EXPERIENCES OF POLICE OFFICERS INTERACTING WITH MENTALLY ILL PERSONS IN A RURAL TOWN IN THE EASTERN CAPE PROVINCE

By

Ntombekhaya Mildred Mjali

Student Number: 213498863

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Supervisor: Prof. J. Strümpher

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DECLARATION BY CANDIDATE

NAME: Ntombekhaya Mildred Mjali

STUDENT NUMBER: 213498863

QUALIFICATION: Magister curationis (Research)

DECLARATION: EXPERIENCES OF POLICE OFFICERS INTERACTING WITH MENTALLY ILL PERSONS IN A RURAL TOWN IN THE EASTERN CAPE.

In accordance with Rule G5.6.3, I hereby declare that the above-mentioned treatise is my own work and that it has not previously been submitted for assessment to another University or for another qualification.

SIGNATURE: 

DATE: 04.12.2017

DEDICATION

This treatise is dedicated to the vulnerable mentally ill persons living in the rural communities where there is little or no support network, who found themselves interacting with ill-prepared police officers whom they are scared of as they associate the police officers with law enforcement and arrest.

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ABSTRACT

The researcher worked as a psychiatric nurse in a psychiatric hospitalin Chris Hani District Municipality and observed when police officers brought mentally ill persons for admission. The mentally ill persons were dealt with harshly and in a degrading manner which raised concerns. It would seem as if police officers did not take into consideration that they were dealing with innocent individuals who were mentally ill. Therefore the researcher sought to explore how police officers experienced interacting with mentally ill persons during their everyday duties.

The aim of the study was to explore and describe the experiences of police officers interacting with mentally ill persons in a rural town in the Chris Hani District Municipality. The study utilised a qualitative, explorative, descriptive and contextual design. The research population consisted of police officers working in a Community Service Centre in a rural town who regularly came into contact with mentally ill persons in the course of their duties. Purposive sampling was utilised to select participants.Data was collected by doing in-depth, semi-structured interviews with an interview guide until data saturation was reached. Data analysis was done using Tesch's method of content analysis. Three themes with sub-themes were identified and described. A literature control was done to compare the findings with current literature. Trustworthiness was ensured using Guba's Model of trustworthiness. A high ethical standard was ensured throughout the research process.

Police officers had regular contact with the mentally ill, usually when they were called out to a community venue where they had to intervene between an aggressive mentally ill person and the community. This gave them a skewed view of mental illness which they always associated with aggression. Police officers found it difficult to communicate with both the mentally ill person and his/her family. They stated that they did not know how to manage aggressive individuals who were not criminals. Police officers also related that they themselves felt vulnerable, they became very angry with the families and the mentally ill persons

and feared that they will be harmed. They also expressed empathy with mentally ill persons.

Recommendations were made that police officers should be trained on what their responsibilities were related to the mentally ill person they encounter. To equip them better to deal with the mentally ill, they should also receive training in effective communication and the management of aggression.

Keywords:Mentally ill person, police officer, family members, community contact, aggression, community service centre, experiences, interacting.

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CHAPTER ONE

BACKGROUND AND LITERATURE

1.1 INTRODUCTION

Mentally ill persons are one of the most defenceless and disadvantaged groups in any community as they are unable to safeguard their own rights and are occasionally exploited by persons who live in the same locality. Townsend (2012:27) affirmed that attitudes towards mentally ill persons may be brutal. The World Health Organization (WHO) declares that mentally ill persons belong to a defenceless category resulting in the public scorning them (WHO, 2010:16). The mentally ill persons are subjected to dishonour and prejudice on regular basis, exposing them to emotional, physical and sexual exploitation (WHO, 2010:16). As such, mentally ill persons are more prone to incapacity and early death compared to the universal inhabitants (WHO, 2010:16). Police officers often come across mentally ill individuals, especially when the person experiences psychotic symptoms causing bizarre behaviour. Police officers may be asked to intervene. However, it would seem as if police officers are inadequately prepared to deal with such interactions, which may be to the disadvantage of the mentally ill person.

This study was interested in trying to determine what happens when a police officer encounters a mentally ill person in the community. The study utilised a qualitative approach and aimed to explore and describe the lived experiences of police officers when having interactions with mentally ill persons living in the rural community of the Chris Hani District. In this area police officers have regular interactions with mentally ill persons, especially when the mentally ill person behaves in a problematic manner.

1.2 BACKGROUND AND LITERATURE

Persons who are mentally ill often present with symptoms associated with the medical condition that can influence their behaviour negatively. Uys and Middleton (2010:200) described these symptoms as being unkempt, hyperactive and sometimes troublesome, they may yell and use strong language towards the people around them, they may behave in an unfriendly manner, be destructive to property and can be physically and verbally hostile. They may stand on street corners and give sermons in the streets, they are often destitute which causes them to seek food

in refuse bins and even sleep out in the open as they often do not live in formal housing. Some individuals may be suicidal and may be liable to kill themselves, due to a specific action or, sometimes, by accident. The patients' behaviours may put themselves and others at risk, for example, setting fires or attacking persons they deem to be a threat. They may also engage in immoral sexual behaviour that exposes them to the risk of being raped or contracting sexually transmitted infections (Uys & Middleton, 2010:200). The patient may be abused financially or otherwise encroached on (Baumann, 2011:642). These behaviours as well as the community's concern may compel community members to draw in the police to intervene in the situation. Interaction between the police and the mentally ill person is often not harmonious and may lead to conflict. This is, however, not only a local problem; it also occurs worldwide.

Van der Brink, Broer, Tholen, Winthorst, Visser and Wiersma (2012:1), in a Dutch study on the role of the police in linking individuals experiencing a mental health crisis, assert that police officers often have to deal with a substantial number of mentally ill persons who may be non-compliant to their treatment regimens. They stated that police officers were often instrumental in linking the mentally ill person with a health establishment, but they also pointed out that police officers need more training on how to interact with mentally ill persons (van der Brink *et al*., 2012:1).

In a study in the United States of America (USA), Compton, Bakerman, Broussard, Hankerson-Dyson, Husbands, Krishan, Steward-Hutto, D'Orio, Oliva, Thompson and Watson (2014:517) revealed that police officers were at the forefront with regard to interacting with mentally ill persons who are experiencing a crisis. They reported that in almost one-third of all the emergencies involving mentally ill individuals police officers had to deal with these persons. Hence, police officers often had to interact with the mentally ill as if they themselves were mental health care providers. In another USA study, Clayfield, Fletcher and Crudzinskas (2011:742) found that the officers often lacked sufficient training in mental health and did not know how to manage the risks associated with mentally ill persons (Clayfield, *et al*., 2011:742).

In the United Kingdom (UK), Heslin, Callaghan, Barret, Lea, Eick, Morgan, Bolt, Thornicroft, Rose, Healey and Patel (2016:1) found that although mental illness was not the focus of their service, police spent a lot of time and money in interacting with

mentally ill persons. Indeed, Quinn, Laville and Duncan (2016:1) indicated that police interaction with mentally ill persons was on the rise and this was mostly seen as a sequel of deinstitutionalization. In another UK study, McLean and Marshall (2010:1) affirmed these findings, attributing the increase in costs to the failure of the mental health system to deliver quality care for the mentally ill persons in the community. However, the police officers felt that their help was not always recognised by fellow professionals (McLean & Marshall, 2010:1). Quinn et al. (2016:1) also found that police officers considered themselves to be inadequately equipped to deal effectively with mentally ill persons because they received minimal training in how to interact with them.

