An investigation on psychiatric referrals from the police and an exploration of the experiences of nurses caring for police referred admissions to a psychiatric hospital in NSW, Australia: A mixed methods study.

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Finally, to my dearest mum, who was always there for me but so unexpectedly passed away just prior to the submission of this final document. I dedicate this thesis in memory of my mum and dad.
Statement of authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

(Signature of Candidate)
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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>Alc</td>
<td>Alcohol</td>
</tr>
<tr>
<td>CISM</td>
<td>Critical Incident Stress Management</td>
</tr>
<tr>
<td>CIT</td>
<td>Crisis Intervention Team</td>
</tr>
<tr>
<td>DSM-IV</td>
<td>Diagnostic and Statistical Manual of Mental Disorders 4th Edition</td>
</tr>
<tr>
<td>D &amp; A</td>
<td>Drug and alcohol</td>
</tr>
<tr>
<td>HIRS</td>
<td>Health Information Record Services</td>
</tr>
<tr>
<td>HoNOS</td>
<td>Health of the Nation Outcome Scale</td>
</tr>
<tr>
<td>HREC</td>
<td>Human Research Ethics Committee</td>
</tr>
<tr>
<td>ICD 10</td>
<td>International Statistical Classification of Diseases and Related Health Problems, Tenth Revision</td>
</tr>
<tr>
<td>LGA</td>
<td>Local Government Area</td>
</tr>
<tr>
<td>LOS</td>
<td>Length of Stay</td>
</tr>
<tr>
<td>MANOVA</td>
<td>Multivariate Analysis of Variance</td>
</tr>
<tr>
<td>MHA</td>
<td>Mental Health Act</td>
</tr>
<tr>
<td>MHCA</td>
<td>Mental Health Council of Australia</td>
</tr>
<tr>
<td>MHIT</td>
<td>Mental Health Intervention Team</td>
</tr>
<tr>
<td>NSW</td>
<td>New South Wales</td>
</tr>
<tr>
<td>PICU</td>
<td>Psychiatric Intensive Care Unit</td>
</tr>
<tr>
<td>PRN</td>
<td>Pro re nata</td>
</tr>
<tr>
<td>21D</td>
<td>Mentally Disordered</td>
</tr>
</tbody>
</table>
Abstract

Police are a major source of referral to psychiatric hospitals under Section 22 of the NSW Mental Health Act (2007). The aims of this two phase sequential mixed method study were to determine whether people referred by the police and admitted to a mental health service in NSW were different and what those differences were, in comparison to referrals from other sources; and to explore nurses’ experiences of caring for patients referred by the police.

The mixed methods study involved two sequential phases. In the first phase of the study quantitative data on the demographic, diagnostic and admission outcomes was collected from the medical records of 200 patients admitted to the psychiatric hospital during a six month period in 2002, to examine statistical differences between 101 police referrals and 99 referrals from other sources.

Of the 200 patients admitted 85% were referred by involuntary legal commitment (100% police referrals and 69% from other sources). Other sources included community mental health teams, general practitioners, courts, families and friends, and self referrals. Patients referred by police were statistically different to those referred from other sources on a number of diagnostic and admission outcome variables. Police referrals were 3 times more likely to be diagnosed with a mental disorder due to substance use (p= 0.000); less likely to be diagnosed with a mood affective disorder (p= 0.006); and less likely to be diagnosed as psychotic (p= 0.03). Police referrals were significantly more likely to: have higher total HoNOS scores (indicating higher levels of difficulties in overall functioning) (p= 0.00); experience problems with behaviour (p= 0.00) and social functioning (p= 0.02); exhibit aggressive behaviour (p= 0.00); be administered sedative/hypnotic medications (p= 0.02); be admitted to the psychiatric intensive care unit (PICU) (p= 0.00); require seclusion (p= 0.00); and spend fewer days in hospital (2 days or less). The most important predictor for a police referral was drug or alcohol problems 2.59 (95% confidence interval: 1.41-4.74).
The second qualitative phase was conducted utilizing a Heideggerian phenomenological framework to explore the experiences of nine nurses caring for patients referred by the police, through semi-structured interviews. While Heideggerian phenomenology, closely aligned with the philosophical position of hermeneutics provided the framework on which this study was based; the procedures for data collection, analysis and interpretation were guided by the work of van Manen. Three themes emerged from the hermeneutic analyses of interviews conducted with nurse participants: *Expecting* “the worst”; *Rescuing the police, rescuing the patient*; *Balancing therapeutic care and forced treatment*. Expecting the “worst” related to the perceptions nurse participants had about patients referred by the police. This included two sub-themes: “We are here to care for whoever they bring in” and “But who deserves care?” The second theme *Rescuing the police, rescuing the patient* included the sub-themes: “Rescuing patients from police” and “Rescuing police from patients”. The third theme *Balancing therapeutic care and forced treatment* included the sub-themes: “Taking control, taking care”, and “Managing power”.

The findings of both phases of the study were integrated and discussed in three areas: “Police as a referral source”; “Diagnostic differences amongst police referrals”; and “The management of police referrals”. The choice of the sequential explanatory design enabled both comparison and expansion of our understanding about police referrals from differing perspectives. The use of a mixed methods design yielded information that: enabled us to identify possible reasons for patients presenting to the hospital at risk of aggression even though aggression was not the main reason for patients coming to the attention of police; led to an improved understanding about why these patients were perceived as the “worst” patients by the participants; and led to understanding that while patients referred by the police experienced more behavioural problems, they were very similar to other patients in relation to their symptoms and impairment. A profiling of the characteristics of patients referred by police has highlighted the need for the development of specific services which may contribute to better outcomes for these patients and in context with the qualitative data provides reasons for clinicians to re-evaluate their judgment of patients referred by the police, particularly for those admitted with drug and alcohol problems.
Chapter 1 : Introduction to the study

1.1 Introduction

Police departments are considered one of the primary agencies for psychiatric referrals. In most developed countries police are given the power under relevant sections of the Mental Health Act to apprehend and detain for psychiatric assessment any person they perceive to be mentally disturbed. Generally, police involvement in issues of mental health occurs when an individual communicates his or her disorder by behaving in a manner that members of the community are aware of it and bring it to the attention of the police. Under Section 22 of the 2007 NSW Mental Health Act (MHA), police can apprehend and refer a person for psychiatric assessment if the person is imminently dangerous to self or others or is threatening or attempting suicide. Concerns have been raised that the use of hospitalisation for safety reasons has the potential to result in the admission of patient populations on basis other than treatability and may have major implications for mental health nursing practice, and the centrality of the therapeutic nurse-patient relationship. There is however, little systematic evidence about who these persons referred by police really are in terms of their characteristics and how they differ in characteristics from persons referred from other sources to psychiatric services.

International studies investigating police referral to mental health services have identified inconsistencies in the magnitude and direction of the differences and similarities between police and non-police referred admissions to mental health facilities, thereby limiting opportunities to make general comparisons. Therefore, there was a need for further research to identify what distinguishes police from non-police referred admissions to psychiatric facilities. In addition, the question of the experience of nurses during episodes of care to patients referred by the police has received little attention in the literature. There was a need to identify the consequences for mental health nursing practice and the nurse-patient relationship during episodes of care of police referred admissions to mental health facilities. It
was likely possible that many patients referred by police and admitted to mental health facilities may have had disorders which were not amenable to therapeutic interventions.

This mixed method study presents the results of an investigation into the characteristics of patients referred by the police and the findings of a hermeneutic phenomenological study that explored nine nurses’ experiences of caring for patients referred by police and admitted to psychiatric acute and intensive care units. This introductory chapter describes the background, purpose and significance of the study and provides an overview of the thesis.

1.2 Background

Police are key frontline responders in mental health emergencies around the world (Fisher, 2007; Fry, O’ Riordan, & Geanellos, 2002; Lamb, Weinberger, & DeCuir, 2002; Stefanis, Rabe-Hesketh, Clark, & Bebbington, 1999), and the trend for community-based mental health care has increased contact between police and people with psychiatric disorders (Fisher, 2007; Watson, Corrigan, & Ottati, 2004). Dealing with people with a mental illness is a common event for police. An Australian survey of police showed more than 10% of their time was spent dealing with people with mental health problems (Fry et al., 2002) and police officers in the United States reported an average of six encounters with people with mental illness in the previous month (Sellers, Sullivan, Veysey, & Shane, 2005).

The police are a major source of psychiatric emergency referrals around the world. A literature review of US studies found that 7-34% of psychiatric emergency referrals came from police over the period 1971-1991 (Way, 1993). The reported percentages of referrals by police to psychiatric emergency services in Europe and the UK are comparable. Police were responsible for referring 11% of psychiatric referrals to the emergency room of a general hospital in Germany in 1993 (Fahndrich, 1999), 26% of referrals to the outreaching Emergency Psychiatric Team in the Netherlands in 1989 (Rijnders & Kuipjers, 1995), and 7% of referrals to a walk-in psychiatric emergency clinic in London in 1995 (Stefanis, et al., 1999). Police are particularly involved in the management of out-of-hours psychiatric emergencies (Fisher, 2007;
Kimhi, Zohar, Barak, & Barak, 1996; Stefanis, et al., 1999) and when mentally disturbed people exhibit disruptive behaviour (Alexius, Berg, & Aberg-Wistedt, 2002; Redondo & Currier, 2003). The police response includes deciding if a person should be taken to an emergency department of a general hospital or to a mental health facility. The power afforded to police under the MHA, particularly in the apprehension and referral of persons for psychiatric assessment, has resulted in the police becoming a major source of psychiatric emergency referrals around the world (Fahndrich, & Neumann, 1999; Spurrell, Hatfield, & Perry, 2003; Stefanis, et al., 1999; Way, Evans & Banks, 1993).

Different understandings of what behaviours are indicative of mental illness may cause tension between police and mental health clinicians (Fry, et al., 2002). Mental health clinicians may question the judgement of police and may see people brought by the police to their service as inappropriate (Lamb, et al., 2002; McNiel, Hatcher, Zeiner, Wolfe, & Myers, 1991; Meadows, Calder, & Van Den Bos, 1994; Reinish & Ciccone, 1995; Watson, Segal, & Newhill, 1993). In earlier American studies, concern has been expressed by psychiatric emergency staff that police referred people who did not meet the legal criteria for involuntary mental health admission (Appelbaum, 1988; Steadman, et al., 1986). Other research studies have found that persons referred by police have lower rates of serious mental illnesses (Kneebone, Rogers and Hafner, 1995; Meadows, et al., 1994; Spurrel, et al., 2003) but high rates of behavioural problems (McNiel, et al., 1991). Police referred admissions in the US have also been reported as more likely to be male, to have psychosocial problems and be violent (Redondo & Currier, 2003); and that domestic violence, assaultive behaviour, destructive behaviour, and substance abuse are significantly higher in the police referred group (Evans & Boothroyd, 2002). The potential for self harm or harm to others has been identified as a major reason for police involvement with mentally disturbed people (Citrome & Volaka, 1999; Kneebone, et al., 1995; McNiel, et al., 1991). This has raised concerns that the use of hospitalisation for safety reasons has changed the profiles of patients presenting to the admission units and created nursing responsibilities in relation to the protection of the patients and others. Within the context of patient characteristics, unsociable or violent behaviour has been identified as a major contributor in impeding the development of
therapeutic relationships between patients and nurses. Concern has been expressed that mental health nurses are taking on the role of “De facto police” when they are expected to control the violent behaviour of people presented by police under Section 22 of the 2007 NSW MHA (Fisher, 2007 p. 230).

Although the police represent an important group under the NSW MHA (2007) there are few Australian studies that have examined the characteristics of the patients referred to a mental health facility by police compared to those referred by others (Kneebone, et al., 1995; Meadows, et al., 1994). Research indicates that there may be demographic and clinical differences in patients referred by police and “others” (Kneebone, et al., 1995; Meadows, et al., 1994; Spurrell, et al., 2003). Furthermore, despite an extensive literature search, there have been no qualitative studies found that addressed the experiences of nurses caring for patients referred by police.

1.3 Aims of the study

The aims of the mixed method study were to investigate whether people referred by the police to a mental health service in NSW were different in demographic characteristics, diagnostic characteristics and admission outcomes when compared to referrals from other sources; and to explore nurses’ experiences of caring for patients referred by the police.

1.4 Hypotheses for study

It was hypothesized that for the quantitative data there would be differences in the demographic characteristics, the diagnostic characteristics and the admission outcomes between police and non-police referred admissions. A list of hypotheses is documented in Chapter 4, the quantitative phase of the study.

1.5 The study design

This study investigated the characteristics of patients referred by police and explored the experiences of nurses caring for patients referred by the police and admitted to the hospital. A sequential mixed methods design was used because there was a need to understand the issue from differing perspectives. The sequential mixed methods
design involved first collecting quantitative data and then qualitative data in consecutive phases. In the first quantitative phase of the study, data on the demographic, diagnostic and admission outcomes was collected from the medical records of 200 patients admitted to the psychiatric hospital during a six month period in 2002, to test for differences between 101 police referrals and 99 referrals from other sources.

The second qualitative phase was conducted utilizing a Heideggerian phenomenological framework to explore the experiences of nurses caring for patients referred by the police, through semi-structured interviews. While Heideggerian phenomenology, closely aligned with the philosophical position of hermeneutics provided the framework on which this study was based; the procedures for data collection, analysis and interpretation were guided by the work of van Manen (1990). The goal of analysis was to capture an ontological understanding of the participants in their own world by interpreting shared meanings from the accounts they gave of their lived experiences, thus preserving the details and the context of their individual experiences (Sorrell & Redmond, 1995).

The rationale for using a sequential method was to use the findings of the quantitative methodology to inform some of the more specific questions asked in the subsequent qualitative methodology. The quantitative analysis assessed for differences between police and non-police referred admissions and the qualitative analysis provided a descriptive understanding of the everyday lived experiences of the nurses caring for police referred admissions, an interpretive understanding of the ways in which nurses managed the experiences as well as some explanation as to why certain factors contributed to the overall perceived differences between the patients referred by the police and those patients referred by other sources.

1.6 Significance of the study

The main purpose of this study was to identify the characteristics of persons referred by the police and determine whether they differed from the characteristics of persons referred by other sources; and to develop a clearer understanding of what the experience of caring for persons referred by the police meant to nurses. In addressing
these central issues and getting to the meaning of the lived experience, this study can:
raise nurses’ awareness of their fears and knowledge deficits, and the effects this has
on the way in which they may perceive and care for their patients; and provide an
impetus for nurses to consider their current practices and beliefs about patients
referred by the police. The study makes a valuable contribution to understanding
about police referrals to psychiatric services and nurses’ experience of caring for this
group of patients, an area that has received little attention in the literature.

1.7 Structure of the thesis

A brief outline of each of the nine chapters of this thesis is presented:

Chapter 1
This is the introduction to the entire thesis. In this chapter, the reader is briefly
informed about the background to the study, the aims, the hypotheses and the
significance of the study to nursing research.

Chapter 2
By tracing the historical management of persons with mental illness, this chapter
provides a review of the religious, social and medical structures of mental illness. It
addresses deinstitutionalization of the mentally ill, the consequences of
deinstitutionalization on police, and how the movement of deinstitutionalisation
changed the focus of in-patient units, and the impact this had on mental health
nursing practice. This literature review provides the context of the study in terms of
the issues which have confronted people with a mental illness, mental health
services, the police, and mental health nurses.

Chapter 3
In this chapter the overall research design is discussed and the rationale for a mixed
methods approach outlined. Information also includes a definition of mixed methods
research, the advantages of combining methods in a research study and the
challenges involved in using this type of research. The chapter also includes
information about ethics approval for the conduct of the study, and introduces the
hospital setting. The chapter concludes with a visual representation of the mixed method procedures used.

Chapter 4
This chapter addresses the first phase (quantitative) of the study and the method involved in obtaining the necessary data to investigate differences between the patients referred by police and patients referred by other sources. In this phase of the study the aims, objectives and hypotheses are outlined. The reasons/indicators for the referral of persons by police to the hospital are also investigated. The variables for investigation are identified and grouped into three categories: demographic characteristics; diagnosis; and admission outcomes. The four statistical techniques used for the analysis of data are also described.

Chapter 5
In this chapter the results of the quantitative phase of the study are presented after hypotheses relating to differences in characteristics between a cohort of 101 patients referred by the police and 99 patients referred by various other sources, who were subsequently admitted to a psychiatric hospital, were investigated. The chapter begins with a focus on the referrals and admission of patients to the hospital and a description of the sample. This is then followed by the indicators/reasons for police referrals. Statistical techniques used for the analysis of data in this section include Chi-Square tests, MANOVA, Mann Whitney U tests and Stepwise Logistic Regression to screen predictors for the outcome referral source.

Chapter 6
In this second phase (qualitative) of the study the methodological framework underpinning the study is discussed. The methodological framework was derived from Heideggerian hermeneutic phenomenology. The first part of this chapter begins with the aims of the qualitative phase, and an in-depth discussion of the methodology. The in-depth discussion traces the development of hermeneutic phenomenology and discusses its contribution to nursing’s ways of understanding human experience in the context of health and illness. Van Manen’s (1990) eclectic approach offered a framework for phenomenological investigation that guided the method and processes of the current study. The chapter concludes with the
application of the Heideggerian philosophy to the current study, an introduction to the participants and the procedures involved in interpretive analysis and hermeneutic phenomenological writing for this methodology.

Chapter 7
The hermeneutic analyses of interviews conducted with nurse participants are discussed in detail in this chapter. The interviews explore the experiences of nine participants caring for patients referred by the police and describe how they experienced caring for these patients admitted to the psychiatric hospital. By keeping in line with hermeneutics, the philosophy on which the study was based, a questioning stance was taken of the data during analysis in the form of “what is it like to be a nurse caring for patients referred by the police to the psychiatric hospital”. Van Manen’s (1990) hermeneutic phenomenological human science approach provided support for the study’s method and a practical way of linking phenomenology as philosophy and health care research method.

Chapter 8
The results of the quantitative and qualitative phases of the study are integrated in this chapter after both quantitative and qualitative research questions were asked to gain a better understanding of the patients referred by police and admitted to the hospital. The use of this design also provided further clarification and additional information and helped explain some of the more subtle differences identified in the study. In so doing, the integration of the quantitative and qualitative phases helped to “tell the full story”. The integration of the two phases of study is discussed in detail under three areas of relevance. Also included in this chapter is a matrix comparing quantitative and qualitative data. This was to illuminate the quantitative and qualitative findings and summarise the congruence and discrepancies between both findings and some additional aspects that were distinct from each other.

Chapter 9
In this final chapter, the overall results of the study is discussed in the context of what they mean and how they fit into the existing body of knowledge and how they
relate to the literature, along with the implications and recommendations for future practice, education and research.

1.8 Conclusion

This chapter introduced the study by explaining the aims of the study, the importance of the study particularly in the context of the absence of research on the topic, the methodology for undertaking the study and the significance of the study to nursing research. The next chapter (chapter 2) reviews the literature to provide the context for the study.
Chapter 2: A Literature Review

2.1 Introduction

By the 1990s there were major changes to the delivery of mental health services in most developed countries. These changes came about following the movement of deinstitutionalization which led to the release of many individuals with mental illnesses from large state psychiatric institutions to integration into communities. Some of the changes brought about to the delivery of mental health services had a huge impact on people with a mental illness, the police and mental health nurses.

This chapter begins with a brief review of the causes and treatment of mental illnesses and the historical management of persons with a mental illness. The review progresses on to the shift in the management of people with a mental illness, from institutional care to deinstitutionalization, under the care of community based services. It identifies how a shortage of community health services to meet the needs of mentally disturbed persons resulted in the cumulative effect of increasing the presence and visibility of people with a mental illness within the community, and increasing the frequency of police encounters with this population. A focus on the law enforcement system identifies some of the reasons that led to them becoming an integral part of the mental health system and contributed to the police being given broad powers under mental health legislation. The review examines the involvement of police in issues of mental health, including their role in the management and referring of mentally disturbed persons for a psychiatric assessment. The review also focuses on how changes to the delivery of mental health services led to changes in the focus of acute in-patient units, the consequences of these changes on traditional understandings of mental health nursing practice and the implications for mental health nursing. This literature review provides a background on the issues which have confronted people with a mental illness, the police, and mental health nurses.
2.2 The causes and treatment of mental illness

A historical review on the way in which mental illness has been thought about and treated incorporates a religious, social and medical perspective. During the Middle Ages (the 5th to the 15th century) emotional and psychological problems were viewed through the prisms of religion (Plante, 2005). People experiencing visions, hearing voices, or enduring seizures were seen as individuals troubled by either God or Satan (Plante, 2005). By blaming possession by a devil, curses, spirits, or witches, alleviation it was thought, would come through supplication to the Deity in the form of prayer, scripture reading and personnel admission of sin and guilt (Millon 2004; Rhi 2001)

The Middle Ages signified a time when people with bizarre thought and behaviour were generally driven out or excluded from community life, but during the Renaissance period (the 14th to the 17th century) they were confined (Plante, 2005). Mad persons had the right to be fed but were morally constrained and physically confined (Laffey 2003) in enormous institutions referred to as asylums (Harcourt, 2007). In these asylums the mad, the poor and various other deviants were confined. (Singh, Benson, Weir, Rosen & Ash, 2001; Harcourt, 2007).

By the eighteenth century, the hysterical outbursts associated with witchcraft and satanic possession subsided, lending credence to the belief that social rather than religious causes led to the maladies (Plante, 2005). Mental illness was defined by the social behaviour of the sufferer in most western countries and the appropriateness of behaviour depended on whether it was judged plausible or not according to a set of social and legal rules that defined the limits of appropriate behaviour and reality (Bolton, 2008; Sargent, 1994). Those who did not conform to the norms of society were placed in large institutions, variously labelled as madhouses and asylums. Even though asylums were originally based on the concepts and structures of moral treatment, they became large impersonal institutions overburdened with large numbers of people with a complex mix of mental and social-economic problems (Wright, 1997).
The late eighteenth and early nineteenth century became known as the era of moral treatment (Wright, 1997). Moral treatment consisted of placing persons in an environment that encouraged behaviour in line with accepted social standards and was pervaded by religious teachings (McDermott and Meadows, 2007). It was only during the early nineteenth century that mental disorders achieved the status of an illness, to be conceptualised, diagnosed and treated as other illnesses (McDermott and Meadows, 2007). The basis of scientific study gave increasing influence to medicine as a scientific practice and held hope that psychiatry as a branch of medicine could devise specialist medical treatment for the insane (McDermott and Meadows, 2007). Asylums came to be thought of not only as a place of confinement (Myers, 1998) but also a place with programs aimed at treating and rehabilitating sufferers. In addition, psychotropic drugs were coming into greater use and helped in the management of large numbers of people in crowded conditions (Shorter, 1997).

During the early 20th century the “mental hygiene” movement, originally defined in the 19th century in the United States, gained momentum and aimed to "prevent the disease of insanity" through guidance clinics and education (Mandell, 2007). With time the term “mental health” as opposed to “mental hygiene” became more popular (Reaume, 2002). Clinical psychology and social work developed as professions alongside psychiatry (Millon, 2004). By the turn of the 20th century a new form of therapy known as psychoanalysis came to the fore (Slater & Bremner, 2003). Sigmund Freud, a psychoanalyst, explained human behaviour in psychological terms and demonstrated that behaviour could be changed under carefully supervised circumstances (Slater & Bremner, 2003). Cognitive behavioural therapy, a psychotherapeutic approach that aimed to solve problems concerning dysfunctional emotions, behaviours and cognitions through a goal-oriented, systematic procedure was developed during this period (Slater & Bremner, 2003). The development of a new psychiatric manual for categorizing mental disorders, led to the first Diagnostic and Statistical Manual of Mental Disorders (DSM). The International Classification of Diseases (ICD) followed suit with a section on mental disorders (Mezzich, 2002).

A number of procedures were introduced mid-20th century for the management of patients with a mental illness and included compulsory sterilisations, lobotomies,
insulin shock therapy and electro compulsive therapy. Lobotomies, which were a
eurosurgical procedure, consisted of cutting the connections to and from the
prefrontal cortex, the anterior part of the frontal lobes of the brain to relieve the
symptoms of the disordered mind (Stone, 2001). Insulin shock therapy was a form of
treatment in which patients were repeatedly injected with large doses of insulin in
order to produce daily comas over several weeks to "jolt" patients out of their mental
illness (Jones, 2000). Electro convulsive therapy involved a treatment in which
seizures are electrically induced in anesthetized patients for therapeutic effect
(Cristancho, 2008). In addition, the neuroleptic chlorpromazine used for the
treatment of psychosis gradually came into use (Healy, 2005) during this period.
Through the 1990s, new selective serotonin reuptake inhibitors (SSRI’s) also known
as antidepressants became some of the most widely prescribed drugs in the world to
alleviate mood disorders (Anderson, 2002).

Currently, mental illness is thought to be caused by a combination of biological,
psychological and environmental factors (Tsuang, Bar, Stone, & Faraone, 2004).
Biologically, some mental illnesses have been linked to an abnormal balance of
special chemicals in the brain called neurotransmitters (Jafee & Price, 2007).
Neurotransmitters help nerve cells in the brain communicate with each other. If these
chemicals are out of balance or are not working properly, messages may not make it
through the brain correctly, leading to symptoms of mental illness (Jafee & Price,
2007). In addition, defects in or injury to certain areas of the brain have also been
linked to some mental conditions (Kaplan & Sadock, 1995). Neurophysiology, the
study of the nervous system indicates that there are disturbances in some brain
function of people suffering from schizophrenia (Harrison, 1999). Schizophrenia
involves and alteration of neural circuits which reflect altered cytoarchitectural,
biochemical and electro-physiological properties of neural systems (Harrison, 1999;
Kaplan & Sadock, 1995). Other biological factors involved in the development of
mental illness include genetics (heredity) (Faraone, Tsuang, & Tsuang, 1999). Many
mental illnesses run in families suggesting that people who have a family member
with a mental illness are more likely to develop a mental illness. Susceptibility is
passed on in families through genes (Faraone, Tsuang, & Tsuang, 1999). Mental
illness itself occurs from the interaction of multiple genes and other factors such as
stress (Tsuang, Bar, Stone, & Faraone, 2004). Psychological factors such as emotional, physical and sexual abuse and environmental factors such as living in poverty can influence, or trigger an illness in a person who has an inherited susceptibility to it (Tsuang, Bar, Stone, & Faraone, 2004).

This brief historical perspective on the causes and treatment of mental illness illuminates how people with mental disorders have been viewed and managed at different times in history. Mental disturbance came to be understood in terms of religion, as an outcome of social processes as well as being described as an illness. As psychiatric thought and practice progressed during the twentieth century largely through ideological changes, and the introduction of physical modes of treatment, there were changes to the understanding of mental illness. Mental illness, similar to other physical illness is now considered a disease, to be diagnosed and potentially cured.

2.3 Differences in the understanding of mental illness

While some differences in thinking still exists, the widely accepted view in the understanding, description and treatment of mental illness are very much a result of society’s increasing knowledge and greater conceptual sophistication (Mandell, 2007). In the last two decades much progress has been made in treating mental illnesses (Mandell, 2007) and as a result society has become more aware that many mental conditions can be effectively treated with one or a combination of medication, psychotherapy and other forms of treatment such as electro-convulsive treatment (Langlieb & Kahn, 2005).

It is now widely acknowledged that mental illness does exist (Mandell, 2007), and that mental illnesses are real, disabling conditions that affect all populations in the nation (Fryers, Melzer & Jenkins, 2003) but are as treatable if not more treatable than other illnesses such as diabetes, cancer or heart disease (National Alliance on Mental Illness, 2002), even though there remains a great deal of further research to be done on the causes and treatment of mental illness (Mandell, 2007). There is also increased recognition that when diagnosed early and treated properly, mental illness can be successfully managed and although some people may become disabled
because of a chronic or severe mental illness, many others fully recover and are able to successfully control their symptoms and live full and productive lives (Langlieb, 2005).

Some organisations such as The Anti Psychiatry Movement, The Recovery Movement and The Hearing Voices Advocates, have however challenged the reality of mental illness. Followers of the “anti psychiatry movement” have challenged the reality of mental illness by arguing that there is no such thing as mental illness because the very notion of mental illness was based on a fundamental mistake or set of mistakes (Foucault, Khalfa, & Murphy, 2006). This sort of view was most closely associated with Dr Thomas Szasz, an American psychiatrist, who as early as in the 1960’s claimed that psychiatric patients were not ill but were individuals that were misfits in society, and therefore put into asylums. Adherents of the “anti psychiatry movement” which began in 1961 often referred to the myth of mental illness, after Dr Thomas Szasz controversial book, “The Myth of Mental Illness” (Szasz, 1960; 1961).

Mental illness according to Szasz was not a real illness because it was typically identified by deviant behaviour and could not be validated by objective tests that demonstrated dysfunctions. Unlike physical illnesses, most mental illnesses have no physiological signs or symptoms and psychiatrists have no recourse to blood tests cytology or x-rays to determine the signs or severity of the illness (Dixit, 2005). Routine diagnostic practice in mental health services typically involves an interview (which may be referred to as a mental status examination), where judgments are made of the interviewee's appearance and behaviour, self-reported symptoms, mental health history, and current life circumstances. Szasz's position was challenged after it was argued that his views had not gained any widespread credence, given the progress of neuroscience and our increasing ability to affect emotions, thought, and behaviour through medication (Reznik, 1991). There was also the belief that psychiatry had, if anything, gained in scientific credibility in the thirty years since Szasz first proposed his critique (Reznik, 1991). The discovery of evidence suggestive of biological and genetic bases for some mental illnesses has also eroded support for the more extreme claims among portions of the anti-psychiatric
movement that mental illness was more a social label than a biological disorder, but such claims have persisted and the debate over the reality of mental disorders still continues (Ahn, Flanagan, Marsh Sanislow, 2006).

The concept of the recovery model to psychiatric disorders arose from the Consumer/Patient Movement, a grassroots self-help and advocacy initiative, particularly within the United States during the late 1980s and early 1990s (Repper & Perkins, 2006). The factors contributing to the evolution of the recovery movement in mental health, included the development of better-tolerated medications (Secker, Membrey, Grove, & Seebohm, 2002); a decline in the number of beds available for hospitalization and the resulting emphasis on community life (Repper & Perkins, 2006) and the desires of psychiatric consumers' to be more in control of their destinies (Davidson, Lawless & Leary, 2005). The philosophy behind the recovery movement varies widely from that of the medical model.

The medical model (US Dept of Health and Human Services and SAMHSA Center for Mental Health Services, 2004) proposes that ill individuals have biologically based disorders and that the primary goal of treatment is “cure” of the illness; and that the goal of treatment for more chronic disorders such as schizophrenia is the “control” of symptoms. Based on the medical model physicians and other medical personnel treat patients to achieve this goal. In contrast to the medical model, the recovery model proposes that at the most basic level, the center of care becomes an active “consumer” of services, not a passive “patient” to be treated (Glynn, Cohen, Dixon & Niv, 2006). The consumer is seen as a person, an equal if not a more important and necessary care team member, and not as a case or a static recipient of a care plan (Glynn, Cohen, Dixon & Niv, 2006). The consumer is viewed as a whole person with preferences, goals, and needs that drive and define care. Each consumer is understood to have a unique background, family constellation, and culture, which must also be acknowledged (Mulligan, 2003). Treatment goals emanate from the consumer and are conceptualized around community integration and enhanced functioning rather than just management of symptoms. Goals are skill, not deficit, focused (Fisher, 2005).
The Hearing Voices Movement was established in 1987 by Marius Romme, a professor of social psychiatry at a University in the Netherlands; and Sandra Escher, a science journalist, after they were challenged by a voice hearer as to why they could not accept the reality of her voice hearing experience (Romme, & Escher, 1989). In 1988, with the active support of Marius Romme, a self help user-run organisation known as The Hearing Voices Network was established in England for people experiencing auditory hallucinations (Martin, 2000). The philosophical trend of both organizations for voice hearers is on how people who hear voices are viewed. Even when members may have a psychiatric diagnosis, the group promotes an alternative approach, where voices are not necessarily seen as signs of mental illness. In their view, hearing voices are aspects of human differentness, rather than a mental health problem (James, 2001).

The argument put forward by both organisations is that some people can lead a valuable and productive existence while hearing voices, and therefore the largely drug-based and potentially coercive treatment of mainstream medicine might do more harm than good in people who can otherwise function adequately (James, 2001; Martin, 2000). The Movement has distanced itself from the psychiatric profession through its alternative philosophy approach and is critical of psychiatry in relation to the way the profession generally understands and treats people who hear voices (Bracken & Thomas, 2005). The Movement holds that their research has led them to the position that schizophrenia is an unscientific and unhelpful hypothesis which should be abandoned (Romme & Morris, 2007). The network has spread to other countries including Italy and Finland in 1995; Wales, Scotland, Switzerland, Sweden, Austria, and Germany in 1998; Norway, Denmark, and Japan in 1996; as well as Israel, New Zealand, Australia and the USA in 2006 (Rufer, 2007).

Understanding of mental illnesses is also shaped by cultural influences, and different cultures have different concepts of what constitutes a mental illness. Cross cultural studies indicate that mental disorders are found in all cultures but the way disorders are perceived and treated within communities varies (Kirmayer, & Young, 1999; Yang, Kleinman, Link, Phelan, Lee, et al., 2007). For example, in most of the non-western world, people with depression complain principally of physical ailments,
such as lack of energy, poor sleep, loss of appetite, and various kinds of physical pain (Tanaka-Matsumi, 2002). However, in the United States and other western societies, depressed people and mental health professionals who treat them tend to emphasize psychological problems, such as feelings of sadness, worthlessness, and despair (Rhi, 2001; Tanaka-Matsumi, 2002). In western society, someone who attempts suicide is likely to be diagnosed with some form of psychological problem (Rhi, 2001) whereas in Japan, suicide is in most cases, not considered problematic, but rather an honourable act committed to save face or for a noble cause (Tanaka-Matsumi, 2002). Similarly, in Islam while the Quran prohibits suicide, “suicide bombers” are not generally considered “suicides” by their zealous supporters – these people are seen as martyrs, prepared to give up their lives for their cause (Perlmutt, 2001). Anthropological work in non-Western cultures suggests that there are many cases of behaviour that psychiatry would classify as symptomatic of mental disorder, which are not seen within their own cultures as signs of mental illness (Rhi, 2001). Indeed, other cultures may not even have a concept of mental illness that corresponds even approximately to the Western concept. Therefore, in addition to biological, psychological and environmental factors, cultural and social influences do play important roles in the understanding of mental health, mental illness and service use (Rhi, 2001).

While different societies or cultures and even different individuals in society or in a culture can disagree as to what constitutes mental illness, people in all cultures may find some behaviour bizarre, or even incomprehensible, but what they feel is bizarre or incomprehensible is ambiguous and subjective. In addition, while the views of the anti psychiatry movement do offer credibility when challenging mainstream psychiatric thought and practice, including assertions that psychiatric diagnoses of mental illnesses may neither be real nor useful (O’Brien, Woods & Palmer, 2001; Weitz, 2003) what is now widely accepted and known, particularly in western society is that many mentally ill people, when treated, have improved significantly perhaps dispelling some of the assertions made by followers of the anti-psychiatry movement.
2.4 Deinstitutionalization of the mentally ill

During the 20th century, in Australia, the UK, and the USA, there was a growing trend emphasizing the care of the mentally ill at home and in the community. The emergence of the human rights movement, aimed at ensuring the civil rights of all citizens played a part in the move towards community treatment. The civil rights movements were critical of institutions and the role of medicine in practices associated with them which were seen as oppressive and abusive (McDermott & Meadows, 2007). In addition, the advent of antipsychotic medication, and changes in public attitudes were some of the other factors that provided the stimulus for the deinstitutionalization of the mentally ill and for major mental health care reform (Australian Institute of Health and Welfare, 2001; Lamb & Bacrach, 2001; Turner, 2004) which consequently led to the closing of many psychiatric hospitals, and what previously used to be called insane asylums (Madianos, 2002; McDermott & Meadows, 2007; Turner, 2004). The aim behind deinstitutionalisation was to provide an opportunity for better treatment and improved life chances for many mentally ill persons and it was based on the principle that severe mental illness should be treated in the least restrictive setting (Lamb & Bacrach, 2001).

