & 103) rely on parents, teachers, counsellors and social workers for information pertaining to the youth.

During an interview, a Patrol Officer (ID 105) described an encounter she had with a male youth during a 911 call to a family home. The officer explained that when she arrived at the residence the youth demonstrated behaviour that was not fully consistent with either 'severe' or 'non-severe' mental illness. This confused her and required her to discuss the youth's mental health history with his parents. The parents described the son as extremely violent, threatening

and abusive toward family, and stated that he often disobeyed authority. After the outburst, these

behaviours were often accompanied by calm and rational behaviour; there was confusion over

his actual mental health diagnosis. Although the youth did not display these symptoms when the

officer arrived at the scene, the description of abnormal behaviours and mental health history

provided by his parents led the officer to categorize the youth with a 'severe' mental illness.

In another example, an officer (ID 101) working in a school zone discussed his reliance

on the youth's teacher and social worker to help him categorize the youth as mentally ill. The

officer explained that upon entering the classroom there was a broken window and desks turned

over. The male youth appeared agitated but was not an immediate threat to himself or others.

However, the teacher and social worker mentioned that prior to the officer's arrival the youth

was out of control, violent, throwing desks, in a state of distress and there was fear that he would

harm himself. The officer relied on the description provided by the trusted adults to categorize

the youth as having a 'severe' mental illness. Because of the potential risk of harm to himself,

the officer apprehended the youth to the hospital.

Finally, Community Resource Officers focus on case management and follow-up with a

youth after the initial responding officer has visited the scene. This follow-up could be days or

weeks after the initial officer has had contact with the youth. Since Community Resource

Officers are not the first responding officer, it is not uncommon for youth to appear calm and

rational in their interactions with the officer. Because such behaviours are contradictory to the

behaviours exhibited by the youth in the report by the initial officer, the Community Resource

Officer must rely on those discussed during case management meetings for a more accurate

description of the mental health history and behaviours presented by the youth in previous

situations. For example, one Community Resource Officer (ID 100) described attending a case

management conference for a youth he had not yet met. During the meeting, the parents,

counsellor and social worker described the youth as having uncontrollable anger, being

withdrawn from school and friends, disruptive and having difficulty following rules. The officer

insisted that the behaviours described by the trusted adults signaled a 'severe' mental illness;

therefore, the officer categorized the youth as such and in follow-up visits took precautions in

case the youth responded in a manner that would cause harm to himself or others.

In a final example, a Patrol Officer (ID 109) recalled an incident with a male youth who

expressed suicidal ideations to his parents and school guidance counsellor. In this situation, the

Patrol Officer was called to a school because there was no School Resource Officer available.

The youth expressed a desire to walk in front of oncoming traffic. The trusted adults also

informed the officer that since the death of the youth's close friends, he had become socially

withdrawn and had a poor state of mind. Relying on this information, the officer categorized the

youth with a 'severe' mental illness. Due to the potential for harm to himself, the officer

apprehended the youth to a hospital.

iii) Zone of City

In the absence of abnormal behaviours, officers may also rely on the zone of the city that

the youth frequents or inhabits in to assist them in identifying if the youth has a severe mental

illness. Roughly half the officers (7/12) indicated that 'severe' mental illnesses are concentrated

in certain zones of the city. The zones of the city that were most frequently discussed by officers

(ID 101-102, 105, 107 & 109-111) included particular high schools, the city's downtown core

and housing developments characterized by low socio-economic status. Because School

Resource Officers are required to patrol high schools, the youth who exhibited abnormal

behaviours were more likely to come to the attention of officers. For example, one School Resource Officer (ID 110) described a male youth who appeared socially isolated, withdrawn and expressed thoughts of self harm. Through frequent interactions with the youth, the officer categorized him with a 'severe' mental illness and connected him with school guidance counsellors, community counsellors and engaged with his parents to create a more nurturing home environment. The officer was also able to facilitate a student assembly at the youth's school to raise awareness about mental illness.

The downtown core is comprised of shelters, group homes, treatment facilities and community resource centres. One-quarter of the officers (ID 101-102 & 111) reported that 'severely' mentally ill youth take up residence in shelters and group homes after failed attempts to live at home. The youth may also seek assistance or be referred to programming that is provided at community resource centres in the downtown core. In one example provided by a Patrol Officer (ID 107), a male youth had been rotating through treatment facilities, community resource centres and his home. Through frequent interactions with the youth at these facilities, the officer categorized the youth with a 'severe' mental illness. Despite best efforts to connect him with additional supports that would aid in his treatment, the youth took his own life. The zones of the city that officers (ID 101-102, 105, 107 & 109-111) suggested to be most associated with mentally ill youth are areas of low-socio economic status, however, the officers were unclear about the casual direction. Roughly half (7/12) of the officers interviewed suggest a link between a breakdown in city infrastructure and the presence of 'severe' mental illnesses in youth. These officers (ID 101-102, 105, 107 & 109-111) attributed the cause of mental illness to the parents who reside in these parts of the city and the disorganized environment itself. For example, one officer (ID 110) noted that the environment these youths are raised in fosters the

onset of behaviours that overtime develop into severe mental illness. Another officer (ID 109) explained that the parents in these areas are too lenient and offer little support for the youth. In these situations, youth are permitted to behave however they want with little punishment which exacerbates the symptoms that correspond with 'severe' mental illness. A third officer (ID 102) argued that perhaps the parents themselves have a 'severe' mental illness – bipolar disorder or schizophrenia – and refuse to acknowledge that they need resources to treat it. This belief is then cast onto the youth causing them to also avoid securing resources to treat their disorder. These behaviours are further accentuated by the lack of resources available in these areas of the city, resources that could assist the already disorganized parents and environment and facilitate treatment for the youth's illness (ID 107 & 110). Notably absent throughout the interviews was information about officers' interactions with youth with 'non-severe' mental illness. Nevertheless, officers in this study constructed a response that they felt contributed to the successful treatment of youth who suffered from all categories of mental illness.

Theme Three - The Restructuring of Traditional Extra-Judicial Measures

A third theme to arise in this study was how responding officers modified traditional extra-judicial measures in order to better suit the needs of mentally ill youth. As previously discussed, officers decision-making with mentally ill youth is governed by two documents: the *Ontario Mental Health Act* (OMHA) and the *Youth Criminal Justice Act* (YCJA). Neither of these documents, however, provide explicit instructions regarding how to handle youth with mental illness who do not meet the threshold for apprehension to a hospital. To alleviate these issues, individual officers informally modify the way they use extra-judicial measures to provide

responses that, in their opinion, were more appropriate for youth with mental illness. This modified or restructured response takes the form of a three-tiered system.

i) Tier One

The first tier outlines the response by officers to 'severely' mentally ill youth with abnormal behaviours at the time of the officer's arrival at the scene of a disturbance. Officers decision-making at this tier is governed by the OMHA. The OMHA is a document that regulates the involuntary admission of mentally ill individuals to hospitals within Ontario. Specifically, section 17 of this Act directs police officers to apprehend a "person [who] is apparently suffering from a mental disorder" (Ontario Mental Health Act, R.S.O. 1990, p. 7) to a hospital if they present harm to themselves or others. This applies to officers when they are dealing with youth or adults. All the officers in the sample reported that this document does an adequate job of setting a threshold for how to respond to these extreme and very rare situations. In fact, all officers were generally positive in their comments about the OMHA and the threshold for apprehension to a hospital.

Nevertheless, a small majority of officers (ID 102-103, 105-107 & 109-110) voiced two major issues with this Act. The first issue with the OMHA relates to how apprehension to a hospital often resulted in a quick release of the youth with minimal access to resources for support (ID 102 & 109). Many of the officers (ID 100, 102-103 & 106-111) reported that they apprehended a severely mentally ill youth because they were required to by law, but not because they felt that doing so would actually result in adequate medical treatment for the youth. Indeed, officers (12/12) voiced a desire to offer these youth resources that could assist them in treating their disorder which would prevent them from future apprehension to a hospital. For example,

one officer (ID 111) described an encounter with a male youth who had committed a criminal act. According to the officer, the original call had not triggered concern about the youth's mental health status. However, in speaking with the youth she realized that he was disconnected from reality and rebelled against authority. Despite having the grounds to apprehend the youth, the officer recognized that the youth most likely suffered from a 'severe' mental illness. She described her desire to help the youth instead of apprehending or charging him criminally because she believed that most mentally ill youth are not provided with a chance to feel appreciated and validated. Therefore, after allowing the youth to vent, the officer had built enough rapport with the youth to convince him to contact a social service agency that would aid in the development of his pro-social coping skills. Essentially this represents a successful diversion effort by police in the face of perceived limitations of the OMHA.

The frustration with the resources provided to mentally ill youth in hospitals was also voiced by a Community Resource Officer. He (ID 100) recalled the number of suicides that have taken place during his time with the Service and expressed his disappointment with the limited responses offered to mentally ill youth by the health care system. Had they been given better treatment and resources, he suggested, perhaps these youths would not have ended their own lives. Due to these issues, officers reserved apprehension to a hospital for youth with the most 'severe' mental illnesses with abnormal behaviours upon arrival, justifying an immediate response to a dangerous situation.