In Canada, Coleman and Cotton (2010:6) conducted a study on police officers' interactions with mentally ill persons and described the same problems as those experienced in the UK and USA. Police officers found interacting with mentally ill persons exhausting; they also reported that mentally ill persons were often detained for minor offences (Coleman & Cotton, 2010:6). The authors also suggested that police officers should be trained in mental health issues in order to provide them with the skills and knowledge required to interact with a mental ill person (Yanick, Crocker & Billette, and 2011:677). Hoffman, Hirdes, Brown, Dubin and Barbee (2016:1) did a study on teaching Canadian police officers how to screen for mental illness symptoms and even developed a tool. The police officers were taught how to use the tool so that they could identify symptoms before transporting individuals to the relevant health establishment (Hoffman, *et al.,* 2016:1*).*

Police officers in South Africa have two acts that can guide them on their role when dealing with the mentally ill. These two acts are the South African Police Act no.68 of 1995 (South Africa, 1995) and the Mental Health Care Act no.17 of 2002 (South Africa, 2002). The South African Police Act (South Africa, 1995) describes the system of rules and regulations which regulate police officers' actions. It describes their main function as having to maintain law and order in the community. However, the Act does not describe how a police officer should approach and interact with mentally ill individuals. In contrast, the Mental Health Care Act 17 of 2002, section 40 (South Africa, 2002:24) clearly states that police officers have a role to play when they come into contact with a mentally ill person who may pose a danger to themselves or others in the community. The Act states that they are authorized to

arrest and transport mentally ill persons to relevant health establishments where the person can receive care, treatment and rehabilitation. However, Taljaard (2012:374) reports that police officers are predominantly unclear about their role and on how to interact with mentally ill persons.

There are numerous reasons why contact is required between mentally ill persons and the police. One situation that occurs frequently is when a mentally ill person absconds from a health establishment where he was being treated and has to be arrested and returned to the facility (Baumann, 2011:581). Another form of contact occurs when a person exhibits symptoms of acute mental illness and where the family or the community ask the police to help with transporting a mentally ill patient to a health establishment where he can receive care. Sometimes police may find it necessary to keep the person in police custody for a period not exceeding 24 hours (Baumann, 2011:581).

Jonsson, Moosa, Jeenah, and Musenge (2013:94) conducted a study on how section 40 of the Mental Health Care Act (South Africa, 2002), which describes the role of police when dealing with a mentally ill individual, was put into effect. The study was performed in Gauteng at the Chris Hani Baragwanath Hospital where the researchers endeavoured to determine how many patients with a history of displaying symptoms of mental illness and who were brought into the hospital by police were in fact mentally ill. It was established that the majority of these persons were not mentally ill and after assessment by professionals were released. This denotes the inability of the police officers to ascertain the mental health status of a person before taking action (Jonsson *et al*., 2013, 94).

Magadla and Kolwapi (2013:170) did a study in the Eastern Cape Province in Mdantsane on police officers' knowledge and skill enabling them to manage mental health care users. They found that police officers exhibited a negative attitude towards mentally ill persons and that they were deficient of the necessary skills for interacting with mentally ill persons. The researchers proposed greater cooperation between police officers and mental health professionals when interacting with mentally ill persons and the necessity for police officers to receive training in how to interact with mentally ill persons when they come in contact with them.

1.3 PROBLEM STATEMENT

The police officers of the South African Police Services (SAPS) have regular interaction with mentally ill persons when executing their duties. There is a need for research on mental health in rural areas. The researcher worked as a psychiatric nurse at a psychiatric institution in the Eastern Cape and observed that police officers regularly brought mentally ill persons to these facilities for admission. The researcher noticed that police officers interacted with the mentally ill persons in a harsh and demeaning manner which raised concerns among health care workers. Police officers are sometimes summoned by the families or by nursing staff to help with mentally ill persons who may be confused, psychotic or aggressive, when they need to be transported to a health facility for medical intervention. The mentally ill person may be transported alone or with a relative in the back of a police van where they or their significant others may be exposed to injury. Often mentally ill persons are brought to a health facility in handcuffs; the police officer does not take into consideration that precautionary measures may be needed before the person is restrained or that there may be more humane methods that can be implemented before restraining the person. The mentally ill person may already be confused due to the mental illness and may not understand what is happening. This may cause additional stress, emotional pain and embarrassment to the mentally ill person as well as to the family. On the other hand, a violent, confused mentally ill person may cause harm to police officers.

1.4 RESEARCH QUESTION

The research question that the researcher needed to be answered is as follows;

- What are the experiences of police officers interacting with mentally ill persons in a rural town in the Chris Hani District Municipality?

1.5 THE PURPOSE OF THE STUDY

The purpose of the study is to explore and describe the lived experiences of police officers interacting with mentally ill persons in a rural town in Chris Hani District community.

1.5.1 Objectives of the study

The study seeks to achieve two overall objectives, namely:

- To explore and describe police officers' experiences when interacting with mentally ill individuals in the community
- To make recommendations based on the research findings regarding police officers' interaction with mentally ill individuals

1.6 CONCEPT CLARIFICATION

- For the purposes of the study the following concepts will be defined, namely, mentally ill persons,police officer, community contact, community service centre, experiences, interacting.

- **Mentally ill person**

According to the American Psychiatric Association (2013:20), mentally ill persons are characterised by significant clinical disturbances in psychological, biological or developmental processes underlying a person's mental functioning, cognition, emotion regulation or behaviour that reflects a dysfunction. For the purpose of this study a mentally ill person is an individual with a positive diagnosis of a mental illness in terms of approved diagnostic criteria made by a mental health care provider where the individual presents with inappropriate behaviour.

- **Police officer**

According to Oxford Dictionary (2007:903), the concept "police officer" relates to a male or female, who is a member of a police service and is responsible to maintain law and public order in the community, protects the rights of citizens, prevents or detects crime and preserves the country's internal security. In South Africa police officers are mandated to also deal with mentally ill individuals by section 40 of the Mental Health Care Act, 17 of 2002 (South Africa, 2002). In this study police officers refer to members of the SAPS who work in the Chris Hani Municipal District in the Queenstown community service centre and who, in their line of duty, interact regularly with the mentally ill persons.

- **Aggression**

Aggression is the behaviour that contravene the rights of other persons. Violence and aggression are used exchangeable and can be either verbal (screaming) or physical (assault) (Kniesl & Trigoboff, 2013:756). In this study aggression refers tohostile behaviour whether verbal or physical, that wasdisplayed by the mentally ill persons in the process of interaction with police.

- **Experiences**

Experiences mean a practicalcontactwith and observationof facts or events (Oxford dictionary, 2007:406). For the purposes of this study experiences will mean, the viewpoint, attached meanings and interpretation of police officers about interacting with mentally ill persons in the execution of their duties.

- **Interacting**

To interact is to act in such a way as to have an effect on another individual (Oxford Dictionary, 2007:600). In this study interaction will mean that police officers will act in such a way as to have an effect on the mentally ill patients. It will also refer to the communication that takes place between police officers and the public or between police officers and the mentally ill.