Deinstitutionalization referred to the name given to the policy of moving severely mentally ill individuals out of large state institutions and then closing part or all of the institutions. Criticisms of public mental hospitals (Ash, Brown, Burvil, Davies, Hughson, et al., 2007), incorporation of mind-altering drugs in treatment (Stroman, 2003), recognition that mental illness could be treated in the community (Wilson, 1999), and state’s desire to reduce cost of mental hospitals (Smark & Deo, 2006) were some of the social forces that led to a move for deinstitutionalization.

Criticisms of public mental hospitals. In 1961 in Australia, there was an investigation by the Royal Commission Inquiry into allegations of cruelty and neglect of patients in mental hospitals. The inquiry revealed overcrowding, low levels of skilled staff to provide services and appalling conditions for both staff and patients (Ash, Brown, Burvil, Davies, Hughson, et al., 2007). Facilities were overcrowded, and patients' lives in institutions were so regulated that they had little opportunity to make any of their own choices about routine, clothing, and food or comfort (Wright, 1997). The
Royal Commission Inquiry heralded the way for major reform of psychiatric services in NSW and the principles of decentralisation and community orientation were promoted. During the 1960’s and 1970’s in Australia, there was also a growing impetus to protect the civil rights of the mentally ill, largely because of reports of bad conditions in mental institutions.

The Role of Pharmacotherapy and Deinstitutionalization. During the 1950s, many new drugs became available and incorporated into therapy for the mentally ill (Stroman, 2003). There were significant outcomes achieved in the development of medication for people suffering from schizophrenia, depression and bipolar mood disorders which enabled people experiencing mental disorders to spend less time in hospital and then only for brief rather than long term admissions (Ash, Brown, Burvil, Davies, Hughson, et al., 2007). The introduction of lithium by John Cade in Australia, was widely adopted in the 1960’s after it was found to be effective in maintenance treatment of bipolar disorders (McDermott & Meadows, 2007). In 1952 in France, chlorpromazine was reported as the first effective antipsychotic in treating psychosis (Colosanti, 2000) and in 1957, the antidepressant effect of imipramine was reported and in the same year the benzodiazepine tranquillisers were synthesised (McDermott & Meadows, 2007). In recent years there have been significant additions to the range of drugs available, many of which have similar effectiveness to the older drugs but with fewer side effects (McDermott & Meadows, 2007). These new drugs were effective in reducing severe symptoms, and which allowed people with mental illnesses to live in communities ranging from their own homes to halfway houses (Stroman, 2003).

Recognition that mental illness could be treated in the community. The effort to deinstitutionalize people with a mental illness, received strong encouragement from advocates of community psychiatry (Wilson, 1999). The aim behind community mental health centres was to provide rehabilitation, counselling and public awareness activities, as well as the development of a number of other initiatives, such as community based services, care givers groups and volunteer movements, thus facilitating the broad basing of mental health services (Fossey, Grigg, Minas, Leggatt, Mcdonald & Meadows, 2007). Policies of deinstitutionalisation sought to
achieve community care in conjunction with two other related policies: mainstreaming, which aimed to provide services for mentally ill people in general hospitals and as part of the general health services with the aim of bringing psychiatric services out of isolation and thereby reducing the stigmatisation of the mentally ill person; and community care, which centred on a caring community supporting sufficient ongoing funding to provide services to enable and support people with mental illness within the community (Wilson, 1999).

Governments desire to reduce cost and spending on hospitalization. From an Australian perspective it was in the interests of the State Governments to move patients out of the State-funded mental hospitals and onto other (federally funded) benefit schemes such as the disability pension or unemployment benefit (Smark & Deo, 2006) largely because the Federal government’s limited universal health care in the 1940’s did not include mental health care (Smark & Deo, 2006). Even after reports identified overcrowding and poor conditions in state mental hospitals in 1950 (Pargiter, 1991) the grants issued by the Commonwealth Government to the various states to improve the worst of their mental hospitals did offer some help towards capital works on mental hospitals but not for the actual ongoing maintenance costs of psychiatric patients (Lewis, 1988). Furthermore, as hospitalization costs increased due to improvements advocated by civic groups, there was motivation to find less expensive alternatives to hospitalization. Community services it was argued would be cheaper and more cost effective (Goetz, Cutler, Pollack, Falk, Birecree, et al., 1998) motivating governments to promote deinstitutionalization.

The emergence of the human rights movement, the advent of antipsychotic medication, and changes in public attitudes were some of the numerous factors that provided the stimulus for the deinstitutionalization of the mentally ill which consequently led to the closing of many psychiatric hospitals. In recognition that mental illness could be treated in the community, deinstitutionalisation did receive a lot of strong advocate support. Often linked with terms such as mainstreaming and community care, it was thought that deinstitutionalisation would provide an opportunity for better treatment and improved life chances for many mentally ill
persons and reduce the stigma and isolation that people with a mental illness had endured through institutionalised care.

2.5 The consequences of deinstitutionalization

Deinstitutionalization was implemented with some of the best of intentions for people with a mental illness (Krieg, 2001) but a number of unintended consequences accrued affecting many people in society, in particular those with a mental illness, as well as members of the community. Some of the negative consequences of deinstitutionalisation were attributed to continued community stigmatisation, and limited access to and availability of services, thereby leading to an increase in contact between police and people with a mental illness.

Continued community stigmatisation. Mental illness has always been a globally stigmatized condition (Beson, 1994; Hinshaw & Cicchetti, 2000; Rose, Pinfold, Kassam, 2007; Thornicroft, 2006) and with limited support systems in place, public stigma was frequently encountered by persons with a mental illness (Crisp, 2001), despite some of the advances made in the understanding and treatment of mental illnesses (Hinshaw, & Cicchetti, 2007). Discrimination in housing, education and employment and increased feelings of hopelessness were also some of the negative consequences associated with the stigma of mental illness (Byrne, 1997). Moves to community living and services led to various concerns and fears, from both the individuals themselves and other members of the community. An Australian survey (SANE Australia, 2000) of people with mental illness and their families reported that less stigma was the number one thing that would make their lives better. They wanted healthcare workers who “treated them with more respect”, who “would appreciate just how far a little kindness goes”, and a community that “would understand that we are not lazy or weak” and that recovery was not simply a matter of “pulling yourself together” (Hocking, 2003, p.47). In 2000, results from a prospective two-year American study of patients discharged from a mental hospital showed that stigma was a powerful and persistent force in their lives, and that experience of social rejection were a persistent source of social stress (Wright, Gronfein, & Owens, 2000). Mental illness has often generated misunderstanding, prejudice, confusion and fear and some people with mental illness have reported that
the stigma can at times be worse than the illness itself (Jorm, 2000). Efforts to reduce stigma through public education campaigns have been run through the media, to challenge the stigma associated with mental illness. Other strategies have included ensuring that journalists have access to accurate, up-to-date information so that reports will not unintentionally reinforce negative stereotypes (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000).

Limited access to and availability of services. While most people with a mental illness benefitted from the increased freedom associated with deinstitutionalization (Krieg, 2001), in the absence of sufficient planning for alternative care with adequate resources (Drake, Green, Mueser, & Goldman, 2003), there were many of the more severely ill who did not receive adequate care (Cutler, Bigelow, Collins, Jackson & Field, 2002). In NSW community mental health programs were established by the mid 1970’s but due to the availability of limited services, the needs of those with persistent and long term mental illness was not met (Rosen and Weir, 2007). In most developed countries, the process of deinstitutionalisation was not accompanied by corresponding supports for mentally ill people to live in the community which left many people with serious illnesses without the help that they needed and deserved (Fahy, Bermingham, & Dunn, 1987; Fahndrich & Neumann, 1999; Sharfstein, 2000; White, Roy & Hamilton, 1997). While the social philosophy underlying community mental health emphasised better access to high-quality care and the allocation of more resources to community treatment, in reality, the increasing scarcity of these resources meant that many people had limited access to community mental health care (Fahy, Bermingham, & Dunn, 1987; Fahndrich & Neumann, 1999; Sharfstein, 2000; White, Roy & Hamilton, 1997).

In 1982 an inquiry into Health Services commissioned by the NSW Government and conducted by Mr David Richmond highlighted the lack of psychiatric services and the funding imbalance between psychiatric hospitals and community services. The Richmond Report as it became known provided a basis for reform and an impetus for national reform (Rosen and Weir, 2007) and was heralded as a major attempt to define future mental health services (National Health Strategy, 1993). Ten years later though, the Burdekin Report, named after the Human Rights Commissioner who
conducted it, outlined the implications for the failure of community care in his 1993 Human Rights and Mental Illness Report (Australian Government Publishing Service, 2003). The Burdekin Report outlined what it termed “the extensive implications of such an inadequate system of community care”, and analysed in detail the complex plight of the mentally ill within the community (Burdekin, 1993). In April 2003 the Mental Health Council of Australia (MHCA) released its “Out of Hospital, Out of Mind” Report, in which it demonstrated the disparity between mental health care policy initiatives and policy implementation across Australia - a disparity that resulted in limited access to and availability of services for those with mental illness (Mental Health Council of Australia, 2003).

This was indication of a mental health crisis in Australia, despite the implementation of two national mental health plans (Australian Health Ministers, 1992; 1998) and decades of changes to public mental health services. The feeling amongst individuals, patients, families, carers and support groups from all around Australia was that the care of mentally ill individuals was a disgrace (Ellingsen, 2005). The experience of these groups was backed up by reports into the state of mental health nationwide, such as the “Not for Service” (2005) report. One of the main problems highlighted in the report was that there were not enough mental health services to meet the needs of patients. Resources for effective community care were reportedly so limited that rationing had to be tightened to extreme degrees resulting in only the most severely ill patients being offered treatment (Mental Health Council of Australia, 2005).

Increased contact between police and people with a mental illness. Limited access to and availability of services to meet the needs of people with a mental illness in the community raised other issues of concern, notably the increased involvement of police in mental health (Wylie & Wilson, 1990). While the involvement of police in mental health has received little attention in the Australian literature, American studies have indicated that as the number of individuals with mental illness residing in the community increased, so too did contact between police and individuals with mental illness (Lamb & Bachrach, 2001; Lamb, Weinberger & DeCuir, 2002), with some earlier studies suggesting a dramatic increase in contact between police and
persons with mental illness (Finn & Sullivan, 1989; Steadman et al., 1986). While mental illness was not, in and of itself, a police problem, it would seem that a number of the problems caused by or associated with people with mental illness often did become police problems (Cordner, 2006). Considering that the core responsibility of the Police Force is for public safety, risk assessment, and prevention of and response to criminal activity (NSW Mental Health Emergency Response, 2007), it is reasonable then to question the involvement of police in the lives of people with a mental illness given that they are not expected to be involved in the lives of people experiencing other illnesses such as diabetes, an illness that causes significant adversity if not treated. The rationale behind police intervention in the lives of persons with mental illness derives from two common-law principles: the power and authority of the police to protect the safety and welfare of the community, and the state's paternalistic authority, which dictates protection for citizens with disabilities who cannot care for themselves, such as those who are acutely mentally ill (Lamb, Weinberger, Walter et al., 2002; Teplin, 2000). Often both principles are involved when police are dealing with persons with mental illness who pose a threat of danger to the community or to themselves (Lamb, Weinberger, Walter et al., 2002).

Despite ambivalence amongst officers about their involvement in dealing with mental health issues the police became the only emergency response agency for the public to turn to in times of crises involving people with a mental illness, irrespective of the type of crisis. In 2005, an Australian Police Journal indicted that police by virtue of their position became, albeit reluctantly, the front line responders in terms of care for people with severe mental illnesses (Carroll, 2005).

Deinstitutionalisation may have resulted in the freedom of persons with a mental illness however, for many individuals who were institutionalised for years, the expectation that community care would lead to fuller social integration did not materialize as it was hoped. Without the appropriate support from community support services, mentally ill individuals released from institutionalized care faced numerous obstacles including public stigma, limited access to services and an increase in interaction with local law enforcement in the community.
2.7 Police powers under mental health legislation

By the early 1980s police were given significant operational policy roles to work with under mental health legislation in most developed countries, when they came into contact with people with mental health problems.

In the United Kingdom for example, two significant pieces of legislation shaped the role that police performed in situations involving their encounters with the mentally disturbed: The Police and Criminal Evidence Act, 1984 and the Mental Health Act, 1983 (updated to the Mental Health Act 2008). In NSW, the 1990 Mental Health Act formed the policy and legislative foundation of the way police worked with people with mental health problems (updated to the Mental Health Act 2007). Under mental health legislation police involvement in the mental health processes varied from general powers and provisions of support such as: to medical practitioners and hospitals both in private and public practice; to mental-health agencies in carrying out treatment orders; and patient security escorts from field situations to health facilities; to even more specific powers and direct intervention under certain section of the Act. Section 22 of the 2007 NSW Mental Health Act gives police officers the authority to take a person to a mental health facility against the person’s will if the person appears to be “mentally ill” or “mentally disturbed” and the officer believes, on reasonable grounds, that: the person is committing or has recently committed an offence; the person has recently attempted suicide; or it is probable that the person would attempt to kill himself or herself or another person, or attempt to cause serious physical harm to himself or herself or another person, and it would be beneficial to the person’s welfare to deal with the person under the MHA rather than otherwise in accordance with law (Mental Health Act, 2007). Of interest the Mental Health Act 2007 makes no reference in relation to substance use apart from Section 68 of the Act which sets out principles for the care and treatment of patients on a community treatment order in relation to counselling for illicit drug use. Yet the use of illicit substances and alcohol is highly associated with police referred patients (Kneebone et al., 1995; Redondo et al., 2003) many of whom are admitted as a result of their presentation. Given that the consumption of illicit substances and alcohol is not in itself a sign of mental illness one can assume that for safety reasons patients presenting at risk to themselves or others while under the influence are referred by
the police and admitted by the medical officer until they have sobered up. Discharge back into the community is considered following a review by a doctor and after the doctor is satisfied that the patient is no longer in need of detention in a mental health facility for reasons of safety.

With the powers afforded to police under mental health legislation they became an integral part of the mental health system in most industrialised countries (Fry et al, 2002; Lamb et al., 1995; Spurrell, M., Hatfield, B., & Perry; Watson et al, 2008) and earned themselves titles such as “street corner psychiatrist”, “psychiatric medics”, “forensic gatekeepers” and “amateur social workers” (Teplin & Pruett, 1992). These roles took the form of “front line mental health worker” (Green, 1997). In this role as front line mental health workers, the police exercised a tremendous amount of discretion when they apprehended someone they perceived to be mentally disturbed and decided between bringing charges or taking to hospital (Whitmer, 1980; Teplin, 1983).

In Australia to formally entrench a partnership arrangement between the states health and law enforcement system, a Memorandum of Understanding (MoU) was developed so that a formalised system of co-operation between the two departments (police and health) existed, particularly for responding to, and interacting in, mental-health crises (NSW Department of Health, 1998). In NSW, the MoU provided a framework for applying Section 22 of the Act (Carroll, 2005). Fourteen indicators were outlined to assist police when considering whether to refer a person to hospital or to charge them with a criminal offence. These indicators amounted to a mental status examination including an assessment of mood, delusions, perceptual distortions, sleep and appetite disturbance, suicidality and behavioural disorganization (NSW Centre for Mental Health, 1998). Given that the police had no adequate knowledge or training to perform this assessment there were concerns expressed by members of the law enforcement system in relation to their ability to perform a mental state examination using the indicators as a guide. In 2007 the new Memorandum of Understanding – Mental Health Emergency Response superceded the 1998 Memorandum of Understanding and the Flow Charts of the 2002 Memorandum of Understanding. The MOU facilitated this purpose by defining clear
roles of agencies in line with the legislative framework including the use of an Overarching Response Flow Chart that outlines the core roles of each agency at points in the flow chart (NSW Department of Health, 2007). Risk assessments are conducted with reference to the Multi Agency Risk, Information and Assistance (MARIA) Guideline. The MARIA Guideline provides a common inter agency guideline for use during the “Community Response and Initial Assessment” phase of the patient’s journey and is used for assessing the risk inherent in situations and indicates the agency presence or involvement. The MARIA Guideline indicates minimal agency presence and it is considered appropriate to request additional agency attendance where services are available, for example, where mental health extended hours and crisis services exist, meaning that these resources may be called upon to assist on site in the community (NSW Department of Health, 2007).

The broad powers afforded to police under mental health legislation shaped the role of police in mental health. They became a vital link in the mental health system with a continued formalised involvement in the provision of mental health care for a varied group of people within society that included the apprehension of persons they perceived to be mentally disturbed and the referral of the person for a mental state assessment against the persons will.

2.8 Police response to mental health crises

The involvement of police in issues of mental health is extensive but the role most commonly associated with police in regards to mental illness concerns their involvement in the management of persons experiencing a mental health crisis (Lamb et al., 2002; Sced, 2006). While most contact between police and mentally disturbed persons in crisis have reportedly been handled without incident (Deane, Steadman, Borum, Veysey, & Morrissey, 1999; Janik, 1992), police interactions with people with mental illness have also been known to be dangerous to police as well as to individuals who are mentally disturbed (Borum, Deane, Steadman, & Morrissey, 1998).

According to the Victorian Department of Health Information (2008), a mental health crisis describes a situation where a person with a mental illness or severe
mental disorder experiences thoughts, feelings or behaviours which cause severe
distress to him/her and those around him/her requiring immediate psychiatric
treatment to assess and manage risk and alleviate distress. The acute stage of a
mental illness is characterised by infrequent yet severely distressing symptoms that
require immediate treatment. This may be the person’s first experience of mental
illness, a repeat episode or the worsening of symptoms of an often continuing mental
illness. A mental health crisis can occur within the context of a pre-existing mental
illness, in response to an extreme traumatic event, and/or as the result of drug or
alcohol consumption and is often associated with extreme levels of distress, and a
high risk of suicide or harm to others (Sced, 2006). As first line responders to mental
health crises police have a duty to intervene in situations where a person is at risk of
harming themselves or others. Studies in Australia and the USA found that police
spent about 10% of their time attending to mentally disturbed individuals with
mental health problems, with 60% of officers responding at least once a month to a
mental health crisis (Fry et al, 2002; Swanson et al, 2001; Watson et al, 2008). The
only research study conducted in country NSW found that 76 % of the police had
direct contact with a mentally disturbed person at least on a monthly basis (Buss,
1995).

By 2004, in New South Wales alone, police responded to 18,000 calls involving
individuals with mental health problems (Silva, 2005) equating to almost 50 calls per
day (Sced, 2006). Concern has been expressed that the presence of a police car or an
officer in uniform also has the potential of escalating a mental health crisis (Sced,
2006). Police themselves have acknowledged that it is common for people suffering
from a mental illness, or acting irrationally, to feel threatened when confronted by
police officers (Carroll, 2005).

A significant number of critical incidents and police shootings have involved
mentally disturbed persons with some police being attacked and sometimes killed by
people in desperate need of medical help. In the United States, for example, 982 of
58,066 police officers assaulted in 2002, and 15 of 636 police officers feloniously
killed from 1993 to 2002, had “mentally deranged” assailants (Federal Bureau of
Investigation, 2004).
The additional argument, in light of these critical incidents, is that encounters with police are also dangerous for people with mental illness. An American study indicated that an average of nine New York City police shootings per year between 1971 and 1975 involved emotionally disturbed people (Fyfe, 2000). Between 1994 and 1999, Los Angeles officers shot 37 people during encounters with people with mental illness, killing 25 (Meyer and Berry, 1999). A review of shootings by the police from 1998 to 2001 in the United Kingdom indicated that almost half (11 out of 24) involved someone with a known history of mental health problems (Dowd, 2004). It was estimated that people with severe mental illness were four times more likely to be killed by police than those without a mental illness (Treatment Advocacy Center, 2005a).

In Australia, a review of fatal police shootings found that just over half (53%) of all fatal shootings by Victoria Police between 1990 and 2004 involved individuals with a mental health problem (Brouwer, 2005). In the majority of incidents, police officers were reportedly the target of some type of threatening behaviour immediately prior to the shooting (Dalton, 1998). While this does not reflect the number of mental health crises attended by police that do not result in the use of force Sced (2006), it does highlight the risks associated with police responding to mental health crises.

While police are expected to respond to individuals experiencing a mental health crisis, without a clear understanding of mental illnesses or with the belief that an individual is resisting apprehension under his or her own freewill, it is possible those police officers may handle the individual with force. This has the potential of placing police officers and mentally disturbed persons at great risk of personal injury, in addition to increasing the likelihood that excessive force will be needed.

2.9 Police training in mental illness

Although relevant sections of the Mental Health Act have given police broad powers to refer persons they perceive to be mentally disturbed for emergency examination and hospitalisation, Australian Police (Fry et al., 2002; Springvale Monash Legal Service, 2005) as well as police in other countries (Borchmann, 2010; Lamb, 2002) have expressed concern that they do not have the adequate knowledge and training to
perform a mental state assessment. The police are not formally trained to recognize and assess mental illness.

An Australian research study by Fry et al, (2002) examined the relationship between mental health services, the police and mentally disturbed people by carrying out a survey of police officers from three police stations in Sydney, NSW. Similar to the findings of international studies (Cotton, 2004; Teller, Munetz, Gil & Ritter, 2006) the study identified that police experienced major concern in the management of mentally disturbed people. Part of the difficulties related to inadequate training and education for police officers in mental health. Recommendations made by the authors of this study included education for police officers and collaborative working relationships between police and mental health professionals which it was argued had the potential to improve the care of mentally disturbed people in the community. The findings from this study that the knowledge and skills demonstrated by police in relation to mental health were mostly acquired through on the job experience (Fry et al, 2002) raised several concerns about police involvement with mentally disturbed people.

First, without training in mental health, great concern was expressed that mentally disturbed people and mental health services will continually be viewed as undue burden on law enforcement agencies (Gillig, Dumaine, Stammer, & Hillard, 1990) because most officers feel poorly equipped to handle these individuals. Second, there was concern that dealing with people with a mental illness was a common event for police (Alexius, 2002; Redondo et al, 2003). In the absence of necessary training in mental illness, (Fry et al, 2002; Lamb, et al, 2002) the other concern was that the police could have seen a psychotic individual whose behaviour was determined by delusions as no different to the criminal who used violence to achieve his or her own objectives (Reuland & Cheney, 2005). It was likely possible that when police officers handled some situations involving mentally disturbed persons, that they would not have always realized that mental illness was involved (such as a shoplifting or a disorderly person) which would have led to them trying to handle the situation as usual (by giving directions, issuing commands, or making an arrest, for example) but not getting the cooperation or compliance expected, sometimes leading
to escalating tension (Cordner, 2006). Mentally disturbed people, especially when in crisis, respond differently to perceived threats but police officers may not be aware of those differences that require them to act in such a way that the situation is brought under control and not made worse (Reuland and Margolis, 2003).

In view of these concerns some critics have called for a reduction in interaction between police and the mentally disturbed. For example, the Task Force Victor report, a 1994 Australian Institute of Criminology study into shootings of the mentally ill by Victoria Police has suggested “that there should be a reduction of interaction between police officers and the mentally disturbed and that contact between police officers and the mentally ill should be kept as low as possible” (McCulloch, 2001 p.205). This view however, neglects to take into account that the police are expected to respond to crisis calls from homes or other sites in the community and are therefore the first line of contact for people who are mentally ill, victims of crime, domestic disputes, socially deprived or for those who are in crisis (Kneebone, Rogers & Hafner, 1995; Meadows et al., 1994; Turner, Ness & Imison, 1992). These important concerns do however highlight the need for police training in mental illness recognition as well as crisis management techniques for all police officers in light of the view that they have to deal with hundreds of incidents involving mentally disturbed people. This makes police training, in dealing with the mentally ill, vitally important.

2.10 Initiatives to improve police response to individuals in crises

In response to the numerous problems that police have encountered during incidents involving interaction with persons with a mental illness, particularly in relation to the use of force, a number of law enforcement agencies, some in collaboration with mental health services have developed specialized approaches or initiatives designed to improve police responses to individuals in crisis.

Earlier specialized response approaches in the USA have included one of the three following programs (Deane et al., 1999): Police-based specialized police response; Police-based specialized mental health response; and Mental-health-based specialized mental health response. The Police-based specialized police response
model involved sworn officers with special mental health training, serving as the first-line police response to mental health crises in the community and acting as liaisons to the formal mental health system. In the Police-based specialized mental health response model, mental health professionals were employed by the police department to provide on-site and telephone consultations to officers in the field. In the Mental-health-based specialized mental health response model, partnerships or cooperative agreements were developed between police and mobile mental health crisis teams (MCTs) to exist as part of the local community mental health services system and operate independently of the police department.

In more recent years in the United States, the Crisis Intervention Team (CIT) model of police-based intervention with behavioural crises was developed. The CIT developed out of a community response to a shooting event which resulted in the death of an individual with a history of mental illness and substance abuse (Cochran, Deane, & Borum, 2000). The CIT model focused on the need for advanced training and specialization for patrol officers, immediacy of the crisis response, emphasis on officer and citizen safety, and proper referral for those persons in crisis (Dupont & Cochran, 2000). CIT has reportedly positively influenced officer perceptions about people with mental health problems, decreased the need for higher levels of police intervention, decreased officer injuries and redirected those in crisis from the criminal justice to the health care system (Reuland, 2004).

Since its inception in 1987, the Crisis Intervention Team (CIT) has become one of the most popular US law enforcement initiatives of its kind (Cochran et al., 2000) and has been adopted by an estimated 400, or more, jurisdictions throughout the United States (Reuland, 2004) and is spreading to other countries including Australia (Steadman et al., 2000). The success associated with programs such as the CIT have demonstrated that with knowledge and skills the police are better equipped to deal with individuals experiencing an emotional, psychological or behavioural crisis (Cochran et al., 2000; Steadman, Deane, Borum, & Morrissey, 2000).

The benefits of the development of initiatives such as the CIT is that people with a mental illness have a better chance of receiving the care they need, police officers
have a better understanding of mental illness and how it affects someone’s behaviour and mental health clinicians can be almost certain that the person being referred by police is someone most likely to benefit from treatment and hospitalisation.

2.11 Police as a referral source

The police are generally the first to encounter mentally disturbed individuals in the community; therefore, they serve as one of the primary sources of referral for psychiatric assessment in most industrialized countries (Dunn & Fahy, 1987; Meadows et al., 1994; Pogrebin & Poole, 1987). A literature review of US studies found that 7 to 34% of psychiatric emergency referrals came from police over the period 1971-1991 (Way, 1993). A more recent North American study by Redondo and Currier (2003) found that police referred 26% of all patients. Other figures in the USA suggest that up to one-third of all emergency mental health referrals are made by the police (Dossche & Ghani, 1998). The reported percentages of referrals by police to psychiatric emergency services in Europe and the UK are comparable (Fahndrich, 1999, Rijnders et al., 1995, Stefanis, 1999). A retrospective study by Fry & Brunero (2005) of mental health referrals to an Australian emergency department (ED) found that 18% of patients were referred by the police.

While police have the power to refer persons for a mental health assessment, they have expressed frustration that in practice, their options in the referral of persons with mental health problems to mental health facilities are limited, because initiating an emergency referral to hospital is often fraught with obstacles, particularly in relation to the legal difficulties of obtaining commitment or treatment from the mental health system for persons they perceive to be mentally ill (Steadman, Morrissey, Braff & Monahan, 1986; Steadman, Braff, & Morrissey, 1988; Way, Evans, & Banks, 1993; Teplin, 2000). Police have also expressed frustration about spending long periods in the emergency room away from their regular patrol duties, and having their referrals refused admission because of inconsistent or unmet criteria for emergency treatment (Steadman, Stainbrook, Griffin, Draine, Dupont, et al., 2001).
American police have also reported feeling “unfairly criticised” by mental health professionals (Gillig et al., 1990, p. 663) because their referrals are viewed as the most undesirable and least likely to result in admission. However, American studies investigating referrals from the police have varied in their findings on admission rates. Some studies have found: that patients referred by police were more likely to be hospitalized, when compared to non police referred patients (Sales, 1991; Watson, Segal & Newhill, 1993); that there were no differences in the admission rates between police and non-police referrals (Redondo et al., 2003); and that police referrals were less likely to result in admission to hospital (Steadman et al., 2000). The counter argument from mental health professionals, in light of the perceptions of police that their referrals are least likely to result in admission, is that police have a high expectation that once a referral is made, the mental health team will take over the case (Fry et al., 1999). The emphasis from mental health professionals are that all police referrals to emergency services are offered a psychiatric assessment, but the decision to admit a person is based on clinical judgment by the acute mental health team, so even though danger to others or self may be a chief criterion for police referral and admission to state hospitals, this may not necessarily denote mental illness (Kessell, Catalano, Christy, & Monahan, 2006; Kneebone et al., 1995; Steadman et al., 1988).

In more recent studies it is encouraging to note that police officers have expressed compassion and understanding of people with mental disorders and reported that they have an appropriate and sometimes positive role with them and in working with mental health services (Mclean & Marshall, 2010). However, police perceptions of persons requiring admission to mental health services may differ from that of mental health professionals, and consequently not everyone referred by them may be accepted for admission to a mental health facility.

2.12 A profile of police presentations to health care facilities

A number of studies undertaken in a variety of countries have examined the demographic and clinical characteristics of police referrals to health care facilities. While different countries have employed different legislative procedures, a major reason identified for the referral of patients by the police was the potential for self
harm or harm to others (Citrome & Volaka, 1999; Kneebone et al., 1995; McNiel et al., 1991). However, studies examining police presentations to health care facilities have varied in their findings on the demographic and clinical information on patients referred by the police.

Younger age (Fry & Brunero, 2005; Kneebone et al., 1995; Lee et al., 2008; Steadman et al., 1986) unemployment (Lee, Brunero, Fairbrother & Cowan, 2008; Kneebone et al., 1995) single (Kneebone et al., 1995) and male (Dunn & Fahy, 1990; Fry et al., 2005; Kneebone et al., 1995; Redondo et al., 2003; Sales, 1991; Way et al., 1993) were patient demographic characteristics significantly associated with police referrals. Soyka (2000) suggested that the reasons for the gender predominance may have been related to the level of violence and symptom severity present among males. However, these findings have not been consistent across studies (McNiel et al., 1991; Steadman et al., 1986).

Research studies in the USA have also identified particular risk factors to be more prevalent amongst police referred presentations. A North American study by Redondo et al., (2003) found that police referred admissions were more likely to be violent when compared with non-police referrals. A comparison of youths referred by the police to those referred by other means to a North American ED found that domestic violence, assaultive behaviour and destructive behaviour, were significantly higher in the police referred group (Evans & Boothroyd, 2002). A North American study by Watson, Segal and Newhill (1993) compared police and non-police referrals in nine emergency services in California and found that patients referred by police were more likely to be more dangerous to others but no more likely to have a criminal record than patients not referred by police.

North American studies have also identified that police referred admissions were more likely to have psychosocial problems (Redondo et al., 2003), alongside poor caregiver competence ratings, substance abuse, and high ratings of severity of symptoms (Evans & Boothroyd, 2002) and were more likely to be psychiatrically disturbed, and more gravely disabled than those (Watson, Segal & Newhill, 1993) not referred by police.
A retrospective study by Fry and Brunero (2005) of mental health referrals to an Australian emergency department (ED) found that the predominant problems experienced by the police referred patients were schizophrenia, psychotic episode and suicide risk. An Australian study by Lee, Brunero, Fairbrother and Cowan (2008) found that police presentations were likely to have past and present alcohol and drug use, and be admitted to the hospital as a result of their presentation. A study by Kneebone et al., (1995) on police referrals to a psychiatric hospital in Australia found that when compared with the non-psychotic patients, the psychotic patients had longer admissions and after discharge relapsed more rapidly. An Australian study by Meadows et al., (1994) on police referrals to a psychiatric hospital found that the most common reasons for referral was situational crisis (29%), self harm (28%), and schizophrenia (18%).

While the number of studies examining the characteristics of patients referred to psychiatric emergency services by police have accrued in more recent years, the magnitude and direction of these differences has not been consistent across studies. In addition, it remains unclear whether the demographic and clinical findings of patients referred by the police were distinct and different to those referrals from other sources, such as families and friends, mental health professionals and mental health facilities and other health care professionals. Therefore, a need exists for more studies to be conducted into the characteristics of patients referred by the police.

2.13 Changes in the focus of acute inpatient units

During the 1990s major changes to the delivery of mental health in most western countries shaped a new era in mental health care reform. Following on from the movement of deinstitutionalisation, the functions and focus of acute inpatient mental health units were reshaped and consequently impacted on traditional mental health nursing practice (Cleary, 2004).

The release of a large number of patients into the community under the care of community mental health services significantly changed the delivery of traditional mental health care particularly in acute in-patient units. Traditionally, mental health nursing practice was based on the concept of the therapeutic nurse-patient
The concept of the therapeutic nurse-patient relationship received a lot of attention in the psychiatric literature ever since the book Interpersonal Relationship in Nursing was first published in 1952 (Peplau, 1952). The therapeutic nurse-patient relationship was considered to be the essence of mental health nursing (Williams & Irurita, 1998) and one which through its support brought about insight and behaviour change in the patient (Fontaine, 2003; Peplau, 1988; Stuart, 2001; Thelander, 1987). In practice this one-on-one relationship meant that the nurse had to engage with the patient in a positive and collaborative manner that empowered the patient to draw on their inner resources to recover (Forchuk, 1999). The theory of interpersonal relations (Peplau, 1952) provided the basis for one of the most significant theoretical frameworks for application in nursing practice (Ryles, 1998) and while it was described as useful in all areas of nursing practice it was found to be especially relevant in psychiatric nursing because of the problems psychiatric patients generally experienced with communication and in relatedness to people (Peplau, 1992).

The expectation in the application of the theory of interpersonal relations to practice was that within the interaction of nurse with patient, the work which the patient did through support by the nurse contributed toward the solution of the patient’s health problems (Peplau, 1952). Relationships with patients were considered to be fundamental to the practice of mental health nursing (Wright, & Giddey, 1993) and in contrast to other nursing sub-specialties, the one-on-one work within the therapeutic relationship was considered the distinguishing characteristic of mental health nursing (O’Brien, 2001). However, given the changes brought about by reforms, and the impact this had on traditional mental health nursing practice, mental health nurses were expected to adjust their practice to accommodate for the changes in service delivery even though there was uncertainty regarding what constituted mental health nursing practice (Hostick, 1998) as it had not been redefined within the changed context of service delivery (Cleary, 2003).

The expectation of acute in-patient units was that systematic assessment and short-term intensive management had to be provided as part of a continuum of care for those people who were unable to be treated adequately in community settings (NSW
Health Department, 1998). Within the context of a “systematic assessment and short-term intensive management” was the implication that treatment in acute in-patient facilities in New South Wales had to be directed towards symptom reduction with the expectation that improvement will occur within a much shorter time frame. According to Cleary (2003) these changes in the focus of care had “a significant impact on the care provided to mental health consumers as well as those involved in service delivery, in particular, mental health nurses in acute in-patient facilities, who have witnessed first-hand the reluctant chaos” (p.139). The “chaos” largely related to the complexities associated with the way nurses and patients interacted in the acute in-patient psychiatric environment following changes to the focus of in-patient units (Cleary, 1999, 2003a, 2003b, 2004; Fisher, 2007), some of which related to the following: the use of hospitalization for safety reasons; an increase in patient acuity and a decrease in the length of hospital stay; the demand for in-patient beds; and contradictions in the provision of care and enforcement of control.