The second issue identified by officers (ID 102-103 & 105-107) is that the OMHA does not provide an outline for how to respond to 'severely' mentally ill youth without abnormal behaviours. More specifically, if the officer has identified that the youth has a severe mental illness through a reliance on factors such as previous experience, trusted adults and zone of city,

yet the youth does not currently meet the threshold for apprehension, how should the officer respond? The frustration felt by officers over this issue is demonstrated in one officer's (ID 109) account of how "cut and dry" the OMHA is. He explained that it is explicit in the fact that they must apprehend if the behaviours presented are of major concern for safety yet it does not specify the action to take if the youth does not present a direct threat to themselves or others around them. For this reason, the officers unanimously reported avoiding apprehension to a hospital for 'severely' mentally ill youth without abnormal behaviours. At no point during the interviews did an officer discuss using apprehension for a 'non-severe' youth.

ii) Tier Two

The second tier outlines the response to youth with 'non-severe' mental illnesses. Officers decision-making at this tier is governed by the YCJA. The YCJA is Canadian legislation that governs how youth aged 12-17 are prosecuted for their criminal offences. The YCJA is unique as it addresses disparities in sentencing, incorporates victims and, most notably, requires officers to consider the use of extra-judicial measures (EJM) before laying a formal charge. EJM's are informal responses that take place outside of the courtroom setting. Typically, this involves referring the majority of delinquent youth who come into contact with police to a community-based program that is relevant to the crime committed by the youth. In this study, all of the officers reported referring delinquent youth to the following four community programs offered by the John Howard Society (JHS): Preventing Property Crime, Drug and Alcohol Awareness, Understanding Anger and Healthy Relationships. Currently, the JHS does not offer a specific program that pertains to mental illness.

When considering whether inclusion in traditional EJM programs is appropriate for youth, officers consider: the severity of the crime committed (ID 100, 102, 107 & 110-111), whether the crime was victimless (ID 100, 102-103 & 107-109), if the youth is remorseful (ID 103-104, 108-109 & 111), and if the youth has had minimal prior contact with the justice system (ID 103, 107 & 111). Every officer interviewed for this study reported that an EJM is a suitable option for mentally ill youth; however, they specified that the current EJM's offered by JHS are only appropriate when dealing with youth who are categorized as having a 'non-severe' mental illness. The behaviours and crimes associated with 'non-severe' mental illnesses are not congruent with high-risk or crisis situations nor do the youth categorized with 'non-severe' mental illness pose a direct threat to themselves or others. It is likely that their crimes meet the criteria listed above for inclusion in a traditional EJM. On the other hand, youth who fit in either of the 'severe' mental illness categories are capable of behaviours and crimes that fall outside of these considerations which make them unsuitable to participate in the traditional EJM programs.

To illustrate this point, one officer (ID 100) provided an example of a youth with depression and anxiety who engaged in property crime. He explained that vandalism is nonviolent and victimless; therefore, vandalism is relatively low in terms of the level of severity. This youth was also remorseful and had minimal prior contact with the justice system despite suffering from anxiety. Because of these factors, this youth was an appropriate candidate for inclusion in a traditional EJM. In contrast, a youth with bipolar disorder, would most likely commit a violent crime which would elicit a different response by the officer (ID 100). All officers agreed that a youth who was 'severely' mentally ill with abnormal behaviours, which included a potential for harm to self or others at the time of arrival, should not receive a

traditional EJM. At no point during the interviews did an officer discuss responding to youth with a 'non-severe' mental illness who commits a serious criminal acts.

iii) Tier Three

The third tier involves the police response to youth with 'severe' mental illness without abnormal or harmful behaviours at the time of the officer's arrival. Decision-making with these youths involves components of both the OMHA and the YCJA. Youth who have a 'severe' mental illness but do not present abnormal or harmful behaviours at the officer's time of arrival, present a particular challenge for decision-making. For example, one officer (ID 111) mentioned approaching a situation with a youth who did not display the aggressive and threatening behaviours that were previously reported to dispatch during the 911 call. The absence of abnormal behaviours prevented the officer from apprehending the youth to a hospital because it was not clear that the youth met the threshold of harm outlined in the OMHA. However, trusted adults (in this case his parents) who were present at the scene told the officer that the youth had a possible bipolar diagnosis and had acted violently towards them several times previously. This led the officer to categorize the youth as 'severely' mentally ill, which ruled out the possibility of engaging the youth in a traditional EJM program. It was evident that neither the OMHA or the YCJA offered clear direction for this officer to respond to youth with a 'severe' mental illness without abnormal behaviours. The ultimate outcome of this situation was not discussed by the officer.

To create a meaningful response for youth with 'severe' mental illnesses who do not display abnormal behaviours, officers have strengthened and expanded their connections to community organizations that specialize in mental health treatment. All the officers viewed

mentally ill youths' involvement in the justice system as unproductive and they sought to find a way to break the cycle. Although police officers are not specialized doctors (ID 110), the officers (12/12) hoped that by providing specialized services for youth, they would receive the treatment necessary to discontinue criminal acts and to focus on their mental well-being. The community resources involved in this response included: organizations that specialize in mental health treatment, specialized mental health nurses, school social workers and counsellors. The decision to refer youth to one of these community resources depended on what the officer identified as the specific mental health needs of the youth (ID 100-103, 106, 109 & 111). The following is an overview of the services officered by the various community resources officers (12/12) mentioned referring youth with a 'severe' mental illness without abnormal behaviours to at the time of arrival:

- A not-for-profit organization that aids those struggling with mental health, housing and employment. When a youth is suffering from a mental health disorder they can attend this organization to receive an assessment, treatment or counselling.

- An organization that works with youth to improve their mental health and to sustain mental wellness. It offers a twenty-four-hour mobile crisis line, assistance for emotion regulation, intensive dialectical behaviour therapy, and counselling services.

- A short-term stay unit for youth suffering with mental illness and who feel unable to participate in daily activities due to it. Youth who receive care here will participate in group programming, recreational activities, and will receive therapeutic assistance.

- A organization that aids those with mental health and addictions issues. Some of the specific programs offered to youth who attend here include: mental health education,

suicide prevention workshops, dialectical behaviour therapy, and they have access to 24/7 distress lines.

- School social workers and counsellors who provide in-school opportunities for support to youth with mental illness. They provide a safe space for youth to vent their frustrations, assist in behavioural intervention planning, and liaison with other community resources to meet the students' specific needs.

Each of these resources provide a unique and potentially beneficial experience for youth who have a severe form of mental illness but who do not meet the threshold for apprehension to a hospital or for a referral to a traditional EJM. Although the youth may not be experiencing a crisis when referred to these resources, the programming they receive from these organizations can help them develop pro-social coping mechanisms which will allow them to better manage their severe mental illnesses in the long-term.

Several of the officers interviewed described the benefits of this community partnership. For example, one officer (ID 106) expressed his frustration with officers who refer a mentally ill youth to a program that does not cater to the needs of the youth. Instead, he suggested that officers should pair the youth with a program that will advance their well-being long-term via specialized services for youth. Another officer (ID 103) discussed a youth with schizophrenia who was not exhibiting symptoms of a 'severe' mental illness at the time of arrest. She (ID 103) stated that although the youth would never be cured of his/her disorder, perhaps with the proper treatment, his/her disorder could become more manageable and s/he will resist future criminal activity. A third officer (ID 105) displayed sympathy for mentally ill youth, stating that the illnesses are not their fault and that to control their abnormal behaviours, officers should pair the youth with resources conducive to their mental well-being. These resources should assist the

youth in pro-social coping mechanisms. She also mentioned that for the youth to be provided

with appropriate resources, officers must learn to sympathize with the youth's state of mind.

Lastly, a fourth officer (ID 102) discussed how some youth with mental illness are not fully

cognisant of their behaviours; therefore, officers should attempt to connect youth to an

organization that would benefit them the most and use criminal charges as a last resort.

Throughout the study, all the officers expressed their desire to help youth with all

categories of mental illness and their reluctance to charge and label a mentally ill youth as

criminal. In fact, when an officer needed to lay a charge all officers suggested that using a

specialized mental health court, which could mandate that the youth attend treatment, would be

more acceptable than custody. Overall, they felt that 'severely' mentally ill youth with abnormal

behaviours at the time of arrival must be dealt with through apprehension to a hospital. While

they do not find this overly useful for the youth, they must respond this way to conform to what

is prescribed in the OMHA. Youth categorized with a 'non-severe' mental illness have

committed less serious criminal behaviours and can be dealt with using traditional EJM's,

outlined in the YCJA. To more appropriately respond to 'severely' mentally ill youth without

abnormal behaviours, all officers informally modified traditional EJM's to include community

organizations that specialize in mental illness. From the point of view of the officers (12/12), this

restructuring incorporates elements of the YCJA as it is the least obstructive option, yet still

holds youth responsible for their actions. It also satisfies the OMHA which requires officers to

take some action with youth who could present a threat to themselves or others, even if they do

not at the time of the officer's arrival. The creation and execution of this three-tier system did not

differ despite differences in the officers' educational background, years of service, gender and

rank.