1.7 RESEARCH DESIGN

Grove, Burns and Gray (2015:45) define a research design as a blueprint for how a research study will be implemented. In this research study the researcher will use a qualitative, explorative, descriptive and contextual design. The study is seen as investigating a human experience from the viewpoint of the research participants, in the context in which the participant is based. The researcher will utilise a qualitative research design, to describe and enhance understanding of the lived experiences of South African police officers interacting with mentally ill individuals in their work environment. These concepts will be discussed in detail in chapter 2.

1.8 RESEARCH METHODOLOGY

Rebar, Gersch, Macnee and McCabe (2011:30) state that the methods section describes the overall process of how the researcher will go about implementing the research study including who will be included in the study, how information will be collected and what interventions are intended. The concepts to be discussed below include the research population and sampling, data gathering and analysis, ensuring the rigor of the study as well as the high ethical standard.

1.8.1 Research population and sampling

According to Creswell (2014:13), a research population refers to the individuals in the universe who possess the specific characteristics the researcher is interested in. The research population of the study will comprise all trained police officers, working in the community service centre of a rural town in the Eastern Cape who, in their line of duty, interact regularly with mentally ill persons.

- **Inclusion criteria**

The inclusion criteria for this study require that the participants be fully fledged police officers; they should have been working at the rural town's community service centre for at least one year and should have had contact with at least onementally ill person in the past. The exclusion criteria for the study require that police reservists and volunteers are excluded because they have not been trained as fully fledged police officers.

1.8.2 Data gathering

Grove, Burns and Gray (2015:47) assert that data collection is the accurate, integral gathering of information that is consistent with the research purpose, questions or specific objectives. The researcher will make use of individual, semi-structured interviews and field notes as a means of gathering data from the participants.

- **Interviewing**

Moule and Goodman (2014:343) state that interviewing is the technique to be used when the researcher uses questions to find out information that relates to exploring

personal accounts, perceptions, beliefs and opinions. An open-ended question with follow-up questions will be utilised to encourage the participants to talk freely.

- **Field notes**

De Vos, Strydom and Delport (2012:358) state that field notes are detailed written accounts of what the researcher heard, observed, experienced and thought in the course of interviewing as well as during data analysis. There are three different types of field notes namely, observational notes, methodological notes and reflective notes (De Vos et al., 2012:358). The researcher will use observational and reflective notes. The researcher will observe non-verbal communication of the participants during the interview and will jot down her impressions immediately thereafter. Data gathering will be discussed in detail in chapter 2

1.8.3 Data analysis

Creswell (2014:197) is of the opinion that data analysis will go hand in hand with the data collection and writing up of findings with the intent of making sense of the data. Tesch's eight steps of content analysis will be used to identify themes. The analysis and coding will be done by the researcher and an independent coder; after consensus discussion the data will be organised into themes and sub-themes. The concept will be discussed in detail in chapter 2.

1.8.4 Pilot study

De Vos *et al.* (2012:237) describe a pilot study as a small study conducted prior to the larger piece of research to assess the adequacy of study methods and procedures, quality of interview questions and the researcher's interviewing technique. One interview will be done to check if the methods are adequate, appropriate and feasible before launching the larger study (De Vos *et al.,* 2012:237). In this study one participant will be selected using purposive sampling and will then be interviewed as described.

1.8.5 Measures to ensure trustworthiness

Lincoln and Guba (1985) in Rebar *et al.* (2011:153) state that trustworthiness refers to the honesty of the data collected from or about the participants. A trustworthy and respectful relationship between the researcher and the participants will be developed

early in the study. The researcher will utilise the following strategies to ensure rigor, namely credibility, transferability, dependability, and confirmability. The concepts will be discussed in detail in chapter 2.

1.9 ETHICAL CONSIDERATIONS

Pera and van Tonder (2012:380) refer to ethics as a system of moral values that is concerned with the degree to which the research procedures adhere to professional legal and social obligations to the participants in a study. To ensure the high ethical standards of the study the principles of autonomy, beneficence and nonmaleficence and justice will be adhered to. The researcher will get permission to conduct the study as well as obtaining ethical approval from the Nelson Mandela University. She will also obtain permission to conduct the study from the area commissioner of police in the rural town where the study will take place. The researcher will sought permission from the participants before engaging them in the study. These concepts will be discussed in detail chapter in 2.

1.10 CONCLUSION

Chapter One contributed a synopsis of the study encompassing, an introduction and background to the study, a literature review, an outline of research design and methodology, the theoretical structure that underpins the study, interpretation of terminology in the study and analysis of the ethical considerations. A comprehensive argument of research methodology will be presented in Chapter Two.

1.11 CHAPTER DIVISION

Chapter One: Background and literature review

Chapter Two: Research design and methodology

Chapter Three: Discussion of results and literature control

Chapter Four: Conclusion, limitations, and recommendations

CHAPTER 2

RESEARCH DESIGN AND METHODOLOGY

2.1 INTRODUCTION

Chapter 1 outlined an overview of the literature, background, problem statement and research question, goals and objectives, conceptual definitions, research design, research methodology and the ethical considerations. Chapter 2 gives a detailed account of research design and methodology, rationale, goals and objectives, trustworthiness and ethical consideration.

2.2 RATIONALE

Maclean and Marshal (2010:63) in the United Kingdom, state that there is an increasing number of mentally ill individuals in the community due to changes in the mental health care systems globally leading to a substantial number of mentally ill persons now living in the community and having to be taken care of. Mentally ill persons living in the community frequently did not comply with their prescribed treatment regimen for a variety of reasons such as having a poor support network. Their mental illness symptoms reappeared and they behaved in a manner that was not acceptable to the community. This meant that the police may be called in by the public to intervene when these individuals act bizarrely. Police officers were summoned to interact with mentally ill persons by family members, members of the community or health care providers. They were often called in response to a mentally ill person displaying violent and destructive behaviour in his/her home, another venue in the community or even in a community health centre (Maclean & Marshal, 2010:63).

Baumann (2011:581) provides a South African perspective which concurred with the authors from other countries and stated that police officers regularly interact with mentally ill persons. Police officers may also interact with mentally ill persons under other circumstances namely, when a mentally ill person escapes from a health establishment where the person had received treatment and started acting in an unacceptable manner or when a mentally ill person presented with psychotic symptoms (Baumann, 2011:581). It has been reported that police officers sometimes

interacted with a mentally ill person in an inharmonious and humiliating manner causing unease amongst health workers.

The researcher worked as a psychiatric nurse at a psychiatric institution in the Chris Hani District and observed that police officers regularly brought mentally ill persons to the health establishment for admission. The researcher noticed that under these circumstances, mentally ill persons were not treated with the respect and dignity they deserved, for example they were shouted at or the police officers would talk down to the individual as if talking to a child whereas the person may be an elderly person. Police officers transported patients in the same police van that they used to transport criminals, which might be dirty and unsafe. It was common practice to transport the mentally ill person alone in the back of police van where there is no view of where they were going. This probably exacerbated the mentally ill person's confusion.

Even when locked up at the back of police van with, perhaps, a relative, the safety of both the mentally ill person and the escort were not guaranteed. The person may be restrained with handcuffs. These conditions caused more confusion and fear, as the person often thought they were arrested and were being taken to jail. On the other hand, a violent, confused mentally ill person might cause harm to police officers or other members of a community.

2.3 THE PURPOSE OF THE STUDY

The purpose of the study is to explore and describe the lived experiences of police officers interacting with mentally ill persons in a rural town in Chris Hani District community.