The use of hospitalization for safety reasons: The use of hospitalization for safety reasons under mental health legislation changed the profiles of patients presenting to admission units and created nursing responsibilities in relation to the protection of the patient and others (Delaney, Cleary, Jordan & Horsfall, 2001; Fisher, 2007; Owen, Trantello, Jones & Tennant, 1998a; 1998b). For example, the requirement of dangerousness as a criterion for involuntary civil commitment posed a challenge for nurses in the delivery of traditional mental health nursing. Within the context of patient profiles, the major contributor identified as impeding the development of therapeutic relationships included unsociable or violent behaviour. Concern was expressed that mental health nurses were taking on the role of “de facto police” (Fisher, 2007). Fisher argued that “mental health nurses become de facto police when they are expected to control the violent behaviour of people presented by police (p. 230)” under Section 22 of the NSW Mental Health Act (2007). The function of acute units meant that nurses working in these settings were increasingly associated with providing care to patients who were complex and challenging in terms of their illness and behaviour.
An increase in patient acuity and a decrease in the length of hospital stay: One of the numerous advantages of community based care was that mentally ill persons could live in communities, but preferences for community based management subsequently resulted in patients being admitted into acute in-patient units at a later stage in their illness. Consequently, they presented with severe clinical symptoms and increasingly disturbed and problematic behaviours (Martin & Oades, 2000). The expectation though was that these patients will improve mentally in a short period of time. Most admissions to acute in-patient units changed to brief durations; that is 2 weeks or less (Jablensky, McGrath & Herrman, 1999). What this decrease in the average length of patient stay reflected was the shift in the focus of care to that of crisis stabilization and referral (Delaney, Ulsafer-VanLanen, Pitula & Johnson, 1995; Garritson, 1999; McGihon, 1999; Thomas, 1996; Treatment Protocol Project, 1999). The goals of mental health care changed to include rapid assessment, stabilization of symptoms and discharge planning all of which had be achieved quickly given the decrease in the length of stay (McGihon, 1999). For mental health nurses, high acuity of patients and decreases in their length of stay in acute in-patient units ideally should have resulted in nurses being taught new structures of providing care to patients, because establishing therapeutic working relationships with patients and maintaining a therapeutic milieu no longer seemed workable given the patient’s length of stay (Delaney et al., 1995).

The demand for in-patient beds: The increased demand for in-patient beds was another contributing factor which impacted on the nurse-patient relationship. High mental health admission rates and high bed occupancy levels have been reported in Australia and other developed countries (Garritson, 1999; Martin & Oades, 2000; Powell, Hollander & Tobiansky, 1995; Thomas, 1996). As bed numbers in state psychiatric hospitals decreased, the demand for in-patient beds increased. The impact of high occupancy rates on nursing staff included extra demands, such as more time spent in locating patient beds, higher patient loads without the provision of extra resources and difficulties resulting from inadequate number of beds (Ryrie, Agunbiade, Brannock & Maris-Shaw, 1998) which consequently left less time for nurses to interact with patients (Martin, 1992).
Contradictions in the provision of care and enforcement of control: The involuntary treatment of patients in acute mental health units posed a challenge to nurses. The expectation within the context of involuntary treatment was that care and treatment had to be provided to patients who did not believe that they required hospitalisation (Breeze, & Repper, 1998). This meant that nurses had the power under the Mental Health Act to enforce certain interventions, such as medicating and secluding patients, without the patient’s consent. Cleary (2003) argued that the level of control afforded to nurses under the Mental Health Act posed challenges for nurses in regard to their relationship with patients. Anthony and Crawford (2000) strengthened this argument by stating the following: “if a nurse is at one moment facilitating client choices and involvement in care and in the next required to enforce compulsory Mental Health Act sections, this is likely to confuse and discourage both parties from engagement in active working alliances” (p. 432). Tension therefore existed between the role of therapy and the role of control. For nurses, balancing therapeutic obligations with the requirement to maintain institutional order and control has posed special challenges and achieving the therapeutic balance between beneficial intervention and client choices has formed the basis of many ethical tensions in mental health nursing (Garritson, 1999; Horsfall, Cleary & Jordan, 1999; Woodward, 1999).

The influence of reforms on mental health has reportedly resulted in a rapid pace of change in service delivery and has had a profound effect on mental health nurses working in acute in-patient mental health facilities as well as traditional mental health nursing roles (Delaney et al., 1995; Higgins et al., 1999; McGihon, 1999; Ryrie et al., 1998; Thomas, 1996; Whittington, 2000). A number of studies into hospital based mental health nursing, documented over the last few decades, seemed to have started from the premise that therapeutic relationships were beneficial and valuable for patients (Reynolds, & Cormack, 1990; Speedy, 1999) but questions have been raised about the ability of nurses to provide traditional models of care in acute in-patient mental health facilities given the numerous changes brought about by reform (Cleary, 2003). The introduction of new reforms in the 1990s impacted on traditional mental health nursing activities which have led to a growing disparity.
between traditional understandings of mental health nursing and actual practice (Cleary, Edwards & Meehan, 1999).

2.14 Future implications for mental health nursing

The nurse patient relationship theory fostered more than fifty years ago has provided a strong focus for the discipline of mental health nursing and without this focus there is great concern that the discipline of mental health nursing will become much weaker, both intellectually and practically (Nolan, 1998). Currently, there still remains uncertainty regarding what constitutes mental health nursing activity but the message from nurse theorists remains clear and consistent - despite the fact that nursing has endured and may endure a number of changes in the future, they stress that it is important to ensure that the nurse patient relationship remains an integral part of nursing care delivery (Fawcett, 1999; Peplau, 1998; Rangel, Hobble, Lansinger, Magers, & McKee, 1998; Travelbee, 1971). If the therapeutic nurse patient relationship is to remain an important component of quality mental health nursing care then research into factors influencing nurse-patient relationships becomes highly relevant (Chambers, 1998) and important given the identified effectiveness of therapeutic alliances between nurses and patients.

In view of the expressed concern that the involvement of police in mental health has contributed to a change in the profiles of patients admitted to mental health units, it is timely and important to determine any implications these changes in patient profile may have on mental health nursing practice, and the centrality of the therapeutic nurse-patient relationship.

2.15 Conclusion

This review has illuminated the social understanding and historical approaches to the management of people with mental illness. In addition, the review examined some of the consequences of deinstitutionalization on mentally ill persons and the impact of mental health reforms on police and mental health nurses. Furthermore, the review identified why the police are considered a valued and integral part of the mental health system and that they have a major role in the referral of persons to psychiatric
emergency departments. While the international literature on referrals from the police have accrued in more recent years, in Australia further research is needed to investigate the similarities and differences between patients referred by the police and other sources and to examine some of the assertions made by previous researchers about the characteristics and disposition of police referrals to the psychiatric emergency room. In addition little is known about the experiences of nurses caring for patients referred by the police and whether there are factors influencing or impeding the development of therapeutic relationships between nurses and police referred patients. Therefore, in addition to investigating the characteristics of persons referred by the police, this study also aims to answer the questions that the research literature has so far not fully addressed. That is, what are the experiences of nurses caring for patients referred by the police and what does it mean for them? A mixed methods approach was the best fit for the purpose of this research study because the complexity of the research questions required an understanding of the issues from a quantitative and qualitative perspective. The next chapter (chapter 3) focuses on the mixed methods design.
Chapter 3 : The Research Design of the Study

3.1 Introduction

This chapter outlines the overall research design, and begins with the aims of the study. This is then followed by information about the rationale for a mixed methods approach, a definition of mixed methods research and the advantages of combining methods in a research study. The challenges involved in using this type of research are also addressed. The chapter also includes information about ethics approval for the conduct of the study, and introduces the hospital setting and concludes with a visual representation of the mixed method procedure used.

3.2 Aims of the mixed method study

The aims of the mixed method study were to investigate whether people referred by the police to a mental health service in NSW were different in demographic characteristics, diagnostic characteristics and admission outcomes when compared to referrals from other sources; and to explore nurses’ experiences of caring for patients referred by the police.

3.3 The study design

For this study a two phase sequential mixed method design was utilized. The first quantitative phase of the study compared the characteristics of patients referred by police to the mental health service to the characteristics of patients referred from other sources. The second qualitative phase of the study employed a Heideggerian hermeneutic approach to explore the experiences of nurses caring for persons referred by the police and admitted to the acute admission units and the psychiatric intensive care unit of a large psychiatric hospital in Sydney, Australia. The sequential method included a quantitative retrospective audit of patients’ medical records (Phase one) followed by qualitative interviews with nurses (Phase two). The
utilisation of the two phase sequential mixed method design involved collecting and analysing quantitative and then qualitative data in two consecutive phases within one study.

3.4 What is Mixed Methods Research

Mixed methods is defined as a research approach where the collecting, analysing, and “mixing” or integrating of both quantitative and qualitative data occurs at some stage of the research process, within a single study, for the purpose of gaining a better understanding of the research problem (Ivankova, Cresswell & Stick, 2006; Tashakkori & Teddlie, 2003). Mixed methods represent one of the three main methodological approaches in the social and behavioural sciences, the others being qualitative and quantitative research. Mixed methods have also been defined as the combination of qualitative and quantitative methods in a single study (Andrew & Halcomb, 2009).

The complexity of health research has resulted in researchers exploring and applying diverse methods to explore research problems. Since the mid 1990s, the interest in mixed methods research has grown steadily and the need to reach different audiences has promoted this form of research. Deriving from triangulation, mixed methods research has come to the forefront in the last decade and has been proposed as a new research paradigm (Tashakkori & Teddlie, 2003) with pragmatism being identified as its philosophical underpinnings. Pragmatism draws on many ideas including “what works”, through the use of diverse approaches and placing value on both objective and subjective knowledge (Creswell & Plano Clark, 2007). The pivotal premise of mixed methods research is that a combination of qualitative and quantitative methods may provide a broader understanding of a research problem than either quantitative or qualitative approaches alone (Creswell & Plano Clark, 2007).

3.5 Rationale for a mixed methods approach for this study

Nursing knowledge and practice is increasingly expected to be based on the best available evidence (Flemming, 2007). Where that evidence is limited, researchers are challenged to determine the most appropriate approach to acquire the evidence. The
depth of insight into a research problem made available by mixed method research makes it highly suitable for studying many complex nursing and healthcare research problems (Andrew & Halcomb, 2006; Flemming, 2007).

For the purpose of this research study, a mixed methods approach seemed the best fit as a need existed to understand the research problems from differing perspectives for the following reasons: Firstly, although the police represent an important group under the NSW Mental Health Act (NSW Institute of Psychiatry, 2007), for the referral of persons to health facilities for a mental health assessment, at the commencement of this study, quantitative studies addressing police referrals to psychiatric services in NSW were few and there were no studies found that addressed this issue qualitatively or in combination. Secondly, the literature addressing the experiences of nurses caring for patients referred by the police were also few. Utilising either a quantitative or qualitative approach by itself was considered inadequate to address the research problems. In view of this, a mixed study was chosen as it offered the possibility of an approach that could combine both an investigation of police referrals to a psychiatric facility and an exploration into the experiences of nurses caring for these patients in the one study. An investigation into police referrals to psychiatric services involved comparing the demographic and clinical characteristics of patients referred by the police with referrals from other sources. This was best answered through quantitative research methods; whereas exploring the experiences of nurses caring for patients referred by the police required a qualitative approach.

3.6 Advantages of utilizing mixed methods research

With the underlying assumption that biases are inherent in any one particular method of data collection or analysis, there is now increasing acceptance that a combination of mixed methods leads to the production of stronger research (Tasakkori & Teddlie, 1998). Within nursing, there is encouragement for nurses “to capitalize on each research approach” (Corner, 1991, p.718) so that they can better understand nursing practice. It has been suggested that mixed method research can provide more comprehensive evidence than that provided by the use of quantitative or qualitative research alone. Lastly, mixed methods research is considered practical for two
reasons, the researcher is free to use all methods possible to address a research problem (Creswell & Plano Clark, 2007) and by using both numbers and words to solve problems a combination of both inductive and deductive thinking is employed to better understand the research problem as evidenced by the mixed method study by Evans, Conte, Gilroy, Marvin, Theysohn, et al., (2008) which used a quantitative study based on the numerical data obtained from surveys and a qualitative study based on phenomenological interviews to explore and better understand (a) why aging workers continue to work past retirement age, (b) how aware occupational therapists are of the needs of the growing demographic of the aging worker, and (c) potential occupational therapy interventions that could better help aging workers. In this study we were able to capitalise on both research approaches by using a quantitative phase based on the numerical data obtained from an audit to investigate demographic characteristics, diagnostic characteristics and admission outcomes of patients referred by the police; and a qualitative phase based on phenomenological interviews to explore nurses’ experiences of caring for patients referred by the police.

3.7 Challenges of using mixed methods research

Despite its value, one of the many challenges of conducting mixed methods research was that it took time and resources to collect and analyse both sets of data. A lengthy amount of time was required to collect and analyse both quantitative and qualitative data and each type of data had to be reported separately as a distinct study. From a personal experience the qualitative data collection and analysis required more time than that needed for quantitative data. The procedures of research also required clear presentation for the reader to be able to sort out the different procedures.

3.8 Reasons for the choice of the explanatory design

The decision about the method design chosen for this study was guided by responses to the questions regarding the sequence, priority, theoretical perspective (Creswell & Plano Clark, 2007) and the purpose of the research being undertaken. While the research problem may be a primary reason underscoring the choice of a design, the researcher still has an element of choice in the type of design chosen for a study. Creswell and Plano Clark’s (2007) description of the four major types of mixed
methods design was used as a guide in this decision. These designs are: the triangulation design, the embedded design the explanatory design and the exploratory design. Teddlie and Tashakkori (2009) caution that there may not be a research design that is a “perfect fit” for a study and therefore recommend that researchers choose the most appropriate or best mixed method design available (p. 163). These authors also recommend flexibility, creativity, combining existing designs and the development of new designs (Teddlie & Tashakkor 2009, p. 163-164).

The triangulated and explanatory designs were both considered for this study. The focus of the triangulation design is to compare and contrast or to validate statistical (quantitative) results with qualitative findings and both sets of data are collected concurrently in a single phase (Creswell & Plano Clark 2007). Two phases are used in an explanatory design with the first phase involving collection of quantitative data followed by a qualitative data collection phase (Creswell & Plano Clark 2007; Kroll & Neri, 2009). The qualitative phase seeks to explain, expand or contextualise the quantitative results (Creswell & Plano Clark 2007; Gutmann, & Hanson, 2003; Kroll & Neri, 2009).

The explanatory design was decided upon because it was found to be well suited to this study in which qualitative data was required to explain significant, and surprising quantitative results and to broaden and expand our understanding of the topic area. So even though from a phenomenological point of view, the overall aim of the qualitative phase of study was to gain in-depth descriptions into experiences of nurses as lived from an ontological perspective and to make sense of the experiences, there existed a need for further explanation and clarification on the chosen phenomena (Maharaj, Andrew, O'Brien, & Gillies, 2009). So while the qualitative interviews with participants commenced with the broad question “Can you tell me about your experiences of caring for patients referred by police” other more specific questions asked of participants in the second (qualitative) phase were informed by findings that emerged from the phase one data. The qualitative data and its analysis not only provided a descriptive understanding of the everyday lived experiences and an interpretive understanding of the ways in which nurses managed the experiences of caring for patients referred by the police but also some explanation as to why
certain factors contributed to the overall perceived differences between the patients referred by the police and those patients referred by other sources. Therefore, the choice of the explanatory model used, was to help explain, expand and clarify the shared lived experience of participants and some of the quantitative results.

Part of the procedures in any mixed-methods design, also involves dealing with issues of the sequence, priority, and integration of the quantitative and qualitative approaches and these are explained in the next sections.

### 3.9 The sequence

A sequence occurs when the researcher implements the methods in two distinct phases, using (collecting and analysing) one type of data before using the other data type (Creswell & Plano Clark, 2007). This study was conducted in two sequential phases within one study and only one type of data was collected at a time (Creswell & Plano Clark, 2007). The first phase involved collecting quantitative data through a retrospective audit of medical records to compare the characteristics of patients referred by police to the mental health service to the characteristics of patients referred from other sources. The second phase involved collecting qualitative data about the perceptions and experiences of nurses caring for patients referred by the police. Quantitative data was collected and analysed prior to the commencement of the qualitative phase.

### 3.10 The priority

Priority refers to which approach, quantitative or qualitative (or both), a researcher gives more weight or attention throughout the data collection and analysis process in the study (Creswell et al., 2003; Morgan, 1998). Although the quantitative data was collected first it was not afforded priority because the scope of both the qualitative and qualitative research questions as well as the data collection methods of both phases were each given equal status in this study.

This decision was influenced by the purpose of the study, which was to investigate the characteristics of patients referred by the police and to explore the experiences of...
nurse caring for these patients. Despite the first quantitative phase of the study being robust, the data collection was limited to an audit of the medical records of patients and the data analysis employed four statistical techniques: chi square, MANOVA, Mann Whitney U Test and logistic regression analysis. The analysis of the qualitative phase not only provided a descriptive understanding of the everyday lived experiences of nurses caring for patients referred by the police but also explained and interpreted some of the statistical results obtained in the first, quantitative, phase. This was achieved through in-depth interviews carried out with nine nurse participants. Thematic hermeneutic analysis was conducted on each of the nine interviews, and the techniques employed for this type of interpretive analysis included data reduction, data display and conclusion drawing (Miles & Huberman, 1994).

3.11 Integration

Integration refers to the stage or stages in the research process where the mixing or integration of the quantitative and qualitative methods occurs in mixed methods research (Creswell et al., 2003; Green, Caracelli, & Graham, 1989; Tashakkori & Teddlie, 1998). In this design the mixing of data was considered a unique aspect of mixed methods designs because by mixing the data sets, a better understanding of the problem is provided than if either of the data sets is used alone. Creswell and Plano Clark (2007) offer three ways in which the mixing of data sets can occur: (1) merging or converging the two datasets by actually bringing them together; (2) connecting the two data sets by having one build on the other; and (3) embedding one data set within the other so that one type of data provides a supportive role for the other data set.

For this study the mixing of data sets involved connecting the two data sets and integrating the results within a single study. Mixing in the sequential explanatory design took the form of integrating quantitative and qualitative results while discussing the outcomes of the whole study and drawing implications. Such mixing of the quantitative and qualitative methods results in higher quality of inferences (Tashakkori & Teddlie, 2003) and underscores the elaborating purpose of the mixed-methods sequential explanatory design. Although the quantitative data was collected
first and informed some of the questions for the qualitative data collection, true integration of the results occurred in the discussion chapter. Some integration of the quantitative results occurred in the summary for the qualitative chapter.

3.12 Rigour of the mixed methods study

As with any research undertaken mixed methods research must ensure that all possible measures are taken to ensure the quality of the design, data collected, and inferences or meanings drawn from the data. Mertens (2005) suggests that mixed methods studies must indicate the purpose of using this approach and that the data collection methods must be congruent with the stated purposes of the study. In addition, the quantitative and qualitative data collection and analysis and inferences or meanings must be consistent with established research principles for these paradigms (Giddings & Grant, 2009; Mertens, 2005; Teddlie & Tashakkori, 2009). Integration of findings from both data sets are an integral part of mixed methods research and therefore the stage of integration must be clearly stated (Mertens, 2005). Teddlie and Tashakkori (2009) suggest integration may not result in a single interpretation of the findings but it must address “meaningful conclusions on the basis of consistent or inconsistent results” (p.305). The purpose of the study phases is clearly stated in this study and the data collection methods and analysis used are congruent and adhere to established research principles for the respective traditions. Integration of the data is presented in chapter 8 and includes the congruence and discrepancies between both findings and some of the additional aspects added that were distinct from each other, with additional interpretations made in the discussion chapter (9).

3.13 The Setting

3.13.1 The Area Health Service

At the time of commencement of the study in 2002, the population covered by the Area Health Service was 645 000 and was made up by five Local Government Areas (LGA’s). In 2005, there were major changes to the area health service following the amalgamation of health services expanding the area health service to cover nearly
9,000 square kilometres and was made up by nine LGA’s. The area is highly culturally diverse: in 2001, under the nine LGA’s the total population exceeded one million (1,044,202) and a total of 292,383 residents reported being born overseas (Area Health Service Annual Report, 2003-2004).

There were notable socio-economic differences between LGA’s in the Area Health Services with certain areas particularly socio-economically disadvantaged according to the Socio-economic indices for areas, with some LGA’s scoring above the mean on all indices while other LGA’s scored below the mean (meaning relatively disadvantaged) on every index. In addition available data from the NSW Health Survey showed persistent patterns of unhealthy behaviours in relation to smoking, diet and physical activity among many residents of the area. These behaviours tended to be more common among residents of particular suburbs who were also more likely to have other adverse risk factors for poor health (Area Health Service Annual Report, 2003-2004).

Integrated health services including mental health are provided throughout the area largely through hospital, community health centres and population health programs. In relation to mental health, the National Survey of Mental Health and Well-Being conducted in 2007 found that one in five Australians aged 16–85 years had a mental disorder according to figures released by the Australian Bureau of Statistics (ABS 2008a). In the 12 months prior to the survey, 1.9 million people accessed services for mental health problems. Mental health related hospitalisation rates among residents of this Area Health Service are high compared to NSW overall (National Survey of Mental Health, 2007). A range of mental health services for all ages and across the spectrum from prevention to treatment to rehabilitation services are provided by the Area Mental Health Services. The hospital in which this study was conducted is one example of a mental health facility that offers services in the form of acute and rehabilitation care for adults suffering from a mental illness.
3.13.2 The psychiatric hospital

The study was undertaken at a university-affiliated, psychiatric hospital in the Sydney Metropolitan Catchment Area. (Area Health Service Annual Report, 2000). At the time of the study there were 342 beds in the psychiatric hospital.

The hospital has a 24 hour admission office which takes self referrals and referrals from other agencies including the police. All admissions are processed through the Admission Office. On presentation to the Admission Office, a liaison nurse obtains preliminary information. This is then followed by a diagnostic examination performed by the duty medical officer generally within four hours of the person’s arrival, but not exceeding more than 12 hours. In cases of violence or extreme aggression, police are expected to escort the patient directly to the psychiatric intensive care unit (PICU) which is a locked ward. This generally takes place under the following circumstances: (1) if a patient transported by the police to the admission office becomes aggressive during the interview with the medical officer or while waiting to be seen by the medical officer, the police are then directed by the medical officer to escort the patient directly to the PICU; (2) if the police perceive that the patient being transported to the hospital for a mental state assessment presents too great a risk of danger to themselves or others, they take it upon themselves to notify the admission desk of their concerns regarding the patient and are then given directions to escort the patient directly to the PICU, instead of the admission office. The nurse at the admission desk is then required to notify the nursing staff in the PICU to prepare for the arrival of the perceived aggressive or violent patient, escorted by the police.

If a patient brought in by the police under Section 22 of the NSW Mental Health Act is not found to be mentally ill or mentally disordered, the patient is returned to the custody of the police within one hour after examination. In the case of a patient who is certified as mentally ill, the patient is then admitted to the acute unit and in accordance with the MHA, the patient has to present before a Magistrate’s Inquiry where a decision is made on whether or not to confirm the order. A decision is also made on the period of detention and care to be given for the patient confirmed as
mentally ill. Patients certified as mentally disordered cannot be detained in a hospital by a doctor for more than 3 working days (Staunton & Chiarella, 2007).

At the commencement of this study, the 1990 NSW Mental Health Act was still applicable but since its introduction, there were significant changes to the NSW health system and the way in which mental health services were organized. On 16 November 2007, the 2007 MHA, passed by the NSW Parliament, came into effect and while it retained many of the significant principles of the 1990 Mental Health Act, there were many new features that included additional provisions of care and treatment. Section 24 of the 1990 MHA changed to Section 22 of the 2007 MHA. However, the power afforded to police under both versions remained the same, that is, similar to Section 24 of the 1990 MHA, under Section 22 of the 2007 MHA, police still had the power to refer and transport people to health facilities for a mental state assessment against the will of the person. For this study, both versions of the MHA are included because as previously mentioned, the study commenced at a time when the 1990 MHA was still applicable and the study was still in progress at the time of introduction of the 2007 MHA.

3.14 Ethical Issues for the Study

3.14.1 Introduction

Permission to conduct the study was obtained from the Human Research Ethics Committee of the Area Health Service and the Research Ethics Committee of the University of Western Sydney. The following section discusses ethical issues relevant to the conduct of the study including the potential risk of harm from research procedures, assurance of anonymity and confidentiality, informed consent, ethical considerations and integrity, respect for persons, beneficence, and justice.

3.14.2 Potential risk of harm from research procedures

Phase one of the studies involved an audit of patients’ medical files, and as such there were no anticipated negative effects on the research population.
Phase two of the study involved nurses participating in an interview. This had potential for some of them to experience some form of discomfort in the form of inconvenience to attend the interview and/or physical discomfort including fatigue, or muscle tension and/or emotional distress when answering certain questions. As a risk minimisation measure, independent counselling was arranged from a member of the Critical Incident Stress Management team (CISM) at the hospital regarding the conduct and progress of interviews. Members on the team had undergone specialist training to respond to requests for critical incident stress debriefing.

Nurses were advised that their participation in this study was voluntary; that they were under no obligation to participate. They had the right to refuse to be interviewed and free to withdraw from the study at any time and that questions that made them feel uncomfortable did not have to be answered.

3.14.3 Assurance of anonymity and confidentiality

All information obtained through an audit of the medical files remained deidentified and confidential. This was achieved by having no names, addresses or other identifying information of patients on data collection forms. File numbers were saved on a separate list and a corresponding study number placed on data collection forms. This strategy allowed for any data anomalies to be traced back to the original file for checking while at the same time ensuring anonymity to all.

To maintain confidentiality, data collected was stored in a locked cupboard in an office of the university, where it will remain for the required seven year period and then shredded at the end of this period. All electronic data collected was saved onto the computer and accessible only by the researcher through use of a password. Electronic data will remain on computer for the required seven year period and then deleted at the end of this period.

Emphasis was placed on anonymity and confidentiality of nursing staff participating in the study. There were no records kept of the participant’s name, address or any other identifying information. Participant’s identity was not linked with data obtained (Burns & Grove, 2009).
3.14.4 Informed consent

Ethical issues relating to NHMRC Guidelines on data from patient files were in accordance with the National Statement on Ethical Conduct in Research Involving Humans (2007). In meeting the requirement of Chapter 4.5.5 of the Act which states “Consent to participation in research by someone with a cognitive impairment, an intellectual disability, or a mental illness should be sought either from that person if he or she has the capacity to consent, or from the person’s guardian or any person or organisation authorised by law”. Consent for the viewing and obtaining of data from patient files was authorised by the medical superintendent of the hospital in which the research study was conducted. This was accepted by the Human Research Ethics Committee (HREC) of the Area Health Service after they initially requested that the consent of the patient’s treating doctor should be obtained prior to viewing of the files. This proved difficult to achieve because as part of their clinical rotation, most of the treating doctors would have moved on to other services making it difficult for them to be traced.

Informed consent was obtained from all nurses participating in the study. Nurses were advised that the study was being conducted as part of the researcher’s PhD and that they were being invited to participate. Nurses were provided with information necessary to make an informed decision about whether to participate (Appendix A). The information included a statement of the research purpose, time commitment, explanation of procedures, assurance of anonymity and confidentiality, potential risks, option to withdraw without penalty, potential benefits, an offer to answer questions and voluntary consent. Potential nurse participants were advised that participation was voluntary and that refusal would have no impact on their relationship with the employer. The signing and returning of the information sheet to the investigator was indicative of the nurse’s consent to participate in the study (Appendix B).

3.14.5 Integrity, respect for persons, beneficence, and justice

The research project was conducted with integrity in its pursuit for knowledge. All aspects of the study adhered to the recognised principles of research conduct and
were conducted in an honest and ethical manner. From the onset of the study, the intention of the researcher was to have the results of the study disseminated and communicated for public and scientific scrutiny. All participants involved in the research were treated with respect, in regards to their rights, beliefs and perceptions. In adherence to the principle of beneficence, every effort was made to minimise any discomfort that participants had the potential of experiencing.

3.14.6 Ethical problems encountered

It was anticipated that the patients admitted to the units would be between 18-65 years of age and permission was initially requested for this age-range. Eight patients however were found to be outside this age range and permission was sought from the Area HREC to include them in the study because it was felt that the inclusion of this age group had potential of contributing valuable information to the literature on reasons for their admission to a mental health facility catering for adults. The age representations of those outside the initial age range were as follows: one patient was 15 years of age; two patients were 16 years of age; four patients were 17 years of age and one patient was 66 years of age.

Approval was granted from the HREC to include all patients with the exception of the 15 year-old as inclusion of this patient required parental/guardian consent. The decision of the researcher was to exclude this patient from the study. The age group falling outside the specified age range included referrals from both police and other sources.

3.15 Conclusion

This mixed methods sequential explanatory design allowed for the investigation of police referrals to a psychiatric facility and exploration of the experiences of nurses caring for patients referred by the police. In the conduct and design of the study, the qualitative and quantitative data were considered to be of equal significance. The qualitative data collected and analysed was informed by Heideggerian phenomenology. The data generated allowed for a rich and deeper understanding of the research problem.
A visual representation of the mixed method procedure (see Figure 3-1) used for a study is considered important because it can lead to a better understanding of the characteristics of the design, including the sequence of the data collection, priority of the method, and the connecting and mixing points of the two forms of data within a study. By utilizing the ten rules developed by Ivankova et al., (2006) which included both the steps to follow and specific guidelines related to its content, a graphical representation of the mixed-methods sequential explanatory design procedures used for the study was created. The model portrays the sequence of the research activities in the study, by depicting the methods being implemented in a definite sequence. The design depicts the relative emphasis or priority given to the different forms of data as shown by the QUAN and QUAL letters appearing in uppercase. The design also specifies all the data collection and analysis procedures, and lists the products or outcomes from each of the stages of the study. It also shows the connecting points between the quantitative and qualitative phases and the related products, as well as specifies the place in the research process where the integration or mixing of the results of both quantitative and qualitative phases occurs. The next chapter (chapter 4) addresses Phase One, which is the quantitative method of the study.
Figure 3.1: A visual representation of the mixed method procedure used for this study
Chapter 4: Phase One of the Study

4.1 Introduction to the quantitative phase

Phase one (quantitative) of the study involved a retrospective audit of patients’ medical files to investigate differences between the patients referred by police and patients referred by other sources. The methodology used in this quantitative study is described in detail. The variables for investigation were identified and grouped into three categories. The four statistical techniques used for the analysis of data are described. This section commences with the aims, followed by the objectives and the hypotheses of the quantitative study.

4.2 Aims of the quantitative phase

The aims of this quantitative phase of the study were to investigate whether people referred by the police to a mental health service in NSW were different and what those differences were, in comparison to referrals from other sources such as community mental health teams, general practitioners, courts, families and friends, and self referrals.

4.3 Objectives of phase one of the study

The objectives of phase one of the study were to:

1. Identify the indicators/reasons for referrals by police as stated in the Section 24 form of the NSW MHA (1990).

2. Compare the demographic characteristics of patients referred by police with patients referred by other sources.
3. Compare the diagnoses of patients referred by police with patients referred by other sources.

4. Compare the admission outcomes of patients referred by police with patients referred by other sources.

4.4 The hypotheses of phase one of the study

4.4.1 Demographic Characteristics

Hypothesis 1: There will be differences in demographic characteristics (gender, age, country of birth, religion, marital status and living situation) between patients referred by the police and patients referred by other sources.

4.4.2 Diagnostic Characteristics

Hypothesis 2: There will be differences in diagnostic categories between patients referred by police compared to patients referred by other sources.

Hypothesis 3: There will be a difference in the percentage of patients diagnosed as psychotic in the group referred by the police compared to patients referred by other sources.

Hypothesis 4: There will be a difference in the percentage of patients referred by police presenting with substance use compared to patients referred by other sources.

Hypothesis 5: There will be a difference in the percentage of patients referred by police presenting with suicidal behaviour compared to patients referred by other sources.
4.4.3 Admission Outcomes

Hypothesis 6: There will be differences in the types of PRN medications administered to patients referred by the police in comparison to patients referred by other sources.

Hypothesis 7: There will be a difference in the percentage of patients referred by police who were admitted to the psychiatric intensive care unit (PICU) compared to patients referred by other sources.

Hypothesis 8: There will be a difference in the length of stay in hospital for patients referred by police compared to patients referred by other sources.

Hypothesis 9: There will be differences between patients referred by police and patients referred by other sources in the HoNOS total scores and the four HoNOS sub-scores, behaviour, symptom, impairment and social functioning.

Hypothesis 10: There will be a difference in the percentage of patients referred by police displaying physical attacks and fear-inducing behaviour compared to patients referred by other sources.

Hypothesis 11: There will be a difference in the percentage of patients referred by the police who spent time in seclusion compared to patients referred by other sources.

4.5 Sample

4.5.1 Power analysis

Sampling procedures involved selecting an adequate size to reduce sampling error and to provide sufficient power. A power analysis conducted on the present sample size was considered adequate based on the following procedure: for a variable that was present in 50% of one group (p1 = 0.5), a sample size of 85 per group was sufficient to detect a 50% difference in that variable in the other group (p2 = 0.25 or
p2 = 0.75) where alpha = 0.05 and Power = 0.90. Therefore, allowing for a margin of error, a sample size of 100 per group was chosen for this study.

4.5.2 Sample population

A list of the 755 patients admitted during the 6 months study period commencing from the 1st of July 2002 to the 31st of December 2002 was generated by staff members of the Area Health Information and Record Services (H.I.R.S). All of the patients were identified from the hospital databases.

4.5.3 Sample size and selection

Two hundred files were selected which included a convenience sample of the first 100 referrals from police and the first 100 referrals from other sources. One patient file was excluded as the patient was a minor and the data could not be used without parental/guardian consent which reduced the number of patients from other sources to 99. To achieve the total of 200 patient files, the first available file was chosen for inclusion in the study, which was of a patient referred by the police. Therefore, the convenience sample included referrals of the first 101 people referred by the police under the appropriate section of the NSW MHA during the six month study period and a convenience control sample of the first 99 people referred from other sources over the same period.

4.5.4 Inclusion criteria

For the selection of police referrals, only patients referred under Section 24 of the MHA (1990) were eligible for inclusion in the study. Where a patient had multiple visits to the psychiatric service during the study period, only the first visit during the specified time frame was included. Two methods were employed to ensure that the sample of patients referred by the police were under Section 24 of the MHA (1990). The first method involved checking the Admission Register of patients against the list of patients. Information on the Section of the Act under which a person was referred, was documented by the admitting nurse in the Register once the patient was admitted. The second method employed validated the first method as it involved a
check in the medical records of patients to determine if a Section 24 form was 
completed by police at the time. If it was, then this was accepted as a true police 
referral. Therefore, the Patient Admission Register was used to screen for possible 
police referrals while the second method was used to validate that they were police- 
referred. Patients conveyed by the police after detention by a doctor, or conveyances 
of patients referred by the police that were initiated by mental health workers were 
not included in the study. The inclusion criteria for non-police referrals were the 
same as the police referrals, that is, where the patient had multiple visits to the 
psychiatric service during the study period, only the first visit during the specified 
time frame was included.

4.6 Data Collection

4.6.1 Presenting problem: reasons/ indicator for police referral

Information on the reasons/indicators for referral from police was obtained from the 
patient's medical file by referring to the Section 24 form, which was routinely 
completed by police at the time of referral. Part of the referral procedure under 
Section 24 was the requirement from police to write a brief description of the 
incident leading to referral of the patient to hospital. The reasons indicated by police 
for referral was copied verbatim from the patient's file on to the data collection form 
by the researcher. Police documentation of factors leading to referral, was content 
analysed (Burns & Grove, 1995). These categories were then grouped according to 
decreasing order of frequency and presented in the results section (chapter 5, Table 
5.2). The categories were decided upon prior to data collection and are same as the 
categories used in a previous study by Meadows, et al., (1994). These categories 
included: Bizarre ideas; Threatening suicide; Violent behaviour; Threatening violent 
behaviour; Seeing things; Threatening self injury; Self injury – actual; Suicidal 
attempt; Wandering aimlessly; Self request to be brought to psychiatric services; 
Stated self to be a psychiatric patient; and hearing voices.
4.6.2 Data collection tools

Data collection was conducted over a 14 day period in 2004. Information was collected onto a structured form designed by the researcher. Data included: the reasons for police referral; demographic variables (gender, age, country of birth, religion, marital status and living situation, legal status and source of referral); diagnostic variables (primary diagnosis, psychosis, substance use, suicidal behaviour) and admission outcomes (types of PRN medications administered, unit admitted to, length of stay, functional scores, aggressive behaviour, and the use of seclusion) which were recorded routinely by the treating medical officers and nurses. These variables are defined further in the following section.

4.7 Variables

4.7.1 Introduction

This section defines the variables which have been grouped into the categories of demographic characteristics, diagnostic characteristics and admission outcomes and how these outcomes were defined.