5.2 Conclusion

This chapter presented the results of the current study on police interactions with youth they reason to be mentally ill. The narrative data collected during the interviews with police officers were analyzed thematically and revealed three over-arching themes. The first theme discussed was the categorization of mental disorders by police officers as severe with or without abnormal behaviours or non-severe. The second theme pertains to the categorization of 'severe' mental illnesses in the absence of abnormal and harmful behaviours. When categorizing these youth, officers rely on previous experience, trusted adults and zone of city. The final theme in this study involved the restructuring of traditional EJM's. This restructure resulted in a three-tier response system and allowed officers to refer 'severely' mentally ill youth without abnormal behaviours to community programs that lie outside of the traditional EJM's but that specialize in mental health services. This three-tier response was believed to be beneficial to mentally ill youth whilst continuing to protect the public. The next chapter will discuss the importance of these findings in the context of existing literature and policy.

Chapter Six: Discussion and Conclusion

Introduction

The findings from this study will add to the scant literature on police interactions with

mentally ill youth in Ontario (Hartford et al., 2009; Schulenberg, 2009; Schulenberg & Warren,

2010; Brown et al., 2017). This study's main goal was to investigate the research question: How

do police officers from one Police Service in Ontario interact with youth who they reason to

believe are mentally ill? The questions asked during these interviews were structured to allow for

the exploration of the following research questions: What behaviours do police officers associate

with youth who they believe are mentally ill? What factors influence police officers construction

of mental illness? How does this construction of mental illness impact officers' decision-making

about how to process young offenders with whom they interact? This chapter discusses the

significant findings related to each of the stated objectives, as well as how each finding can be

explained using the theories and past literature presented in Chapters Two and Three. Next, the

implications of this study are discussed, with an emphasis on how the findings might help police

services across Ontario. The limitations of this study are then presented, followed by suggestions

for future research.

6.1 Defining Mental Illness: Police Culture versus Health Care Culture

The first research question that this study explored was: what behaviours do police

officers associate with youth who they believe are mentally ill? In 1985, theorist Kenneth Gergen

predicted that different cultures will have differing perceptions of mental illness, mainly because

the factors that influence members of one culture may be different than the factors that the

influence another (Gergen, 1985). Therefore, it is expected that the language that members of

one culture use to describe mental illness will be different than the language used by members of another. Perhaps not surprisingly given the very different mandates of those working in the police service versus health care system, the results show that police officers and health care professionals – such as psychologists and psychiatrists – differ in their perceptions of mental illness. (Farrell & Marshall, 2007; Erdner & Piskator, 2013; Mitchell, Nabavi & Nutt, 2015). More importantly, the factors that influence these perceptions are different for police officers versus health care providers. For instance, police officers categorize mental illness in terms of the level of risk the youth presents to themselves or society and they construct this categorization through reliance on the youth's behaviour exhibited at the scene. Importantly, the presence of co-morbidity and substance disorders are not contributing factors in officers' assessments and categorization of mental illness (Schulenberg, 2009; Cheong, Walsh & Yun, 2014; Fisher et al., 2017). In contrast, clinicians construct mental illness with reference to the DSM-V and rely on assessment tools to inform their construction. Unlike officers, co-morbidity and substance disorders are major contributors in health care providers assessments and categorization of mental illness (Farrell & Marshall, 2007; Daley et al., 2009; Erdner & Piskator, 2013; Mitchell, Nabavi & Nutt, 2015; Barbaree et al., 2016). As predicted by Gergen, these differences pose issues in the transfer of language between members of these two cultures which convolutes the treatment of mentally ill youth.

The Objectives of Two Cultures

Police officers are bestowed two responsibilities: to act as enforcer of the law and to assist the helpless – parens patrie (Engel & Silver, 2001; Fulambarker, Watson & Wood, 2017). Although both responsibilities are entrenched into the teachings officers receive at the Ontario

Police College, the role of law enforcer has traditionally taken precedent (Teplin, 1983; Mullaly

& Wachholz, 1993; Green, 1997; Engel & Silver, 2001; Martinez, 2010). Until the

deinstitutionalization movement, officers main focus was on the perceived level of risk and

danger present at the situation to which they responded. When confronted with a delinquent

youth, officers assess the level of violence and potential public safety issues as an indication that

the youth is mentally ill (Barbaree et al., 2016). Depending on the severity to which the youth

demonstrates violence or threat to public safety, the youth will be categorized as either:

extremely mentally ill/highest risk to public safety or less severe mental illness/lower risk to

public safety (Bohrman, 2014; Babaree et al., 2016). Bohrman (2014) finds that youth who are

categorized by police as extremely violent, hostile and uncooperative are perceived to be

severely mentally ill and a greater risk to public safety and security than someone who is calm

and cooperative (Bohrman, 2014). Youth who present a disrespectful demeanor or who act

aggressively toward the officer – which is often accompanied by more violent crimes – are more

likely to be identified and categorized with a mental illness (Schulenberg, 2009; Cheong, Walsh

& Yun, 2014; Fisher et al., 2017). Despite an increase in interactions between officers and youth

with mental illness (Paoline, 2003; Bohrman, 2014), officers continue to be less interested in the

specific diagnosed mental illness and more focused on the overall level of risk the youth presents

(Bittner, 1967; Engel & Silver, 2001; Schulenburg & Warren, 2009).

Focusing on risk may also have valuable practical components. Police officers respond

to a broad range of unpredictable situations and in a large majority of these situations, officers

are provided with limited information concerning the offender and their background (Cheong,

Walsh & Yun, 2014). Without useful resources such as a doctor's diagnosis or a trusted family

member's confirmation of the individual's mental health identification and history, officers must

rely solely on the behaviours individuals exhibit at the time of response as an indicator of mental illness (Hartford, 2006). Relying on the youth's behaviours at the scene rather than a full mental health assessment allows the officer to quickly identify and categorize the individual with a mental illness to allow for a more timely response to what is commonly a heightened and uncertain situation (Erdner & Piskator, 2013).

Nevertheless, police perceptions of mental illness are likely to change. Because people with mental illness have traditionally been dealt with through the health care system, officers were not required, or perhaps did not care, to consider the complex needs of the mentally ill. Therefore, officers' current categorization and perceptions of youth with mental illness, which focus on risk, could be thought of as a representation of how officers have learned to adapt to people with mental illness while still utilizing traditional policing methods. Yet, as interactions between police officers and youth with mental illness continue to be scrutinized by the public (Engel & Silver, 2001), it is possible, as Gergen predicts, that members of the police culture will develop new perceptions of individuals with mental illness which could influence how officers exercise their discretion with mentally ill youth (Gergen, 1985).

In contrast, members of the health care culture – psychologists and psychiatrists – are primarily focused on providing appropriate care to mentally ill youth (Farrell & Marshall, 2007; Daley et al., 2009). To ensure the care is suitable, clinicians diagnose disorders as they are outlined in the DSM-V. In fact, the DSM-V is the most heavily relied upon document by health care members when dealing with youth or adults with mental health issues (Daley et al., 2009). Clinicians report relying on this document for identifying and diagnosing the 297 mental disorders currently identified, for creating treatment plans for mentally ill individuals, and for issuing financial statements to insurance companies for those with mental illness (Farrell &

Marshall, 2007; Daley et al., 2009). Although clinicians acknowledge the complexity of this document, they cite using the DSM-V consistently to diagnose the plethora of disorders currently outlined in the document. They suggest that using the DSM-V and diagnosing disorders by their specific manifestation rather than their overall severity, eliminates inconsistencies in client treatment and creates reliability when billing insurance companies (Daley et al., 2009).

To diagnose an individual with a mental illness, clinicians rely on comprehensive psychiatric assessments guided by the DSM-V (Erdner & Piskator, 2013). Psychiatric assessments are administered by psychologists and psychiatrists and involve an analysis of multiple variables including an individual's mood, behaviour and risk for self harm (Daley et al., 2009). Patients are often asked to partake in multiple interviews and mood-tests. Throughout history, the DSM has undergone multiple revisions, altering the variables involved in the assessment process (Michailakis & Schirmer, 2014). That said, clinicians suggest that assessments based on a multifaceted document such as the DSM-V and multiple variables allow them to make comprehensive diagnoses which can better guide the treatment offered to the mentally ill individual (Daley et al., 2009). Moreover, increased interactions with mentally ill individuals, coupled with the high value placed on the DSM by members of the health care culture, help to explain why mental illness is perceived differently within the health care culture compared to the police culture.