2.4 RESEARCH DESIGN

Grove, Burns and Gray (2015:45) define a research design as a blueprint for enhancing control over factors that could hinder the study's desired results. In this study the researcher used a qualitative, explorative, descriptive and contextual design to study the experiences of the police officers interacting with mentally ill persons in the community. These concepts will be discussed in the following paragraphs.

2.4.1 Qualitative research design

According to Brink, van der Walt, and van Rensburg (2012:120), a qualitative research design focuses on the aspects of meaning, experience and understanding. Creswell (2014:4) is of the opinion that a qualitative research design involves developing questions, strategies, gathering data at the participant's environment, data analysis that is inductively building forms specific to general themes and the researcher making clarifications of the connotation of the data. A qualitative research design provides the researcher with opportunities for adaptability according to circumstances that cropped up during the study (Creswell, 2014:4).

The researcher utilised a qualitative research design to describe and enhance understanding of the lived experiences of South African police officers interacting with mentally ill persons in their work environment. In the process she was subjectively involved with the participants whilst collecting data, by building relationships and interacting with them. The researcher was the principal data gathering tool interviewing participants. Semi-structured interviews were employed as they are a qualitative data collection method. The researcher used an interview schedule as a data gathering tool to guide the interview. The data was inductively analysed, focusing on personalised meaning and the importance of data

2.4.2 Explorative design

De Vos et al. (2012:95) assert that an explorative design is used in areas where there is little known on the topic, both theoretical and factual. It was conducted to gain insight into a situation, phenomenon, community or individual. The authors explained that an explorative design was best employed where there was lack of fundamental information in a new area of interest. This means that explorative design could mark the starting point for a series of studies still to come. Therefore explorative research is primarily utilised to build theoretical knowledge (De Vos, 2012:95).

A literature search indicated that few studies on this topic were conducted in South Africa. In the Eastern Cape there is one quantitative study on the knowledge and skills of police officer in handling the mentally ill persons (Magadla & Kolwapi, 2013). The researcher wished to gain an insight into the phenomenon in a rural setting where little was known. Therefore the researcher sought to explore and describe the

experiences of police officers who often interacted with mentally ill persons while executing their duties.

2.4.3 Descriptive design

De Vos *et al.* (2012:321) articulated that the purpose of a descriptive design was to observe, describe, and document aspects of a situation as it occurred in its natural setting. According to Burns and Grove (2011:256), descriptive research presented a picture of the specific details of a situation, social setting or relationship as found in real life situations.

In this study attempts were made to describe the experiences of the police officers interacting with mentally ill persons in their day to day practice. As a psychiatric nurse the researcher observed the phenomenon in the natural setting. As such the researcher tried to understand the specific details from the participant's worldview. The use of semi–structured interviews, an interview guide, open ended questions, and communication techniques provided an opportunity for participants to come up with in-depth meanings of their experiences. The methodology used in the study was also described in detail to ensure trustworthiness.

2.4.4 Contextual design

According to Burns and Grove (2011:75) and Creswell (2014:185), a contextual design is one where the phenomenon is studied in terms of its immediate context in which the interaction took place. The contextual design focuses on specific events in naturalistic settings, which are uncontrolled real life situations, sometimes referred to as field settings. Qualitative studies were contextual in description, relating to a particular setting and therefore not meant for generalisation.

In this study, context referred to the police officers' work environment, which included the Community Service Centre, the communities they served and the designated health establishments to where mentally ill individuals were transported on occasion. In this study the researcher interviewed the participants directly and observed them behaving and interacting within their context which is a prominent feature of contextual design.

2.5 RESEARCH METHODOLOGY

Rebar et al. (2011:30) state that the methods section describes the overall process of how the researcher went about implementing the research study, including who was included in the study, how information will be collected and what interventions were intended. The concepts discussed below include the research population, sampling, data gathering and analysis, a pilot study and ensuring the rigor of the study as well as ensuring a high ethical standard.

2.5.1 Research population

According to Creswell (2014:13), a research population refers to the individuals in the universe who possess the specific characteristics the researcher is interested in. The population of the study comprised all trained police officers working in the community service centre of a rural town in the Chris Hani District Municipality who, in their line of duty, interact with mentally ill persons.

- **Inclusion and exclusion criteria**

Grove, Burns and Gray (2013:353) asserted that a study can have inclusion or exclusion sampling criteria or both. Inclusion sampling criteria are attributes that an individual has to be a constituent of the target population. Exclusion sampling criteria are attributes that cause a person or element to be eliminated from the target population. Researchers needed to furnish valuable reasons for their inclusion and exclusion criteria as certain groups were eliminated in the past without justification to guard against unfair discrimination.

The inclusion criteria for this study required that the participants were to be fully fledged police officers; they should have been working at the rural town's Community Service Centre for at least one year and should have had contact with at least one mentally ill person in the past. The exclusion criteria for the study required that police reservists and volunteers be excluded because they had not been trained as fully fledged police officers.

2.5.2 Sampling procedures

According to Polit and Beck (2014:391), sampling was the process of selecting a portion of the population to represent the entire population for the purpose of the

study. Non-probability sampling method denotes that not all elements in the research population had equal chances of being selected. According to Creswell (2014:189), a purposive sampling method was to purposefully choose participants or sites that would best assist the researcher to understand the phenomenon and the research question. Purposive sampling is also called judgemental sampling because the sample is composed of elements that contain the most characteristics of the population that serve the purpose of the study (De Vos *et al.,* 2012:232). Remler and Van Ryzin (2015:158) affirm that purposive sampling was selecting people who have the unique perspective or occupy important roles. In purposive sampling the researcher intentionally selects participants who were considered to be representative of the population (LoBiondo–Wood & Haber, 2014:238). In purposive sampling the number of participants could not be predetermined but would be determined by data saturation (Creswell, 2014:189).

This study utilised non-probability purposive sampling technique based on the inclusion criteria, the judgement of the researcher and the purpose of the study. The researcher obtained a list of names of all the police officers working at the service centre. All the police officers working at the community service centre were invited for the researcher to explain information (see addendum H) related to the study to all police officers who came to the meeting. The researcher, with support from the gatekeeper, selected participants from those who agreed to participate and who met the inclusion criteria.

- **Gaining access and appointment of gatekeepers**

The researcher submitted REC-H form to Ethics Committee requesting permission to conduct the research (see addendum A).Permission and ethical approval (H16-HEA-NUR-018) were granted by the Faculty of Postgraduate Research Committee to continue with the study (see addendum B). The researcher gained access to the site by seeking approval of the gatekeepers. Creswell (2014:188) stated that the gatekeeper was a person at the research site who gave access to the site and permitted the research to be conducted. The station commissioner and the relief commander acted as gatekeepers. The researcher visited the Community Service Centre to build trust with the station commissioner and submit the letters requesting permission to conduct the study. A copy of a proposal, letters requesting permission

from both station commissioner (see addendum C) and provincial Area Commissioner (see addendum E), letter to participants (see addendum D) and consent forms (see addendum I) were explained. Permission was granted by the Station Commissioner of Queenstown (see addendum D) and the Area Commissioner SAPS (see addendum F).