4.7.2 Demographic characteristics

Demographic characteristics included: gender, age, country of birth, religion, marital status and living situation. These are outlined in this section.

Gender
This related to the sex of the patient - either male or female.

Age
The age group for admission to the psychiatric intensive care unit and the acute admission units ranged from 18 to 65 years according to the Area Health Service policy. The age groups were categorised as: less than 20; 21-30; 31-40; 41-50; 51-60; and older than 60.
Country of Birth
The patients’ respective countries of birth were recorded. These included the following countries: Australia, Fiji, New Zealand, Tonga, India, Pakistan, Sri Lanka, Malaysia, Singapore, China, Philippines, Turkey, Italy, Germany, Poland, Greece, UK, Romania, Lithuania, Cambodia, Sudan and Mauritius.

Religion

Relationship Status
Patients who were married or in de facto relationships were classified as “in relationships” and single, divorced, widower, and separated patients were classified as “not in relationships”.

Living Situation
The living situation of patients was classified as following: living alone; homeless; or living with others.

4.7.3 Diagnostic characteristics
Data on diagnostic characteristics included: primary psychiatric diagnosis of the patient according to the Diagnostic and Statistical Manual of Mental Disorders 4th Edition (DSM-IV); the presence of psychosis; substance use and suicidal behaviour.

Primary psychiatric diagnosis according to DSM-IV
In Australia both the DSM IV and the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10) (Bramley, Peasley, Langtree, & Innes, 2002; WHO, 2005) diagnostic codes are currently used in psychiatric settings. Consequently the coding of diagnoses by clinicians was based either on the DSM IV or the equivalent ICD-10 diagnostic categories. To maintain consistency, all diagnoses under DSM IV (American Psychiatric Association, 2000) were coded as ICD-10 by Health Information Record Staff (H.I.R.S). Because of the
large number of sub-diagnoses, diagnostic categories were collapsed into broad diagnostic categories. For example, paranoid schizophrenia and undifferentiated schizophrenia were both coded simply as schizophrenia. The six final diagnostic categories included: schizophrenia, schizotypal and delusional disorders; mental and behavioural disorders due to psychoactive substance use; mood affective disorders; neurotic, stress-related and somatoform disorders; disorders of adult personality and behaviour; and other disorders.

Psychosis
All people who were referred to the mental health facility were categorised as having a psychotic or non psychotic diagnosis based on the primary psychiatric diagnosis. When diagnosing a patient, the medical officer specifies on the admission paperwork that the patient has either a psychotic disorder or psychosis. For those patients whose diagnosis did not specify either a psychotic disorder or psychosis, they were considered free of psychotic symptoms. For example, a doctor may diagnose a patient with a “mental and behavioural disorders due to use of alcohol – acute intoxication” whereas another patient could be admitted with a diagnosis of “mental and behavioural disorder due to use of alcohol – psychotic disorder”. All patients were classified as “psychotic” or “non psychotic”.

Substance use
During the mental state assessment, patients were asked about their drug and alcohol history; whether substance use was of concern to them; and if they were at the time of assessment under the influence of drugs or alcohol or both. This was rated by the treating medical officer on the comprehensive mental health assessment form. Some patients were given a primary diagnosis of mental and behavioural disorders due to psychoactive substance while there were other patients presenting with a secondary diagnosis of substance use alongside a primary diagnosis of a mental disorder. For many of the patients in this study, substance use was a secondary diagnosis alongside a primary diagnosis of mental illness.
Suicidal behaviour
During admission, patients were assessed for self harm and/or suicidal behaviour which were documented on the assessment forms if they were identified by the admitting medical officer.

4.7.4 Admission Outcomes

Data on admission outcomes included: legal status; types of PRN medications administered; admission of patients to the PICU; length of stay; HoNOS total scores and four sub-scores; aggressive behaviour and the use of seclusion.

Legal status
The legal status of patients fell under one of two categories: voluntary or involuntary. The term voluntary refers to patients who are admitted to a hospital at their own request and may leave when they want to or when they are well enough to be discharged. Involuntary refers to patients who are admitted and detained in a hospital for the purposes of receiving care, treatment and control against the person’s wishes on the grounds that the person was a mentally ill person or a mentally disordered person as defined in the MHA (2007) (Staunton & Whyburn, 1994).

PRN medications
In mental health settings, patients may be administered PRN medications for numerous reasons some of which may include the following: to relieve patient distress or modify bizarre or uncontrollable psychotic behaviour (Carson, 2000); patients request it; physical aggression was likely to occur; after physical aggression had occurred; to relieve patient distress and prevent aggression (McLaren, Brown, & Taylor, 1990); and for agitation (Craven, Voore, & Voineskos, 1987; Curtis & Capp, 2003). All PRN medications were grouped into the following four categories to determine the types of medication most used in the treatment and management of patients referred by police to the acute units and the PICU: typical anti-psychotics; atypical anti-psychotics; anxiolytics; and sedatives/hypnotics. (Typical anti-psychotics refer to a first generation of antipsychotics discovered in the 1950s, examples of which include chlorpromazine and haloperidol while the atypical anti-
psychotics refer to the second generation, which have been developed more recently and include olanzapine, and clozapine).

**Admission to the PICU**
After a patient was assessed by the admitting medical officer, a decision was made on the disposition of the patient in relation to the unit the patient will be admitted to. Patients displaying the highest degree of risk of aggression and absconding were usually admitted to the psychiatric intensive care unit (PICU). All other patients were admitted to one of the acute admission unit. Once a patient was no longer considered at risk of aggression and absconding he or she was then transferred from the PICU to the acute unit.

**The length of stay**
The length of stay (LOS) referred to the total number of days that the patient spent in hospital and included the first day of admission to the day the patient left or was discharged from the hospital.

**HoNOS**
The Health of the Nation Outcome Scale (HoNOS) measures consumer outcomes (Wing, Beevor, Curtis, 1998). It contains 12 items, across four outcome domains: Behaviour, Impairment, Symptoms and Social Functioning. Each item is rated on a five point scale of severity (0-4) for example zero indicates no problem while a rating of four indicates a severe to very severe problem. The HoNOS was administered by nursing staff following completion of the first comprehensive clinical assessment by the medical officer.

The scale was found to be a simple, brief and clinically acceptable instrument which takes approximately two or three minutes to fill in (Bebbington, Brugha, Trevor, Marsden & Windows, 1999). It was found to have acceptable validity and reliability (Bebbington, et al., 1999; Orrel, Yard, & Handysides, 1999; Wing, et al., 1998), and has entered routine practice in this area mental health service. The reliability coefficients for HoNOS items were between 0.74 and 0.88 (Wing, et al., 1998) while
the concurrent validity was between 0.56 and 0.69 (Orrel, Yard, & Handysides, 1999).

Aggressive behaviour
The presence or absence of aggressive behaviour during admission within the study period was included. Accounts of aggressive behaviour from the file notes were coded using McNiel, Binder and Greenfield’s, (1988) modified version of the ratings form developed by Lagos, Perlmutter and Saexinger (1977) which was found to have acceptable inter-rater reliability (Bartko & Carpenter, 1976). The reported inter-rater reliability was 0.80 with a predictive validity of 53.4% (McNiel, Binder & Greenfield, 1988). Aggressive behaviours included verbal attacks, threats to attack persons, and attacks on objects and physical attacks. Information relating to physical aggression was obtained from the accident/incident forms which were completed by health care staff during events of physical aggression or serious accidents or incidents. All other accounts of aggressive behaviour were documented by nursing staff in the patient’s medical files.

Seclusion
In Australia the definition of seclusion is both legislated and policy driven. Therefore, for the purpose of the thesis, seclusion is defined as “the supervised confinement of a patient alone in a locked room, from which the patient cannot leave of their own accord, at any time and for any duration and for any purpose” (NSWHDPD2007_054, p3). The names of all patients secluded were documented in the seclusion register and the patient’s medical file. The data that was recorded was whether the patient had been secluded during their admission.

4.8 Statistical analysis

4.8.1 Introduction

In this section, the methods used in the statistical analysis of the data are described. All data collected by the researcher on to a structured data collection sheet were entered into the Excel spreadsheet by a research assistant.
Data on demographic, diagnoses and admission outcomes of patients referred by police were examined and compared to patients referred from other sources by using chi square analyses, multivariate analysis of variance (MANOVA), Mann Whitney U test and logistic regression. All analysis was done using SPSS version 14. For all tests \( p < 0.05 \) was considered significant. The analyses are detailed below.

4.8.2 Chi square analysis

Pearson’s chi square is a non-parametric (distribution-free) test used most frequently to test the statistical significance of results reported in categorical tables (Connor-Linton, 2003). For this study the hypotheses tested was whether or not people referred by the police and people referred by other sources, were significantly different on categorical characteristics.

The categorical variables were all of the demographic variables: gender, age, country of birth, religion, marital status, and living situation and the diagnostic variables: diagnosis, psychosis, substance use and suicide and the admission variables: PRN medication, PICU admission, aggressive behaviour and seclusion.

For the analysis: the age of patients was classified into two categories, that is, greater than thirty (> 30) and less than and equal to thirty (\( \leq 30 \)) years of age; country of birth was classified into two categories, “Australian-born” and “Others” because only a small number of participants were born in the above mentioned countries other than Australia; religion was collapsed into two groups – “Christianity” and “Other religion”, after it was discovered that only a small number of participants practiced the other four religions. Marital status was classified as “in relationships” and “not in relationships”; under aggressive behaviour, verbal attacks, threats to attack persons, and attacks on objects were classified as “fear inducing behaviour” and completed acts of assault was classified as “physical attacks”

4.8.3 Multivariate Analysis of Variance (MANOVA)

MANOVA is a technique for assessing group differences across multiple continuous dependent variables simultaneously, based on a set of categorical variables acting as
independent variables (French & Poulsen, 2002). The advantage of using MANOVA over univariate tests is that it protects against inflating the Type 1 error due to multiple comparisons. MANOVA was used to test for differences between referral groups on the admission variables, the total HoNOS scores and domain scores (Hypothesis 9). Where the multivariate result was significant, Dunnett’s t-test was used to determine which variables were different between groups.

For the analysis, scores were calculated on each of the four outcome domains and a calculation of the total scores was undertaken which provided information on the patient’s overall functioning. Lower scores indicated lower levels of difficulties.

4.8.4 The Mann Whitney U test

The Mann-Whitney test is a non-parametric alternative to the t-test for comparing data from two independent groups (Altman, 1991, p.194). Mann Whitney U test was used to test one variable under admission outcomes which was “length of stay” (Hypothesis 8).

4.8.5 Logistic Regression

In order to examine the relative importance of associations among study variables, a forward stepwise Likelihood Ratio Logistic Regression analysis was performed to screen predictors for the outcome of referral source.

Predictor variables entered into the model were the demographic variables and diagnostic variables previously outlined in the methods section. Where predictor variables were found to be significant, the relative contribution of the variables was identified through partial correlation coefficients.

4.9 Conclusion

The methodology used in this quantitative phase of the study has been described in detail. The research hypotheses were designed to identify differences in demographic
characteristics, diagnostic characteristics and admission outcomes between patients referred by the police and patients referred by other sources.

A retrospective audit of 200 medical files was undertaken to collect both demographic and clinical variables of patient characteristics. Four statistical techniques were used for the analysis of data. These included: Chi square tests, Manova, Mann Whitney U tests and Stepwise Logistic Regression. The results for the statistical analysis of the data are presented in Chapter Five.
Chapter 5 : Phase One Results

5.1 Introduction

In this chapter, the results of the phase one (quantitative) of the study are presented of a retrospective audit of patients’ medical records. In this phase, hypotheses relating to differences in characteristics between a cohort of 101 patients referred by the police and 99 patients referred by various other sources, who were subsequently admitted to a psychiatric hospital, were investigated. Comparisons of differences between the two groups were in relation to demographic characteristics, diagnostic characteristics and admission outcomes. The chapter begins with a description of the referral sources for the overall population and the study sample of patients admitted to the hospital over the study period. This is then followed by the indicators/reasons for police referrals. The results are thereafter presented on the demographic characteristics of patients, the diagnostic characteristics and the admission outcomes of the two referral groups.

5.2 Referrals and admissions for the overall population

A total number of 1462 persons were referred to the hospital over the study period 1st of July 2002 to 31st of December 2002 and assessed by an admitting duty medical officer during the study period. This included 269 persons referred by police and 1193 persons referred by other sources. From the 269 persons referred by police, 146 patients were admitted to the hospital. From the 1193 persons referred by various other sources (community mental health teams; hospitals outside the area health service; hospitals within the area health service; self referrals; families/relatives; mental health facilities; psychiatrists/GP’s; psychologists/welfare workers), 609 patients were admitted bringing the total number of admissions to the hospital to 755. Table 5.1 compares the source of referral in the study sample to the overall admission population over the study period.
### Table 5.1: A comparison of the study sample versus the population sample

<table>
<thead>
<tr>
<th>Sources of referrals</th>
<th>Sample (n = 200)</th>
<th>Population (n = 755)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Police</td>
<td>101</td>
<td>50</td>
</tr>
<tr>
<td>Other Referrals included:</td>
<td>99</td>
<td></td>
</tr>
<tr>
<td>Community mental health teams</td>
<td>28</td>
<td>14</td>
</tr>
<tr>
<td>Hospitals outside the area health service</td>
<td>26</td>
<td>13</td>
</tr>
<tr>
<td>Hospitals within the area health service</td>
<td>19</td>
<td>10</td>
</tr>
<tr>
<td>Self referrals</td>
<td>13</td>
<td>6</td>
</tr>
<tr>
<td>Family / Relatives</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Mental health facilities</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Psychiatrists / GPs</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Psychologists / Welfare workers</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

**5.3 Reasons/indicators for police referrals**

The reasons/indicators for referrals by police as stated in the Section 22 form of the NSW MHA was identified and are listed in decreasing order of frequency (Table 5.2).
### Table 5.2: Reasons for the referral of patients by Police

<table>
<thead>
<tr>
<th>Reasons for police referrals</th>
<th>Number of patients</th>
<th>Percentage of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bizarre ideas</td>
<td>33</td>
<td>33%</td>
</tr>
<tr>
<td>Threatening suicide</td>
<td>29</td>
<td>29%</td>
</tr>
<tr>
<td>Violent behaviour</td>
<td>14</td>
<td>14%</td>
</tr>
<tr>
<td>Threatening violent behaviour</td>
<td>9</td>
<td>9%</td>
</tr>
<tr>
<td>Seeing things</td>
<td>4</td>
<td>3%</td>
</tr>
<tr>
<td>Threatening self injury</td>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>Self injury – actual</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>Suicidal attempt</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>Wandering aimlessly</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>Self request to be brought to psychiatric services</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Stated self to be a psychiatric patient</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Hearing voices</td>
<td>1</td>
<td>1%</td>
</tr>
</tbody>
</table>

5.4 Demographic characteristics

The demographic characteristics of the two referral groups were compared. Bivariate variables included gender, age ($\leq 30$; $> 30$), Australian-born, identified as Christian and relationship status. Categorical variables included living situation. Pearson Chi-Square tests of significance was used for both Bivariate and categorical variables. The demographic characteristics of the two groups are presented in Table 5.3.

Hypothesis (1)

There will be differences in demographic characteristics (gender, age, country of birth, religion, marital status and living situation) between patients referred by the police and patients referred by other sources.

Gender

There was no significant difference in the percentage of males referred by police ($n = 74, 73\%$) compared to the percentage of males referred by other sources ($n = 61, 62\%$; $x^2 = 3.09, df = 1, p = 0.05$). Hypothesis rejected (Table 5.3).
Age
There was no significant difference in the percentage of younger patients, that is less than and equal to 30 years of age in the police referred group (n = 50, 49%) compared to patients referred from other sources (n = 39, 39%: $x^2 = 0.15$, df = 2, $p= 0.16$). Hypothesis rejected (Table 5.3).

Country of birth
There was no significant difference in the percentage of Australian born patients in the police referred group (n = 70, 69%) compared to Australian born patients referred by other sources (n = 58, 59%: $x^2 = 2.49$, df =1, $p= 0.08$). Hypothesis rejected (Table 5.3).

Religion
There was no significant difference in the percentage of patients who practiced Christianity in the police referred group (n = 52, 61 %) compared to patients referred by other sources (n = 57, 72 %: $x^2 = 2.91$, df = 2, $p= 0.23$). Hypothesis rejected (Table 5.3).

Relationship status
There was no significant difference in the percentage of patients who were in relationships in the police referred group (n = 16, 16%) compared to patients referred by other sources (n = 21, 21%: $x^2 = 0.77$, df = 1, $p= 0.38$). Hypothesis rejected (Table 5.3).

Living situation
There was no significant difference in the percentage of police referred patients who lived alone (n = 32, 32%) compared to patients referred by other sources (n = 47, 47%: $x^2 = 5.28$, df = 2, $p= 0.07$). Hypothesis rejected (Table 5.3).
<table>
<thead>
<tr>
<th>Demographic</th>
<th>Total (n = 200)</th>
<th>Police Referral (n = 101)</th>
<th>Other Referrals (n = 99)</th>
<th>(x^2)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>135 (68)</td>
<td>74 (73)</td>
<td>61 (62)</td>
<td>3.09</td>
<td>0.05</td>
</tr>
<tr>
<td>Female</td>
<td>65 (32)</td>
<td>27 (27)</td>
<td>38 (38)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; 30</td>
<td>111 (55)</td>
<td>51 (51)</td>
<td>60 (61)</td>
<td>0.15</td>
<td>0.16</td>
</tr>
<tr>
<td>&lt; = 30</td>
<td>89 (45)</td>
<td>50 (49)</td>
<td>39 (39)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Country of Birth</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>128 (64)</td>
<td>70 (69)</td>
<td>58 (59)</td>
<td>2.49</td>
<td>0.08</td>
</tr>
<tr>
<td>Other</td>
<td>72 (36)</td>
<td>31 (31)</td>
<td>41 (41)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christianity</td>
<td>109 (54)</td>
<td>52 (51)</td>
<td>57 (58)</td>
<td>2.91</td>
<td>0.23</td>
</tr>
<tr>
<td>No religion</td>
<td>39 (20)</td>
<td>22 (22)</td>
<td>17 (17)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>16 (8)</td>
<td>11 (11)</td>
<td>5 (5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No response</td>
<td>36 (18)</td>
<td>16 (16)</td>
<td>20 (20)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In relationships</td>
<td>37 (19)</td>
<td>16 (16)</td>
<td>21 (21)</td>
<td>0.77</td>
<td>0.38</td>
</tr>
<tr>
<td>Not in relationships</td>
<td>158 (79)</td>
<td>81 (80)</td>
<td>77 (78)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No response</td>
<td>5 (2)</td>
<td>4 (4)</td>
<td>1 (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living situation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alone</td>
<td>79 (40)</td>
<td>32 (32)</td>
<td>47 (47)</td>
<td>5.28</td>
<td>0.07</td>
</tr>
<tr>
<td>Homeless</td>
<td>15 (7)</td>
<td>9 (9)</td>
<td>6 (6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>106 (53)</td>
<td>60 (59)</td>
<td>46 (47)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 5.3: Demographics of patients referred by police and other sources

5.5 Diagnostic characteristics

In this section the diagnostic characteristics of the two groups were compared. Categorical variables included primary diagnosis. Bivariate variables included psychosis, substance use and suicide. Pearson Chi-Square tests of significance was used for both bivariate and categorical variables.
Primary diagnosis

Hypothesis 2: There will be differences in diagnostic categories between patients referred by police compared to patients referred by other sources.

Of the six diagnostic categories (schizophrenia, schizotypal and delusional disorders; mental and behavioural disorders due to psychoactive substance use; mood affective disorders; neurotic, stress-related and somatoform disorders; disorders of adult personality and behaviour; and other disorders) there was a significant difference between groups in diagnosis ($x^2 = 29.14$, df = 7, $p = 0.00$). Hypothesis accepted (Figure 5.1). Based on the post-hoc analyses, there was a significantly higher percentage of patients presenting with mental and behavioural disorders due to psychoactive substance use ($n = 35, 35\%$) in the police referred group compared to patients who were referred by other sources ($n = 10, 10\%$: $x^2 = 17.28$, df = 1, $p = 0.000$). There was also a significantly lower percentage of patients presenting with mood affective disorders in the police referred group ($n = 7, 7\%$) compared to patients referred by other sources ($n = 20, 20\%$: $x^2 = 7.54$, df = 1, $p = 0.006$).
(\(x^2 = 29.14, \text{df} = 7, p = 0.00, \text{NS} = \text{Non Significant}\))

**Figure 5.1:** Primary diagnosis of patients referred by police and other sources based on ICD 10

**Psychosis**

Hypothesis 3: There will be a difference in the percentage of patients diagnosed as psychotic in the group referred by the police compared to patients referred by other sources.

There was a significantly lower percentage of patients diagnosed as psychotic (n = 51, 51%) in the police referred group compared to the group referred by other sources (n = 63, 64%: \(x^2 = 4.72, \text{df} = 1, p = 0.03\)). Hypothesis accepted (Table 5.4).

**Substance use**

Hypothesis 4: There will be a difference in the percentage of patients referred by police presenting with substance use compared to patients referred by other sources.

There was a significantly higher percentage of patients presenting with drug and alcohol problems in the police referred group (n = 72, 71%) compared to the patients
referred by other sources (n = 49, 50%: $x^2 = 9.94$, df = 1, p = 0.00). Hypothesis accepted (Table 5.4).

Suicidal behaviour

Hypothesis 5: There will be a difference in the percentage of patients referred by police presenting with suicidal behaviour compared to patients referred by other sources.

There was no significant difference between the percentage of patients presenting with suicidal behaviour (n = 29, 29%) in the police referred group compared to the patients referred by other sources (n = 20, 20%: $x^2 = 1.96$, df = 1, p = 0.16). Hypothesis rejected (Table 5.4).

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Total (n = 200)</th>
<th>Police Referral (n = 101)</th>
<th>Other Referrals (n = 99)</th>
<th>$x^2$</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Psychosis Present</td>
<td>114</td>
<td>57</td>
<td>51</td>
<td>51</td>
<td>63</td>
</tr>
<tr>
<td>Psychosis Absent</td>
<td>86</td>
<td>43</td>
<td>50</td>
<td>49</td>
<td>36</td>
</tr>
<tr>
<td>Substance Misuse Present</td>
<td>121</td>
<td>61</td>
<td>72</td>
<td>71</td>
<td>49</td>
</tr>
<tr>
<td>Substance Misuse Absent</td>
<td>79</td>
<td>39</td>
<td>29</td>
<td>29</td>
<td>50</td>
</tr>
<tr>
<td>Suicidal Behaviour Present</td>
<td>49</td>
<td>25</td>
<td>29</td>
<td>29</td>
<td>20</td>
</tr>
<tr>
<td>Suicidal Behaviour Absent</td>
<td>151</td>
<td>75</td>
<td>72</td>
<td>71</td>
<td>79</td>
</tr>
</tbody>
</table>

**Table 5.4:** Diagnostic characteristics of patients referred by police and by other sources

5.6 Admission outcomes

In this section the outcomes following the admission of patients were compared between the two groups. Bivariate variables included legal status; admission to the PICU; and if they were put into seclusion. Categorical variables included types of PRN medications; and aggression. Pearson Chi-Square tests of significance was used.
for both bivariate and categorical variables. As data was not normally distributed, the Mann Whitney U test was used to test whether there was any difference between referral groups in the variable “length of stay”. Multivariate analysis of variance (MANOVA) was used to test for differences between groups in the total score of the Health of the Nation Outcome Scale (HoNOS) and the HoNOS sub-scores of behaviour, symptoms, impairment and social functioning.

Legal status
There was a significant difference between the two referral sources in the percentage of patients that were admitted under involuntary legal status. All 101 patients (100%) that were referred by the police were admitted under involuntary status (Section 24 was of involuntary status) and 68 (69%) patients referred by other sources were referred under involuntary status ($x^2 = 37.43$, df = 1, p= 0.00: Table 5.5).

<table>
<thead>
<tr>
<th>Legal status</th>
<th>Total (n = 200)</th>
<th>Police Referral (n = 101)</th>
<th>Other Referrals (n = 99)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Voluntary</td>
<td>31</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Involuntary</td>
<td>169</td>
<td>85</td>
<td>101</td>
</tr>
</tbody>
</table>

Table 5.5: A comparison of the legal status of patients referred by police and by other sources

PRN medications
Hypothesis 6: There will be differences in the types of PRN medications administered to patients referred by the police in comparison to patients referred by other sources.

There was no significant difference in the percentage of patients administered typical anti-psychotic medications in the police referred group (n = 65, 65%) compared to the patients that were referred by other sources (n = 51, 52%: $x^2 = 3.38$, df = 1, p= 0.07). Hypothesis rejected (Table 5.6).
There was no significant difference between patients referred by police (n = 9, 9%) compared to patients referred by other sources (n = 5, 5%) in the percentage who were administered atypical anti-psychotic medications ($x^2 = 1.14$, df = 1, $p = 0.29$). Hypothesis rejected (Table 5.6).

There was no significant difference between patients referred by police (n = 53, 53%) compared to patients referred by other sources (n = 49, 50%) in the percentage who were administered anxiolytic medications ($x^2 = 0.18$, df = 1, $p = 0.67$). Hypothesis rejected (Table 5.6).

There was significant difference between patients referred by police (n = 62, 61%) compared to patients referred by other sources (n = 45, 46%) who were administered sedative/hypnotic medications ($x^2 = 5.10$, df = 1, $p = 0.02$). Hypothesis accepted (Table 5.6).

<table>
<thead>
<tr>
<th>Medications</th>
<th>Total (n = 200)</th>
<th>Police Referrals (n = 101)</th>
<th>Other Referrals (n = 99)</th>
<th>x²</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRN medications</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administered</td>
<td>163</td>
<td>84</td>
<td>79</td>
<td>0.38</td>
<td>0.54</td>
</tr>
<tr>
<td>Typical Anti-psychotics</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administered</td>
<td>116</td>
<td>65</td>
<td>51</td>
<td>3.38</td>
<td>0.07</td>
</tr>
<tr>
<td>Atypical Anti-psychotics</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administered</td>
<td>14</td>
<td>9</td>
<td>5</td>
<td>1.14</td>
<td>0.29</td>
</tr>
<tr>
<td>Anxiolytics</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administered</td>
<td>102</td>
<td>53</td>
<td>49</td>
<td>0.18</td>
<td>0.67</td>
</tr>
<tr>
<td>Sedatives/Hypnotics</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administered</td>
<td>107</td>
<td>62</td>
<td>45</td>
<td>5.10</td>
<td>0.02</td>
</tr>
</tbody>
</table>

Table 5.6: Comparisons between patients referred by police and other sources in the types of PRN medications administered.
PICU admission

Hypothesis 7: There will be a difference in the percentage of patients referred by police who were admitted to the psychiatric intensive care unit (PICU) compared to patients referred by other sources.

There was a significantly higher percentage of patients admitted to the PICU ($n = 70, 69\%$) in the police referred group compared to patients who were referred by other sources ($n = 37, 37\%$: $x^2 = 20.49$, df =1, $p= 0.00$). Hypothesis accepted (Table 5.7).

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total ($n = 200$)</th>
<th>Police Referrals ($n = 101$)</th>
<th>Other Referrals ($n = 99$)</th>
<th>$x^2$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disposition</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PICU</td>
<td>107 53</td>
<td>70 69</td>
<td>37 37</td>
<td>20.49</td>
<td>0.00</td>
</tr>
<tr>
<td>Acute Units</td>
<td>93 47</td>
<td>31 31</td>
<td>62 63</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 5.7: A comparison between referral groups in disposition of patients to the PICU

Length of stay

Hypothesis 8: There will a difference in the length of stay in hospital for patients referred by police compared to patients referred by other sources.

There was a significant difference between the two referral groups in the length of stay in hospital. A significantly higher percentage of patients spent fewer days (2 days or less) in the police referred group ($n = 44, 40\%$) compared to patients referred by other sources ($n = 20, 20\%$: $x^2 =16.63$, df =1, $p= 0.01$). The length of stay category was set at 0-2 days because within this health facility, some patients are admitted for a short stay in the hospital, amounting to less than 48 hours. Hypothesis accepted (Table 5.8).
Table 5.8: A comparison between referral groups of the length of hospital stay

<table>
<thead>
<tr>
<th>Length of stay</th>
<th>Police (n = 101)</th>
<th>Others (n = 99)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>2 days or less</td>
<td>44</td>
<td>44</td>
<td>20</td>
</tr>
<tr>
<td>2 to 40 days or more</td>
<td>57</td>
<td>56</td>
<td>79</td>
</tr>
</tbody>
</table>

Hypothesis 9: There will be differences between patients referred by police and patients referred by other sources in the HoNOS total scores and the four HoNOS sub-scores, behaviour, symptom, impairment and social functioning.

There was a significant difference between referral groups in the multivariate results for the HoNOS total score and sub-scores (F = 5.29, df = 141, p = 0.0001). Results of the post-hoc analyses for differences between groups and the total score and domain scores follow.

There was a significant difference between referral groups in the univariate results for the total HoNOS scores (F = 16.51, p = 0.00). The mean total score of patients who were referred by police was 12.26 (95% CI: 10.76 – 13.76) compared to 8.37 (95% CI: 7.19 – 9.55) for patients who were referred by other sources. Hypothesis accepted (Table 5.9).

There was a significant difference between referral groups in behavioural scores (F = 16.41, p = 0.00). The mean behavioural score of patients who were referred by police was 4.61 (95% CI: 3.95 – 5.26) compared to 2.80 (95% CI: 2.20 – 3.40) for patients who were referred by other sources. Hypothesis accepted (Table 5.9).

There was no significant difference between referral groups in symptom scores (F = 1.28, p = 0.26). The mean symptom score of patients who were referred by police was 3.78 (95% CI: 3.25 – 4.30) compared to 3.36 (95% CI: 2.91 – 3.80) for patients who were referred by other sources. Hypothesis rejected (Table 5.9).
There was no significant difference between referral groups in impairment scores ($F = 1.99, p= 0.16$). The mean impairment score of patients who were referred by police was $1.00$ (95% CI: $0.60 - 1.40$) compared to $0.66$ (95% CI: $0.36 - 0.95$) for patients who were referred by other sources. Hypothesis rejected (Table 5.9).

There was a significant difference between referral groups in social functioning scores ($F = 6.06, p= 0.02$). The mean social functioning score of patients who were referred by police was $2.77$ (95% CI: $1.95 - 3.59$) compared to $1.52$ (95% CI: $0.93 - 2.11$) for patients who were referred by other sources. Hypothesis accepted (Table 5.9).
<table>
<thead>
<tr>
<th>Variable</th>
<th>Police</th>
<th>Others</th>
<th>F (Univariate)</th>
<th>P</th>
<th>F (Multivariate)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>HoNOS total score</td>
<td>12.26 (10.76 – 13.76)</td>
<td>8.37 (7.19 – 9.55)</td>
<td>16.51</td>
<td>0.00</td>
<td>5.29</td>
<td>0.0001</td>
</tr>
<tr>
<td>Sample N</td>
<td>73</td>
<td>73</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behaviour</td>
<td>4.61 (3.95 – 5.26)</td>
<td>2.80 (2.20 – 3.40)</td>
<td>16.41</td>
<td>0.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample N</td>
<td>79</td>
<td>74</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Symptoms</td>
<td>3.78 ( 3.25 – 4.30 )</td>
<td>3.36 (2.91 – 3.80)</td>
<td>1.28</td>
<td>0.26</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample N</td>
<td>76</td>
<td>76</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impairment</td>
<td>1.00 ( 0.60 – 1.40)</td>
<td>0.66 (0.36 – 0.95)</td>
<td>1.99</td>
<td>0.16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample N</td>
<td>74</td>
<td>73</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Functioning</td>
<td>2.77 (1.95 – 3.59)</td>
<td>1.52 (0.93 – 2.11)</td>
<td>6.06</td>
<td>0.02</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample N</td>
<td>74</td>
<td>73</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 5.9: A comparison of HoNOS total scores and four HoNOS sub-scores between patients referred by police and patients referred by other sources
Aggressive behaviour
Hypothesis 10: There will be a difference in the percentage of patients referred by police displaying physical attacks and fear-inducing behaviour compared to patients referred by other sources.

There was a significant difference in the percentage of patients that displayed physical attacks (n = 4, 4%) and fear inducing behaviour (n = 45, 45%) in the police referred group compared to the patients referred by other sources, none (n = 0, 0%) of whom displayed physical attacks but did display episodes of fear inducing behaviour (n = 13, 13%) (x² = 30.02, df = 1, p = 0.00). Hypothesis accepted (Table 5.10).

Seclusion
Hypothesis 11: There will be a difference in the percentage of patients referred by the police who spent time in seclusion compared to patients referred by other sources.

There was a significantly higher percentage of patients referred by the police who spent time in seclusion (n = 30, 30%) compared to the patients referred by other sources (n = 12, 12%) who were secluded (x² = 9.32, df = 1, p = 0.00). Hypothesis accepted (Table 5.10).
<table>
<thead>
<tr>
<th>Clinical Variable</th>
<th>Total (n = 200)</th>
<th>Police Referrals (n = 30)</th>
<th>Other Referrals (n = 12)</th>
<th>x²</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggression</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Attacks</td>
<td>4  2</td>
<td>4  4</td>
<td>0  0</td>
<td>30.02</td>
<td>0.00</td>
</tr>
<tr>
<td>Fear Inducing behaviour</td>
<td>58  29</td>
<td>45  45</td>
<td>13  13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Aggression</td>
<td>138  69</td>
<td>52  51</td>
<td>86  87</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seclusion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present</td>
<td>42  21</td>
<td>30  30</td>
<td>12  12</td>
<td>9.32</td>
<td>0.00</td>
</tr>
<tr>
<td>Absent</td>
<td>158  79</td>
<td>71  70</td>
<td>87  88</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 5.10: A comparison of violent behaviour and seclusion between patients referred by police and patients referred by other sources

5.7 Logistic regression results

A forward stepwise Likelihood Ratio Logistic Regression analysis was performed to screen predictors for the outcome referral source. The predictors that were entered were age, gender, whether or not they were psychotic, suicidal, had a drug or alcohol problem, lived alone or were Australian-born. Data from all 200 cases was available for this analysis. One, two and three step models were all significantly predictive models for whether or not people were referred by police or other sources (p=0.002, p<0.001, p<0.001). In the one step model drug or alcohol problems was the only predictor entered. In the two step model the predictors drug or alcohol problems and living alone were entered and in the three step model the predictors drug or alcohol problems, living alone and psychosis were entered. The overall prediction rate for the three step model (61.5% overall) was slightly higher than the one and two step models (61.0% and 57.0% respectively). When all three variables were entered into the three step model the Exponential B value for the predictors drug or alcohol problems, psychosis and living alone were respectively 2.59 (95% confidence interval: 1.41-4.74), 0.55 (95% confidence interval: 0.30-0.99) and 0.45 (95% confidence interval: 0.25-0.83). Therefore, based on this data the most important predictor for a police referral was drug or alcohol problems. However, although more people that were referred from other sources were diagnosed with psychosis or
lived alone, these variables also contributed positively to the likelihood of a police referral.