Overall, due to differences in the objectives of the police versus health care culture, mentally ill youth are assessed and perceived differently by clinicians and police, leading to differences in how the youth is categorized. Policy makers should be especially mindful of the dissimilar categorizations as different responses will produce different medical responses to mentally ill youth. Overall, the disconnect in the categorization of mental illnesses by members

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of the police culture versus the health care culture perpetuates pre-existing issues in information sharing between members of both cultures (Erdner & Piskator, 2013). In turn, this leads to greater issues in the development of consistent identification and treatment of youth with mental illness.

Co-Morbidity and Substance Disorders

In this study co-morbidity – the presence of two or more mental illnesses – and substance disorders did not prove to be major factors in police officer's identification and categorization of mental illness, whereas these concepts are considered by clinicians. In fact, officers in this study maintained that substance disorders were separate from mental illnesses. Yet, substance disorders commonly manifest along with other mental disorders; however, individuals who do not necessarily have a substance disorder can have co-existing mental disorders. The presence of substance disorders and/or co-morbidity has become a mainstream issue for clinicians (Farrell & Marshall, 2007; Daley et al., 2009; Mitchell, Nabavi & Nutt, 2015; Barbaree et al., 2016). As such, the relationship between substance disorders and other mental illnesses will be discussed in greater detail.

Mentally ill individuals have the highest rate of substance abuse within the population (Farrell & Marshall, 2007). Research suggests that during the initial stages of a mental illness, individuals attempt to alleviate their abnormal and sometimes debilitating symptoms by using drugs, alcohol and nicotine (Farrell & Marshall, 2007; Barbaree et al., 2016). Over time, individuals develop a dependency to these substances which leads to a substance disorder and in some cases, works to exacerbate the initial mental illness (Farrell & Marshall, 2007). This concept has been termed the self-medication hypothesis (Farrell & Marshall, 2007). The co-

occurrence of substance disorders and mental illness increases an individual's risk for developing additional mental disorders and for committing suicide (Farrell & Marshall, 2007; Barbaree et al., 2016). Although research indicates that clinicians understand this risk, a large majority of police officers do not (Erdner & Piskator 2013; Barbaree et al., 2017).

Mental disorders can also co-exist without substance disorders. Mitchell, Nabavi & Nutt (2015) find that individuals who have bipolar disorder have higher rates of anxiety and may also have increased rates of depression (Farrell & Marshall, 2007; Mitchell, Nabavi & Nutt, 2015). In all cases, the prevalence of more than one mental illness increases individuals' likelihood of mood episodes, substance abuse and suicide, especially among developing youths' (Mitchell, Nabavi & Nutt, 2015).

Substance disorders and co-morbidity should always be considered in mental illness diagnoses or categorization to ensure the safety and appropriate treatment of mentally ill individuals. However, the ability of health care providers to communicate an individual's complex diagnoses to police, which could lead to a collaborative safety and treatment effort, is strained by the complexity of the psychiatric language used by health care professionals (Erdner & Piskator 2013). Nonetheless, a small study conducted in Ontario revealed that the initiation of a collaborative language program between officers and mental health workers increased officers' ability to identify mental illness, which lead to more synchronization between health care providers and police officers (Barbaree et al., 2017). Furthermore, attempts to transfer language between criminal justice system actors and health care actors is slowly occurring at the court level. It is hoped that as specialized courts, such as mental health and drug treatment courts, increase across Ontario, the transfer of language between police officers and health care

providers will improve which could contribute to better outcomes for youth being diagnosed and treated for mental illness.

6.2 Class-, Gender-, and Race-Based Policing

The second research question this study sought to answer was: what factors influence police officers construction of mental illness? Since the mid-1900's, dispatch operators have played a significant role in relaying pertinent information about an offender to police officers, prior to their arrival at 911 calls (Parent, 2011; Marcussen et al., 2011). In fact, Parent (2011) finds that interactions between officers and persons with mental illness were improved when dispatch operators relay all pertinent information about the situation to the responding police officer. When police officers were provided pertinent information, there was less use of force by the responding officer, fewer fatalities and improved safety for all people involved at the scene (Parent, 2011). However, in line with the results reported by Marcussen et al. (2011), this study found that the way incidents are dispatched is a minor contributor in officers' construction and identification of mental illness. Although the literature presents mixed results over the role dispatch operators play in officers' construction of mental illness, what remains clear is that officers rely on a variety of factors when constructing their mental health schemas, including youths' class, gender and race.

Class-Based Policing

Consistent with prior research, this study found that an individuals's socio-economic status or class plays a role in officers' mental health schemas. A large number of studies suggest a correlation between homelessness, mental illness and police contact (Wilton, 2004; Lurigio,

2011; Crocker et al., 2016). Lurigio (2011) suggests that individuals with low socio-economic status have higher rates of mental illness than those with high socio-economic status. This may be true for at least two reasons. Firstly, individuals of low socio-economic status are more likely to experience stress due to their inability to achieve basic life essentials, such as food or housing. The accumulation of stress then triggers the onset of mental illness (Lurigio, 2011; Crocker et al., 2016). Secondly, the symptoms that accompany mental illness may interfere with an individual's work, school or home life, resulting in losing their job, dropping out of school or losing their home and family (Lurigio, 2011). Moreover, individuals of low socio-economic status often have difficulty in obtaining treatment which allows their illness(es) to go untreated, further perpetuating the deterioration cycle (Lurigio, 2011).

Individuals, especially youth with low socio-economic status, have the greatest level of contact with police (Wilton, 2004; Lurigio, 2011; Statistics Canada, 2015a; Crocker et al., 2016). At an individual level, homeless individuals have high rates of substance abuse, high rates of impulsivity and antisocial tendencies (Lurigio, 2011; Crocker et al., 2016). They may also wear dirty or weathered clothing and find it difficult to maintain their hygiene (Wilton, 2004). At a structural level, homeless individuals live in precarious housing developments or may have no housing at all (Wilton, 2004; Crocket et al., 2016), making them more visible to police. In combination, these issues socially exclude individuals with low socio-economic status and cause them to appear suspicious and abnormal. As a result, they are more likely to be perceived by officers as mentally ill irrespective of their behaviour.

It is not clear whether homeless individuals have greater contact with police because of their mental illness or because of their visibility. Since the deinstitutionalization movement of the 1960s, individuals with mental illness have had an increased presence within the community,

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especially in areas characterized by low socio-economic status (French, 1987; Herman & Smith, 1989; Martinez, 2010). The combination of increased visibility of these marginalized individuals and the poor social interactions they have had with the public and law enforcement, have led to poor perceptions of mentally ill homeless individuals and greater police presence to patrol these neighbourhoods (Engel & Silver, 2001; Lurigio, 2011; Crocker et al., 2016). This can often cause a downward spiral for youth, whereby they begin to accumulate criminal records for minor drug possession or theft, eventually possibly leading to incarceration. Overall, policy makers need to be mindful of the fact that class influences who officers consider to be mentally ill (Martinez, 2010; Lurigio, 2011; Crocker et al., 2016). It is essential that policies do not direct officers to criminalize homeless youth for minor criminal infractions, as this will only further disadvantage these youth.

Gender-Based Policing

Phenomenologist Alfred Schutz (1970) predicts that criminal justice actors create typifications, or categories, which leads to a more manageable reality. For example, Thomson (2010) suggests that individual's manifestation of illness is perceived differently, depending on how they are typified – such as female or a male. Female offenders are perceived as suffering from higher rates of anxiety and depression whereas male offenders portray behaviours congruent with antisocial personality disorder and substance disorders (Thompson, 2010). These predictions stem from traditional gender expectations whereby females are typified as nurturing and caring and males are typified as violent and aggressive (Thompson, 2010). The current study and existing literature provides mixed support for these predictions.

This study produced mixed results about the role that a youth's gender plays in the construction of officers' mental health schemas. Again, given the exploratory nature of the study, no firm conclusions can be drawn to support or refute the above predictions. Nevertheless, seven of the officers in this study believed that mentally ill youth are equally likely to be male or female. This finding is consistent with Thompson's (2010) mental health findings. For example, Thompson (2010) argues that males and females experience mental illnesses at similar rates. However, males have higher rates of substance abuse and antisocial personality disorder whereas females have higher rates of depression and anxiety; both genders are equally likely to be diagnosed with schizophrenia (Thompson, 2010). In contrast, two of the officers in this study report that males have higher rates of mental illness and greater police involvement. Similarly, Brown et al. (2017) conducted a study with youth aged 14-17 and found that 63.8 percent suffer from a mental illness. In this study, boys had higher rates of mental illness than girls; therefore, boys had more contact with police (62%) than girls (38%). Lastly, three of the officers in the current study suggest that females have higher rates of mental illness and greater police involvement.

In general, there are mixed results pertaining to the role that gender plays in police officers' construction of mental illness. While some research suggests that officers interpret mentally ill youth in light of the gender expectations previously listed (Thompson, 2010), limited conclusions should be made about the extent to which elements of social constructionist theory, such as assumptions pertaining to gender stereotypes, fully explain officers' construction of mental health schemas. As such, future research should continue to explore how gender influences police offices construction of mental illness.