The gatekeepers invited the Station Commissioner and the Area Commissioner to a meeting with the researcher at the boardroom of the Community Service Centre. Potential participants were given letters requestingpermission (see addendum G) and consent forms (see addendum H) and information about the study was explained to them. Information in relation to the title of the study, the purpose of the study, the interview process, the right to refuse participation and, if need be, the right to withdraw during the study was explained. Confidentiality issues were explained, that is only the research team will have access the information (see addendum H). The participant letter requesting permission (see addendum G) and consent form (see addendum H) were discussed in detail at the meeting. Over and above this it was emphasised that participants should feel free to ask questions if they did not understand some aspects during the research process. The researcher together with potential participants scheduled time for individual semi-structured interviews. Interviews took place over two consecutive days as police officers were on duty and therefore attending to community calls in between attending for the interviews.

2.5.3 Data gathering

Grove, Burns and Gray (2015:47) assert that data collection is the accurate, integral gathering of information that is consistent with the research purpose, questions or specific objectives. Creswell (2014:189) suggests that the interview session should last from 20-30 minutes. In this study the researcher requested permission to use an audio tape to record the interviews; all participants granted permission for the recordings to take place. The audio-recorder was used to capture each interview. The recording device was correctly placed so as to pick up sounds but caution was taken not to disturb the participants. The recorded information was transcribed within 3 days following each interview while the researcher still remembered the details of the information.

In this study the researcher made use of personal semi-structured interviews and field notes namely observations and reflection, as a way of gathering data from the participants. The researcher started the interviews by building trust, greeting, asking how each participant was doing, making sure that the participant was seated comfortably, asking whether the participant was ready to start. Open-ended questions were employed by referring to the questions in the interview guide (see addendum I). Participants were given enough time to respond, without interruption. The use of communication techniques were applied to encourage participants to speak freely. The researcher had to keep gathering data until data saturation was reached or when additional interviewing provided no new information. The researcher noticed that no new information was found after participant number ten and only redundancy was observed. This denoted that data saturation was reached and the researcher had to stop the interviews. Therefore the sample size was ten participants. At the end of the session the researcher gave each participant an opportunity to debrief immediately after the interview. No participant needed counselling. Each participant was thanked for participating. Debriefing will be discussed further below.

While analysing the data the researcher realised that the participants mainly focused on discussing situations where patients reacted aggressively towards them. They did not really discuss experiences where aggression did not play a role. For this reason it was decided to re-interview the participants asking the following research question; “In the first interview you discussed your experiences of patients being aggressive. Can you tell me what other experiences you had during your contact with mentally ill persons living in the community?” Unfortunately all participants still focused on aggression and no new information was obtained.

- **Debriefing**

According to De Vos et al, (2012:122) debriefing is when the participants are provided with an opportunity, after the study, to work through their experiences and its aftermath. During the session participants should have answers to their questions and misunderstandings should be eliminated. Participants are taken through a reflective process particularly in qualitative research. Through debriefing problems created by the research experiences would be cleared. The effective way of debriefing was to discuss participant’s feelings soon after the interview session or

sending them a newsletter notifying them about the basic aim or the outcome of the study (De Vos et al., 2012:122). In this study all participants were asked to comment on how they felt after the interview. Most of them indicated that they felt relieved because the topic under study was their main concern. They further deliberated that by participating in the study they hoped that at last they would get a workshop on mental illness.

- **Interviewing**

Moule and Goodman (2014:343) state that interviewing is the technique to be used when the researcher uses questions to find out information which relates to exploring personal accounts, perceptions, beliefs and opinions (Moule & Goodman, 2014:343). In this study the researcher utilised semi-structured interviews as discussed in the following paragraph.

- **Semi-Structured Interviews**

De Vos et *al.* (2011:351) assert that semi-structured interviews are utilised to obtain a detailed account of participant's beliefs about or perceptions of a particular phenomenon. Semi-structured interviews are a principal methods of data gathering in qualitative research. De Vos et *al. (2011:351*) further assert that the purpose of using this strategy was to get insight into the personal experiences of persons in their social reality. Botma, Greeff and Mulaudzi (*2010*:27) assert that semi-structured interviews are individual interviews on a one-on-one basis, and involve exchanging of information between the researcher and the participant. According to Kvale and Brinkmann (2009:27), semi-structured interviews are carried out using an interview guide which concentrates on a particular topic and incorporates proposed questions. A semi-structured interview is an endeavour to perceive topics of the lived everyday world from the participant's opinion. It is semi structured since it is neither an open everyday conversation nor a closed questionnaire. The semi-structured interview is closely related to day to day conversation. However, as a professional interview it has a purpose and includes a certain approach and method (Kvale & Brinkmann, 2009:27; Sam, 2015:19). In this study the researcher employed semi-structured interviews coupled with an interview guide. Semi-structured interviews were used to obtain a comprehensive account of a particular phenomenon. In semi-structured interviews the researcher is at liberty to make use of communication techniques to

facilitate the participant's communication so as to get in-depth information. The interview guide will be discussed below;

- **An Interview guide**

De Vos et *al.* (2012:352) defines the interview guide (see addendum I) as a questionnaire compiled to guide interviews and which supplies a researcher with pre-set questions. Kvale and Brinkman (2009:27) define the interview guide (see addendum I) as a schedule that concentrates on specific questions and incorporates suggested questions (Kvale & Brinkman, 2009:27). The interview guide (see addendum I) allowed the researcher to obtain homogenous data from all participants. The interview schedule comprised of one main open ended question and follow up questions as stipulated below:

- Tell me your experiences about interacting with mentally ill persons?

The follow up questions may include the following;

- Tell me how you interact with mentally ill persons displaying hostile behaviour?
- Briefly tell me your understanding of Section 40 of the Mental Health Care Act?
- Tell me about the training you received on interacting with mentally ill patients?

In this study the above questions constituted an interview guide and the researcher referred to them to conduct interviews.

- **Venue for interviewing participants**

De Vos et al. (2011:350) states that the setting should provide privacy, comfort, be non-threatening and should be accessible. Seating arrangements should promote action and interaction and there should be no barriers between the researcher and the participant. In this study interviews took place at the police officer's boardroom for some participants but a few preferred to be interviewed in their offices. The places used were quiet and private, with no interruptions, a 'Do not disturb' sign was put on the door to prevent people from entering during the interview session. The

researcher utilised communication skills to enhance the interview process as will be discussed below:

- **Communication techniques**

According to De Vos et al. (2011:345), the interviewer should adhere to communication skills to facilitate the interview process. The following communication techniques were employed, questioning, paraphrasing, reflecting feelings, summarising, minimal verbal response, clarifying, active listening, silence and probing (Kneisl & Trigoboff, 2013:195).