<table>
<thead>
<tr>
<th></th>
<th>Chi –Square</th>
<th>df</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>10.029</td>
<td>1</td>
<td>0.002</td>
</tr>
<tr>
<td>Step</td>
<td>10.029</td>
<td>1</td>
<td>0.002</td>
</tr>
<tr>
<td>Block</td>
<td>10.029</td>
<td>1</td>
<td>0.002</td>
</tr>
<tr>
<td>Model</td>
<td>10.029</td>
<td>1</td>
<td>0.002</td>
</tr>
<tr>
<td>Step 2</td>
<td>6.277</td>
<td>1</td>
<td>0.012</td>
</tr>
<tr>
<td>Step</td>
<td>16.305</td>
<td>2</td>
<td>0.000</td>
</tr>
<tr>
<td>Block</td>
<td>16.305</td>
<td>2</td>
<td>0.000</td>
</tr>
<tr>
<td>Model</td>
<td>16.305</td>
<td>2</td>
<td>0.000</td>
</tr>
<tr>
<td>Step 3</td>
<td>4.035</td>
<td>1</td>
<td>0.045</td>
</tr>
<tr>
<td>Step</td>
<td>20.340</td>
<td>3</td>
<td>0.000</td>
</tr>
<tr>
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</tr>
<tr>
<td>Model</td>
<td>20.340</td>
<td>3</td>
<td>0.000</td>
</tr>
</tbody>
</table>

**Table 5.11:** Logistic Regression Table - A
<table>
<thead>
<tr>
<th>Observed</th>
<th>Source of Referral</th>
<th>Others</th>
<th>Police</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step1</td>
<td>Others</td>
<td>50</td>
<td>49</td>
<td>50.5</td>
</tr>
<tr>
<td></td>
<td>Police</td>
<td>29</td>
<td>72</td>
<td>71.3</td>
</tr>
<tr>
<td></td>
<td>Overall Percentage</td>
<td></td>
<td></td>
<td>61</td>
</tr>
<tr>
<td>Step2</td>
<td>Others</td>
<td>71</td>
<td>28</td>
<td>71.7</td>
</tr>
<tr>
<td></td>
<td>Police</td>
<td>58</td>
<td>43</td>
<td>42.6</td>
</tr>
<tr>
<td></td>
<td>Overall Percentage</td>
<td></td>
<td></td>
<td>57</td>
</tr>
<tr>
<td>Step3</td>
<td>Others</td>
<td>55</td>
<td>44</td>
<td>55.6</td>
</tr>
<tr>
<td></td>
<td>Police</td>
<td>33</td>
<td>68</td>
<td>67.3</td>
</tr>
<tr>
<td></td>
<td>Overall Percentage</td>
<td></td>
<td></td>
<td>61.5</td>
</tr>
</tbody>
</table>

Table 5.12: Logistic Regression Table - B
<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>S F</th>
<th>Wald</th>
<th>df</th>
<th>Sig</th>
<th>Exp(B)</th>
<th>Lower</th>
<th>Upper</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step1</td>
<td>Drug/Alc or not</td>
<td>0.930</td>
<td>0.298</td>
<td>9.733</td>
<td>1.000</td>
<td>0.002</td>
<td>2.533</td>
<td>1.413</td>
</tr>
<tr>
<td></td>
<td>Constant</td>
<td>0.545</td>
<td>0.233</td>
<td>5.446</td>
<td>1.000</td>
<td>0.020</td>
<td>0.580</td>
<td></td>
</tr>
<tr>
<td>Step2</td>
<td>Alone</td>
<td>0.754</td>
<td>0.304</td>
<td>6.130</td>
<td>1.000</td>
<td>0.013</td>
<td>0.471</td>
<td>0.259</td>
</tr>
<tr>
<td></td>
<td>Drug/Alc or not</td>
<td>0.995</td>
<td>0.305</td>
<td>10.646</td>
<td>1.000</td>
<td>0.001</td>
<td>2.71</td>
<td>1.488</td>
</tr>
<tr>
<td></td>
<td>Constant</td>
<td>0.287</td>
<td>0.255</td>
<td>1.268</td>
<td>1.000</td>
<td>0.260</td>
<td>0.750</td>
<td></td>
</tr>
<tr>
<td>Step3</td>
<td>Alone</td>
<td>0.790</td>
<td>0.309</td>
<td>6.551</td>
<td>1.000</td>
<td>0.010</td>
<td>0.454</td>
<td>0.248</td>
</tr>
<tr>
<td></td>
<td>Drug/Alc or not</td>
<td>0.951</td>
<td>0.308</td>
<td>9.504</td>
<td>1.000</td>
<td>0.002</td>
<td>2.587</td>
<td>1.414</td>
</tr>
<tr>
<td></td>
<td>Psychotic or not</td>
<td>0.607</td>
<td>0.304</td>
<td>3.987</td>
<td>1.000</td>
<td>0.046</td>
<td>0.545</td>
<td>0.301</td>
</tr>
<tr>
<td></td>
<td>Constant</td>
<td>0.107</td>
<td>0.324</td>
<td>0.110</td>
<td>1.000</td>
<td>0.741</td>
<td>1.113</td>
<td></td>
</tr>
</tbody>
</table>

**Table 5.13**: Logistic Regression Table - C
5.8 Overall summary of phase one results

The findings indicate that patients referred by police to mental health services in NSW were similar to patients referred by other sources in respect to their demographic characteristics, but had different characteristics in relation to diagnosis and admission outcomes.

The distribution of psychiatric diagnosis among patients referred by police differed to those referred by others. Patients referred by police were significantly more likely to be diagnosed with a mental and behavioural disorder due to psychoactive substance use; more likely to have a secondary diagnosis of substance use; less likely to be diagnosed with a mood affective disorder; and less likely to be diagnosed as psychotic.

Other aspects of the clinical presentation of the two groups also showed clear differences. The outcomes following the admission of patients to the hospital indicated that patients referred by the police were significantly more likely to: be administered sedative/hypnotic medications; be admitted to the psychiatric intensive care unit (PICU); spend fewer days in hospital; have higher total HoNOS scores (indicating higher levels of difficulties in relation to overall functioning); experience problems with behaviour and social functioning; exhibit aggressive behaviour and require seclusion in the PICU.

5.9 Conclusion

The results presented in this chapter suggest that persons referred by police to the psychiatric hospital in New South Wales Australia represented a group of patients with different characteristics compared to patients referred by other sources. The reasons contributing to these patients coming to the attention of police in the community and for referral to the hospital was mostly due to bizarre behaviour and threats of suicide. Only a small percentage of patients were referred by police for violent or threats of violent behaviour. The threat of aggression amongst the police referred patients however, was more a risk factor following their presentation and admission to the hospital environment and this was in the context of a higher number
of patients displaying incidents of fear inducing behaviour and a small number of patients displaying physical attacks. The implementation of restrictive measures such as admission to a locked environment (PICU) would have become necessary in an effort to control for the behaviour of aggression or potential aggression. While the police referred patients were more likely to be administered sedative/hypnotic medication and be secluded, it is unknown whether these were for reasons of aggression or potentially aggressive behaviour as a risk minimization measure for the safety of the patient and others. The qualitative phase of the study explores the experiences of nurses caring for patients referred by the police. The focus of Chapter 6 is on Phenomenology, the methodological framework underpinning the qualitative phase of the study.
Chapter 6 : Phase Two of the Study

6.1 Introduction

The methodological framework for phase two, the qualitative phase of the study, was derived from Heideggerian hermeneutics phenomenology and the procedures for data collection, analysis and interpretation were guided by the work of van Manen (1990). The first part of this chapter begins with the aims of the qualitative phase, followed by the reasons which contributed to the choice of phenomenology for the study. The in-depth discussion of the methodology traces the development of hermeneutic phenomenology and discusses its contribution to nursing’s ways of understanding human experience in the context of health and illness. The chapter concludes with the application of Heideggerian philosophy to the current study, an introduction to the participants and the interviews held with participants and finally the procedures involved in interpretive analysis and hermeneutic phenomenological writing for this methodology.

6.2 Aim of phase two of the study

The aim of phase two of the study was to explore nurses’ experiences of caring for patients referred by the police. Guided by the hermeneutical method, this section of the study sought to discover meaning and understanding of the experiences of nurses as expressed in their own accounts of caring for patients referred by police.

6.3 Reasons contributing to the choice of phenomenology

For the qualitative research phase for this study, choosing a research design, or more correctly a methodology from the wide variety of approaches available, proved to be a daunting task. Extensive reading on other methodologies including grounded theory, ethnography and interpretive descriptive approaches was undertaken.
Nevertheless, irrespective of the methodology chosen, firstly it had to be well matched to the values and philosophical orientation of the researcher and secondly, it had to be a good match to the research problems and questions. For these reasons, phenomenology, closely aligned with another philosophical position known as hermeneutics, was found to be the best suited methodology for the study because they both concerned exploring, describing and discovering uncensored phenomena or the lived experience of subjects in that context. In short, this methodology fitted the purpose of this study and was considered most appropriate in order to explore the experiential descriptions of the phenomena.

After utilizing a quantitative approach for the first phase of the study, the results of an investigation into the characteristics of persons referred by the police to the PICU and the acute units of a psychiatric hospital was already obtained. A phenomenological approach seemed a good fit with my intent to explore the lived experiences of nurses caring for persons referred by the police with the overall purpose of seeking to discover meaning and understanding of the experiences of nurses caring for patients referred by the police.

The information that follows in this chapter describes a historical perspective on phenomenology, its relationship to knowledge development, and the procedures necessary to embark on this form of qualitative research. While Heideggerian phenomenology provided the framework on which this study was based, it was van Manen’s (1990) eclectic approach that guided the method and processes of the current study. Van Manen’s (1990) Researching Lived Experience: Human Science for an Action Sensitive Pedagogy was found to be particularly valuable because he provided the “how to carry it out” guide to the research act, enlisting what he referred to as procedures rather than a method on how the analysis of the data should be carried out. The process of analysis through writing and language was made clear through van Manen’s suggestions for textually organising writing. Organising writing was not concerned with merely arranging the text but in searching for a sense of form and wholeness of the text consistent with the methodology. Van Manen’s (1990) hermeneutic phenomenological human science approach provided support for
the study’s method and a practical way of linking phenomenology as philosophy and health care research method.

6.4 Historical perspective on phenomenology

Phenomenology is a philosophy, a perspective and an approach to practice and research (Crotty, 1996). It is best described as the study of human experience and the way we come to understand our everyday world (Gurwitsch, 1966). Van Manen (1990) sums up phenomenology as the study of the life-world as is, or put in another way, pre-reflectively, meaning, prior to conceptualizing, categorizing or reflecting on it. Phenomenology “aims at gaining a deeper understanding of the nature or meaning of our everyday experiences” and asks “what is this or that kind of experience like?” (van Manen, 1990, p.9). Phenomenology is not about the discovery of theory to explain the world but rather it offers the possibility of plausible insights that bring us in more direct contact with the world. Phenomenological thinking describes the structure of experience in the way that they present themselves to the consciousness (Dreyfus, 1996). Therefore, there is no recourse to theory or deduction in phenomenological thinking (Dreyfus, 1996).

Phenomenology was born out of the work of German philosophers and social scientists, including its forerunner, Edmond Husserl (1964). It was his student Heidegger, who took up his work and placed a different emphasis on the approach, and as it developed over time others such as Gadamer (1975) and van Manen (1990) did the same. Consequently, there are now four basic phenomenological perspectives that are distinctive in their approaches.

6.5 Husserl’s transcendental descriptive phenomenology

Husserl’s transcendental descriptive phenomenology was based on the belief that whatever the true example of the phenomena was, it was within the things themselves which could not be separated from the experience of them. Husserl’s phenomenology described how the world was constructed and experienced through consciousness. According to Husserl (1964), it was intentionality, which he described as the inseparable connectedness of the human being to the world through
consciousness of something, which was required for someone to experience something.

Central to Husserl’s (1970) concept of phenomenology was the idea of the world of lived experience in which he implied how a person immediately experienced the world pre-reflectively or the world as already there. This was supported by van Manen (1990) who confirmed that lived experience was the starting point and end point of phenomenological research. Inherent within van Manen’s approach to the lived experience was the notion that the relationship between the self and the world frames the experience of the phenomena and the individuals understanding of its meaning. The focus of Husserls’ transcendental phenomenology was to explore, describe and interpret how a given phenomenon presents itself to human consciousness and what it means for people and their world.

6.6 Heideggerian hermeneutic interpretive phenomenology

Heideggerian phenomenology, more commonly known as hermeneutics is described as the theory and practice of interpretation. The work of Martin Heidegger asserts that the interpreter is linked to the object of interpretation by pre-understandings that prevent the adoption of a neutral stance (Bleicher, 1980). Heidegger was a former student and colleague of Husserl but he developed a shift in his philosophical thinking regarding the nature of persons and their relationship to the world. Spiegelberg (1975) describes the influence of Martin Heidegger on modern day philosophy as “an enigma” (p. 271) because of the immense impact his work has on the many areas of twentieth century thinking. The move from epistemology (the theory of knowledge) and the adoption of ontology (being) has become central to Heideggerian hermeneutical thought after he identified that traditional philosophers had continuously failed to address the real issues or ask the important questions concerned with the true nature of what exists in the world (Wulff, Pederson & Rosenberg, 1990). Comparatively, Heidegger’s philosophy centred on his belief that human reality and lived experience was existence in the world which was in stark contrast to Husserl’s belief that human reality was consciousness of the natural world. Central to the framework of the current study, other concepts of Heidegger’s phenomenology which informs van Manen’s contemporary method of inquiry.
includes hermeneutics, Being and time/Being-in-the-world, understanding and language, time and the hermeneutic circle.

### 6.6.1 Hermeneutics

Heideggerian phenomenology is grounded in hermeneutics. Hermeneutics has its tradition in Greek Mythology and is linked to the God Hermes who interpreted his message to humankind (Bleicher, 1980). It is a term derived from the Greek word hermeneia, meaning interpretation and is defined as “the theory or philosophy of the interpretation of meaning” (Bleicher, 1980, p.1). According to Bleicher, (1980), hermeneutic interpretation, described as an art as well as a science, became a creative reconstruction with the interpreters approximating as closely as possible the perspective of the author while reconstructing the original creative act within themselves. Heidegger used hermeneutics to interpret human Being suggesting that hermeneutics is essentially “the attempt to understand the phenomena of the world as they are presented to us, the attempt to understand how it is we go about understanding the world as it is presented and the attempt to understand being itself” (Cohen, Kahn & Steeves, 2000, p. 5).

### 6.6.2 Heidegger’s being and time/being-in-the-world

In his major work “Being and Time” it was quite obvious that Heidegger had moved away from Husserlian phenomenology after denying the notion of phenomenological reduction (1927; 1962). The Husserlian phenomenological approach was criticised as being reductionist because it attempted to separate the person from the world. The Cartesian mind/body dichotomy, maintained in Husserlian phenomenology, viewed the mind as being independent of the body. The Husserlian phenomenology was described by Walters (1994) as “the culmination of the Cartesian tradition” (p.136) where people’s relationship to the world is thought of in terms of detached subjects knowing objects. Heidegger believed that we are influenced by what we do in the world, therefore it is impossible to bracket out our experiences (Dreyfus, 1996). Heidegger stated that as human beings, we first have to be dwellers in the world prior to us being observers in the world thus transforming the long held Cartesian “cogito” to Heidegger’s hermeneutic understanding of “Being-in-the-World” (Crusiuss, 1991).
Heidegger’s seminal work “Being and Time” (1927; 1962) has been compared in its greatness to Hegel’s “Phenomenology of Spirit”, Plato’s “Republic”, and Kant’s “Critique of Reason” (Inwood, 1997). Inwood (1997) describes the book as one of the most difficult books to understand in its overall structure and somewhat obscure and original use of language. Other authors such as Guignon (1993) describe it as bringing “a breath of fresh air to traditional philosophical puzzles” (p. 4). Heidegger (1962) restated the question of being and for the first time Western philosophers were invited to ask “What is being, what is beingness in its being” (Steiner, 1978, p.79). He (1962) argued that although the subject of “being” is generally held to be self evident, “the very fact that we live in an understanding of being and that the meaning of being is still veiled in darkness proves that it is necessary in principle to raise the question again” (p.23).

In order to capture the meaning and describe the term human “Being” Heidegger uses the German terminology “Dasein”. The term has many meanings including “to exist”, “to be there”, and “to be here” (Inwood, 1997, p. 22) and is likened to a “journeying through life”. Dasein is “human Being-in-the-world” (Crusius, 1991, p.22) because humans are immersed in the world and this world is the root of all ontological understanding (Steiner, 1978). Heidegger pointed out that to be a human is to already understand what is meant by “Being” (Dreyfus, 1991).

Heidegger referred to the term “world”, not as a geographical place but as a personal world, inseparable from the self (Palmer, 1996). People and their environment are not at two distinct poles but co-constitute each other (Dreyfus, 1991). According to Dreyfus (1991), Cartesian and Husserlian phenomenology place too much emphasis on the conscious subject which is in contrast to Heidegger’s Dasein which cannot be interpreted as a conscious subject because consciousness is merely grounded in the temporality of Dasein, which then makes the individual subject dependent on shared and social practices.
6.6.3 Time

Heidegger’s concept of time focused on lived time or temporality, a time that either sped up or slowed down depending on one’s experience. In Heidegger’s Dasein, time as past, present and future carried specific meanings. The past lives on in the present thereby informing the present situation. Dasein then rebounds into the present informing the immediate future equally. Temporality then, is a continuous experience because when we reflect on our experience, it is an exposure into the immediate past and future or as noted by Sokolowski (2000), “the initial absences of pastness and futurity are present in all our experiences” (p. 136).

Van Manen’s (1990) approach to phenomenology encompasses Heidegger’s concept of time. Van Manen noted that in questioning the temporal aspects of an experience the significance and meaning inherent may be disclosed and described. Reflection on lived experience then is recollective, meaning that one cannot reflect on an experience while at the same time living through it.

6.6.4 Heidegger’s understanding and language

Heidegger argued that we are thrown into a world that is already rich with knowing and understanding (Steiner, 1978) and the shared skills and everyday practices that we are socialized into provide the necessary conditions for us to pick up objects, to understand ourselves as subjects and to make sense of our world and our lives (Dreyfus, 1991). According to Benner and Wrubel (1989), from the time of birth, people’s backgrounds provide them with cultural meanings which are incorporated into their lives. These meanings are shared and passed on culturally through language, skills and practices. Similarly, people come to an encounter with a history of culture and experience that is bound in language (O’Brien, 2003). As ontology, Heideggerian phenomenology transcends descriptions to include interpretation of phenomena in historical, cultural and social contexts. It does this through the language of hermeneutics. Heidegger (1962) describes hermeneutics as an interpretation of Being, an understanding of Being through language. According to O’Brien (2003) the process of understanding is brought together when perspectives influenced by the past “are articulated through shared language” (p.196).
Gadamer (1975) believed that understanding was rooted in a tradition and that all tradition was married to language. According to Gadamer (1975), language is at the core of understanding as the “essence of tradition is to exist in the medium of language” (p. 389). In addition Gadamer stated that “the fusion of horizons that take place in the understanding is actually the achievement of language” (1989, p.378). The concept of understanding in Gadamer’s hermeneutics brings together the horizons of the past and the present.

6.6.5 The hermeneutic circle

The hermeneutic circle refers to the way humans develop understanding of themselves and their world. It was developed from the hermeneutic tool that was used for centuries (Ricoeur, 1974) to develop text. The hermeneutic circle is a process of interpreting experience or a text, in which one must move back and forth between an overall interpretation and an interpretation of significant parts of the experience. The hermeneutic circle of understanding is a dialectical process of moving between a background of shared cultural meanings and practices and a more specific experience within the broader life-world (Walters, 1994). Gadamer (1988) described the hermeneutic circle as that of a “rule” which required one to understand the whole from the individual and the individual from the whole. However, Martin Heidegger dismissed the structural confines of a formal relationship between the individual and the whole by recognizing that understanding is constantly determined by pre-understanding (Gadamer, 1988).

Pre-understanding is a term used by Heidegger which refers to the context and culture into which we are all born and according to Crusius (1991), no human can exist without a context. Audi (1995) describes humans as self interpreting beings who bring into their circle of hermeneutic understanding a background that dictates what is real; and a pre-understanding, which is brought into focus when interpreting a new situation (Koch, 1995). Furthermore, Koch (1995) suggested that our understanding of our world is formed from the world in which we live but at the same time we are developing our world from our own experiences. According to Walters (1994), this is the essence of Heidegger’s hermeneutic circle – the movement
between the shared cultural background and a specific experience during the interpretation process.

6.7 Van Manen’s human science approach

According to van Manen (1990) an educationalist, contemporary hermeneutic phenomenology was committed to understanding the everyday lived experience, seeking descriptions of the way the world is experienced, the nature of conscious knowing. Van Manen’s human science approach addressed how things appear and how they became meaningful. Van Manen’s approach was clearly informed by Heidegger’s philosophy and he supported Heidegger’s desire to expose often unreflected meanings ascribed to phenomena.

Consistent with Heidegger’s search for the ontological meaning of being, the intent of van Manen (1990) was to search for the meaning of Being in a particular context that could add to the meaning of Being in the broader context of “Being-in-the-world”. Furthermore, van Manen’s belief that language was a pivotal medium for hermeneutic inquiry was also consistent with the views of Heidegger (1962).

The idea of narrative is closely aligned with hermeneutic phenomenology. According to van Manen, language was the method of narrative and he elaborated that if a description was phenomenologically powerful, it then acquired a transparency that permitted the reader to see the deeper significance or meaning of the lived experience it described. Van Manen argued that language and writing was therefore essential in revealing the lived experience of the person and the meaning ascribed to that experience. Cohen, Kahn, and Steeves (2000) support this view explaining that the movement from identification and comparison of themes to coherent picture of the whole occurs through the reflective process of writing and rewriting.

Heidegger’s influence on van Manen’s approach to hermeneutic human science provided the necessary understanding of the development of phenomenological thought and its implication for nursing research in particular for the current study. The goal of phenomenology according to van Manen (1990) was to understand the nature and the meaning of the phenomenon as an essentially human experience.
Therefore as a methodology, phenomenology has been widely embraced as a philosophy and method for nursing research to extend the understanding of nurses’ in the context of health and illness related phenomena (Darbyshire, 1994; Thornton & White, 1999). Van Manen (1990) gives a thoughtful description of his approach for phenomenological research describing it as a dynamic interplay between the following four activities: (1) turning to a phenomenon which seriously interests us and commits us to the world; (2) investigating experience as we live it rather than how we conceptualise it; (3) reflecting on the essential themes which characterize the phenomenon; and (4) describing the phenomenon through the art of writing and rewriting (pp. 30-31).

In seeking to meet the requirements of the four activities outlined by van Manen (1990), the following perspectives are presented for this study. The motivation for the commencement of this study on “psychiatric referrals from the police” arose from an identification of a gap in the literature following my completion of a project to meet the requirements of a post graduate course-work Master of Nursing (Mental Health). The knowledge acquired on the topic was extensive and fulfilled van Manen’s (1990) second procedural activity. This was achieved after the writer had undertaken an investigative report for the Master of Nursing (Mental Health). The report investigated the role of the police in mental health through an extensive review of the literature and from wide reading which partially contributed to the literature review in Chapter 2 for this study.

Part of the writer’s interest in relation to the mental health and law enforcement system was to gain a better understanding about the role of police in mental health. The literature on interactions between mental health and law enforcement systems was extensive particularly in the USA and the UK, but despite the establishment of formalised partnerships between the two systems in Australia, there was a paucity of literature within the Australian context.

There was no qualitative literature found that addressed the implications for mental health nursing when caring for persons referred by police. The experiences of the writer as a nurse working in a mental health facility, was to regularly sight police
presenting with apprehended persons for assessment at the admission unit almost on a daily basis. There was an increased need by the writer to know more about the characteristics of persons referred by the NSW police to mental health services and to explore the experiences of nurses who cared for these patients referred by the police.

6.8 Phenomenology as a methodology for nursing research

Phenomenology has been widely adopted by nurse researchers as a method of inquiry into exploring the nature and meaning of various phenomena (Benner & Wrubel, 1989; Koch, 1994; Madjar & Walton, 1999; Sadala & Adorno, 2000). Various studies by these researchers have provided rich understandings of the lived experiences of patients, families and nurses enhancing nurses’ interest in humanistic caring processes (Omery, 1983). Therefore, phenomenology with its philosophical basis in human experience has become a valued and useful mode of extending nurses’ understanding of health and illness. In addition, phenomenology is often the most appropriate approach for the study of concepts and issues within nursing whose meanings have remained unclear or unexplored (Munhall & Oiler, 1986) where the experience and meaning to human beings is sought.

6.9 Criteria for selecting the phenomenological approach

The criteria suggested by Streubert and Carpenter (1995) for selecting the phenomenological approach include: the need for further clarification on the chosen phenomena; clarification for the shared lived experience being the best source of data for the phenomena under question; the time frame required for the completion of the study; the audience the research will be presented to; and the researchers own personal style and ability to engage in the method in a rigorous manner.

In meeting the requirements of Streubert and Carpenter’s (1995) criteria, further clarification for the reasons for the chosen phenomena revolved firstly, as previously mentioned, around the paucity of literature in Australia on psychiatric referrals from the police and secondly around the implications for mental health nursing when caring for persons referred by the police. It was anticipated that the best source of
data collection when attempting to capture the rich and descriptive experiences of nurses when caring for persons referred by the police, would be from the nurses themselves. Through utilization of a framework informed by Heideggerian hermeneutic phenomenology, it felt possible to be able to explore the broad question “What does the experience of caring for persons referred by the police mean to nurses?” By adopting a questioning stance the intention was to capture the deeper meaning of the lived experience of the nurses as described. Through their language and my writing the meaning ascribed to their experiences of caring for police referred patients could be revealed.

The four general criteria used to evaluate the rigour of this qualitative research were: credibility; dependability; transferability and confirmability. Credibility was concerned primarily with the accuracy of description and interpretation of experiences. Dependability, also referred to as consistency, applies when the researcher in a qualitative paradigm acknowledges the constant state of change and attempts to account for those changes within the context of the study. Transferability in qualitative research refers to a deep understanding of the meaning of the phenomena and how meanings are applied within a particular context and required in order to transfer findings between settings. Confirmability refers to the accuracy of the data collected within the context and also about the trustworthiness of the researcher, the methods of collection, analysis and interpretation and that of the participants as well.

6.10 Application of Heideggerian philosophy to the current study

Heideggerian phenomenology was the most appropriate methodology for this study that sought to discover meaning and understanding of the experiences of nurses when caring for persons referred by the police. This type of phenomenology transcends description to include interpretation of phenomena in social cultural and historical contexts (Allen, Benner, & Diekelmann, 1986). The fundamental beliefs underpinning Heideggerian phenomenology, in particular the contention that “understanding” and “interpretation” are a priori ways of being-in-the-world influenced my thinking on how to approach my conversations with the participants of the study. Heideggerian phenomenology offered an appropriate methodology to
transcend current notions of health to incorporate the notions of the experiences of nurses caring for persons referred by the police. This understanding was derived through the hermeneutic language (Heidegger, 1971a). Heidegger used hermeneutics to interpret human Being, suggesting that hermeneutics is, essentially, “the attempt to understand the phenomena of the world as they are presented to us, the attempt to understand how it is we go about understanding the world as it is presented and the attempt to understand being itself” (Cohen et al., 2000, p.5).

Hermeneutics was the language that expressed, interpreted and translated meanings about the experiences of nurses when caring for certain patient populations. As an ontology Heideggerian phenomenology was concerned with what it means to be a person as well as recognizing the inseparable relationship of the person with their world (Leonard, 1989). It involved incorporating an interpretation of “being-in-the-world”, “co-constitution”, “the hermeneutic circle” and “the fusion of horizons” in order to understand people’s experiences. Thus, hermeneutic phenomenology provided the framework “that defines the view of persons and their being-in-the-world” (O’Brien, 2003, p.196).

When approaching the conversations with participants, it was firstly done as a nurse with an attitude of care and secondly as a researcher. Within the concept of care, the fusion of thought, actions and feelings had the potential of creating meaningful understanding and providing directions for action (Benner & Wrubel, 1989). Heidegger’s extension of the hermeneutic circle to an ontological expression of Dasein has been described as an understanding and caring mode of “Being” (Reeder, 1988). The use of the word “caring” in this context indicates that certain situations and things matter more than others. In hermeneutics, the researcher is also the instrument for the research process. The researcher interacts with the researched and their words by incorporating and modifying pre-understandings to result in understanding lived experiences. I came to this study with the experience of having worked in acute admission units, and the PICU. I was aware of some of the difficulties experienced by nurses when patients were apprehended and brought to the hospital against their will by police for a mental state assessment. The research questions that I raised arose from this experience and it is through the lens of my
experience that I could formulate the questions to ask of the nurses, and understand their descriptions. My initial concern was trying to understand who these patients referred by the police were and whether some of the difficulties and frustrations expressed by the nurses were an accurate reflection of their descriptions of the patients. The goal of my analysis was to capture an ontological understanding of the participants in their own world by interpreting shared meanings from the accounts they gave of their lived experiences, thus preserving the details and the context of their individual experiences (Sorrell & Redmond, 1995). By adopting the phenomenological perspective, the study approached the research question not so much as a problem in search of answers but as a complex human experience to be fully explored as it is lived. The focus of the participants through their conversations was on the world that they described - a world that they existed in and interacted with their daily work environment which they brought into focus as they described their experiences. The new understandings they developed from their experiences in this world were formed within their own hermeneutic circles of understanding and against the background of the meanings already present in their shared social environment and their own previously developed interpretations (Heidegger, 1962).

While the study utilized a predominantly hermeneutic framework informed by Heidegger, the approach adopted for the analysis was largely driven by van Manen’s (1990) eclectic approach. Van Manen (1984) emphasised that phenomenology was the study of life-world, the world as we immediately experienced it rather than as we conceptualised, categorised or theorised about it. Phenomenology aims at describing and explicating the meaning structures of everyday life (van Manen, 1990) and gaining insight into practical experiences. According to van Manen (1984), “phenomenology differs from almost every other science in that it attempts to gain insightful descriptions of the way we experience the world. So phenomenology does not offer us the possibility of effective theory with which we can now explain/ and or control the world but rather it offers us the possibility of plausible insight which brings us more direct contact with the world (p. 37-38)".
6.11 The participants

In qualitative research, data can be elicited from one or a small number of people to understand the world as experienced by them (Kvale, 1996). According to O’Brien (2003), it is the richness of the data collected from participants that is of importance rather than the number of participants recruited for a study. Consequently, a total of nine nurses from the three units were recruited for participation. This procedure constituted another recommendation outlined by van Manen (1990) in his guide to data collection – that is to collect descriptions of the phenomena of interest from others. According to van Manen (1990), the primary criteria in selecting participants is that they should have direct personal knowledge about the phenomenon being explored and be able to readily discuss their experience. In keeping with van Manen’s suggestion, in order to be eligible for inclusion in the study, only registered nurses with a minimum of two years nursing experience in acute and/or the psychiatric intensive care units were included. In Australia, a registered nurse is one who has completed a course in nursing of not less than three years, with theoretical and practical components that have the potential to lead to positions of responsibility within the health care system (Laufer, 1992). The sample consisted of registered nurses working in two acute psychiatric units and one psychiatric intensive care unit of a psychiatric hospital. It was expected that the nurses would have a range of educational, management and clinical experiences (e.g. clinical nurse consultants, clinical nurse specialists, registered nurses with and without research degrees and nurse unit managers).

Nurses were provided with information necessary to make an informed decision about whether to participate after meet with interested nurses on four different occasions in all three units and providing verbal information about the study by explaining the intention of the visit and the purpose of the research. Nurses were also provided with written information in the form of a written statement (see Appendix A). The information included a statement of the research purpose, time commitment, explanation of procedures, assurance of anonymity and confidentiality, potential risks, option to withdraw without penalty, potential benefits, an offer to answer questions and voluntary consent. Potential nurse participants were advised that participation was voluntary and that refusal would have no impact on their
relationship with the employer. The signing and returning of the information sheet to the investigator was indicative of the nurse’s consent to participate in the study. Nine participants gave written consent. After agreeing to participate in the study, each participant was given the participation information sheet and consent form to sign. A week later phone calls were made to all nine individuals to arrange a date and time for the interviews.

The age of the participants ranged from 28 to 60 years of age. Their educational preparation included hospital based training, Bachelor of Nursing, Bachelor of Health Science, Master of Nursing (Mental Health) and Master of Health Service (Management) The clinical position of participants included registered nurses, clinical nurse specialists, acting nurse unit managers and nursing unit managers. Their nursing experience ranged from 5 years nursing experience to 35 years of nursing experience in mental health services.

6.12 The interviews

I had a professional relationship with all of the participants shared by a common working environment within the hospital complex even though in different units. The relationship between researcher and participant is considered important to the outcome venture and to the ontological nature of self discovery through dialogue (Miller, 1996). Although there is an asymmetry of power in which the interviewer defines the situation, introduces the topic and directs the interview (Kvale, 1996) the possibility of approximating warmth and spontaneity such as that in a social conversation is realistic and this was something I hoped to achieve with all participants. It is for this reason that Riessman (1993) suggests that it is through giving up control, and symbolically power over the interview process and by taking a conversational approach, that the generation of data is most fruitful. While the term “conversation” as opposed to “interview” is preferred by some researchers because the term interview conjures up images of a hierarchical, exploitive relationship, this was certainly not my intention. Nurses participating in this study were respected and considered the experts in their area of mental health nursing practice. In this regard, I set a friendly, non-threatening tone in the interview, and a style of interaction that I hoped would allow for freedom of interaction and expression of ideas and feelings. I
did get the impression that participants did benefit from the opportunity of expressing their thoughts and feelings in relation to the phenomenon of interest and this was demonstrated by their positive comments and farewells following the conclusion of the interview sessions.

In hermeneutics the researcher is the instrument for the research process. The researcher interacts with the researched and their words by incorporating and modifying pre-understandings to result in understanding lived experiences. This is achieved through the process of listening – listening in-depth to thoughts as well as feelings. Forrester (1980) draws distinction between listening and hearing and describes hearing as auditory, passive, safe, uninvolved and dismissive of ambiguity while listening demands that the interviewer interacts personally with people and their contexts so that peoples’ languages can be heard and behaviours observed in situ (Minichiello, Aroni, Timewell & Alexander, 1995). Throughout all of the interviews I tried to aspire to quality listening for fear that failure to do so would result in distortions in communications. More importantly though, I found that attentive listening conveyed respect and care for the interviewee thus establishing the possibility of true understandings in the encounter.

A total of nine interviews were conducted individually in a quiet room, within the hospital complex over a two week period. The time for each interview varied but generally did not exceed more than one hour and fifteen minutes. A time and day for the interview was negotiated with each participant. All interviews were completed within a period of ten days.

Each conversation was arranged and conducted by the researcher. In keeping with van Manen’s (1990) recommendations, data was collected through interviews which were audio-taped. Data collected from participants included the following demographic variables: length of nursing experience, educational preparation, age, clinical position and number of years worked in the intensive care unit and the acute admission unit. The type of interview adopted is described as semi-structured, in-depth, and exploratory (Oppenheim, 1992). All of the interviews began with the introductory question “Can you tell me about your experiences of caring for patients
referred by the police under the MHA”. For those nurses who required prompts, examples of such prompt questions included “can you remember an occasion when you cared for someone referred by the police under the MHA – what happened during this episode of care?” Following on from this, other more specific examples of questions included:

What interventions did you implement to manage patients referred by the police? What kind of problems did this create on the unit? How important is the development of a therapeutic relationship with patients referred by police? Is this relationship achieved effortlessly and consistently in your practice? What are the barriers that constrain the forming of a therapeutic relationship with these patients? Does the enforcement of certain sections of the Mental Health Act pose any challenge to you in regard to your relationship with these patients? Are there patients referred by the police who are not suicidal or drug and alcohol affected? How would you describe the characteristics of these patients?

A personal detailed reflexive journal was used following each interview to record notes, and descriptions of the original context, relevant issues, occurrences, thoughts, feelings and observations.

6.13 Transcriptions

All taped interviews were transcribed verbatim. Analysis was undertaken through thorough interpretation by re-hearing, re-reading, reflecting and interpreting the words of participants in the hope of preventing differences in the depth of understanding between transcripts (Burnard, 1991). In addition, I wanted to capture all the “ums” and “ahs” reflected in the written transcripts as well as the non-verbal cues as accurately as possible. Wellard and Mckenna (2001) recommend that qualitative researchers develop an approach that can chronicle the non-verbal as well as the spoken components of each interview.
Hermeneutic phenomenological reflection

Hermeneutics involves the interpretation of data and the discovery of themes which represents the structure of the lived experience through interpretation of data. According to van Manen (1990) themes are the stars that make up the universe of meaning we live through. The third of van Manen’s (1990) procedural activities, phenomenological reflection involves two major steps: conducting thematic analysis and determining essential themes. The aim of this approach is to look for meaningful relationships in the data and to arrive at a detailed and systematic investigation of themes. Van Manen (1990) outlines three approaches to accomplishing analysis: the holistic approach – which requires attending to the whole text and attempting to capture the fundamental meaning or main significance of the text as a whole; the selective approach – which requires reading the text several times to identify essential or revealing statements or phrases about the experiences of participants; the detailed line-by-line approach – which requires looking at every single sentence or sentence cluster while considering what the sentence or cluster sentence reveals about the experience.