Although race did not emerge as a theme in the current study, prior research suggests that a youth's race is an important contributing factor in officers' construction of mental health schemas. For example, research demonstrates that male youth, who are of a racialized minority and low socio-economic status have more frequent police interactions and are more likely to be presumed mentally ill than Caucasian youth (Thompson, 2010; Lurigio, 2011; Borum et al., 2012; Bohrman, 2014; Crocker et al., 2016). Therefore, the intersectionality of class, gender and race is vital for gaining a comprehensive understanding of the specific experiences that police officers rely on when constructing their mental health schemas. Moreover, research should continue to monitor the factors that influence officers perceptions of mental illness as changes to the police culture, which includes hiring officers who differ in race, gender and socio-economic status (Myers, Paoline & Worden, 2000; Paoline, 2003), continue to evolve.

6.3 The Gray Zone in Policing

The third research question that this study asked was: how does officers' construction of mental illness impact their decision-making about how to process young offenders with whom they interact? Officers' construction of mental illness assists them in characterizing youth they perceive to be mentally ill. However, how the officer chooses to respond to the youth depends on what options police officers view as being the most effective at meeting the needs of the youth. As such, both the construction of mental illness and the views held by members of the police culture are important for understanding police decision-making.

Police officers are in a unique position of power that allows them to deliver justice to young offenders through a range of formal and informal measures (Schulenberg & Warren, 2009; Cheong, Walsh & Yun, 2014). In line with the current study's findings, officers are most

likely to use informal measures when the youth has had minimal prior contact with police, when the crime is less serious and when the crime is perceived as victimless (Schulenberg & Warren, 2009; Cheong, Walsh & Yun, 2014). As previously mentioned, other factors that play a role in their decision-making process include the youth's race, social class and gender (Wilton, 2004; Thompson, 2010; Martinez, 2010; Lurigio, 2011; Borum et al., 2012; Crocker et al., 2016). The most notable factor to influence police decision-making is the youth's demeanor, including their level of psychological distress (Cheong, Walsh & Yun, 2014).

Police decision-making with mentally ill youth is a complex phenomenon. As previously discussed in chapter five, traditional Ontario Police College training does little to prepare officers for dealing with the diverse needs of mentally ill individuals because it primarily focuses on the enforcement of laws (Engel & Silver, 2001). Therefore, officers often make decisions by relying on post-training experiences (Herz, 2001; Stewart & Smith, 2004; Colwell et al., 2006). These decisions are often referred to as the "gray zone in policing" as they encompass responses that have not been formally articulated in laws or Provincial and Federal Acts (Bittner, 1967). However, consistent with the extant research, the current study finds that police officers reserve apprehension to a hospital and formal charges for the most severely mentally ill and/or harmful youth (Green, 1997; Erdner & Piskator, 2013; Bohrman, 2014). Conversely, police officers utilize informal measures to respond to all other mentally ill youth (Bittner, 1967; Green, 1997; Hartford, 2006; Bohrman, 2014; Fulambarker, Watson & Wood, 2017).

Apprehension to Hospital

Research indicates that police officers' decisions to apprehend a mentally ill youth to a hospital is reserved for extremely rare and uncommon situations characterized by violence,

aggression and disruption (Bittner, 1967; Green, 1997; Barbaree et al., 2016; Hartford, 2006). In these situations, the youth presents extreme psychological distress, has lost control and has attempted or is likely to attempt suicide (Bittner, 1967). The decision not to apprehend mentally ill youth to a hospital would likely invite danger to the youth and their surroundings to proliferate (Bittner, 1967). Therefore, officers apprehend severely mentally ill youth to the hospital to eliminate the potential for danger (Bittner, 1967). It is worth acknowledging that Provincial documents, such as section 17 of the *Ontario Mental Health Act*, set the threshold for apprehension – when there is harm or danger to self or others – but police officers interpret how and when this is applied (Bittner, 1967).

Although officers admit to apprehending some mentally ill youth to the hospital, officers remain dissatisfied with the responses provided by the health care system when a youth is apprehended for two reasons (Bittner, 1967; Green, 1997; Erdner & Piskator, 2013; Bohrman, 2014). Firstly, as officers in the current study also point out, they are frustrated that apprehension to a hospital results in waiting hours for a clinician then a quick release of the youth (Bittner, 1967; Green, 1997; Erdner & Piskator, 2013). The quick release is often accompanied by an insufficient number of resources to treat the youth's disorder, which could assist them in disengaging in future violence (Bittner, 1967; Erdner & Piskator, 2013). Secondly, although less common and not discussed in the current study's findings, apprehension to a hospital poses the risk that the youth is forced into treatment. From the perspective of police officers, this outcome deprives youth of their civil liberties and should not be the responsibility of police who traditionally deal with issues, within the criminal realm and not the civil realm (Bittner, 1967; Fulambarker, Watson & Wood, 2017). As discussed in this study, officers believe that due to these issues mentally ill youth should be dealt with by professionals who lie outside of the

traditional justice system and who are trained to deal with these complex situations (Bitter, 1967; Green, 1997; Borum et al., 1998; Hartford, 2006; Erdner & Piskator, 2013; Bohrman, 2014; Fulambarker, Watson & Wood, 2017).

As a result, the construction of mental illness is not in itself enough to indicate whether an officer will respond with apprehension to a mentally ill youth. Instead, researchers must consider the views held by members of the police culture for a more accurate understanding of when officers will apprehend a youth. For instance, based on the limited sample used in this study, officers are committed to helping mentally ill youth – parens patrie – and are generally dissatisfied with the health care system response when a youth is apprehended (Bittner, 1967). These cultural views are equally important for understanding the situations that officers believe warrant the use of apprehension with mentally ill youth. Future research should continue to explore the complexity of police culture views to better understand the use of apprehension.

Formal Charge

Formal charges were less frequently discussed in the current study. In contrast to the earlier predictions set out by Abramson in his criminalization hypothesis (Engel & Silver, 2001), however, the literature suggests that officers are less likely to lay formal charges with mentally ill youth (Green, 1997; Hartford et al., 2005; Hartford, 2006; Bohrman; 2014). Green (1997) reported that police officers view formal action as inadequate as it fails to address the underlying mental illnesses which cause the individual's violent outbursts. With that said, if the individual presents a heightened potential for danger, which is a relatively uncommon occurrence, formal charges may be employed to maintain public safety (Green, 1997; Bohrman, 2014; Fulambarker, Watson & Wood, 2017). Even rarer, Bohrman (2014) describes, is officer's use of force with

mentally ill individuals. Although police rarely use force with mentally ill individuals, if the individual is resistant or has a weapon or drugs which signals a possible danger to the public's safety, the officer may invoke force to take charge of the hazardous situation (Bohrman, 2014).

When invoked, use of force or formal measures are not applied consistently among police officers, as the choice of when to employ these responses is up to the discretion of the individual officer (Bohrman, 2014). However, Bohrman (2014) stipulates that the use of force and arrest with mentally ill youth is more common if the youth is under the influence of drugs or alcohol, if the youth is a person of colour or is extremely hostile. Nonetheless, the majority of mentally ill individuals do not pose any danger to society, and so use of force by officers is a fairly uncommon occurrence. Moreover, the prevalence of multiple variables – gender, race, use of drugs or alcohol – convolutes any direct link between mental illness and use of force or arrest with police officers (Engel & Silver, 2001) cautioning researchers to be mindful of using this as evidence for the criminalization hypothesis. As such, more research should be conducted to determine the link between these variables and likelihood of arrest or use of force. This research should focus on youth, specifically within a Canadian context as it remains relatively under-researched.

Informal Measures

As other scholars have noted and in accordance with the duty of parens patrie, the police officers in the current study preferred using informal measures with youth with mental illness when youth do not meet the threshold for apprehension or do not pose a danger to themselves or others (Bittner, 1967; Durham et al., 1984; Borum et al., 1997; Hartford, 2006; Schulenberg & Warren, 2009; Bohrman, 2014; Fulambarker, Watson & Wood, 2017). While the goal with

informal measures is to help obtain treatment for the youth, the specific informal measure used is different depending on the specific needs identified for the youth (Bittner, 1967; Green, 1997; Borum et al., 1998; Hartford, 2006; Schulenberg & Warren, 2009; Cheong, Walsh & Yun, 2014). According to the literature, the three most common informal measures utilized by police are de-escalation strategies, relinquishing care to a family member and engagement with community partners. Ultimately each police officer is entitled to use each measure at his/her own discretion.