- **Questioning:** Using open-ended questions which allowed concentration on the phenomena under discussion but still spared the person liberty of response (Kniesl & Trigoboff: 2013:195). To allow the participant to share experiences freely without interruptions.
- **Probing:** Encouraging the person to talk (Kniesl & Trigoboff, 2013:195).To let the participant tell the researcher more experiences on interacting with mentally ill persons. Responses such as, 'tell me more…', 'and then…' were used.
- **Paraphrasing:** This gives an opportunity to examine your understanding of what the participant is trying to tell you (Kniesl & Trigoboff, 2013:199). For example, "in other words you said….". In this study paraphrasing was used to limit misinterpretation.
- **Reflecting**: This is repeating the client's statement and gestures for the participant's benefit, "It sounds like you are angry…" (Kniesl & Trigoboff, 2013:198). During the interviews reflection on feelings was utilised to understand the participant's non-verbal response, where participants were sharing emotions such as anger and frustration without verbalising them.
- **Summarising:** Summarising highlights or the main ideas expressed in an interaction (Kniesl & Trigoboff, 2013:201). In this study experiences that were significant to the phenomenon were emphasised during the interviews to indicate that the researcher was listening.
- **Clarifying:** Giving information to clarify areas of misunderstanding (Kniesl & Trigoboff, 2013:199). The researcher would ask for clarity where there was uncertainty such as participants would talk about the use of "verbal judo" for

aggressive mentally ill. Participant explained that it is used to shout at violent mentally ill persons who may be armed persons in an effort to scare that person. The idea was to let the person drop the weapon and give police officers a chance to grab hold of the person.

- **Active Listening**: Mindful listening (Kniesl & Trigoboff, 29013:197). In this study the researcher listened actively, mindful throughout the interviews to understand the phenomenon from the participant's opinion.
- **Using Silence**: Remaining quiet yet mindful and focused by maintaining eye contact (Kniesl & Trigoboff, 2013:197). The researcher utilised silence to encourage the client to deliberate more on the topic in question. It also encouraged participants to talk more on a topic.
- **Non-verbal responses**: The use of body gestures, but caution should be taken not to overdo nonverbal communication as it may annoy others (Kniesl & Trigoboff, 2013:195). Occasionally the researcher would use nonverbal communication according to participant's responses, such as nodding, maintaining eye contact and leaning forward.
- **Minimal verbal response:** A verbal response that corresponds with occasional nodding, for example 'mm-mm, mh-mm', 'yes, I see' (de Vos et *al.,* 2011:344). In this study the researcher used minimal verbal responses to show the participant that she was there and listening.

The researcher is well versed with interviews and communication skills. The researcher is a qualified psychiatric nurse and as such interviews were a familiar practice. However the researcher practised the interview with a colleague and used the communication techniques to make sure that she dug deeper to get sufficient information from the participants. Interviews were conducted in English as the policemen are professionals and competent in the language.

- **Field notes**

De Vos *et al.* (2012:358) state that field notes are detailed written accounts of what the researcher heard, observed, experienced and thought in the course of interviewing as well as during data analysis. There are three different types of field notes that were utilised namely, observational notes, methodological notes and reflective notes (De Vos *et al*., 2012:358). However for the purpose of this study the

researcher used observational and reflective notes. Reflective notes and field notes will be explained below.

Reflective notes

Botma, Greef, Maluadzi and Wright (2010:218) describe these as personal notes of the researcher's unique thoughts, emotions, impressions and problems encountered during the interview. In view of the above the researcher had a diary to jot down her experiences immediately after each interview. The researcher felt empathetic for the participants who were not familiar with the symptoms of mental illness. The researcher felt good to have done a study of this nature in an area that needed so much attention, as participants were already expressing gratitude at the end of the interviews. Additionally the researcher utilised observational notes as will be discussed below.

Observational notes

According to Creswell (2014:190), the researcher should take notes on the behaviour and activities individuals at the setting where research took place. The researcher recorded all behaviours and activities that took place during the interview process as participants freely provided their experiences (Creswell, 2014:190). In this study participants reflected various emotions during the interview; anger, frustration and anxiety were shown through non-verbal cues such as facial expression, agitation, restlessness, sad look, indicating frustration, apprehension and restlessness. The emotions that the participants could not verbalised were observed as they were interviewed and were recorded in a diary. When the interview was transcribed, the researcher added this information to the interview transcripts.

2.5.4 Data analysis

Creswell (2014:197) is of the opinion that data analysis should go hand in hand with the data collection and writing up of findings with the intent of making sense of the data. Thereafter the researcher and the independent coder engaged in deliberation until agreement was reached when data was organised into themes and sub-themes. All interview transcriptions were analysed and transcribed verbatim. The data bank for the study was drawn from ten interview transcriptions (see addendum

J) and copies of field notes from the researcher's diary. Tesch's eight steps of content analysis (see addendum K) were used to develop the codes as follows;

- Get the sense of the whole by carefully reading all transcripts to get and record concepts that come to mind as you read.
- Choose one transcript that seems to stimulate your interest or the one that is on top of the others, probably the shortest one and read it. Reflect on it searching for the underlying meaning and record the ideas that come to your mind as you read in the margins.
- The researcher continues reading several transcripts and makes a list of themes that emerge. Group similar themes into columns. Arrange as major, unique, and leftover topics.
- The researcher should go back to the data base with the above list. Abbreviate the themes as codes. Record codes next to appropriate segments of the text. Establish whether new themes come out.
- Find the most definitive wording for your themes and return them into class. Decrease total list of categories by putting together categories related to each other. Sketch lines between categories to indicate similarities.
- A final decision should be reached on arranging, abbreviating, and codifying each category.
- Gather data material belonging together under each category in one place and conduct a preliminary analysis.
- If there is a need the researcher should recode the prevailing data (Creswell, 2014:198).

It was this method that enabled the researcher to identify themes and sub-themes for the study. Subsequently the researcher was able to explore and describe the experiences of police officers interacting with mentally ill persons.

- **Independent coding**

Creswell (2014:203) indicates that cross checking of codes can be done by different researchers comparing results that were independently developed. The researcher used the services of an independent coder to analyse the data. The independent coder has a doctoral degree in nursing science with experience in qualitative data analysis. The independent coder was provided with transcriptions (see addendum J)

of the ten interviews and a copy of Tesch's eight steps of content analysis (see addendum K). The independent coder identified themes and sub-themes independently. The researcher and the independent coder then engaged in deliberations and reached an agreement which is called an inter-coder agreement. The decision is based on whether the researchers coded the same data with homologous codes. It is recommended that the consistency of coding should be in at least eighty percent agreement for good qualitative reliability (Creswell, 2014:203).

- **Pilot study**

De Vos *et al.* (2012:237) describe a pilot study as a small study operated prior to the larger piece of research to assess the adequacy of study methods and procedures, the quality of interview questions and the researcher's interviewing technique to decide whether the strategies will be effective, so as to identify areas that need improvements before launching on the bigger project (de Vos *et al.* 2012:237). The same methods that were to be used in the main study were used to test the feasibility of the study.

The interview took place at the boardroom of the Community Service Centre where there was no noise. The interview guide (see addendum J), diary for reflective and observation notes and the voice recorder were utilised for piloting as planned for the main study. The participant was interviewed using communication techniques as discussed above.

Data collected was transcribed verbatim. Content analysis was done using Tesch's eight steps to determine whether themes would arise from the questions used. Themes and sub-themes emerged from the transcribed data. The results of the pilot study revealed that the strategies were feasible. After discussions with the supervisor, the pilot study was incorporated and became part of the main study. Conducting a pilot study gave assurance that data gathered during the main study will be accurate and trustworthy. The pilot study also gave an estimated approximation of time for the entire interview. This interview was done to check if the methods were adequate, appropriate and feasible, before launching the larger study.