To follow through with all of the above recommendations, each transcript was analysed separately. Furthermore, as I read through each transcript I documented notes of my thoughts in the margin of the text. I replayed the tapes on several occasions. Listening to voices on tapes brought back memories of the conversations that had taken place through the interview process. I also returned to the notes I made in my journal which reminded me of the context in which these interviews took place and deepened my understanding of some of the nuances of inflections that participants had used.

I performed the detailed line-by-line reading approach searching for themes and highlighted descriptive expressions or certain words or phrases that stood out for me. Descriptive expressions and statements were documented in the left margins of the transcripts while broader themes were documented in the right margins. For each of the participants’ statements I interpreted the message by asking myself “What is this nurse telling me about the phenomenon of caring for patients referred by police”. Responses from nurses were then framed into thematic statements. An example of
this is as follows: when Janet said “If they're handcuffed they're complaining bitterly about the cuffs being too tight.....The thematic statement ‘patients’ apprehended and transported by police to the ward are subjected to discomfort by police and are in distress’ was documented. As the themes began to emerge from the lived-experience description, some commonalities were becoming quite obvious. I highlighted a group of sentences that pertained to a developing theme. I was then able to proceed into a deeper level of analysis which provided the key to the themes for me. In essence, the process of thematic hermeneutic analysis resulted in many levels of textual interpretation. Firstly, text was analysed by selecting meaningful chunks of phrases, sentences or paragraphs. Secondly, through further analysis they were reduced to smaller units of “preliminary sub-themes”. Sub themes were then gathered from all 9 texts and organised into major themes. Major themes therefore were supported by sub-themes and sub-themes were initially held together by sub-headings. For example the theme “Rescuing the patient, rescuing the police” was supported by the sub-theme “Rescuing the patient from the police” which supported the sub-headings: alleviating the distress of patients by removing handcuffs; meeting physical needs; and reassuring patients. In the final stages of analysis major themes were supported only by sub-themes. The final step of the analysis incorporated a hermeneutic description that was concerned with interpretation and identifying the meaning of being within the phenomenon.

6.15 Interpretive analysis

The purpose of analysis was to provide a descriptive understanding of the everyday lived experiences and an interpretive understanding of the ways in which nurses managed the experience. Koch (1995) referred to the idea of interpretation as essential to understanding the historicality of understanding and the hermeneutic circle. Her description of interpretation was that people encounter the world with reference to their own background understanding, and all encounters entail interpretation based on this background. Thus, according to Heideggerian phenomenology we are self-interpreting beings which leads to questioning “What does it mean to be a person?” and the answer to which is found in Dasein or being-in-the-world.
Phenomenological research emphasises the meaning of the lived experience and according to van Manen (1990) “The point of phenomenological research is to borrow other peoples experiences and their reflections on their experiences in order to better be able to come to an understanding of a deeper meaning or significance of an aspect of human experience in the context of the whole human experience” (p. 62).

The Heideggerian view of people as self interpretive beings involves an interpretation on the part of the researcher in order to understand human experience (Leonard, 1994). But these experiences according to Boyd (1993) are in the context of what he refers to as the “perceived world” adding that “the focus of phenomenology is, then, a focus on human involvement in a world” (p.103). Perception, according to Munhall (1994, p. 15) “takes place through the body as an individual’s access to experience in the world” - implying that the aim when describing lived experiences is actually a description of the perceptions of that lived experience. The focus of the research then was based on the perceptions of the experiences of nurses during care of patients referred by the police, and irrespective of whether they told the “truth” or recalled from “reality”, the importance was the “interpretation of the experience from the individuals’ unique perception of events (Munhall, 1994, p. 16). The intention when interviewing participants then was to pursue the deeper goal of exploration of the nature of their experiences (van Manen, 1984) and not to gain the subjective experiences of nurses for the sake of reporting how things were from their perspectives. Interpretive analysis required an approach that questioned “What is it to be a nurse caring for a patient apprehended and brought in by the police to an acute admission unit?” A questioning position was taken in relation to the themes obtained through analysis. For example in the theme “Expecting the worst patients from police”, I asked “what is it like to be a nurse expecting the worst patients from police”. The description of being in this example was being prepared for patients referred by police for reasons of “threats of suicide” and patients who came to the attention of police due to violent/aggressive and disturbed behaviour in the context of illicit substances and alcohol misuse. All the themes obtained were subjected to the above process to understand the nurse’s experiences of being-in-the-world.
6.16 Hermeneutic phenomenological writing

According to van Manen (1990), phenomenology can be described as providing one’s own unique orientation to lived experience while hermeneutics which is an interpretation of the text is essentially a writing activity. Van Manen’s process of analysis through writing and language was made clear through his suggestions for textually organizing writing. Organising writing is concerned primarily with arranging text and searching for a sense of form and wholeness of the text consistent with the methodology. In hermeneutics, the intention of analysis is to recapture the perspectives of the participant’s perspectives while simultaneously interpreting the concealed meanings in the phenomena (Sorrell & Redmond, 1995). Consequently, irrespective of whether I was listening or writing, the hermeneutic analysis progressed as I sought the meaning of the text and linked the common meanings into themes. The writing process was not delayed until the final stage because together, listening and writing co-constituted the development of hermeneutic understanding.

For the qualitative phase of the study, certain strategies were used for providing evidence for the themes in order to convince the reader that the themes presented emerged from the data. These strategies included: conveying sub-themes, citing specific quotes, using different sources of data and providing multiple perspectives from individuals to show the divergent views.

6.17 Conclusion

In conclusion, the aims of this phase of the study have been clearly identified. Through appraisal of the philosophical underpinnings of the Heideggerian hermeneutic phenomenology and Husserlian phenomenology, clear distinctions between the two traditions have been drawn which influenced my approach with the participants for the interview. My concern from an ontological Heideggerian hermeneutic phenomenology was to explore what the experiences of caring for patients referred by the police mean to nurses as opposed to describing the experiences of nurses caring for patients referred by the police as from the epistemological Husserlian tradition. Epistemological questions I have discovered seek answers to what can be known about the world while ontological questions are
concerned with the true nature of what exists in the world. Understanding Husserlian phenomenology and acknowledging its influence and contribution to the development of Heideggerian phenomenology is of importance to ensure adherence to the philosophical phenomenological methodology utilised in a study. Understanding the clear distinction between the two dominant traditions within the phenomenological movements has resulted in the emergence of the philosophical side of my study. In this chapter, the phenomenological research process has also been described and the means of van Manen’s (1990) approach through which the analysis of the data would be carried out identified. Bearing in mind that phenomenological research is predominantly a written mode of inquiry, consideration has been given to the processes used to enhance trustworthiness, credibility and quality of the descriptions presented in the next chapter. The next chapter (chapter 7) describes the nurse participants’ lived experiences and the interpretation of the phenomenon of caring for patients referred by the police.
Chapter 7 : Phase Two Findings

7.1 Introduction to the findings

In this chapter, the hermeneutic analyses of interviews conducted with nurse participants are discussed in detail. The interviews explore the experiences of nine participants caring for patients referred by the police and describe how they experienced caring for these patients admitted to the psychiatric hospital. In accordance with hermeneutics, the philosophy on which the study was based, a questioning stance was taken of the data during analysis in the form of “what is it like to be a nurse caring for patients referred by the police to the psychiatric hospital”.

The voices of all nine participants are heard at various points and while it was important to ensure this, difficulties did arise at times in deciding what to include, with concern that other equally important words had to be excluded. In this sense I tried hard to include the diverse subjectivities of participants which are considered important to the interpretive paradigm. The words of the participants were all copied verbatim from the transcripts and are italicized. The following three themes emerged from the text: Expecting “the worst”; Rescuing the police, rescuing the patient; Balancing therapeutic care and forced treatment.
### Themes of the Study

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<th>Themes of the Study</th>
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<td>Expecting “the worst”</td>
<td>We are here to care for whoever they bring in.</td>
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<td>Taking control, taking care</td>
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#### 7.2 Expecting “the worst”

The theme expecting “the worst” related to the perceptions that nurse participants had about patients referred by the police. When the participants were alerted to the arrival of patients referred by the police they anticipated the arrival of “the worst” patients. Under this theme the participants explained who these “worst” patients were and what caring for “the worst” patients meant to them and their practice. They also recognised that their perceptions of patients referred by the police did not always fit their descriptions of “the worst” patients.

#### 7.2.1 We are here to care for whoever they bring in

The nurse participants were of the perception that some of the patients referred by the police were inappropriate for admission in the hospital but recognised that they had no choice or control over the admission of patients. So irrespective of how they felt about certain patient characteristics or the problems some patients referred by the police presented with, they simply had to get on with the job of caring for these patients: “… we’re here to care for whoever they bring in … so we have to do it” (Janet).
Those patients admitted for problems in relation to illicit substance use and alcohol were viewed as the worst patients by the participants. These patients were described as highly disturbed and aggressive. The participants working in the PICU, a locked and secure unit, perceived that as high as ninety percent of patients referred by police were admitted with a drug-induced psychotic illness: “Usually the ones that the Police bring in are the ones who are the most disturbed ... probably 9 times out of 10 it is drug induced” (Wayne). The PICU was designed for the care of patients at risk of violence but some participants were of the perception that the aggression displayed by patients referred by the police differed from that of patients referred by other sources:

... of all the aggressive patients ... the police would probably bring in the most extreme ... and I suppose if there is any wrong aspect ... it seems to be the drug nature of the patients ...(David).

Many of these police-referred patients required escort by police directly to the locked ward because of concerns that they presented with a high risk of violent behaviour. The behaviour of these patients on presentation to the unit while under the escort of police was described in various terminologies by the participants in order to emphasise the behavioural characteristics of these patients:

... they are so wound up... they've gone right to crisis point ... all they want to do is fight, they are not coherent, they are irrational, they are agitated, they are often very delusional ...(Wayne).

The participants cited numerous problems in the care of patients experiencing problems with drug and alcohol. The patients were not always able to provide information on what substances they had taken or how much which was frustrating for the nurses because it meant delaying treatment until urine drug screens or blood tests could be carried out to detect the substances consumed: “Often it will be alcohol and marijuana and amphetamines ... multiple drug abuse” (Wayne).

Certain illicit substances were known to complicate the treatment process and the participants spoke of the difficulties experienced in helping patients to stabilise quickly:
Marijuana changes people’s personality as well as makes them mentally ill and they are harder to treat … the longer you’re on drugs the harder it is to get you well (Steve).

For many of the participants it seemed that the chemical make-up of illicit substances had such a profound effect on the mental state of patients that it outweighed the efficacy of the newer medications designed to stabilise the mental state of patients. Patients who did not respond as well as expected to pharmacological intervention were described as “treatment resistant” (Steve). Caring for such patients meant having to deal with behavioural problems for a much longer period of time than anticipated. This had a negative impact on those patients thought to be making progress in their treatment: “they [the other patients] actually become worse …they tend to fall back into the rhythm of the more disturbed patients and become less functional” (Terence). The participants recalled some of their past experiences of caring for patients with drug and alcohol problems and expressed some of their current concerns for patients using substances:

When I first started here …drug induced psychosis was really not that common, it was mainly schizophrenia and your bipolar disorders … those that abused drugs, they weren’t such potent drugs and they weren’t quite as damaging perhaps (Janet).

The perceptions amongst some participants were that patients referred by police were not so much experiencing symptoms of a psychosis but that their behaviour posed such concern in the community that police had little choice but to refer them to a mental health facility. Patients under the influence of alcohol, presented by police were common, but the participants did not consider it as big a problem as illicit substances. Wayne estimated the number of patients referred by police with alcohol abuse as “probably 1 in 10, it’s not the main one”. The participants explained that alcohol abuse exacerbated the problems experienced by some patients by contributing to a depressed mental state and increasing the risk of suicidal behaviour. They also felt that alcohol abuse increased the risk of violence amongst some patients.
The participants spoke of patients presenting with alcohol abuse and often spending just one night in the locked ward only to be reviewed by the doctor and discharged the next day once they had sobered up and were no longer considered a risk to themselves or others, “... if it’s alcohol it usually means it’s a 21D [mentally disordered] and often by the time they sober up you can discharge them the next day” (Wayne). Most of the participants felt that they were taking responsibility for the safety of the community by caring for patients who posed a risk to the safety of the community, and many of them felt that the overnight admission of patients for safety reasons was beneficial to the patients and to the community:

Even the drunks that wake up in the morning ... at the end of the day we’ve given him a safe night, kept him from maybe killing himself or killing his wife (Janet).

But the participants agreed that the overnight admission of patients for safety reasons created a lot of the additional work within the ward situation. They also expressed frustration about moving patients who were making progress with their treatment in order to create space and accommodation for those patients only admitted for safety purposes:

... there is a lot of resentment amongst nursing staff here ... it’s the moving of people that could well benefit from another week or so in our ward ... we have to move them on to make way for someone that’s only here overnight and they’re not going to benefit ... but the public will be safe from their anger and behaviour (Janet).

For many of the participants, the frustration arose from having no choice but to do as they were “directed”. They spoke of “being ordered” to create bed space for the admission of patients perceived to be at risk to the safety of others and some of the consequences this had on patients admitted for treatment purposes:

... we’ll get a phone call to say there’s a Section 24 [police referral] coming around to us that must have a [locked ward] bed, so we will move perhaps a schizophrenic ... who’s on clozapine that’s doing reasonably well, but not quite ready to move yet ... we will move them
to an open ward to make way for our 21D substance abuse person who rants and raves and whatever, we put him in seclusion and medicate him, he wakes up... *he’s alright, the next day he’s discharged. In the meantime our clozapine treated schizophrenic has absconded from an open ward and is therefore back to square one and we feel very strongly on doing that, we’re very much against it ... however we don’t seem to have much say ... we’re ordered from above “you will take this patient” (Janet).

Most participants believed that the focus of care for patients admitted with substance use was on crisis stabilisation, and they explained some of the short term treatment interventions implemented to stabilise patients admitted for alcohol abuse: “they come in, we give them 2 Valiums, put them to bed and give them Thiamine injection, they sleep it off and in the morning the doctor says 21D [mentally disordered] you can go” (Steve).

Once the patient had stabilised mentally they were then referred to drug and alcohol services for treatment of their addiction problems. Some of the participants felt that the referral of patients to drug and alcohol services for help was not necessarily working because the same patients were presenting to the hospital for admission with the same problems. There was doubt in the minds of the participants whether these patients actually attended drug and alcohol services for treatment.

*It’s the same ones ... they get referrals to The Centre for Addiction Medicine but whether they actually go there or complete any of those programs I don’t know ... I doubt it because quite often they are back here before they could possibly have completed any sort of program (Janet).

The participants felt that partnerships between services were not always functioning efficiently. They agreed that a breakdown in communication between hospital and community staff was one of the major problems affecting the ongoing care of patients who experienced problems with alcohol and illicit substances.
... we are so focused on intake and control of severe exacerbations and symptoms that we don’t look at the continuing of care back into the community ... we tend to do our part in the chain ... but not worry about liaising with community staff in terms of making sure that we keep them well ... so that they are getting supportive counselling ... they are in a 12 step program or whatever else they might need to stay well ... (Wayne).

A concern amongst the participants related to them having regular contact with patients with drug and alcohol problems yet they had minimal or no specialist training to address substance use, either from formal education, or continuing education. Most of the participants recognised that education and training was necessary if nurses had a continued role to play in the management of patients with drug and alcohol problems and agreed that, “… these are basic issues which could be addressed with educational packages…” (David).

7.2.2 But who deserves care?

When discussing the clinical and diagnostic characteristics of patients referred by police most of the initial discussion from the nurse participants focussed on patients presenting with illicit substances and alcohol abuse. A few of the participants also spoke of the many patients referred by police and admitted to the acute wards who were perceived to benefit from care and treatment. This applied mostly to patients diagnosed with a major mental illness who the participants referred to as being “normal referrals” and described them as being very similar to patients referred by other sources. “Normal referrals” referred to those patients who presented with symptoms of a major mental illness such as schizophrenia:

... on those occasions that Police bring patients in ... they’re actually quite like a normal referral, from the community or wherever ... and actually a lot of them are chronic schizophrenia ... on presentation there is every evidence of persecutory ideas and paranoia and all that ... (Lily).
Terminology such as “mentally ill” and “mentally disordered” were widely used by the participants to differentiate between patients. Mentally ill patients suffered from a condition that seriously impaired, either temporarily or permanently, the mental functioning of the person and was characterised by the presence of one or more symptoms such as delusions, hallucinations, serious disorder of thought form, and/or a severe disturbance of mood. Mentally disordered patients referred to persons whose behaviour for the time being was so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control of the person was necessary for the person’s own protection from serious physical harm, or for the protection of others from serious physical harm. Caring for mentally ill patients was different to that of caring for mentally disordered patients whose behavioural problems were challenging. Mentally ill patients were seen as deserving of the care of the nurse participants. These were patients who were suffering from symptoms of a “real illness” which was beyond their control and they were therefore seen to be more deserving of care, understanding, compassion and empathy:

I think nurses are aware that this person [mentally ill patient] is out of control through no fault of their own and the more you see of it … the more empathy you are able to extract from yourself and apply it to that person (David).

Some of participants expressed disappointment that they did not have as much time to devote to the care of mentally ill patients because much of their time was taken up caring for mentally disordered patients, whose behaviour was considered irrational largely due to substance use:

in terms of the people who might just be purely schizophrenic or have a mood disorder ... and it's not drug induced ... you're kind of thinking ... you are spending so much time looking after the dual diagnosis, the mentally disordered ... that the really mentally ill people aren't getting any care (Wayne).

A few of the participants agreed that not all of the patients referred by police experienced problems with drugs and/or alcohol or displayed behavioural problems and indeed, not all of them fitted the description of the “worst patients”:
I suppose from experience we expect the worst [from police referrals] *but that’s not always the case. I mean you get quite a variety of* patients that come through, some extremely agitated and hostile, some quite placid and cooperative and seemingly understanding the process that takes place and cooperating with it (David).

Lily felt that the patients referred by the police were judged negatively and stereotyped by nurses:

> A lot of times we either associate people that are brought in by police as criminals or they are illicit drug users ... *often we have these* preconceived ideas because they are coming in through the police.

Patients referred by police with suicidal behaviour were also judged by the participants. All of the participants working in the acute admission units were of the perception that there was an increase in the number of patients referred by the police with suicidal behaviour. They described mixed experiences and feelings about patients with suicidal behaviour. On the one hand participants held positive views on caring for potentially suicidal patients and recognised that failure to admit to hospital a person at risk of suicide may lead to undesired outcomes but on the other hand, they expressed negative feelings about some persons with suicidal behaviour and took the view that not all persons who threatened suicide required hospitalization in a psychiatric hospital. There was scepticism from some of the participants that this group of patients were acting intentionally and exploiting police and the mental health system for reasons other than care and treatment:

> ...*sometimes Police bring them in, they have done something wrong,* they may be looking at being charged for something and patients will *turn around and say that they are suicidal at the time,* ...*but on* assessment they might not be found to actually be suicidal.... *they might be suicidal because they don’t want to go into jail... if they threaten self harm or suicide* ...*the police will bring them here* (Pauline).
Information relating to “pending charges” influenced how the nurse participants cared for patients presenting with suicidal behaviour. Some participants felt that they were justified in adopting a questioning stance about whether these patients were genuinely suicidal, particularly after reading the notes documented in the medical files of the patient:

... nursing staff know full well... when you read the admission papers
...this patient is pending charges for whatever it was.... and now they
have become suicidal?... you generally don’t believe them (Rachel).

Participants spoke of disconnecting, emotionally distancing themselves and demonstrating little care for those patients perceived to be acting out intentionally. They explained how some patients perceived to be “using the mental health system” were benefiting from their admission to the hospital:

...they know that the hospital is safe, it’s free... they don’t have to
spend money, they have a clean bed, a roof over their head, they don’t
have to do anything ...they can be here and have the attention (Eddie).

Some participants expressed negative judgement about these patients because they believed that patients voicing suicidality were manipulative, attention-seeking, and in control of their suicidal urges and were therefore less deserving of care and less in need of admission to the hospital. There was strong indication from some of the participants that the admission of such patients referred by police with suicidal behaviour was inappropriate. Comments such as, “some of the patients that we admit should really not be admitted” (Eddie) and “I don’t think they are appropriate to come into this hospital” (Rachel) indicated how strongly the participants felt about the admission of certain patients.

The participant’s explained why they felt that the doctors “had to” admit these patients and this related to the fear amongst the doctors that they could be held liable and that the area health service could be sued if they did not admit a person presenting at risk of suicidal behaviour and the person did commit suicide:
If you say you feel like killing yourself... you will get into the hospital because the doctors are frightened to be sued... because it has happened in the past... like somebody will say “why did you let my son out”, “my son killed himself” an incident like that (Eddie).

From the discussion with the participants, citing suicide as a reason for admission into the hospital was not exclusive to patients referred by the police. An equally high number of patients referred by other sources also presented with suicidal behaviour and Eddie gave me examples of some of the things patients would say or do to demonstrate their risk of suicide:

...sometimes they will ring the Police... but other times they will present to the emergency department with some superficial lacerations or whatever... or sometimes they will be brought in by friends who will say they have taken an overdose... of two Panadol’s... or something like that... I mean that's putting it mildly.

7.2.3 Summary

The referral by police of a high number of patients with behavioural disturbances due to the use of illicit substances and alcohol was challenging for the participants. This finding could help explain why they expected the worst patients to be referred by police. This taken for granted attitude was derived mostly from the nurses’ everyday practices of linking patients referred by the police to certain behaviours.

In relation to substance use, some participants had developed perceptions of patients referred by the police – that they were drug affected, violent and unco-operative. While this was true for some presentations it was not so for all patients referred by the police. However, the participants recognised that they required education and certain skills to effectively care for this group of patients. They expressed their lack of ability to effectively care for patients with substance use problems and identified that a lack of cooperation, communication and collaboration between clinicians was a barrier for the delivery and continuity of care for this group of patients.
The findings also indicate that the attitude of nurses’ towards patients with suicidal behaviour was filtered through their judgment of the reasons largely connected to the circumstances and reasons for their admission and influenced how the participants cared for these patients. Police referrals were judged against a hypothetical “normal” patient and “normal behaviour” for a mental health facility with police referrals seen as being mostly outside this norm. Therefore, these patients were viewed as the “worst” patients.

7.3 Rescuing the patient, rescuing the police

Under this theme, “rescuing the patient” related to the perceptions of the participants that they had to quickly take over the care of patients from police because police handling of patients added to the distress of patients during apprehension and transportation of patients to hospital. “Rescuing the police” related to the perception of the participants that they had to relieve police of their role as quickly as possible because the police appeared uncomfortable in dealing with mentally disturbed patients. The participants discussed in detail the circumstances under which patients were brought by police to hospital, the attitude of police towards nurses and patients and the reasons why they wanted police and patients distanced from one another.

7.3.1 Rescuing patients from police

The participants felt that it was necessary to intervene promptly in order to separate and create distance between the police and patients once the patients were brought to the wards, escorted in the police vehicle. This they perceived was necessary in order to defuse some of the anger and hostility displayed by patients towards police on arrival to the locked ward. For some of the participants the emotions displayed by patients towards the police were so intense that they felt as though some patients could not bear to be anywhere close to the police, “they [patients] want to get away from the police” (Steve). Other patients transported by the police were also described as “either very frightened or very paranoid” (Wayne), when they first arrived.

The participants believed that patients felt more calm once they witnessed the presence of nurses because they realised that they did not have to remain any longer
under police apprehension. There was also the perception amongst the participants that patients were not informed of their destination once they were picked up by the police in the community and that patients perhaps felt that they had committed a criminal offence and were apprehended by police for those reasons: “a lot of them are scared they’re going to jail and when they realise they’re in a hospital they’re actually relieved” (Steve).

The patients who came to the attention of police in the community were already in a state of crisis but the participants felt that that the manner in which police managed these patients during apprehension and transportation to the hospital impacted even further on their emotional well being:

A noticeable number of patients come in an agitated state and they are directing their agitation directly back towards the Police and the way they’ve been treated since they were picked up or once they’ve been transported. For one reason or another there are occasions where the police seem to exacerbate the situation and cause the patient to be more agitated (David).

The participants described police arriving at the wards in “fairly emergency type situations” (Wayne). The nurses were given little warning of the arrival of the police with the patient: “we generally get a phone call saying “incoming” which means prepare because within the next 5 to 10 minutes they’re going to be at the back door with the wagon” (David). On the odd occasion the participants explained that one patient could be escorted by a number of police “sometimes you’ll get five or six police cars show up with the one patient” (Wayne).

The participants felt that the conditions patients were exposed to during transportation to the hospital in the back of the police vehicle posed a risk to the health and safety of the patient:

Nine times out of twelve they are like in the back of the paddy wagon, they’re very hot if they’ve been there for a long time, they’re [vehicles] not very well padded, they [patients] can be knocked around....often
they bang or smash or punch into the lock at the back of the van, they harm themselves (Janet).

While the participants acknowledged that police were often the first to respond to crisis situations involving mentally disturbed patients in the community, they perceived that the measures used by police to subdue patients in crisis were extreme and distressing to the patient. Sometimes patients arrived under mechanical restraints complaining of discomfort:

Somewhere in the region of 50% would arrive in handcuffs. They [patients] nearly always complain that they’re on too tight, that may be because they have been struggling with them in the back of the wagon on route, sometimes they have been capsicum sprayed prior to arrival which also adds to the agitation (David).

In light of the perceived manner in which police managed the patients, the concern and focus of the participants was on taking over from police and responding to the distress of patients and alleviating some of the distress. The participants felt that in order to assist patients in reaching acceptance in terms of their admission and illness it was important to ensure that the patients felt supported, received relevant information, and understood what was going to happen next:

We introduce ourselves, and reduce some anxiety, let them know what is about to happen, why they’re there, what we’re waiting for, how long we might be waiting for the doctor (David).

In order to make the admission process less stressful for the patients, the participants spoke of providing reassurance to patients, many of whom felt scared after police apprehension and clearly unhappy to be admitted in a locked environment:

We’ve got to sort of reassure the patient that they’re going to be safe, that we’re going to look after them and get them well again and they’re quite uptight about being in a locked environment (Janet).

For many of the participants it was considered important for patients to tell their stories in the hope that it would defuse some of their anger and ease the way for them
to express their feelings and share how they perceived and experienced the problem that brought them to the attention of police. After listening to the patients tell their stories most participants were of the belief that because the patients were angry with police they were keen to blame the police rather than assume responsibility for some of their own feelings, actions and behaviour:

*If they have any bruises or anything on them they’re very keen to blame the police for causing them despite the fact that they may have been quite violent towards the police or somebody else before they were apprehended (Wayne).*

The reasons given by patients for referral to the hospital did at times contradict the reasons documented by police for the referral of patients:

*Most of them will minimise the reason why they came here and in fact they will sort of say “they were just sitting on the footpath and suddenly the police pounced on them or… I was sitting in my bedroom and they pounced on me” and in fact we find that it isn’t true when we read the full details from the police (Janet)*

The participants found that only after a few days when the patients felt more settled, they were then able to give a much clearer account of the circumstances leading to police apprehension. But by rescuing patients from the police, giving them a voice, and responding to their emotional distress, the participants perceived that they would be able to settle some of the patients and set the stage for subsequent therapeutic nurse-patient contact.

### 7.3.2 Rescuing police from patients

The participants acknowledged that the police had an important role to play in mental health, but most of them felt that police had little understanding of how to respond to mentally disturbed patients in crisis. There was little doubt amongst the participants that police reacted with hostility when confronted by hostile persons. The participants felt that if people were handled more sensitively and effectively by the police, then the police would have been able to defuse some of the crisis situations
and that persons presenting with police to the hospital would feel less stressed and agitated:

One does sometimes get the feeling that police have aggravated the situation somewhat either through over reacting to some of the hostility from the patient or perhaps from the things that the patient has said to them ... they've over reacted to it (David).

Comparisons were drawn between community mental health nurses and the police and the participants emphasised that even when patients were brought into hospital involuntarily by community mental health nurses, there still was a willingness from the patients to come to the hospital. This was rarely the case for patients brought in by the police:

Generally like if community staff brings them in... even though they may have been scheduled they're generally more willing to come with community staff. When they're coming with police ...they don't want to (Rachel).

Most of the participants felt that the police were not particularly happy to have their time taken up by people with mental health problems, “I don’t think they feel that it’s their primary role in life to go around chasing psychiatric patients and bring them into hospital” (David). Comments made by some police officers also indicated to the participants that the police felt frustrated that they were expected to transport mentally disturbed patients to the hospital as part of their role “in the past I’ve heard the word ‘taxi service’ and I suppose to some degree some police feel that that is the case”(David).

The participants agreed that when in their presence, most police appeared calmer and were observed to interact rather well with patients. Some participants described police in favourable terms. They reflected on their involvement with police over the years and felt that the attitude of police towards mentally disturbed patients had somewhat improved: “I think that’s one of the main differences from yesteryear - the approach by police in particular is much more understanding and compassionate” (Terrence). Some police were described as caring, “sometimes the police... you
might get an aggressive one, but a lot of the times you get a lot of caring police” (Steve), and the younger police were found to be more liberal in their views of mentally disturbed patients:

Some of the younger ones are probably a little more compassionate ... or the newer ones coming through, and they ... at the end of their training, might be a little bit more broad minded on things than some of the older style police (Wayne).

There was even empathy from some participants towards the police when they acknowledged the difficulties and challenges experienced when dealing with mentally disturbed patients:

Managing a lot of patients by trained health professionals can be quite challenging...but for Police who are relatively untrained to have to deal with those people ... I think they do a remarkable job (Terence).

The participants agreed though that not all police could be praised for doing a remarkable job: “there are exceptions; but from my dealings with the police they’ve been very helpful, they will stay around and help you support the patient if you wish them to” (Steve).

But irrespective of how disturbed or violent patients were when first admitted, the offer from police to help participants with the patients was at most times declined by the nurses. Most of the participants had no intention of keeping police in the ward any longer than they had to, “generally we discharge them pretty quickly from the scene” (Wayne), because of the tension that existed between police and patients:

It doesn’t matter how compassionate they [police] are or how understanding they are, they’ve plucked them out in their most distressed state and brought them into where most of them don’t want to be (Terence).

The relationship between the participants and the police was described as “getting on really well” (David). Comments from the police such as: “how come the nurses can settle them but we couldn’t” indicated to the participants that they were held in high
regard by the police. For many of the participants it also indicated that the police experienced difficulty relating to and developing rapport with mentally disturbed patients. The participants were of the belief that “for most part they rely on our negotiation skills to settle the patients down” (Wayne).

The feeling amongst participants was that they had gained the respect of police for taking responsibility for the care of persons whose behaviour was often considered unpredictable by police and perceived that by accepting and taking over the care of patients, they were rescuing police and alleviating some of the anxiety of police in having to deal with the mentally disturbed patient any longer:

They’re quite respectful of the nurses because we are now about to rescue them from that situation and take control of those situations that they don’t really want anything to do with anyway (David).

The handing over of patients by police to the care of nurses was described by the participants as being “quickly”, “the nurses usually virtually take over at the door” (David) and the police were described as “relieved” once the nurses took over the care of patients from them:

It’s almost like a relief thing, a lot of them are willing to stay if you ask them, the other ones, it’s like they want to get out the door as soon as they pass them [patients] over to you (Wayne).

The participants were just as eager for police to leave the ward as soon as possible. But contrary to the perceptions of the police that they were being rescued from patients by the nurses, the rationale for relieving police from their role related to the perceptions of the nurse participants that police presence around patients impacted negatively on the emotional state of the patients. The participants felt that by allowing police to leave the ward as soon as the patient was admitted, they were creating a distance between police and patients. This they considered important because they felt that as long as the police were in close proximity to the patients in the ward environment, patients were unable to settle. They summed up their
observations of the behaviour of patients once the police had left the unit, “generally they settle somewhat once the police have left” (Janet).

7.3.3 Summary

The nurse participants recognised and acknowledged that the police played a vital role in the mental health system. However, while the police were expected to provide initial intervention to mentally disturbed persons in crisis, the techniques and tactics used by the police when responding to mentally disturbed patients were perceived to have little impact on defusing the situation of the patients or bringing about modification to the disturbed behaviour. The transportation of patients in the back of a police van “the paddy wagon” often handcuffed, and at times even sprayed with capsicum spray were factors thought to exacerbate the crisis situation even further. The participants were of the belief that mentally disturbed patients in crisis could have been subdued if police provided reassurance, support and understanding during the crisis period. But the manner in which police handled the situation increased the agitation of patients and made the admission process more stressful for the patient.

The involuntary admission of patients to the hospital could have been less stressful if patients were managed effectively by police during apprehension and transportation to the hospital. However, it was often left to the nurses to communicate with and assist in calming the patient. The immediate priorities for many of the participants when rescuing angry and potentially violent individuals from the police were to maintain caring and concern, and a non-authoritarian, therapeutic manner that helped to defuse their anger, while at the same time preventing their behaviour from escalating into violence.

7.4 Balancing therapeutics and forced treatment

Under the theme “balancing therapeutics and forced treatment” participants spoke of how they balanced the care and control of patients. Within the notion of care and control, they explained how through use of clinical judgement they were able to manage complex patient situations and were still able to develop therapeutic relationships with their patients even when the use of restrictive treatment measures
was required. Participants perceived that they were able to distinguish between potentially contradictory intentions and perceived benefits in the best interest of their patients.

7.4.1 Taking control, taking care

There was the recognition from most participants that a therapeutic relationship and forced treatment were not mutually exclusive and were realistic possibilities for patients being cared for in the acute admission units. In this sense, participants gave a complex picture of both control and care of patients. On the one hand the participants spoke of patients being forced to take medications, forced into seclusion, physically restrained and coerced into changing negative behaviour. On the other hand, the participants spoke of the importance of demonstrating respect, concern and care, and engaging in opportunities for building therapeutic relationships with patients.

Control of the patient was deemed necessary when the safety of the patient and others were at risk of aggression and violence, even for those patients admitted to the PICU, a locked and secure unit because eliminating or preventing violence even in a controlled environment was not always a possibility. The participants felt that at times other restrictive interventions had to be implemented in order to prevent or reduce potential accidents or incidents when safety of the patient, nurses or others was compromised. The participants indicated that negotiating with the patient was used as a first measure when safety became a concern, “You offer negotiation and limits and see what the compliance level is. If they become agitated, or threaten then you shut that down very quickly” (David).

The participants acknowledged having the power to enforce more restrictive treatment measures which gave them the confidence to manage any level of violence:

*I can’t honestly say that we are not ever able to cope with the level of violence, we have different levels of intervention that we have to use on the different levels of violence. The most extreme would be [physical] restraint, chemical sedation and seclusion* (Janet).
The participants spoke of administering medications and/or chemical sedation to patients to modify uncontrollable behaviour and to relieve patients of their distress. They explained that “taking control” when confronted with bizarre and uncontrollable behaviour, often meant medicating patients without their consent or involvement in the decision making process. Under these circumstances there was great resistance exhibited by patients which often necessitated the requirement of additional staff for the physical restraint of the patient in an attempt to medicate them, “We have extra staff in attendance so that we can medicate them” (Steve).

Seclusion was also used as a measure to control for violent or potentially violent behaviour and was considered an effective strategy when violence was a concern, “Seclusion allows us to get them into a safe environment where they can’t hurt themselves or anybody else” (Steve). Seclusion was mostly considered when other interventions were found ineffective:

If I couldn’t manage them any other way ... the nursing team weren’t able to guarantee the safety of the other patients and the staff, if we felt that we couldn’t manage them out in the open environment they certainly would be secluded (Janet).

While the participants spoke about taking control of patients when the safety of the patients and others was at risk, they also emphasized the importance of developing therapeutic relationships with patients. For all of the participants, the development of the therapeutic relationship with patients still remained one of the most important aspects of mental health nursing care, “it’s at the core of everything that we do” (Wayne).