As reported by officers in the current study, de-escalation strategies are a common method for responding to mentally ill youth who appear frustrated but are not in crisis (Bittner, 1967; Borum et al., 1998; Fulambarker, Watson & Wood, 2017). According to Bittner (1967), officers report that during most of their encounters with mentally ill youth, they can bring the person to a state of "normalcy" using basic de-escalation methods. In some situations, the individual is removed from the stress-provoking situation to establish boundaries. In other situations, individuals present at the scene who are causing stress to the mentally ill individual are removed (Bittner, 1967). Contrary to officers' views of the Ontario Police College, in all these informal situations, the officer employs a problem-solving mentality and relies on elements of their de-escalation training, which they have previously learned through traditional Police College training, to respond to the needs of mentally ill individuals (Borum et al., 1998).

Officers may respond to mentally ill youth informally by relinquishing them into the care of trusted family members or friends (Bittner, 1967). This response is used less with youth who have strong social ties because during mood episodes their family members are more likely to already be present at the scene and providing support (Bittner, 1967). Instead, this option is most commonly used if the individual is known to police and is homeless (Bittner, 1967; Fulambarker,

Watson & Wood, 2017). Officers maintain personal relationships with their "regulars" which allows them to easily identify when they need care. If the individual appears to be in need of care, officers rely on their connections within the neighbourhood or zone to connect the mentally-ill individual to their family members or close friends who can provide appropriate shelter and support (Bittner, 1967).

The final and most commonly reported finding in the current study is officers' use of community partnerships to respond informally to mentally ill youth. Community partnerships can take on a variety of different forms. The most common forms include mental health professionals who work and ride alongside police to mental health calls, connections with mobile mental health units and partnerships with services that specialize in mental health programming to which officers can refer youth (Borum et al., 1998; Wilton, 2004). From the perspective of police officers, these community partnerships offer a more adequate and beneficial response to mentally ill youth than could be obtained through apprehension or formal measures (Bittner, 1967; Borum et al., 1997; Hartford, 2006; Schulenberg & Warren, 2009; Bohrman, 2014; Fulambarker, Watson & Wood, 2017).

In summary, during encounters with mentally ill youth, police typically fulfill the role of parens patrie which involves making decisions outside of the traditional methods learned at Police College or that exist within laws and statutes in order to provide care and assistance to helpless individuals. The decisions they make depend on the views held by members of the police service and on the availability of mental health programs. In general, officers try to customize the response to meet the needs of individual mentally ill youth (Colwell et al., 2006; Stewart & Smith, 2004; Herz, 2001). Because police services have different resources available to them, responses are not applied consistently to youth-related incidents by police officers

across Canada (Chappell, 2008; Forcese, 1992). Forthcoming research should focus on what mental health programs officers view as more valuable so that efforts can be made for all police services and mentally ill youth across Ontario to have access to them.

6.4 Theoretical and Policy Implications of Key Findings

While the topic of mental illness has garnered increasing interest in recent years, little is known about police officers' use of discretion with mentally ill youth. As police officers face a growing number of interactions with mentally ill youth, it is vital to explore how they exercise their discretion to ensure treatment of mentally ill youth remains consistent, just and fair. This study provides a unique exploration of police officers' exchanges with mentally ill youth within a Canadian context. The results from this study have important theoretical and policy implications, which I discuss below.

Theoretical Implications

This study relied on the assumptions of social constructionist theory to explore how police officers interact with mentally ill youth in Ontario. As discussed in chapter two, social constructionist theory suggests that society defines mental illness depending on the specific historical, cultural and context interactions that members within a particular society have experienced (Dewees, 1999; Sahin, 2006; Gergen, 2015). Experiences shape how individuals understand situations they encounter which shapes their response-patterns (Houston, 2001; Sahin 2006). In Western culture, mental illness is defined scientifically with reference to the DSM-V; however, depending on the unique interactions individuals, such as police, have experienced within their culture, their definition of mental illness is unlikely to mirror the DSM-V exactly. As

social constructionist theory predicts, several factors contributed to officer's construction of mental illness.

The Ontario Police College and police culture taught officers specific values, beliefs and language (Campeau, 2015). Two important concepts taught during that time were risk and de-escalation tactics (Hruby, 2001; Woody, 2005). Risk influenced how officers categorized youth with mental illness as well as their response-patterns. Youth who presented greater risk to themselves or society, exhibiting extremely hostile, aggressive or violent behaviour, were viewed more negatively and subsequently as more mentally ill than those who presented minimal risk, such as those presenting moody and attention seeking behaviour. Youth who posed a greater risk to themselves or society, were typically responded to with formal measures, such as apprehension to a hospital, whereas youth who posed less of a risk were responded to with informal measures. De-escalation also influenced officers' construction of mental illness. If the officer believed they could de-escalate the youth to a point that they would no longer present a threat to public order and safety then they would proceed with a de-escalation tactic. Although officers claimed the Ontario Police College did little to assist them in their understanding of mental illness, it was evident that key concepts such as risk and de-escalation tactics were in fact, as social constructionist theory predicts, influential.

Post-training experiences also contributed to officers' construction of mental illness. As Alfred Schultz (Thompson, 2010; Bohrman et al., 2014) predicted, the experiences officers have while on-the-job causes them to typify mentally ill youth differently. The most notable factors to influence officer's mental health typifications pertained to age, socio-economic status and gender. Unsurprisingly, when officers encounter situations, they compare the variables at the current scene to the variables they have encountered at scenes in the past. Depending on how the

variables are viewed, the officer will respond to the situation positively or negatively (Myers, Paoline & Worden, 2000). For example, in this study officers reported responding to youth with mental illness differently if they were from an area of high socio-economic status versus an area of low socio-economic status, suggesting that the officers had made typifications based on economic status. As such, not only was it important to consider pre-existing definitions and practices held by members of the police culture, but it was equally important to consider unquantifiable personal experiences as major contributes to officer's construction of mental illness with youth.

Overall, this study demonstrates that several factors contribute to officers' construction of mental illness and decision-making with youth who they presume to suffer from a mental illness. Limited studies however, have utilized the social constructionist perspective to understand this topic (Paoline, Myers & Worden, 2000; Paoline, 2003; Schulenberg & Warren, 2009; Ingram, Paoline & Terril, 2013; Bohrman, 2014). Perhaps one reason for this is due to difficulty in measuring the extent to which historical, cultural and context factors contribute to officers' constructions of reality. Moreover, this task is particularly difficult because the police culture is characterized by a code of silence which tends to cause similar response patterns during interviews. It would be valuable for future researchers to utilize this approach with active-officers, as well as past police officers who are no longer employed by a Police Service, so that comparisons can be made of officers' mental health definitions.

Policy Implications

This study has important implications for policy surrounding the treatment of youth with mental illnesses. It was beyond the scope of this study to determine if formal and informal

measures are applied consistently with mentally ill youth across Ontario. With that said, police

services across Ontario are governed under the YCJA and section 17 of the OMHA. Under these

Acts, all police services across Ontario must consider the use of an extra-judicial measure prior

to laying formal charges with youth (Government of Canada, 2015) and/or they must apprehend

any mentally ill youth who appears to be harmful to them self, others or the community at large

to a hospital (Ontario Mental Health Act, R.S.O., 1990, c. M. 7). Despite these stipulations,

research demonstrates that officers exercise an enormous amount of discretion within these

situations (Green, 1997; Watson et al., 2014) which makes their application of formal and

informal measures across Ontario inconsistent (Forcese, 1992; Chappell, 2008). To ensure that

youth across Ontario are receiving the same access to mental health resources, research must

assess the number of mentally ill youth who are responded to using formal versus informal

action by each police service. Doing so will increase the likelihood that youth with mental illness

are being responded to with fair, consistent, effective and just action (Government of Canada,

2015), as required by the YCJA, and will provide evidence of where the OMHA needs to be

expanded to provide subsequent direction for police officer handling of mentally ill youth.

Secondly, this study has added to the current conversation around the necessity of mental

awareness training and specialized officers. Throughout this study, officers reiterated their

dissatisfaction with the level of applicable mental health training they receive (Green, 1997;

Lurigio, 2011; Barbaree et al., 2016). Moreover, the training they do receive on mental illness is

normally only focused on handling adults with mental illness and not youth, despite each group

requiring unique and differing responses (Schulenberg, 2009). The inclusion of mental health

awareness training as a mandatory police training requirement may assist officers in recognizing

when a youth has a metal health concern (Barbaree et al., 2016; Fulambarker, Watson & Wood,

2017) and direct officers in their decision-making which would lead to greater consistency and effectiveness when officers deal with mentally ill youth. Additionally, research demonstrates the usefulness of specialized youth officers when assisting mentally ill individuals (Fulambarker, Watson & Wood, 2017). Specialized youth resource officers are more likely to advocate for more therapeutic treatment options, divert to external social service agencies and lay fewer criminal charges (Hartford, Carey & Mendonca, 2006; Schulenberg & Warren, 2009; Colwell, Villarreal & Espinosa, 2012). Specialized youth officers' presence at mental health calls has also been shown to decrease officer injuries (Fulambarker, Watson & Wood, 2017). Therefore, as calls pertaining to mental health continue to grow for responding officers, the inclusion of specialized youth officers at reported incidents could lead to better safety for all individuals involved and a greater focus on youth's mental health treatment rather than punitive sanctions.