2.6 MEASURES TO ENSURE TRUSTWORTHINESS

Lincoln and Guba (1985), in Rebar *et al.* (2011:153), state that trustworthiness refers to the honesty of the data collected from or about the participants. Trustworthiness refers to rigor in qualitative studies ensuring that data collected is valid and reliable. The researcher utilised the following strategies to ensure rigor: credibility, dependability, consistency, and neutrality;

2.6.1 Credibility

De Vos et al*. (*2012:419) argue that the goal of credibility as the alternative to validity is to demonstrate that the enquiry was conducted in such a manner as to ensure that the topic was accurately identified and described. The strategies that will be used in this study to ensure credibility include prolonged engagement, member checking, independent coding, reflexivity, triangulation, interview technique, and pilot study (De Vos et al*.,* 2012:419).

- **Prolonged engagement**

Prolonged engagement is related to spending adequate time in data gathering procedures in the field to get a comprehensive understanding of the culture, language and views of the participants. Prolonged engagement helps the researcher to examine misinformation and to build trust with participants (Polit & Beck, 2010:332).

The researcher initially went to the site to introduce the study. At the site the researcher appointed and orientated the gatekeepers as well as participants about the study, the letters requesting permission (see addendum G) and consent form (see addendum H) were given to participants. Each participant was given sufficient time to answer the research questions. At some stage the researcher had to go back to the field to get more data.

- **Member checking**

Creswell (2014:200) indicates that member checking is a strategy of ensuring the accuracy of qualitative findings through taking the themes back to participants to find out if they felt they were accurate. The researcher gave the transcripts to participants to validate whether the information was a true reflection of their experiences to ensure accuracy of the data.

- **Independent coding**

Creswell (2014:203) indicates that cross checking of codes can be done by different researchers comparing results that were independently developed. The researcher used the services of an independent coder to co-analyse data. The independent coder was provided with transcripts and a copy of Tesch's eight steps of content analysis (see addendum K). The independent coder identified themes and sub-themes independently. The researcher and the independent coder engaged in deliberations and reached a consensus for what is called the inter-coder agreement. The decision was based on whether the researchers coded the same data with similar codes. It is recommended that the consistency of coding should be in at least eighty percent agreement for good qualitative reliability.

- **Reflexivity**

Polit and Beck (2010:298) are of the opinion that reflexivity incorporates being conscious that the researcher carry to the study a background set of values and professional identity that influences the research process. Reflection includes regularly paying attention to the researcher's influence on the collection, analysis and interpretation of data. Through self-interrogation and reflection, researchers seek to correctly position themselves to dig deeper and understand the experience, process, culture under study through the eyes of participants. Creswell (2014:2002) states that reflexivity are remarks compiled by the researcher about how their interpretation of their findings is shaped by their background such as their gender, culture, history and socio economic origin. In this study the researcher reflected on emotions displayed by police officers during the interviews.

- **Triangulation**

Creswell (2014:200) is of the opinion that various data sources of information can be scrutinised to build strong supporting evidence from the sources to justify themes. If the themes are based on multiple sources or a perspective from a participant, the process can be claimed as adding validity of the study. Triangulation of data gathering was done through the use of multiple methods such as interviewing, field notes and a literature review. Triangulation of data analysis occurred by involving the researcher, supervisor and independent coder to analyse data. When writing up the

data the researcher made use of all the information from different participants as indicated by quotes and listing the details of contributors.

- **Interview technique**

Interviews encourage the participants to freely discuss the important dimensions of a phenomenon and to give a detailed account of what is relevant to them. Qualitative researchers are not restricted to asking questions in a specific order or phrased in a given way. Instead a general question is asked followed by follow-up questions. The researcher has to encourage the participant to talk freely about all topics on the interview guide. The participant is offered an opportunity to tell their narratives in a naturalistic manner (Polit & Beck, 2010:204). In this study semi-structured interviews were utilised in conjunction with an interview guide to ensure that all areas have been attended to.

- **Pilot study**

A pilot study is one of the strategies to ensure trustworthiness. It has already been discussed above.

2.6.2 Dependability

Polit and Beck (2014:322) refer to dependability as the stability of data over time and over conditions, and is analogous to reliability in quantitative studies. Dependability is a question of whether the study findings would be duplicated if the enquiry was repeated with the same methods and at the same setting (Polit & Beck, 296:296). In this study the researcher will use the following strategies to ensure dependability namely, dense description to be discussed below and independent coding, the latter being a strategy that has already been discussed.

2.6.3 Transferability

Rebar et al. (2011:154) state that transferability refers to the extent to which the findings of a study are confirmed by or are applicable to a different group or in a different setting from that where the data was collected. However the research population in a qualitative study is usually very small, therefore the findings cannot be transferred or generalised. The methodology used will be described well enough to allow other researchers to apply the information to their own situations. The

strategies to be used include dense description, purposive sampling and data saturation to enhance transferability as discussed.

- **Dense description**

Creswell (2014:2002) states that dense description is a rich, thick description to convey results. Dense description may portray the research site and give a discussion on an element of shared experiences. A qualitative researcher may give a comprehensive account of the research site. In this study the researcher provided a detailed description of participants, research procedures, and the research site where the study was conducted to allow other researchers to be able to transfer the information to other settings by looking at the description provided and deciding whether it can be transferred.

- **Purposive sampling**:

Purposive sampling is not seen as enhancing trustworthiness as the researcher chooses participants herself and this may skew the study. The positive thing about this form of sampling is that you can select the best source of information. Grove, Burns and Gray (2013:365) indicated that purposive sampling is sometimes referred to as selective sampling. Qualitative researchers consciously select information-rich cases or individuals who can teach them a great deal about the purpose of the study. Creswell (2014:189) states that in purposive sampling the researcher purposefully selects participants who will best assist the researcher to gain insight into the phenomena and the research question. The participants in the study were chosen purposively because they possessed characteristics that the researcher was interested in, to answer the research question and they were seen as information-rich resources.

- **Data saturation**

Polit and Beck (210:418) alluded to the fact that data saturation means the gathering of qualitative data to the point where a sense of closure is achieved because new data yields redundant information. The researcher collected data using semi-structured interviews and data saturation was reached at participant number ten.

2.6.4 Confirmability

Brink *et al.* (2012:173) state that confirmability refers to the potential for congruency of data in terms of accuracy, relevance or meaning. The data will reflect the voice of the participants, and be free from the researcher's biases (Brink *et al.,* 2012:173). In this study the researcher employed field notes and reflexivity to ensure confirmability and were discussed earlier. Quotes from data were used in this study to reflect the voices of participants. Data was transcribed verbatim to retain the voice of the participants. The researcher used reflective notes to qualify emotions related to the quotes, as previously discussed.

- **Field notes**

Polit and Beck (2014:404) assert that field notes are the notes captured by the researcher to document the unstructured observations made in the research site. In this study the researcher used observation and reflexive notes as discussed.

- **Authenticity**

Polit and Beck (2014:323) argue that authenticity is met when the methods used are appropriate for the true reporting of the participant's ideas. The researcher will adhere to authenticity by choosing relevant methods to provide the readers with a heightened sensitivity to the experiences of police officers whilst handling the mentally ill patients. These methods include interview techniques, data that was transcribed verbatim to portray the voice of the participants. These methods were discussed earlier.