David was of the belief that without a therapeutic relationship “you can have more prolonged problems”. The quality of the nurse-patient relationship was considered a relatively powerful predictor of outcome in treatment and was therefore “very important” in assisting patients improve mentally and physically:

... if you can’t get a collaboration in care then the person doesn’t improve ... or I guess in terms of resistance they won’t cooperate, they won’t have a physical, they won’t let you take bloods from them, so the
more that you can develop that therapeutic relationship the better (Wayne).

The participants’ spoke of the difficulties and challenges in developing relationships with some patients. The difficulties was attributed to the nature of the patient’s illness or distress and because patients were detained in hospital and were receiving care and treatment against their will. Some patients demonstrated little motivation to enter into a therapeutic relationship with nurses, but for many of the participants, the influencing factor for the development of therapeutic relationships with patients depended largely on the nurses’ abilities and skills:

Some patients take a bit longer but eventually it does happen. When patients are very agitated and unwell they’re very oppositional and resistive but once they start getting better the relationship starts forming then. Some nurses are better at it than others (Steve).

The attitude adopted by most of the participants was that irrespective of how unwell patients were, the development of therapeutic relationships with patients was always a possibility as long as nurses were sensitive to the problems experienced by patients, and applied a humanitarian approach to care and reminded themselves that they were dealing with people and not just with their minds and bodies:

... for a lot of patients ... once they start to get part of their rational mind back they’re very embarrassed, they’re very ashamed, so you’ve got a lot of the stigma issues and things to deal with so the more sensitive the staff are to the human side of what’s occurring the better the whole thing goes (Wayne).

The participants agreed that involuntary treatment elicited strong feelings from the patients yet they denied that the application of other restrictive treatment measures had potential of impacting on treatment relationships with patients. They felt strongly that even when the application of restrictive treatment measures became necessary for the control of the patient, therapeutic relationships were still achievable depending on the way in which forced treatment was initiated and how follow-up, control and withdrawal were conducted. Within the context of forced treatment, the
participants stressed the importance of conducting their interactions and implementing interventions in ways that demonstrated sensitivity and concern for the individual in order to facilitate the development of the therapeutic relationship. Being aware of the consequences of one’s actions had to be taken into consideration when enforcing treatment:

_You’re not always doing the things that you choose to do but you are conscious of the effects of what you do so that you minimise any negative effects_ (Terence).

Some participants were able to confront their own feelings when describing how they felt about enforcing treatment to patients and recognised that what they said and what they did had potential of confusing patients because they represented very contradictory ways of behaving. In addition, when involved in coercive treatment they did not like the feelings it evoked:

_You are trying to tell them that you are not here to hurt them and that everything’s okay, that they are in a safe environment … those sorts of things. But then you’re dragging them down the hallway with several staff members called, to give them medication against their will, that is very scary and I mean … it’s the worst feeling in the world when you have to do that to someone but occasionally you have to be cruel to be kind_ (Rachel).

Most participants perceived that forced treatment, control and care was part of the treatment and healing process but emphasised that it was imperative that when implementing control, patient safety and well being simply had to be maintained by consistent attention to duty of care because apart from the implications this had for the development of therapeutic relations, most patients were also able to recall the interventions that they were subjected to by nurses even during periods of crises. With this thought in mind, David explained why it was important for him to conduct all interactions in ways which demonstrated concern and sensitivity to the patient:

_It’s critical to me for the long term relationship... and you shouldn’t see your situations as an interim source, all situations are part of an_
ongoing development of that therapeutic relationship... so what you do in that critical time is often remembered by the patient and if you conduct yourself appropriately and in the best way that you can at that time then that often pays dividends with the relationship building somewhere down the track (David).

In the interest of promoting patient safety and well being and relationship development, some of the participants felt that it was absolutely essential to intervene when patient care was compromised by unsafe and unlawful practice. In this sense some nurses were challenged when their decision making or interventions appeared inappropriate. The participants spoke of incidents which necessitated them intervening and taking appropriate action to prevent unprofessional nursing conduct and more importantly to prevent the care of the patient being impeded:

I’ve spoke to staff [nurses] in the past ... who told me about pressure points that you could use on patients to effect control and my argument against that is ... that apart from the moral and ethical issues which are clear ... is that it destroys your future relationship with that patient because you might have control momentarily with that patient but quite often they remember that later and it is a barrier to that relationship. You’ve been abusive ... you haven’t been of any help really (David).

The participants were aware that the application of restrictive measures had potential to increase the agitation of patients and David recalled some of the emotional reactions from patients who were subjected to restrictive treatment measures, “They hate you ... at that moment”. But the reaction of the patient towards the nurse thereafter depended to a large extent, on the careful and suitable follow-up, and on the expertise of the nursing care provided. There was no doubt in the minds of the participants that control and forced treatment was at times necessary to help some patients improve mentally, but most participants agreed that forced treatment should only be advocated based on patients' needs and in the best interests of patients. The participants also believed that it was important for patients to be debriefed and explanations given about the rationale for forced treatment:
I mean patients may see it as a punishment but after seclusion they’d be debriefed and when they’re in a better frame of mind we’ll tell them “you were hurling tables around, you were threatening me … so for your safety and ours we had to put you in there, we had to give you injections and yes we did have to lock you up and now look at you … you’re out here sitting talking to me” (Janet).

Through debriefing sessions the participants took it upon themselves to ensure that patients were aware that seclusion and other restrictive measures were used as a safety measure and not as a form of punishment for the aggressive or violent behaviour displayed.

### 7.4.2 Managing power

When the participants spoke of taking control of the “out of control behaviour” of the patient, they recognised that they were assuming “power over” patients and that the patients consequently felt disempowered or powerless. Patients reacted when they felt disempowered, “people [patients] who are disempowered can and will try and re-establish a power balance, and that will come in the form of insults or racist or sexist statements” (Wayne). For many participants this behaviour from patients demonstrated their struggle to gain a notion of control. Consequently, the competence and control of nurses were challenged by patients. Most participants were able to demonstrate sensitivity to this power struggle and knew that they had to find creative ways of addressing concerns relating to power so that power could be shared with patients.

There was recognition from some participants that the frustration and anger of being admitted and treated against one’s will, was reflected in the emotional responses of patients towards nurses, “you get sworn at, you get threatened ‘I’m going to kill you and your family’ that sort of thing” (Steve). Most participants realised that there was only one way of coping with verbal abuse from patients. “Whatever is said can’t be taken personally or you’ll become non effective” (Terence).
The loss of control and power were often issues critical to patients in the perception of participants. Therefore, the concept of empowerment - the power to give another power – was viewed by some of the participants as one effective method of enhancing the self-esteem and confidence of patients and minimizing conflict between nurses and patients.

Some participants felt that labelling the abusive behaviour of patients negatively was less useful than empathizing with patients and acknowledging how they felt about being involuntarily detained and treated in hospital. Participants gave examples of what they would say to help patients feel more understood so that they could regain a sense of control and diminish the urges to act aggressively:

... regardless of how you feel towards me I’m here because I care about you, I’m here to help you, you may not recognise it at the moment ... I don’t want you to be here, I want you to be at home but you can’t be at the moment. Work with us, let us help you ... if we work together we’re going to achieve that much quicker (Terence).

By adopting a reality-based, problem solving approach the participants felt that they were giving patients a sense of mastery over their internal drives and their symptoms. But not all nurses were prepared to engage in meaningful sharing of power and the participants spoke of incidents witnessed where some nurses demonstrated an abuse of power over certain patients. Terence provided me with an example of what he would say to a nurse observed abusing their power:

I would say to a person [nurse] who is just for no particular reason causing grievance in a patient, I would say “stay in the background” so as not to perpetuate or give them [patients] good reason to think “oh well you are a ratbag, you are doing this to annoy me.”

The participants perceived that once the patients were mentally stable, they could then help patients reflect and make sense of their experiences by increasing the patients understanding of their behaviour responses to certain stimuli in relation to their own experiences:
...often they can be very angry at everybody and blaming everyone else for the fact that they’re here and it’s a matter of pointing and saying “Well whatever you did in your outside life is what caused you to be here, things got so bad in your life that you came to the attention of the Authorities [police] and were brought into hospital (Wayne).

Communication with patients was believed to be important in helping patients recognize that there were consequences for the continuous display of anti-social behaviour. Terence provided me with an example of what he would say to a patient who continued to display violent behaviour following admission, “If you’re angry and hitting people and disturbed by your thoughts, obviously you still need to be here”. This approach, based on modifying the patients’ thoughts and behaviours, was aimed at influencing the emotions of the patient positively by revealing habits that were unhelpful, in the hope that the patient would try out new ways of behaving and reacting. Most of the participants felt that patients reacted positively to this approach:

People [patients] respond appropriately ... and it’s just an insight gathering exercise and through that process they often say “oh yeah maybe I’m not that well” but it’s telling them in a subtle way, telling them in a friendly and caring way that they’re not well (Terence).

7.4.3 Summary

The patients referred by police were perceived to experience severe deficits in their capacities to make treatment decisions, therefore forced treatment, control and care was deemed necessary to bring about insight and behaviour change in the patient. However, the manner in which treatment and control was enforced had potential of significantly improving patients experiences of involuntary treatment, lending some confidence to the view that involuntary detention and forced treatment did not always have to be perceived as punitive by patients.

For many of the nurse participants in this study, the perception of forced treatment and control were recognized as desirable factors during treatment because it
positively influenced the patient's cooperation in the treatment process when balanced with care and sensitivity from the nurses. Equally important, the nurse participants took constructive steps to help patients reflect and make sense of their experiences in order to convey the message that the aim of involuntary hospitalisation and treatment was not to punish but to help patients make emotional and behavioural changes. The participants were of the perception that there were many patients whose beliefs about hospitalization changed during and after treatment when they were able to acknowledge that they did indeed require treatment and admitted improvement in their mental health after the psychiatric care episode, even though they may have thought otherwise when initially admitted.

7.5 Conclusion

In this chapter the meaning of the nurses’ experiences of caring for patients referred by the police has been explicated and described. Three main themes that contributed to the experience were illuminated from the nurses’ narratives. Expecting the worst patients from police described the expectations that the participants had about patients referred by the police. Police referral of patients who misused illicit substances and alcohol and those patients “supposedly” at risk of suicide were viewed as the worst because they presented numerous challenges for the participants. These patients stood out from the rest of the patients admitted to the PICU and the acute admission units because much of the time and attention of the participants were taken up caring for them.

However, when the participants re-examined their practices and beliefs some participants were able to identify that not all patients referred by the police fitted their descriptions of the worst patients and they acknowledged that patients referred by the police fitted the criteria of both mentally ill and mentally disordered patients.

The participants were of the belief that the consumption of illicit substances and alcohol exacerbated symptoms of mental illness and increased the risk of violence and suicidal tendencies which often were the contributing reasons for these patients coming to the attention of the police in the community. However, it would appear that police handling of the situation did little to defuse the crisis, sparking
speculation amongst the participants that the authoritarian manner adopted by police may have inflamed the situation even further, causing the patient to become more agitated. Patients presenting to the hospital escorted by police were observed to be highly agitated and hostile towards the police and the participants often had to intervene and act as “go-between” to separate police from the patients, in the hope that the patients would settle once the police left the ward environment. This practice was described as “Rescuing the patient, rescuing the police”. While the police appeared grateful and relieved for the nurses taking over the care of the patients and rescuing them from the patients, many of the participants felt that the admission process could have been less stressful if police were more sensitive and tactful in the manner in which they dealt with mentally disturbed patients during apprehension and transportation to the hospital.

The participants indicated an understanding of the need to form a therapeutic alliance in order to care for these patients during this traumatic period but despite the skills and strategies implemented to settle patients, participants felt the need to use restrictive treatment measures when the safety of the patient or others was threatened. By “Balancing therapeutic care and forced treatment” the participants were able to control the behaviour of patients and still develop therapeutic relationships with patients. Therapeutic relationships were considered essential in order for patients to improve mentally. The participants took into consideration that patients were brought to the hospital by the police for reasons that the patients could not understand especially when under the influence of intoxicating substances, but that by providing care and support, and by helping patients reflect and make sense of their experiences, most patients were able to make behavioural changes even if only for a short period of time.
Chapter 8: Integration of Phases One and Two: The Study Findings

8.1 Introduction

In this chapter, the findings of the phase one and two (quantitative and qualitative phases) of the study were integrated. Integration is an integral part of mixed method studies and involves merging the findings from the two phases to give a deeper understanding of the study topic area (Creswell & Tashakkori, 2007). As indicated in a previous chapter (chapter 3) both quantitative and qualitative research questions were asked to gain a better understanding of the patients referred by police and admitted to the hospital. The choice of the sequential explanatory design used for this study, provided further clarification and additional information and helped explain some of the more subtle differences and allowed for the full story to be told. This was achieved by one method (quantitative) being implemented first, and the results used to inform some of the more specific questions asked in the other method (qualitative). The integration of the two phases of study is discussed in detail under three areas of relevance and under the headings of: “police as referral source”; “diagnostic differences amongst police referrals”; and “the management of police referrals”. Prior to the conclusion of this chapter a matrix has been added summarising the congruence and discrepancies between the quantitative and qualitative findings and some of the additional aspects that were distinct from each other.

8.2 Police as a referral source

The participants perceived that the police referred a high number of persons to the mental health facility. Quantitative data indicated that of the 1193 patients referred during a six month period of time, 269 patients (22.5%) were referred by the police while the balance of the patients (924) were referred by various other sources. Police
Departments were identified as the second most utilised agencies for the referral of persons to the mental health systems after community mental health teams. The participants however, did emphasise that not all persons referred by police met the criteria for admission to the hospital. While the quantitative findings indicated that of all of the people who were referred involuntarily by police for psychiatric assessment (269), just over half met the criteria for admission, at 54%, these rates of police referred admissions was similar to the 51% of non-police referred persons who met the criteria for admission to the hospital.

However, when the participants were asked to explain their perceptions of the reasons for police referrals, they perceived that patients referred by the police came to the attention of police due to violent/aggressive and disturbed behaviour in the context of illicit substances and alcohol misuse. From the results of the quantitative study, and contrary to the perceptions of the nurses, violent/aggressive behaviour was not the predominant reason for the referral of patients by the police. In fact, the most common reasons for police referral of patients in this study were for bizarre behaviour (37%). Bizarre behaviour included seeing things, hearing voices and verbalising bizarre ideas. Violent behaviour and the threats of violent behaviour were cited as reasons for referral for a smaller percentage of patients (respectively 14% and 9%).

Many of the participants also believed that a high number of patients were referred by police for reasons of “threats of suicide”. While this was the second most common reason for the referral of patients by police, the percentage of police referrals admitted for reasons of “threats of suicide” were just over a quarter (29%), which were similar in rates to the non police referred admissions (20%). Although not directly stated, it appeared that the participants felt as though they were caring for too many patients presenting at risk of suicide, but for whom substance use appeared to be a more frequent precursor rather than that of a depressive illness. They leaned towards the view that while these patients frequently sought help, it was poorly used. Most participants expressed a strong belief that the police were uncomfortable in dealing with people who threatened suicide, and therefore they were quick to refer them to mental health services in the hope that the mental health team would take
responsibility for the care of this group of people. While the view taken by participants was that not all police referred patients who threatened suicide required admission in a psychiatric hospital, an important point as indicted by the data, was that there was no significant differences between referral groups in the rates of admission for those persons presenting at risk of suicide. Therefore, the view taken by participants that patients presenting at risk of suicide were likely to be associated with police referrals, appears incorrect. The participants did however express great concern for those patients thought to be “genuinely at risk of suicide”, but were assertive in their expression that some patients exaggerated suicidality to increase the likelihood of a hospital admission. These patients were described as exploiting police and the mental health system for reasons other than care and treatment, and some of the reasons included patients using the hospital as a substitute for social services and as a means of avoiding criminal charges. While the perception amongst some of the participants was that some patients referred by the police were using the mental health facility as a place to stay there was no difference found in the rates of homelessness between the police and the non-police referred patients in the quantitative study (9% and 6% respectively). The perception of the nurses was not supported by quantitative data. Furthermore, the fact that these patients were homeless did not necessarily mean that they did not suffer from a mental illness, because all persons detained in the hospital had to fall within the definition of a “mentally ill” or a “mentally disordered” person as set out in the Act.

8.3 Diagnostic differences amongst police referrals

Some participants believed that patients referred by police and admitted were not so much experiencing symptoms of a psychosis, which is a major mental disorder, but that their behaviour posed a threat to the community and that police had little choice but to refer them to a mental health facility, because they either presented a risk to their own safety or to the safety of others. But contrary to the perception of the participants that a high number of police referrals were admitted because of behavioural problems rather than a psychosis, findings from the quantitative study indicated that just over half (51%) of patients admitted after referral by the police were diagnosed as psychotic at the time of admission.
When discussing the diagnoses of patients, some participants were of the perception that they were caring for more police referred patients admitted for drug and alcohol related problems as opposed to a diagnosis of mentally ill, while there were other participants who acknowledged caring for a high number of police referred patients diagnosed with the major mental illness of schizophrenia as well as with problems of substance use. Comments such as “police refer patients with drug and alcohol problems as well as patients with schizophrenia” were made by some participants. They made empathic statements when discussing those patients diagnosed with schizophrenia. Their compassion towards these patients it would appear, was derived from their knowledge and understanding that patients with schizophrenia suffered from a complex, biologically based environmentally sensitive disease that affected all areas of their life and functioning and this understanding was emphasized with comments such as “patients with schizophrenia are out of control through no fault of their own”. The participants made it clearly known that these patients were deserving of their care and rightfully admitted to the hospital for treatment.

Some participants spoke of not having as much time as they would have liked, to care for and enhance the well-being of patients diagnosed with schizophrenia because their time was taken up primarily caring for patients with alcohol and illicit substance related problems. While this may very well have been the case, the findings from the quantitative study did indeed confirm that police referred as many patients diagnosed with “schizophrenia, schizotypal and delusional disorders” (33%), as they did of patients diagnosed with a mental and behavioural disorder due to psychoactive substance use (35%).

Furthermore, while the 35% of patients referred by the police and admitted were given a primary diagnosis of a mental and behavioural disorder due to psychoactive substance use which was higher when compared to 10% of those patients referred from other sources and admitted, there were nearly twice as many police referred admissions (65%) who were given a primary mental health diagnosis other than that of psychoactive substance use. In addition to the 33% of patients diagnosed with schizophrenia, schizotypal and delusional disorders, patients referred by the police were also diagnosed with mood affective disorders; neurotic, stress-related and
somatoform disorders; and disorders of adult personality and behaviour. What does become quite evident from this data, is that the perceptions amongst the participants that patients referred by the police were admitted primarily because they experienced problems with substance use was contradicted by the findings of the quantitative study, which clearly indicate that a high number of police referred admissions did in fact suffer from a mental illness. Also, while the 71% of patients referred by the police and admitted experienced problems with substance use, which was significantly higher than those people referred and admitted from other sources, at 50%, the proportion of patients with substance use issues amongst the non-police referred admissions was still very high.

The challenges of caring for patients with a dual diagnosis were more forthcoming when the participants explained the difficulties associated with treatment of patients with a mental illness and substance use problems. Most apparent was that these patients were harder to treat and consequently took a much longer time to improve mentally than anticipated.

8.4 The management of police referrals.

The participants explained that the PICU was designed for the care of patients at risk of aggression and they were adamant that the patients referred by police were most likely to be admitted to the PICU, and often required police escort in the police vehicle directly to the PICU because they presented with a high risk of aggressive behaviour and at risk of absconding.

Findings from the quantitative study did indeed indicate that a higher percentage of police referred patients (69%) were admitted to the PICU. However, these findings were surprising considering that most patients were referred by police because of bizarre behaviour rather than accounts of aggressive behaviour. Only 14% of patients were referred by the police for reasons of violent behaviour and 9%, for reasons of “threats of violent behaviour”. But the reasons for patients presenting to the PICU at risk of aggressive behaviour may have been explained by a few of the participants who perceived that the patients who came to the attention of police in the community were already in a state of crisis but that the manner in which police managed these
patients during apprehension and transportation to the hospital may have impacted even further on their emotional well being, leading to increased levels of agitation among the patients. These participants speculated that the aggressive behaviour displayed by some patients on presentation to the PICU may have been related to the management process used by police.

There was consensus amongst the participants that patients referred by the police and admitted were more likely to display aggressive behaviour during and after admission to the hospital. This was confirmed by the quantitative results that 4% of police referred admissions were involved in physical aggression and 45% displayed fear inducing behaviour compared to referrals from other sources, none of whom were involved in physical aggression but 13% of patients did display fear inducing behaviour. There were numerous reasons offered by the participants for the display of aggressive behaviour by the patients referred by the police and admitted. Most of this behaviour was evidenced during admission to the hospital when patients presented escorted by police. Once again, aggressive behaviour displayed by patients, was explained in the context of the manner in which police managed these patients during apprehension and transportation to the hospital. In this study, while a few of these incidents of aggressive behaviour were actual physical attacks, it would appear that fear inducing behaviour remained a risk factor for staff following the admission of police referrals. There was recognition amongst the participants that the frustration and anger of being admitted to a locked and secure unit and treated against one’s will, was reflected in the emotional responses of patients towards the nurses and others and the participants acknowledged that it was not unusual for patients to be verbally abusive and threatening during episodes of care because they felt disempowered or powerless. The participants also leaned towards the possibility that substance use may have been a contributing factor for the display of aggressive behaviour.

The belief amongst participants that patients referred by police were alcohol and drug affected, aggressive and unco-operative were perhaps also reinforced when the patient's level of overall psychiatric functioning was measured at the time of admission using HoNOS. Patients who were referred by the police and admitted
scored higher on the behaviour subscale (4.6 vs. 2.8) and social functioning (2.7 vs. 1.5). The behaviour subscale combined scores on three individual items: overactive, aggressive, or disruptive behaviour; self-harm; and problem drinking or drug taking. The participants confirmed that these were often the more obvious problems evidenced by patients during presentation to the hospital for a high number of police referred admissions. From the quantitative findings though, it was interesting to note that the patients referred by the police and admitted scored very similarly to non-police referred admissions on the “impairment” and “symptoms” subscale, indicating that apart from problems of substance misuse, police referred admissions also experienced these problems on a comparable level to that of the non-police referred admissions. The participants appeared to be less aware of the similarities between people admitted after referral by the police and people admitted after referral from other sources, than they were of the differences.

The perception amongst the participants was that patients referred by police and admitted spent fewer days in hospital because they were most likely to be diagnosed as mentally disordered patients. This again was reinforced by their accounts of patients presenting as intoxicated or under the influence of illicit substances, presenting a risk to their own safety or the safety of others and only requiring admission until the crisis period had elapsed. The participants explained that patients certified as mentally disordered could not be detained in the hospital by the doctor for more than 3 working days. However, while a high percentage (44%) of patients referred by police and admitted spent fewer days in the hospital (2 days or less), most of the police referred admissions (56%) spent longer periods of time in hospital amounting to 2 to 40 days or more.

8.5 Matrix comparing quantitative and qualitative data

In order to illuminate the quantitative and qualitative findings a matrix has been added summarising the congruence and discrepancies between both findings and some of the additional aspects added that were distinct from each other.
<table>
<thead>
<tr>
<th>Issue</th>
<th>Quantitative Findings</th>
<th>Qualitative Findings</th>
<th>Integration</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEMOGRAPHIC CHARACTERISTICS</td>
<td>No statistically significant differences in demographic characteristics between police and non-police referred admissions.</td>
<td>Nurses felt that some patients referred by the police were using the mental health facility as a place to stay.</td>
<td>Disparity between qualitative and quantitative findings. Rates of homelessness between police (9%) and non-police referrals (6%) were similar.</td>
</tr>
<tr>
<td>Gender; age; country of birth; religion; marital status; living situation.</td>
<td></td>
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<tr>
<td>DIAGNOSIS</td>
<td>Statistically significant differences between police and non-police referred admissions in rates of patients diagnosed with a mental and behavioural disorder due to psychoactive substance use. (35% vs.10%)</td>
<td>Nurses felt that they were caring for more police referred patients admitted for drug and alcohol related problems as opposed to a diagnosis of mentally ill.</td>
<td>Disparity between qualitative and quantitative findings. Police referred as many patients diagnosed with “schizophrenia, schizotypal and delusional disorders” (33%), as they did of patients diagnosed with a mental and behavioural disorder due to psychoactive substance use (35%). Nearly twice as many police referred admissions (65%) were given a primary mental illness diagnosis other than that of psychoactive substance use but substance use was high in both groups.</td>
</tr>
</tbody>
</table>
| Psychosis          | Statistically significant difference in rates of psychosis between police and non-police referred admissions.  
|                   | (51% vs. 64%)  
|                   | Nurses felt that patients referred by police experienced more behavioural problems rather than symptoms of a psychosis.  
|                   | Disparity between qualitative and quantitative findings.  
|                   | Just over half of the police referred admissions were diagnosed as psychotic.  
| Substance Misuse  | Statistically significant difference in rates of substance misuse between police and non-police referred admissions.  
|                   | (71% vs. 50%)  
|                   | This included patients with a primary diagnosis of mental and behavioural disorder due to psychoactive substance as well as patients with a secondary diagnosis of substance misuse.  
|                   | Nurses felt that a high number of police referred admissions experienced problems with substance misuse.  
|                   | Confirmation between 2 data sets but at 50%, the proportion of patients with substance misuse amongst the non-police referred admissions was also very high.  
| Suicide           | No statistically significant difference in rates of suicide between police and non-police referred admissions.  
|                   | (29% vs. 20%)  
|                   | Nurses felt that a higher number of police referred patients presented at risk of suicide.  
|                   | Disparity between qualitative and quantitative findings.  
| ADMISSION OUTCOMES| Statistically significant difference between police and non-police referrals.  
| Legal Status      | (100% vs. 69%)  
|                   | Patients referred by police under Section 22 of the MHA (2007) are of involuntary status.  
|                   | Qualitative findings provided expansion to the quantitative findings.  

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Details</th>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>PICU</td>
<td>Statistically significant difference between police and non-police referred admissions in disposition to the PICU.</td>
<td>(69% vs. 37%)</td>
<td>Nurses were adamant that the patients referred by police were most likely to be admitted to the PICU because they presented the risk of violence.</td>
</tr>
<tr>
<td></td>
<td>Confirmation between 2 data sets.</td>
<td>Qualitative findings provided expansion to the quantitative findings.</td>
<td></td>
</tr>
<tr>
<td>Length of Stay</td>
<td>Statistically significant difference between police and non-police referred admissions in length of stay.</td>
<td>(44% vs. 20% spent 2 days or less) (56% vs. 80% spent 2 to 40 days or more)</td>
<td>Nurses perceived that police referred admissions spent fewer days in the hospital.</td>
</tr>
<tr>
<td></td>
<td>Disparity between qualitative and quantitative findings.</td>
<td>A high percentage of police referred patients spent fewer days in the hospital but most of the police referred admissions spent longer periods of time in hospital.</td>
<td></td>
</tr>
<tr>
<td>HoNOS</td>
<td>Statistically significant difference between police and non-police referred admissions in total HoNOS scores and sub-scores of behaviour and social functioning.</td>
<td></td>
<td>Nurses believed that substance use, and violent and unco-operative behaviour were problems mostly associated with police referred admissions.</td>
</tr>
<tr>
<td></td>
<td>Confirmation between 2 data sets.</td>
<td></td>
<td></td>
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<tr>
<td>Violence</td>
<td>Statistically significant difference in rates of violence between police and non police referred admissions (4% vs. 0 in display of physical attacks) and (45% vs. 13% in display of fear inducing behaviour).</td>
<td></td>
<td>Nurses felt that violent behaviour was a risk with police referrals during and after admission.</td>
</tr>
<tr>
<td></td>
<td>Confirmation between 2 data sets.</td>
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</table>

**Figure 8.1:** Matrix comparing quantitative and qualitative data
8.6 Conclusion

While some of the qualitative findings reflected consistency with the quantitative data, there were also major differences. The use of a mixed methods research firstly yielded information which would not have been possible had we used just one source of evidence to investigate the characteristics of police referrals. From the qualitative phase of the study we able to identify possible reasons for patients presenting to the hospital at risk of aggression even though the quantitative phase of the study indicated that aggression was not the main indicator or reason for patients coming to the attention of police in the community. Secondly, it led to an improved understanding about why these patients were perceived as the “worst patients” by the participants, but helped clarify, that their perceptions about these patients being admitted because they experienced significant problems primarily with substance use was not as clear cut as they had thought. Lastly, it also led to our understanding that while patients referred by the police experienced more behavioural problems, they were very similar to other patients in relation to their symptoms and impairment.

The combination of qualitative and quantitative data provided a more complete picture by identifying quantitative trends as well as in-depth knowledge of participants’ perspectives. In this study a need existed to enhance the quantitative phase with a second source of data, and by integrating the quantitative and qualitative results we were able to tell a more detailed story. The findings of this study will be discussed in greater detail in the next chapter which is the discussion section, through comparison with the findings from the literature.
Chapter 9 : Discussion

9.1 Introduction

In the previous chapter the results of the quantitative and qualitative phases of the study were integrated through utilisation of the sequential explanatory design. One method (quantitative) was implemented first, and the results used to inform some of the more specific questions asked in the other method (qualitative). The aim of this chapter is to demonstrate what the results drawn from the integration of the quantitative and qualitative phases of the study mean and how they fit into the existing body of knowledge. This was done in an interpretive manner through a critical discussion in the context of existing literature. This chapter highlights: how the results have provided new insights about the characteristics of people referred by the police to a psychiatric hospital in NSW; the ability of police to recognize mentally disturbed persons; and the deficits experienced by mental health nurses in their care of patient populations referred by the police. In telling their stories, nurses have provided not only the means to deepen our understanding of what it is like to care for police referred admissions but also some insight into misunderstandings about police referred patients which can be used to improve care and better support these patients through, and after, the experience of involuntary admission. The chapter begins with a recapitulation of the results obtained from the quantitative and qualitative phases as well as those results obtained following the integration of the quantitative and qualitative phases of the study prior to an in-depth discussion on the conclusions drawn from the overall results.

9.2 Summary of quantitative findings

In this first quantitative phase of the study, hypotheses relating to differences in characteristics between a cohort of 101 patients referred by the police and 99 patients referred by various other sources, who were subsequently admitted to a psychiatric
hospital, were investigated. Comparisons of differences and similarities between the two groups were in relation to demographic characteristics, diagnostic characteristics and admission outcomes. The findings of this phase of the study indicated that patients referred by police to mental health services in NSW were similar to patients referred by other sources in relation to demographic characteristics, but different to patients referred by other sources in relation to certain diagnoses. A higher percentage of patients were diagnosed with mental and behavioural disorders due to psychoactive substance use in the police referred group; and were given a secondary diagnosis of substance use. The police-referred admissions were less likely to be diagnosed with mood affective disorders or as psychotic. Following their admission to the hospital the police referred group were more likely to be administered sedatives/hypnotics, to be admitted to the PICU, spend fewer days in hospital, display physical attacks and fear inducing behaviour, and spend time in seclusion. Patients referred by the police also scored higher on the behaviour and social functioning subscales and total HoNOS scores indicating higher levels of difficulty in overall functioning.

9.3 Summary of qualitative findings

This second (qualitative) phase of the study employed a Heideggerian hermeneutic approach to explore the experiences of nine nurse participants caring for persons referred by the police. Guided by the hermeneutic method, this section of the study sought to discover meaning and a descriptive understanding of the everyday lived experiences and an interpretive understanding of the ways in which nurses managed the experience of caring for patient referred by the police. It also provided an understanding of the experiences of participants as expressed in their own accounts of factors that impacted or influenced the manner in which they cared for patients referred by the police.

Two layers of meaning emerged from the analytical processes in this phase of the study and together provided the full description. In the search for understanding the phenomenon, a first layer of meaning was uncovered through thematic analysis in which the participants’ accounts were closely examined. Further hermeneutic phenomenological interpretation provided the second layer of meaning by providing
understanding of what it is to be a nurse caring for patients referred by the police and admitted to the acute units of a mental health facility. Three elements or ways of being were revealed which provided an interpretation of the nature of the phenomenon: Expecting “the worst” patients from police; Rescuing the police, rescuing the patient; Balancing therapeutic care and forced treatment.

9.4 Integration of the quantitative and qualitative phases of the study

In chapter 8 the results for each phase of the study were integrated thereby providing clarification, and explanation of some of the more subtle differences between qualitative and quantitative data. In addition to this, each phase also provided additional information that was specific to that data-set. The use of a mixed methods research yielded information which provided a more complete picture which would not have been possible had we used just one source of evidence to investigate the characteristics of police referrals and explore the experiences of nurses caring for these patients. Some major differences emerged once the quantitative and qualitative results were integrated. Mixed methods research contributed to a better understanding of the perspective of nurses and the reasons for their misperceptions surrounding those persons referred by the police and admitted to the hospital, particularly in the context of substance use, aggressive behaviour and suicidal behaviour. The integration of the two phases of study was discussed under the headings of: “police as referral source”; “diagnostic differences amongst police referrals”; and “the management of police referrals”.

Five major findings emerged from the integrated phase of the study and the following section presents a discussion of these findings under the headings of: “Do police referred patients to psychiatric facilities have a mental illness?; Do the police have the ability to recognize mental illness?; Are mental health nurses adequately prepared to care for patients with substance use?; Are police referred patients predominantly aggressive?; Why do nurses stereotype patients referred by police as the ‘worst’?”. Understanding is furthered in this chapter by discussing these findings in relation to the existing literature. This section also discusses the implications for nurses and other health care professionals both in their practice and education and for further research.
9.5 Discussion and meanings

9.5.1 Do police referred patients to psychiatric facilities have a mental illness?

More than half of the patients (54%) referred by the police in this study were deemed to require immediate involuntary hospitalization. At the time of admission, just over half of the patients referred by police and admitted were diagnosed as psychotic meaning that these patients experienced severe mental illnesses that caused abnormal thinking and perceptions. This finding differed from the perceptions of the participants, many of whom believed that patients referred by police experienced more behavioural problems rather than symptoms of a major mental illness. The referrals of these psychotic patients by police, necessitated detention in the mental health facility because they presented with acute mental health issues as opposed to behavioural problems. While this finding was different in that the rates for psychosis were lower when compared to the non-police referred admissions, this difference was small. However, studies investigating rates of psychosis between police and non-police referred admissions have varied in their findings. Sales (1991) found that police referred admissions to a psychiatric emergency service in Cincinnati were more likely to be diagnosed as psychotic compared to non-police referred admission while a study in New York City indicated that police referrals to a hospital were less likely than other referrals to involve psychotic individuals (Steadman et. al., 2000). Similarities in rates of psychosis between police and non-police referred admissions to a medical centre in the state of New York have also been reported (Redondo & Currier, 2003).

Patients referred by the police and admitted were diagnosed with acute psychotic illnesses as well as with non-psychotic illnesses but nevertheless significant problems related to mental health (suicidal behaviour and drug and alcohol dependency). Indeed nurses reported caring for a high number of police referred admissions diagnosed with schizophrenia, and the proportion of police referred admissions diagnosed with the major mental illness of schizophrenia was found to be almost twice as high than that reported in a study in South Australia (Meadows et al., 1994). The finding in this study of no differences in the proportion of police referred admissions diagnosed with the major mental illness of schizophrenia when compared
to non-police referred admissions was similar to that of a number of other international studies (McNiel et al., 1991; Redondo & Currier, 2003; Reinish et al., 1995; Sales, 1991, Watson, et al., 1993). Patients from the police-referred group were also diagnosed with the major mental illness of mood disorders, but these rates were lower when compared to non-police referred admissions. Similarity in rates of diagnosis of mood disorder between police and non-police referred admissions has been reported in some studies (Redondo & Currier, 2003; Reinish et.al. 1995).