Thirdly, efforts should be made to invoke a collaborative language between health care providers and police officers. Police officers learn many of their definitions of mental illness through the formal training process which involves a review of federal and provincial laws, policies, and protocol and through post-training experiences (Schulenberg, 2009; Seagrave, 1997). These definitions vary greatly from the definitions used by health care providers (Farrell & Marshall, 2007; Daley et al., 2009; Mitchell, Nabavi & Nutt, 2015; Barbaree et al., 2016). A small study conducted in Ontario revealed that a collaborative language between officers and mental health workers increased officers' ability to identify mental illness, which lead to more synchronization between health care providers and police officers (Barbaree et al., 2017). Despite the potential to eliminate these inconsistencies in language, training academies have remained reluctant to make changes to the training process that could result in shared definitions and synchronization (Seagrave, 1996; Black et al., 2007; Chappell, 2008). Moving forward, if

similar efforts were made by all police services and training academies, officers would feel more supported and perhaps less frustrated with the health care system.

Lastly, attempts must be made to increase the number of mental health resources which officers can refer youth to across Ontario. Specialized treatment has proven to be effective among youth who struggle with mental illnesses (Hartford, Carey & Mendonca, 2006; Schulenberg & Warren, 2009; Colwell, Villarreal & Espinosa, 2012). This approach has led to significant improvements emotionally and behaviourally by youth, greater cooperation between the youth and law enforcement, lower recidivism rates, and better school attendance (Schulenberg & Warren, 2009; Colwell, Villarreal & Espinosa, 2012). With the goal of reducing crime rates in mind, policy makers need to consider providing additional resources that will assist in treating youths' mental illnesses. These resources need to be provided equally to services across Ontario so that youth in all regions of the Province can obtain treatment and desist from future crime.

6.5 Limitations and Future Research

Given that this study was exploratory in nature, several unanswered questions remain. Firstly, the generalizability of the results are limited due to the small sample size and city selection. This study examined a restricted number of police officer opinions and only those officers who volunteered were included (from only one police force and direct quotes were not permitted). Therefore, a large majority of officers were excluded from the study as were their views on the topic. The extent to which these findings can be generalized to other police services across Ontario is limited. Additionally, research suggests that officer's decision-making differs

depending on the rank, gender or education of the officer (Myers, Paoline & Worden, 2000; Herz, 2001; Schulenberg, 2010; Ingram, Paoline & Terrill. 2013). Again, the small sample size did not allow for confident conclusions to be made about differences in decision-making. Future studies should be conducted across police services in Ontario to create a comparative perspective for differences in training, gender or rank which would influence the response patterns of police officers.

Secondly, because of the occupational and organizational pressures faced by police officers (Paoline, 2003), they may have felt obligated to respond to the interview questions in a particular manner, resulting in reporting bias. This could have occurred to protect possible negative views of the police service from being published, which could undoubtedly affect the public's confidence in the police service (Woody, 2005; Ingram, Paoline & Terril, 2013; Campeau, 2015). Reporting bias makes it difficult to rule out whether additional factors were relied upon by police officers to construct their mental health schemas or to respond to mentally ill youth. For example, the extent to which officers in this study discussed the Ontario Mental Health Act or the Youth Criminal Justice Act was limited. Therefore, the extent to which these Acts truly guide police decision-making with mentally ill youth is unknown. As well, officers rarely discussed the influence of race, gender and socio-economic status on their perceptions of mentally ill youth. Future Canadian research should consider the role of gender, race and socio-economic status in police interactions, specifically with youth with mental illness, to gain a more sophisticated understanding of how these factors influence police officers' construction of mental illness. Additional studies that delve into police culture could also help to clarify this issue.

Lastly, this study presents the mental health assessments of a small number of police officers and do not necessarily capture the actual mental health status of the youth at the scene. As such, the findings should be viewed as one group's general views of mental illness and should not be confused with health care providers' diagnosis of mental illness of youth or confirmation that the youth has been diagnosed with a mental illness. Perhaps future studies should consider comparing police officer's construction of mental illness to health care providers views of mental illness in youth to more accurately explain the disconnect between these views.

6.6 Conclusion

Traditionally, studies on mental illness have focused on youth's treatment by the court and correctional system (Campbell & Schmidt, 2000; Kakar & Potter, 2002; Borum et al., 2012; Colwell, Espinosa & Villarreal, 2012). The limited studies conducted on police and people with mental illness focused on adults and not youth. Ideally, the results of this study, which offer insight into the behaviours police officers associate with 'severe' versus 'non-severe' mental illness, will provide policy makers and researchers with a framework for future studies on police officers construction of mental illness. The current study also delved into how police officers respond formally and informally to mentally ill youth. In general, officers preferred to help obtain treatment and support for mentally ill youth as opposed to using force or resulting to arrest. Knowledge mobilization efforts should be made so that policy makers consider this when making decisions pertaining to mental health training for police officers and the inclusion of specialized youth officers. Although continued efforts are necessary to provide a more comprehensive analysis of police officers' construction of mental illness and subsequent

decision-making with mentally ill youth in Ontario, this study encourages future mental health

research by providing preliminary evidence pertaining to officers' interactions with mentally ill

youth in Ontario.

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Appendix A: Study Overview

STUDY OVERVIEW

UNIVERSITY of GUELPH

COLLEGE OF SOCIAL AND APPLIED HUMAN SCIENCES
Department of Sociology and Anthropology
REB #16JN042

PROJECT TITLE: Police Interactions with Mentally Ill Youth: A Social Constructionist Analysis

You are asked to participate in a research study conducted by Kelsey Allen (MA student), under the supervision of Professor Carolyn Yule, from the Department of Sociology and Anthropology at the University of Guelph. The data collected from these interviews will be used as part of my Master's thesis project.

The purpose of the proposed research is to explore police interactions with youth who suffer from mental illnesses. Although numerous studies have attempted to understand the decision making processes of court personnel, including judges, lawyers and juries, in dealing with such youth, very little research has been conducted on the decision making processes of police officers who come into contact with mentally ill youth. A better understanding of how police officers determine whether a youth is mentally ill and how they subsequently choose to react to the youth (i.e., using formal sanctions like court or informal sanctions like diversion to community programming).

The goals of this study are three-fold. First, it will identify what police officers consider to be a mental illness. Second, this study will attempt to better understand what historical, cultural and context-specific experiences police officers rely on when constructing their mental health schemas. Third, this study will determine how the particular schemas used by police officers' impact their decision-making processes with youth who they perceive to have a mental illness. This study will ask: how do interactions with the public while on the job, as well as police culture shape how police officers have come to construct mental illness? Furthermore, how does this construction of mental illness impact officers' decision making about how to process young offenders with whom they interact?

If you volunteer to participate in this study, we would ask you orally answer approximately 14 questions; this should not take more than 30 minutes to complete and will be undertaken at the police service. These questions will include some of the following topics:

- Interactions with young offenders
- Decision Making Processes
- Knowledge of mental illness(es)
- Potential external factors that influence your conduct (eg. Police culture)

Please note that should you choose to participate, you have the right to quit this interview at anytime. Your decision on these matters will not affect the researchers grade; nor will it impact your position with the police service.

If you have any questions about this study and/or would like to arrange for an interview time, please contact:

Kelsey Allen, Student Investigator
519-803-0749
kallen09@mail.uoguelph.ca

Appendix B: Participant Recruitment Email

PARTICIPANT RECRUITMENT E-MAIL

UNIVERSITY
of GUELPH

COLLEGE OF SOCIAL AND APPLIED HUMAN SCIENCES
Department of Sociology and Anthropology
REB #16JN042

PROJECT TITLE: Police Interactions with Mentally Ill Youth: A Social Constructionist Analysis

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If you volunteer to participate in this study, we would ask you orally answer approximately 14 questions; this should not take more than 30 minutes to complete and will be undertaken at the police service. These questions will include some of the following topics:

- Interactions with young offenders
- Decision Making Processes
- Knowledge of mental illness(es)
- Potential external factors that influence your conduct (eg. Police culture)

Please note that should you choose to participate, you have the right to quit this interview at anytime. Your decision on these matters will not affect the researchers grade; nor will it impact your position with the police service.

If you have any questions about this study and/or would like to arrange for an interview time, please contact:

Kelsey Allen, Student Investigator
519-803-0749
kallen09@mail.uoguelph.ca

Appendix C: Consent Form

CONSENT TO PARTICIPATE IN RESEARCH

UNIVERSITY
of GUELPH

COLLEGE OF SOCIAL AND APPLIED HUMAN SCIENCES
Department of Sociology and Anthropology
REB #16JN042

PROJECT TITLE: Police Interactions with Mentally Ill Youth: A Social Constructionist Analysis

You are asked to participate in a research study conducted by Kelsey Allen (MA student) and Professor Carolyn Yule, from the Department of Sociology and Anthropology at the University of Guelph. The data collected from these interviews will be used as part of my (Kelsey Allen) Master's thesis project on police interactions with mentally ill youth. If you have questions concerning the study after your interview, you can contact Kelsey (519-803-0749, or by email at kallen09@mail.uoguelph.ca) or Carolyn (519-824-4120 ext. 53546, or by email at cyule@uoguelph.ca). You may also contact us if you wish to receive a copy of the final report, which we anticipate will be available about a year following your interview.

PURPOSE OF THE STUDY

The purpose of the study is to explore police interactions with youth who suffer from mental illnesses. Although numerous studies have attempted to understand the decision making processes of court personnel, including judges, lawyers and juries, in dealing with such youth, very little research has been conducted on the decision making processes of police officers who come into contact with mentally ill youth. A better understanding of how police officers determine whether a youth is mentally ill and how they subsequently choose to react to the youth (i.e., using formal sanctions like court or informal sanctions like diversion to community programming).

The goals of this study are three-fold. First, it will identify what police officers consider to be a mental illness. Second, this study will attempt to better understand what historical, cultural and context-specific experiences police officers rely on when constructing schemas of mental health. Third, this study will determine how the particular schemas used by police officers' impact their decision-making processes with youth who they perceive to have a mental illness.

PROCEDURES

If you volunteer to participate in this study, you will be asked to answer approximately 14 questions in a face-to-face interview which will take approximately 30 minutes to complete. The researcher will enter your responses on an encrypted laptop computer. The interview will focus on some of the following topics:

- Interactions with young offenders
- Decision Making Processes
- Knowledge of mental illness(es)
- Potential external factors that influence your conduct (eg. Police culture)

POTENTIAL RISKS AND DISCOMFORTS

This study may pose the following risks:

1. psychological risks: being uncomfortable disclosing information about particular incidents, feeling worried or upset
2. Social Risks: feeling as if your reputation with other officers has been reduced

However, you are free to skip any question you feel is too difficult to answer. You are also free to withdraw from the interview completely at any point, without any penalty to either you or the researcher (i.e., your decision to withdraw from the study will not impact the grade of the student investigator).

POTENTIAL BENEFITS TO PARTICIPANT'S AND/OR TO SOCIETY

Benefits to Participant: The results of this study may encourage supplementary training for officers in order to help them recognize when a youth has a mental health concern that should be taken into consideration when deciding on formal and informal responses to crime.

Benefits to Society: It is hoped that this study will lead to a better understanding of how the police determine whether or not a youth suffers from mental illness and, in turn, how this shapes the charging decision. The results of this study could have important implications for policy surrounding the treatment of youth with mental illnesses.

PAYMENT FOR PARTICIPATION

Participants will not receive compensation for participation in this study.

CONFIDENTIALITY

The researchers conducting this study is not associated with any department of the Ministry of Community Safety and Correctional Services and no one in the police service will have access to any of the information you provide. Every effort will be made to ensure confidentiality of all identifying information that is obtained in connection with this study. The results of this study will be presented in the student investigator's MA thesis and may be published in academic journals and/or presented at scientific meetings. All measures will be taken to ensure that your identity remains confidential. Your confidentiality will also be protected by procedures which ensure that the information you give cannot be linked to you. The information entered into the laptop computer will include an ID code but not your name. Only the researchers will have a separate file that links your ID to your name – and this will be kept in a password protected file. Please note, however, that the *confidentiality* offered to participants may be *limited* by the legal obligation to "report information to authorities to protect the health, life or safety of a participant or third party" or that "a third party may seek access to information obtained and/or created in confidence in a research context" through either "voluntary disclosure" or "force of law".[TCPS2, Article 5.1]

VOLUNTARY PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study of not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. A decision to participate or not participate in the study will not have any impact on your job at the Waterloo Region Police Service. You may exercise the option of removing your data from the study. You may remove your data from this study at any point prior to the completion of the final written report. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances warrant doing so. This project has been reviewed by the Research Ethics Board for compliance with federal guidelines for research involving human participants (REB # 16JN042). You do not waive any legal rights by agreeing to take part in this study. If you have questions regarding your rights as a research participant, contact:

Research Ethics Officer   Telephone: (519) 824 – 4120, ext. 56606
University of Guelph   E-mail: sauld@uoguelph.ca
437 University Centre   Fax: (519) 821 – 5236
Guelph, ON N1G 2W1

Do you understand the information I have told you about this research? ☐

Do you have any questions? ☐

Do I have your consent to continue with this interview? ☐

Interviewer Signature:

Participant Signature:

Date:

Kelsey Allen

Graduate Student

Department of Sociology and Anthropology

Appendix D: Interview Guide

Interview Guide
Kelsey Allen
M.A. Student, University of Guelph

This study focuses on <u>youth</u> who appear to be mentally unstable who come into contact with the criminal justice system.

1. How long have you been a police officer? _____

2. What is your current job title? _____

3. What is your current rank? _____

4. Do you live in the Kitchener/Waterloo area? _____

5. What level of education did you have before becoming a police officer? _____

6. Can you explain the agency training you have received to prepare you for your position?

_____

_____

_____

_____

     a) Can you clarify any training you have received specifically on mental health and illnesses for suspects or victims involved in the criminal justice system?

    _____

    _____

    _____

7. What factors do you use to determine if a person you come into contact with while on the job is mentally unstable?

_____

_____

_____

_____

8. How do you decide what action to take if the victim or accused is mentally unstable?

_____

_____

_____

_____

a) At what point do you decide to take action with this individual?

_____
_____
_____

b) To what extent does the Ontario Mental Health Act guide your decision-making when dealing with those who you believe to be mentally ill?

_____
_____
_____

9. Is it more difficult to determine if a youth who you come into contact with is mentally unstable compared to an adult? Explain.

_____
_____
_____
_____

10. Do you think a diversionary measure (like an EJM) is a suitable option for at least some mentally ill youth? If yes, under what circumstances is a diversionary measure appropriate?

_____
_____
_____

a) If you come into contact with a youth whom you believe is mentally unstable, are you more inclined to lay a charge or use diversionary measures? Explain.

_____
_____
_____

b) In your view, when you are giving a diversionary measure and not laying an official charge, what sorts of things (i.e., talking to parents, requiring participation in programs, etc.) do you think work best for you when you deal with a youth who you feel is mentally unstable who has committed a crime?

_____
_____
_____

c) Do you think mentally ill youth who go to court could be dealt with in more appropriate ways that would lead to lower levels of future offending?

_____
_____
_____

d) Do you think it is appropriate to have specialized mental health courts for youth with mental illness? Why or why not?

_____
_____
_____

11. On a monthly basis, approximately how often do you have contact with a young person who appears to be mentally ill offender?

_____
_____
_____
_____
_____

12. Are there certain areas of the city where you spend most time dealing with calls with youth who you believe to have mental health problems?

_____
_____
_____
_____

13. Are these youths most likely to be male or female? _____

14. Are there any resources that are available to you that lie outside of the criminal justice system that you have relied upon to deal with youth who you have reason to believe have a mental health issue?

_____
_____
_____
_____

15. Recall your last occurrence with a youth who you believed to have a mental illness. Please describe the incident:

_____
_____
_____
_____
_____
_____
_____

a) Behaviour:
- ☐ Assaultive/ violent
- ☐ Loud/ obnoxious
- ☐ Bizarre
- ☐ Crying/ tearful
- ☐ Confused
- ☐ Uncooperative

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☐ Passive
☐ Intoxicated (drugs or alcohol)
☐ Scared
☐ Incoherent
☐ Cooperative
☐ Injuries to self
☐ Embarrassed/ ashamed
☐ Depressed
☐ Agitated
☐ Untidy
☐ Non-communicative
☐ Other:_____

b) Disposition:
☐ Informal (diverted)
☐ Formal (Charge)
☐ No action
☐ Warning
☐ Arrest – station
☐ Arrest – hospital
☐ Other

Disclaimer: **"Please do not include any detail that might directly or indirectly identify an accused, victim, anyone protected by the YCJA or court order or a protected investigative technique or procedure."**

16. Are there any additional comments or thoughts you wish to share regarding police contact with youth who appear to be mentally unstable?

_____
_____
_____
_____

Appendix E: Behaviour Frequency Table

Variable	N	Percentage (%)
*Behaviour***	9	75
Assaultive/ Violent	9	75
Crying/ Tearful	8	67
Loud/ Obnoxious	8	67
Depressed	8	67
Agitated	8	67
Uncooperative	8	67
Injuries to self	6	50
Embarrassed/ Ashamed	5	42
Scared	5	42
Cooperative	5	42
Non-communicative	4	33
Bizarre	4	33
Confused	4	33
Passive	4	33
Untidy	3	25
Incoherent	3	25
Intoxicated (drugs or alcohol)	1	8
Other: shy	1	8
Other: too talkative		

**These totals do not equally 100 as the list was not mutually exclusive.