Similar to the study by Redondo and Currier (2003), this study found no difference in rates between the two groups of patients who were admitted because they were considered to be suicidal. Yet, the perceptions of the participants’ about the suicidality of patients referred by the police differed. The participants felt that the number of patients referred by police at risk of suicide was high. At 29% this figure was high, but no higher than the patients referred by other sources who presented at risk of suicide (20%). Explanations for the nurses belief that the police referred a high number of patients at risk of suicide may include that caring for these patients may have had a strong impact on nurse’s memories resulting in them linking this back to the fact that the patients were police referrals to the mental health facility. Another possible explanation is that for a high number of police referred patients presenting at risk of suicide, alcohol misuse may have been the contributing factor rather than that of a depressive illness and this may have presented a challenge for the nurses. Nurses may be sympathetic to those patients who are considered “really ill” as a result of depression and may view them as being “not responsible for their actions” (Porter, 1993), but those patients presenting at risk of suicide exacerbated by alcohol use may be denied the sympathy of nurses because they are perceived to be irresponsible for not taking control of their suicidal urges. It is therefore possible that a diagnosis of “suicidal ideation in the context of alcohol use” may be interpreted by some mental health nurses as pejorative, and one that does not arouse their empathy. However, it is highly important that nurses feel competent in undertaking suicide risk assessments because people who have a high level of alcohol and drug use and often or always become intoxicated are considered at higher risk of suicide (McAuliffe & Perry, 2007).
The same proportion of patients referred by the police at risk of suicide were also admitted for this same reason, indicating that there were perhaps no differences between the police and the admitting clinicians in their assessment of suicidal behaviour. This finding may possibly reflect the appropriate assessment of patients by the police on this very important issue, which differed from the findings of the study by Redondo and Currier (2003). In their study, Redondo and Currier (2003) found that the number of patients assessed as suicidal by clinicians and admitted (27%) was much less than the percentage of patients who were referred by the police (51%) for this same reason (Redondo & Currier, 2003).

The finding that there were more police referred patients who spent longer lengths of stay in hospital than those who did not, is of some indication that these patients perhaps required long term care and treatment for symptoms of mental illness. Nowadays, treatment in the acute admission in-patient facilities is directed towards the reduction of symptoms with the expectation that improvement will occur within a relatively short period of time (Cleary, 2003). Therefore, most admissions to the acute units are of brief duration; that is two weeks or less (Jablensky, McGrath & Herrman, 1999). However, the perceptions of the nurse participants that the length of stay for police referred admissions would be shorter because these patients were perceived more likely to be diagnosed as mentally disordered, were partially unfounded. Whilst some patients referred by police were detained for 2 days or less, most police referred admissions spent longer periods of time in hospital, with some spending as many as 40 days. Many reasons contribute for longer periods of detention in hospital and these include the patient’s experiences of severe symptoms and perhaps poor response to treatment, as well as patients who have other risk factors for poor compliance, relapse and readmission and on a smaller scale for those patients experiencing limited access to suitable housing, and inadequate social supports (Cleary, 2004).

During the study period, police initiated 19 percent of referrals to the hospital. Police departments in this study were the second most utilized agencies for the referral of patients after community mental health teams. When compared to the patients referred by other sources, there were no differences found in the admission rates.
between police and non-police referred admissions. This finding was similar to those by Redondo and Currier (2003) who found no difference in the admission rates between police and non-police referrals but differed from that of Steadman and colleagues (2000) who found that police referrals to a hospital in New York City were less likely to result in admission to an in-patient psychiatric unit. Findings from research studies that patients referred by police are more likely to be hospitalized, when compared to non police referred patients have also been reported (Sales, 1991; Watson et. al., 1993).

9.5.2 Do the police have the ability to recognize mental illness?

Mental illness is often difficult for even trained professionals to diagnose in a given individual. So for police officers, who have limited training in the recognition of mental illness or no training at all (Fry et al., 2002; Lamb et al., 2002), the finding that a comparable percentage of police referrals were admitted to the psychiatric hospital as those referred from other sources was indicative that police were able to make judgments of mental or emotional disturbances in persons they confronted by recognising abnormal or bizarre behaviour that indicated a mental disorder, or behaviour that was potentially destructive and/or dangerous to self or others.

A brief description of the incident leading to referral was documented by police and handed to the admitting nurse at the time of referral to the psychiatric facility. From the description of the incidents leading to referral, police were able to document reasons for the referral of persons to the hospital. For the majority of cases the reasons documented by the police for the referral of persons to the mental health facility amounted to signs and symptoms associated with mental disorders as opposed to signs associated with behavioural issues as perceived by the participants during the qualitative interviews.

It is quite likely possible that some of these police officers may have received specialized training in mental health after an Australian research study (Fry et al., 2002) in NSW found that police officers had major concerns about managing people with mental disturbances. Part of the difficulties experienced by police related to inadequate training and education. Recommendations made by the authors of this
study, led to the development of a training program for police in this area, however, it is unknown whether this training was in place at the commencement of this study. The training program involved police being taught to differentiate between mentally ill and mentally disordered clientele; and to carry out a mini assessment on the mental state of people they were asked to transport to hospital on the grounds of mental illness. Police were also taught to recognise various behaviours, and develop skills that made them feel more comfortable in managing clients with mental health problems (Mental Health Coordinating Council, 2005).

Indeed police officers in this study may have been able to recognize mental illness, given that there were more patients who were referred by them and admitted, which was similar to the rates of admission of those patients referred by other sources. However, there were slightly less than half of the persons referred by them (46%) who were not admitted and released back into the care of the referring police officers. These rates of non admissions were also similar for patients referred by other sources. In attempting to understand the reasons for this non-admission of a high number of persons referred, it is likely that they did not meet the criteria for either that of a mentally disordered or a mentally ill person, as defined in the NSW MHA, and were thus inappropriately referred, according to the admitting medical officer conducting the mental state examination and assessment. The point being made here is that it is likely that police do at times refer persons who do not meet the criteria for admission to mental health services in NSW, but the perceptions of police that their referrals are refused admission because of inconsistent or unmet criteria for emergency treatment (Steadman et al., 1986; 1988; 2001; Way, Evans, & Banks, 1993) may appear unfounded given that patients referred from other sources are just as likely to be refused admissions. However, given that the role of police as frontline responders to mental health crises has increased considerably over the years, and that they play an important role in referring mentally disturbed patients to mental health facilities, aspects in determining the methods used by police for the referral of patients to mental health facilities may warrant further study.

Furthermore, it is most likely that the police will remain the first to respond to individuals with mental illness who are experiencing a crisis (Munetz, Fitzgerald,
Woody, 2006) given the numerous problems associated with community based mental health services in the provision of community based support for people with a mental illness (Australian Council of Social Service, 2005; Smith & Gridley, 2006). Many argue that the needs of these patients are not met because the necessary resources required for effective care has never materialised. Smith & Gridely (2006) found that the reality of private/public community care in NSW, Australia was that people with a mental illness were largely left to fend for themselves, putting them at greater risk of relapse, and increasing their encounters with the police. Therefore, while it does appear that police in this study were able to recognize mental illness, it is still highly recommended that all police undergo further training to develop their knowledge and improve those skills necessary for handling such a population. Knowledge and skills in mental health can further improve their efficiency in the recognition of mental illness and the management of people experiencing mental health problems (Keram, 2005). Studies conducted in America have identified that training in mental health have increased the knowledge and skills of police resulting in more effective law enforcement responses to persons with mental illness (Compton, Esterberg, McGee, Kotwicki, & Oliva, 2006; Watson, Morabito, Draine, & Ottati, 2008).

9.5.3 Recent developments to improve the management of mentally disturbed persons in crisis

One recent development in an effort to respond safely and effectively to individuals with mental illnesses who are in crisis has resulted in police and mental health clinicians in NSW implementing strategies aimed at helping frontline police interact with people suffering a mental illness. In recognition that police are often the first responders for individuals who are experiencing a mental illness crisis, the formation of the Mental Health Intervention Team (MHIT) was developed in 2007 to address the NSW Police Force’s response to people with a mental illness or mental disorder. The MHIT comprises police personnel working in collaboration with mental health professionals to provide specialized training for police officers, the aim of which is to educate police with respect to identifying behaviours in the field indicative of mental illness, and providing them with the tools to effectively deal with the situation. These tools range from communication strategies, risk assessment, crisis
intervention techniques and an understanding of the current Mental Health Act (2007), as well as the Memorandum of Understanding between the NSW Police Force, Ambulance Service and Department of Health.

As a result of a study of best practices across the world, the NSW MHIT formed its basis on the Crisis Intervention Team (CIT) which bears its origin in Memphis, USA. The Memphis model of the Crisis Intervention Team (CIT) program has established itself as a prototype of law enforcement-mental health collaboration with the overall aim of training law enforcement officers to respond safely and effectively to individuals with mental illnesses who are in crisis. Since its inception in 1987, the “Memphis Model” Crisis Intervention Team (CIT) has become one of the most popular US law enforcement initiatives of its kind (Cochran et al., 2000). The CIT is used throughout the USA in over 200 Law Enforcement agencies (Watson, Morabito, Draine, & Ottati, 2008). Canada has also adopted this program and it is under review in a number of Asian Countries as well. The MHIT has formed a partnership with NSW Health and other agencies to achieve its objectives, modified from the Crisis Intervention Team, to meet the needs and operating environment of the NSW Police Force. The Key Stakeholders are NSW Police Force, NSW Health, NSW Governor and Non Government Mental Health Organizations. An independent evaluation of the MHIT by Charles Stuart University in May 2010 identified that: MHIT training had increased officers’ understanding of mental illness; MHIT-trained officers reported greater confidence, awareness, and use of de-escalation techniques when engaging mental health consumers in crisis, and reported that they thought that this had reduced the risk of injury for both police and the public (Herrington, 2010).

Another strategy implemented in NSW (Mental Health Act, 2007) to improve the care of mentally disturbed persons in the community involves authorised ambulance officers being given the core responsibility of providing transport of persons to a mental health facility in situations where the officer believes the person may be mentally ill or mentally disturbed. Part of the expectation is that the ambulance service will respond to emergency mental health situations in the community and provide clinical risk assessment, preliminary mental health assessment, clinical stabilisation, behavioural management and safe transport to the nearest clinically
appropriate hospital or health care facility, as agreed by local interagency protocols (NSW Mental Health Act, 2007). This is highly relevant given that police vehicles have been found to be unsuitable for the transportation of persons with mental health problems because they have potential of creating occupational health and safety implications for police and patients (Carroll, 2005). It has also been suggested that people with mental illness should not be subjected to the transportation methods used for offenders, and that detention in a police vehicle may further exacerbate their symptoms (Carroll, 2005). This is supported from the findings of this study that the procedures used by police during apprehension and transportation of patients have the potential to contribute to patients presenting to the emergency service at increased risk of aggression. While the police will still have obligations to transport, or assist in the transport of a person to a health care facility, their role in other transport of mentally ill persons should be limited to situations where there is assessed serious risk to the person or others such that police presence is required. It is envisaged that the ambulance services will provide concurrent transport, care and the safety necessary for people who are already in distress (Cybulka, 2005; Silva, 2005). The findings of this study has relevance for the education of paramedics in assessing and managing people who are emotionally and/or psychological distressed and disturbed. It is imperative that paramedics are provided with the tools and training necessary to respond appropriately and ensure not only their safety, but also that of the person in mental health crisis. Further research will be needed to investigate the benefits of the ambulance service in the transportation of mentally disturbed patients to health care facilities.

9.5.4 Are mental health nurses adequately prepared to care for patients experiencing problems with substance use?

A major difference found between the two groups in this study was the higher proportion of police referred admissions diagnosed with disorders due to psychoactive substance use and a higher proportion of police referred admissions presenting with a secondary diagnosis of substance use compared to referrals from other sources. The finding in this study that patients referred by police were more likely to be given a primary diagnosis of mental and behavioural disorders due to psychoactive substance use is comparable to studies in other Australian settings.
(Kneebone et al., 1995; Meadows et al., 1994) and reflects much of the findings from international literature as well (Evans et al., 2002; Fahy et al., 1987; McNiel et al., 1991; Reinish et al., 1995) in that people referred by police are more likely to have substance use-related diagnoses in comparison to patients referred by other sources. However, substance use-related diagnoses were also high for those patients referred by other sources to the mental health service in this study.

It remains questionable though whether there was any therapeutic outcome or benefit for this group of persons diagnosed with a mental and behavioural disorders due to psychoactive substance use and/or a secondary diagnosis of substance use because the interventions required for the care and treatment of this group were not always within the range of skills possessed by nursing staff. Indeed, through their clinical experiences of caring for a high population of patients with substance use, nurses in this study had learned certain skills and developed some knowledge in relation to substance use, but they identified not having the relevant training to equip them to deliver targeted interventions to patients presenting with drug and alcohol problems. Nursing staff acknowledged the need for more training about substance use, and more information on substance use within the units. Apart from the recognition that they required formal training in the treatment of substance misuse, there was also the realization that improved communication with other agencies was essential to proactively address substance use.

The admission of a high number of police and non-police referred patients with mental health diagnoses concurrent with drug and alcohol problems does indeed highlight the requirement of specific services for the care and treatment of people with a dual diagnosis. Nurses identified numerous problems in the care of patients for whom drug, alcohol and mental health disorders coexisted. Patients with both disorders were thought to have poorer prognosis which meant that they spent longer periods of time in the hospital. Nursing care of the dually diagnosed client is complex and studies in America and Australia have identified that neither drug and alcohol services nor mental health services provides adequate clinical care to those clients with a dual diagnosis of substance use and mental illness (Drake, Essock,

Edward and Munro (2009) undertook a review of the literature to ascertain whether there was improvement in the service management of clients with a dual diagnosis, and to determine the best practice interventions in the area of mental health nursing in Australia. They found that gaps still remained in the provision of services and identified that while mental health nurses were in the best position to provide integrated care to those clients with a dual diagnosis they required the skills in substance use detection and knowledge of potential care implications for the client in the context of their substance use. Integrated care relates to treatment, in which the same staff treats both disorders in the same setting. Research studies have concluded that integrated care by a single team delivers better outcomes than serial care (sequential referrals to different services) or parallel care (more than one service engaging with a patient at the same time) (Abou-Saleh, 2000; Harrison & Abou-Saleh, 2002; Drake & Mueser, 2000). Edward and Munro (2009) concluded that a collaborative approach to care with better integration of drug and alcohol services within mental health would benefit clients with a dual diagnosis.

9.5.5 Are police referred patients predominantly aggressive?

Contrary to suggestions in the literature that persons are referred by the police for violent behaviour (Evans et al., 2002; Redondo & Currier, 2003) and dangerous behaviour (Watson et al., 1993; Way et al., 1993), the results of this study found that the most common reason for the involuntary referral of patients by the police was for bizarre behaviour followed closely by suicidal behaviour. And even though patients referred by police were more likely to demonstrate aggressive behaviour after admission to the hospital, aggression was not the predominant reason for police referrals in this study.

One explanation given for this discrepancy is due to the variability in mental health systems and commitment statutes (McNiel et al., 1991) around the world. The model of civil involuntary admission varies notably according to countries, and the difference in legal regulations around the world concerning involuntary psychiatric
hospitalization of patients also differs widely. Likewise, there are differences in the MHA amongst States and Territories in Australia. What this may perhaps mean is that the criteria for the admission of patients will differ and therefore sub-population of patients considered appropriate for admission to mental health services in other parts of the world may be considered inappropriate in NSW or other parts of Australia.

However, this study found that a much higher proportion of patients were considered to be aggressive after admission to the psychiatric hospital than the proportion that were actually referred by police for reasons of aggressive behaviour. This was quite the opposite of the findings by Redondo and Currier (2003). In their study (Redondo & Currier, 2003), only about one third of the patients referred by police for reasons of violence were considered to be violent by the assessing clinicians, meaning that police and mental health clinicians differed in their perceptions of violence.

While aggression remained a risk factor for police referred admissions overall, the percentage of patients that displayed physical attacks were few (4%) while 45% of patients displayed fear inducing behaviour. The number of administrations of PRN medications for the modification of behaviour did not differ between the police referred admissions and the non-police referred admissions. Neither did the types of PRN medications administered between the police and the non-police referred admissions differ markedly. The police referred admissions were more likely to be administered sedatives/hypnotics but the difference between the two groups in the administration of sedatives/hypnotics was small.

The presentation of police referred patients as aggressive and under the influence of substances during admission contributed to higher scores on the behaviour subscale when their level of overall psychiatric functioning was measured at the time of admission using the Health of the Nation Outcome Scale (HoNOS).

In this study, two reasons were identified as possible contributing factors for the increased rates of aggressive behaviour displayed by police referred patients on admission. Firstly, it is possible that the aggressive behaviour which brought these
patients to the attention of police in the community may have been related to their substance use (Gillies & O'Brien, 2006; Wright, Gournay, Glorney, & Thornicroft, 2002) given that police referrals in this study experienced significant problems with substance use. Subjects with alcohol or drug use disorders are reportedly more than twice as likely as those with schizophrenia to exhibit violent behaviour (Swanson, Holzer, Ganju, & Jono, 1990) and substance use disorders are found to be associated with the highest risk of assaultive behaviour among both men and women (Swanson et al., 1990). Secondly, from the findings of this study, another possible explanation for patients presenting at greater risk of aggression, related to their experiences of admission (Craven, Voore, & Voineskos, 1987) in the context of the manner in which these patients were apprehended and transported by police to the psychiatric hospital. Therefore, investigations into the procedures used by police during apprehension and transportation of patients may help explain the reasons contributing to patients presenting to the emergency service at increased risks of aggression. Without the skills necessary for working with people with mental illness, it is possible that the police may approach forcefully in order to resolve the situation quickly, which in turn could escalate the situation and increase the risk of aggression, violence and injuries to the officer and the person with a mental illness (Ruiz & Miller, 2004).

The risk of aggression also contributed to a higher proportion of the police-referred patients requiring acute interventions such as admission to the PICU, a locked environment in which patients displaying the highest degrees of risk and need for containment are placed (Wynaden, McGowan, Chapman, Castle, Lau, et al., 2001) and the use of seclusion as a possible risk minimisation measure for the safety of the patient and others. Overall, the percentage of patients requiring seclusion in this study was higher when compared to the number of police referred admissions secluded in the study by Kneebone and colleagues (1995). Seclusion amongst police referred admissions was also found to be significantly more likely in the study by McNiel and colleagues (1991).

Seclusion remains a controversial topic and the source of ongoing debate (Amos, 2004; Bowers, 2006; Donat, 2005; Wynaden, Orb, McGowan, Castle, Zeeman, et al.,
2001a) because it is viewed as a coercive measure (Muir-Cochrane & Holmes, 2001). In view that an individual’s aggressive behaviour is often associated with identifiable precipitants and common triggers (D’Orio, Purselle, Stevens, & Garlow, 2004) there is strong suggestion that early identification and management of problematic behaviours can reduce the use of seclusion (Curie, 2005; Kaltiala-Heino, Tuohimaki, Korkeila & Lehtinen, 2003). National and international literature highlight that seclusion raises serious human rights issues and may increase stress, harm therapeutic relations and impede or worsen psychological recovery from mental illness (Amos, 2004; Bowers, 2006; Donat, 2005; Muir-Cochrane & Holmes, 2001 Wynaden et al., 2001a).

9.5.6 Why do nurses stereotype patients referred by police as the worst?

Patients referred by the police were stereotyped as the “worst patients” by nurses because certain characteristics of these patients were perceived to be easily distinguishable by the nurse participants. While the participants made little reference to the demographic characteristics of patients, stereotyping in this study was based on the perceptions of the participants that certain clinical characteristics were associated with patients referred by the police.

Police referrals have been significantly associated with certain demographic characteristics such as younger age (Fry et al., 2005; Kneebone et al., 1995; Lee et al., 2008; Steadman et al., 1986) and male gender (Fry et al., 2005; Kneebone et al., 1995; Redondo & Currier, 2003; Sales, 1991; Way et al., 1993), but this was not the case for police referred admissions in this study. In fact, there were no differences found in any of the demographic characteristics of police referred admissions when compared to non-police referred admissions. Findings though that patients referred by the police were more likely to be females have also been reported in other American studies (McNiel et al., 1991; Steadman et al., 1986).

However, the participants perceived that patients referred by the police were aggressive and mentally and behaviourally disturbed due to illicit substance and alcohol use and presented more at risk of suicidal behaviour. In this study, aggression was associated with the police referred admissions but the incidents of physical
assault were reported for only a small proportion of the police referred admissions. Even though the diagnosis “mentally and behaviourally disturbed due to illicit substance and alcohol use” was significantly associated with police referred admissions, the proportion of patients referred by other sources experiencing problems associated with mental and behavioural disturbances due to illicit substance and alcohol use was also high. In attempting to understand why patients referred by the police were stereotyped by the participants one can assume that these salient features (aggressive, drug and alcohol misuse, suicidal) stuck in the minds of the nurses, so much so that their perceptual and cognitive resources may have focused on what they considered to be the most pertinent characteristics of patients referred by the police (Niebur, Hsiao, & Johnson, 2002). The danger of stereotyping patients is that it results in negative attitudes towards patients (Siegfried, Ferguson, Cleary, Walter, & Rey, 1999a). In the qualitative interview, the participants spoke about the development of therapeutic relationships with patients as always being a possibility as long as nurses were sensitive to the problems experienced by patients, but while they indicated knowing what they should do, the participants expressed negative judgement and bias towards certain patients referred by the police. Patients experiencing violent and suicidal behaviour in the context of drug and alcohol problems were labelled as the worst patients. Patients who were diagnosed with disorders of substance use were judged more negatively than were patients with other diagnoses such as schizophrenia. Differences were found in how participants perceived patients diagnosed with schizophrenia and those diagnosed with substance use which led to distinctive reactions - extra care on the one hand, active neglect on the other. Findings of a research study suggest that patients labelled and judged negatively are always at risk of not being considered real patients, in need of and deserving of care (Koekkoek, van Meijel, & Hutschemaekers, 2006).

Those patients labelled as the worst would have made the interpersonal contact difficult. Negative judgements of patients are easily and rapidly communicated among nurses and may lead to care of less quantity or quality (Russel, Daly, Hughes, & Hoog, 2003). Being assigned the negative label of “the worst patient” serves to de-legitimize patients, and impedes the rebalancing of power and control in the nurse-patient relationship. Stereotyping though is often generated by ignorance, fear and
knowledge deficits of a person or group that is different from the observer. Therefore, nurses do need to be confident and knowledgeable about caring for patients with substance use problems and those at risk of suicide, because this study has identified that the stereotyping of patients by the participants was based on wrongly held assumptions because substance use was as problematic for patients referred from other sources even though not as high in rates as found amongst police referred patients and the percentage of police referred admissions presenting at risk of suicide was similar to non-police referred admissions.

9.6 Implications and recommendations

By using mixed methods I have attempted to uncover data that have previously remained poorly understood. This study has shown that certain patient characteristics were more likely to be associated with the police referrals but none of the characteristics were unique to patients referred by the police. This study also offers insights into the lived experiences of nurses, and the relationship between nurses, police and patients. Such insight can raise nurses’ awareness of their fears and knowledge deficits, and the effects this has on the way in which they perceive and care for their patients.

The findings of this study have practical implications for nurses caring for patients referred by the police, particularly for those with a dual diagnosis (a person affected by mental illness and substance use) and for police and other pre-hospital personnel such as paramedics in their management of mentally disturbed patients. As part of the conclusions within any research study is that specific recommendations for practice, education and research should be made. The intent of the recommendations is also to enhance the awareness of nurses during their episodes of care of police referred patients to the PICU and the possibilities for change within nursing practice, education and further research.
9.6.1 Implications for clinical practice and education

The Implications for clinical practice and education relate to three identified areas: nursing care of patients experiencing drug and alcohol problems; police management of mentally disturbed patients; and the clinical management of patients with a dual diagnosis.

People experiencing a high level of alcohol and drug use and who often or always become intoxicated are considered at higher risk of suicide (McAuliffe & Perry, 2007). Deficits in knowledge and skills in relation to the care of this population as well as those presenting at risk of suicide under the influence of substances has the potential of resulting in negative attitudes towards substance users (Kelleher, 2007) and the potential to stereotype patients.

Nurses in this study were unclear regarding the care and treatment of patients with alcohol and drug use. Without the knowledge and skills, the stress of caring for such a population had implications for the quality of the service that mental health nurses were capable of giving. Furthermore, drug and alcohol use can give rise to many areas of concern (Rassool, 2002), so apart from health consequences, there are often social, cultural and economic consequences of drug and alcohol use which also require addressing (Hatfield, 1993; Kelleher, 2007; Patrick, 2003) and without proper interventions, the practice of admitting these patients can create a revolving door syndrome.

This study also highlights the implications for police practice and education in relation to police management of mentally disturbed patients. Police officers encounter persons with mental illness in a variety of situations, not just those persons who are experiencing a mental health crisis. It is quite understandable that police may perceive certain persons with mental disturbances to be dangerous, because the price of letting down their guard is too high, but addressing these perceptions through education, skills training in effective communication and de-escalation strategies will assist officers in successfully resolving contacts with persons with mental illness who are in crisis. Training in de-escalation techniques can lead to
improved handling of violent or potentially violent encounters; decrease the risk of harm to officers and to persons with mental illness; and aid officers in managing a person who is threatening suicide.

This study identified that the practice of admitting people with a dual diagnosis to mental health facilities in Australia can be problematic because separate services exist for the treatment of substance misuse (Edward & Munro, 2009) which means that persons admitted to mental health services may not be adequately treated for their substance use issues and just as likely, persons with mental health issues attending drug and alcohol services may not be adequately treated for their mental illness. In view of the above implications, recommendations are made in the following section.

9.6.2 Recommendations for clinical practice and education

Nurses do need to feel confident and knowledgeable about caring for patients experiencing drug and alcohol problems. The discipline of nursing needs to accept responsibility for the care they provide to this population and for this to occur the relationship between mental health and substance use needs to be reviewed so that all mental health nurses can develop generic skills for the identification, engagement and management of persons with concurrent substance use and mental health issues.

It is highly recommended that nurses feel competent in undertaking suicide risk assessments irrespective of the contributing factors for the suicide risk because without the relevant knowledge and skills patients may be potentially at risk of being assigned negative labels and stereotyped by nurses.

While the study identified that the police referred more persons who met the criteria for a mental illness and who were consequently admitted, it is considered essential that all police officers undergo at least some basic mental health training, irrespective of the strategy of response to improve their confidence in identifying, approaching and managing persons with a mental illness (Daly, 2006). Without specialised knowledge and skills in mental health training, not only will the police response to
complex mental health crises result in patients presenting to mental health facilities at greater risk of aggression, but may also lead to increased rates of arrest and incarceration of persons with mental illness, rather than referral to mental health services for care and treatment. It is therefore encouraging to note that strategies have been implemented in NSW by the MHIT to address this issue. It is also encouraging to note that changes to the NSW MHA have expanded to include ambulance officers in the transport of mentally disturbed persons to hospital limiting the reliance on police for this purpose. It is however essential that all ambulance officers undergo some basic mental health training, to improve their confidence in identifying, assessing, approaching and managing persons with a mental illness during transport to the health facility.

If patients with a dual diagnosis are to benefit from psychiatric hospitalization, the response needs to be one of integrated service delivery and treatment as opposed to treating one disorder then another as if they exist separately. Without appropriate responsive mental as well as drug and alcohol healthcare initiatives, the mental health sector will not be able to respond effectively to persons with co-occurring disorders. Recently, there has been recognition of the importance of initiatives which support and enable the mental health sector to respond more effectively to persons with co-morbid substance use disorders (Burns & Teesson, 2002; Hughes, 2009; NSW Drug & Alcohol Plan, 2007; NSW Health, 2008) and although successive reports have recommended greater coordination between mental health and drug and alcohol services, much more research needs to be conducted in this area in order to determine the most effective methods of providing effective care for these patients and translating this into effective policy.

9.7 Strengths and limitations of the study

A particular strength of this study was the mixed methods approach. Firstly, through a quantitative study it was possible to investigate the similarities and differences between patients referred by the police and other sources and to examine some of the assertions made by previous researchers about the characteristics and disposition of persons referred by the police to the psychiatric hospital. Secondly, the qualitative study enabled an exploration of the lived experience of nurses caring for persons
referred by the police and admitted to the psychiatric hospital. Prior to this there was no qualitative study found that explored the lived experience of nurses caring for police referred admissions to a psychiatric hospital which created a major gap in understanding the phenomena from the nurse’s subjective point of view during episodes of care of these persons. This study has provided valuable insight into these experiences by illuminating some of the misperceptions held by nurses about police referred patients. The data provides reasons for clinicians to re-evaluate the judgment of patients referred by police to the psychiatric hospital. This important field of research may also provide nurses with a greater understanding of how they can assist patients in their coping and functioning at a time of crisis, and how they can help patients regain some control in their lives. In understanding such events, nurses may be able to provide a more holistic approach to caring for the patient in line with the therapeutic partnership paradigm.

This study has several limitations. The quantitative study was retrospective and a reliance on the medical records of patients’ limited access to other variables which may have been available if the study was conducted prospectively. In addition, the quantitative and qualitative data was collected from a single Australian area health service. Furthermore, the hermeneutic study investigated the experiences of a small group of nurse participants. The findings, therefore, are specific to the context in which the study took place. In order to develop broader understandings, it will be necessary for further studies to be conducted in a variety of health care settings.

9.8 Concluding comments

The sequential mixed methods design used in this study has enabled an understanding of the issues from differing perspectives. In the first quantitative phase of the study, an investigation into the characteristics of patients referred by police through comparisons to the characteristics of patients referred by other sources has identified similarities and differences in the demographic, diagnostic and admission outcomes between police and non-police referred patients as stated in chapter 5. The objectives of the first quantitative phase of the study have therefore been achieved. In the second qualitative phase of the study, an exploration of the experiences of nurses caring for patients referred by the police through utilization of a Heideggerian
Phenomenological framework has provided a descriptive understanding of the everyday lived experiences and an interpretive understanding of the ways in which nurses managed the experience of caring for patient referred by the police. The goal of analysis which was to capture an ontological understanding of the participants in their own world by interpreting shared meanings from the accounts they gave of their lived experiences, has therefore been achieved. A profiling of the characteristics of patients referred by police has highlighted the need for the development of specific services which may contribute to better outcomes for these patients and in context with the qualitative data provides reasons for clinicians to re-evaluate their judgment of patients referred by the police, particularly for those admitted with drug and alcohol problems and suicidal behaviour.
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Appendices

Appendix A: Participant Information

PARTICIPANT INFORMATION

Title of Project: Psychiatric referrals from police: Consequences for mental health nursing.

Name of Investigator

This research project is being conducted by Reshin Maharaj from the Sydney West Area Mental Health Service. The project is being conducted as part of the Doctor of Philosophy (PhD), which I am currently undertaking through the University of Western Sydney.

What is the purpose of the Study?

The purpose of the study is to explore the consequences for mental health nursing when caring for patients referred by police. The study seeks to discover meaning and understanding of your experiences of factors that impact on the manner in which you care for patients referred by the police.

Who will be invited to enter the Study

Registered nurses with a minimum of 2 years nursing experience in the acute units and/or the psychiatric intensive care unit will be invited to participate in the study.
What will happen on the Study?

If you decide to participate in the study, you will be interviewed individually in a quiet room within the hospital complex, but distant from your work unit for no longer than one hour about your views on the characteristics of patients referred by police in relation to the following: (1) factors that are likely to hinder or influence nurse-patient interaction; (2) factors that facilitate or impede the caring process; and (3) interventions used in caring for persons referred by police. The procedures for participation include: (1) responding to a semi-structured interview on patients referred by police which will be audio-taped and (2) completing a demographic data sheet (age, length of nursing experience, educational preparation, clinical position and number of years worked in mental health units). Your participation in the study has the potential of identifying factors that foster or inhibit the development of therapeutic nurse-patient relations as well as the potential of identifying appropriate interventions to meet the needs of patients who may not be responding to current interventions used by nurses in mental health units.

Signature of participant ________________________ Date: ____________
PARTICIPANT INFORMATION

Title of Project: Psychiatric referrals from police: Consequences for mental health nursing.

Are there any Risks?

During participation in the interview, it is possible that you may experience some form of discomfort. This may be in the form of mere inconvenience to attend the interview and/or physical discomfort including fatigue, or muscle tension and/or emotional risk when answering certain questions. Any discomfort experienced though, may be minimal and of a temporary nature. However, as a risk minimisation measure, independent counselling has been arranged from a member of the Critical Incident Stress Management Team (CISM) at Cumberland Hospital regarding the conduct and progress of interviews. Members on the team have undergone specialist training to respond to requests for critical incident stress debriefing.

Do you have a Choice?

Your participation in this study is voluntary; you are under no obligation to participate. You have the right to refuse to be interviewed, refuse to allow the interview to be audio-taped, or if you agree to the interview being audio-taped to review the tape. Furthermore, if you do not feel comfortable with any of the questions, you may choose not to answer them. You have the right to withdraw from the study at any time and this will have no adverse consequences for you or your relationship with the employer. Your decision to participate in the study will remain confidential. Your identity will not be linked with answers obtained during the audio-taped interviews. Neither will your name, address or any other identifying information be revealed.
Complaints

If you have any concerns about the conduct of the study, you may contact the Sydney West Area Health Service Human Research Ethics Committee Secretary, Telephone No 9845 8183, or fax 98458352, or email researchoffice@westgate.wh.usyd.edu.au

Contact details

If you have any problems while on the study, please contact Ms Reshin Maharaj

Working hours Telephone No – (02) 9840 3558
After hours Telephone No – (M) 0416 279 805

Signature of participant ____________________________ Date: ____________
Appendix B: Consent to participate in the research

Title of Research Project: Psychiatric referrals from police: Consequences for mental health nursing

Name of Researcher: Reshin Maharaj

I understand that the researcher will conduct this study in a manner conforming with ethical and scientific principles set out by the National Health and Medical Research Council of Australia and the Good Clinical Research Practice Guidelines of the Therapeutic Goods Administration.

I acknowledge that I have read, or have had read to me the Participant Information Sheet relating to this study. I acknowledge that I understand the Participant Information Sheet. I acknowledge that the general purposes, methods, demands and possible risks and inconveniences which may occur to me during the study have been explained to me by Reshin Maharaj and I, being over the age of 16 years acknowledge that I understand the general purposes, methods, demands and possible risks and inconveniences which may occur during the study.

I acknowledge that I have been given time to consider the information and to seek other advice.

I acknowledge that refusal to take part in this study will not affect my employment.

I acknowledge that I am volunteering to take part in this study and I may withdraw at any time.

I acknowledge that this research has been approved by the Sydney West Area Health Service Human Research Ethics Committee.
I acknowledge that I have received a copy of this form and the Participant Information Sheet, which I have signed.

Before signing, please read ‘IMPORTANT NOTE’ following.

Name of participant ____________________________________ Date of Birth _____________

Address of participant __________________________________________

Name of parent or guardian (where applicable) ____________________________________

Address of parent or guardian (where applicable) ________________________________

Signature of participant ___________________________Date: ________________

Signature of parent or guardian (where applicable) ________________Date: ________________

Signature of researcher ______________________________________Date: ________________

Signature of witness ________________________________________ Date: ________________
IMPORTANT NOTE

This consent should only be signed as follows:

Where a participant is over the age of 16 years, then by the participant personally.
Where the participant is between the age of 14 and 16 years, it should be signed by the participant and by a parent or guardian.
Where the participant is under the age of 14 years, then the parent or guardian only should sign the consent form.
Where a participant is under a legal or intellectual disability, eg unconscious, then particular consent should be sought from the Human Research Ethics Committee as to whether the person should take part in the research.

INDEPENDENT WITNESS:

I, ________________________________________ (name of independent witness)

of ________________________________________ hereby certify as follows:

I was present when ________________________________________ (“the participant”) appeared to read or had read to him / her a document entitled Participant Information Sheet.

I was present when Reshin Maharaj explained the general purposes, methods, demands and the possible risks and inconveniences of participating in the study to the participant. I asked the participant whether he/she had understood the Participant Information Sheet and understood what he/she had been told and he/she told me that he/she did understand.
I observed the participant sign the consent to participate in research and he/she appeared to me to be signing the document freely and without duress.

The participant showed me a form of identification which satisfied me as to his/her identity.

I am not involved in any way as a researcher in this project.

Name of independent witness ________________________________

Address ________________________________________________

Signature of independent witness ___________________________ Date:
_______________

Relationship to participant of independent witness
______________________________________
Appendix C: Publications and Presentations

Publications


Presentations


Maharaj, R. (October 2002). Collaboration between mental health services and the police – giving new meaning to the concept of community psychiatry for mental health nurses. ANZCMHN 28th International Conference. Sydney Convention & Exhibition Centre, Darling Harbour.