2.7 ETHICAL CONSIDERATIONS

Pera and van Tonder (2012:380) refer to ethics as a system of moral values that is concerned with the degree to which the research procedures adhere to professional, legal and social obligations towards the participants in a study. Ethics also explores whether something ought to be done or whether people such as the researcher have the right to do something. Basic ethical principles are guidelines that are related to general ethical instruction and assessment of human actions (Belmont report, 1979:1). The four common principles applicable to ethics of research in human subjects were the principle of respect for persons, beneficence, justice and non-

maleficence (Belmont report, 1979:1). To ensure high ethical standards of the study all four principles will be adhered to and will be discussed below.

2.7.1 Respect for persons

According to the Belmont report (1979:1), respect for persons includes at least two ethical declarations. Firstly, that individuals should be regarded as autonomous representatives and secondly, that persons with decreased autonomy are qualified to be protected. The principle of respect to persons is divided into two namely; the requirement to acknowledge autonomy and the requirement to protect those with diminished autonomy (Belmont report, 1979:1). Currently a researcher usually recognises four ethical principles: respect for persons, nonmaleficence, beneficence, and justice. However the Belmont report (1979:1) combines beneficence and nonmaleficence.

In this study the researcher explains the four principles separately. An autonomous person is an individual capable of deliberations about personal goals and of acting under the direction of such deliberation. To respect autonomy is to give weight to an autonomous person's considered opinions and choices while refraining from obstructing their actions unless these are clearly detrimental to others (Belmont report, 1979:1). These concepts will be discussed below. Respect of participants demands that subjects enter into the research voluntarily and with sufficient information (Belmont report, 1979:1). In this study the researcher gave information about participation and the right not to participate. The strategies related to respect to persons are informed consent, and autonomy and will be discussed below.

- **Informed Consent**

LoBiondo-Wood and Haber (2014:261) affirm that informed consent (see annexure G) is a legal principle that ensures that participants understand the implications of participating in research and knowingly agree to participate. Participants should be told about the study purpose, possible risks and discomforts and benefits as well as the credibility of the researcher. The researcher obtained informed consent (see addendum H) before involving participants in the study. The researcher requested permission from the Ethics Committee of Nelson Mandela University using REC-H form (see addendum A). The researcher obtained permission as well as ethic approval for the research from the Nelson Mandela Metropolitan University [now

Nelson Mandela University] (see addendum B) and permission to conduct the study from the Provincial Area Commissioner of Police (see addendum F) as well as from the Station Commissioner of Community Service Centre (see addendum D) in the rural town under study as well as from the individual participant(informed consent signed) (see addendum H).

- **Autonomy**

According to Pera and van Tonder (2012:53), participants should have the freedom to manage their lives as autonomous individuals without external control, coercion or exploitation, especially when they are requested to partake in research. Participants should be provided with the opportunity to agree to or decline a request to participate in a study. In this study participants were informed about their right to withdraw from the study at any time, to refuse to give information if they do not want to participate and to ask for further clarification about the purpose of the study (see addendum H). Autonomy is the same as respect for persons therefore the researcher respected the participant's freedom to choose as autonomous beings.

2.7.2 Beneficence

According to the Belmont report (1979:1), persons are treated in an ethical manner not only by respecting their decisions and protecting them from harm, but making efforts to secure their wellbeing. Beneficence includes acts of kindness or charity that go beyond strict obligation. Beneficence in a stronger sense is an obligation. Two general rules of beneficence are to do no harm and to maximise possible benefits and minimise harm. Pera and van Tonder (2012:55) describe beneficence as the prevention of harm and the promotion of good. It was explained that getting an opportunity to share their concerns during interviews would help them to release their emotions as a form of psychotherapy.

2.7.3 Non-maleficence

According to the Belmont report (1979:1), non-maleficence means intentionally refraining from actions that can cause harm to participants. The researcher should secure the well-being of the participants who have a right to protection from discomfort and harm of any kind, whether physical, emotional, spiritual, social or legal. It is the researcher's obligation to protect the participants from all forms of

discomfort or risk of injury. The strategies to ensure non-maleficence are anonymity and confidentiality (Belmont, 1979:1). In this study the researcher debriefed the participants after each interview but nobody needed counselling. When the experiences of police have been determined, it may be possible to make recommendations to help the police officers manage a mentally ill person's behaviour with greater ease. Questions were carefully designed and a pilot study was performed to avoid interview questions that could evoke strong emotions in participants. Anonymity and confidentiality were the strategies used to protect participants from discomfort and harm. These strategies will be discussed below.

- **Anonymity**

Babbie (2013:35) is of the opinion that anonymity is achieved in a research study when neither the researcher nor the readers of the results could associate a given response with a given participant. In this study, participants were made aware that anonymity could not be completely ensured as the researcher knows who she interviewed but will not share the information with others instead assigning codes to the transcripts. Anonymity was ensured in writing the final report, by using pseudonyms instead of the participants' real names.

- **Confidentiality**

Pera and van Tonder (2012:61) articulate that confidentiality means no information provided by participants should be divulged in any way, except for research purposes. Only the researcher and the independent coder had access to the transcribed interviews. The information was pass coded and kept in a locked, safe place. According to Nelson Mandela University ethics committee rules all information must be kept for five years for auditing purposes. Participants were assured that no unauthorised persons will access the information. There were no hidden microphones or hidden tape recorders during interviews. The information was safeguarded from unauthorised persons.

- **Privacy and dignity**

LoBiondo-Wood and Haber (2014:259) state that privacy is the freedom of the person to decide about the time, extent and circumstances under which private information is shared or withheld from others. Grove, *et al.* (2013:169) states that the

information consists of one's attitudes, beliefs, behaviours, opinions and records. The Protection of Personal Information Act no. 4 of 2013 (South Africa, 2013) promotes the protection of personal information processed by public or private bodies. In this study interviews were conducted in a private place for each participant, where there were no interruptions. Participants gave permission before the interviews. No hidden microphones were concealed from the participants.

2.7.4 Justice

Pera and van Tonder (2012:57) are of the opinion that, in order to ensure justice, participants should not be discriminated against on grounds of gender, race, age and social status or religion. Justice is also to ensure that all legal requirements are met. Polit and Beck (2014:125) argue that to ensure protection of the participants, the researcher should adhere to the following strategies as a measure of critiquing the ethical aspects of the study: confidentiality, anonymity, privacy and dignity, and informed consent as already discussed above. According to the Belmont report an injustice occurs when some benefits for which the person qualifies are denied without good reason or when a burden was imposed unduly. In this study participants were selected for reasons directly related to the study phenomenon to ensure fair selection and treatment of the participants throughout the research process.

- **Debriefing**

As already discussed under interviewing

2.8 CONCLUSION

Chapter Two deliberated on the detailed description of the research design and methodology utilised in this study. In Chapter Three, the researcher will discuss the data analysis and interpretation and literature control for this study.

CHAPTER 3

DATA ANALYSIS AND INTERPRETATION

3.1 INTRODUCTION.

Chapter 2 provided a full description of the research design, strategy and methods. This chapter will explain how the study was done and describe the identified themes according to the data using a narrative approach with pertinent quotations from the participants. Interviews were audiotaped and then transcribed verbatim within 36 hours of conducting the interviews. The data were considered saturated when similar themes arose during the in-depth semi-structured interviews conducted with police officers regarding their experiences in interacting with mentally ill persons.

3.2 IMPLEMENTING THE RESEARCH PLAN

The Faculty of Health Sciences Post Graduate Research committee gave permission to continue with the study as well as giving ethical approval (H16-HEA-NUR-018). Permission was obtained from the Commissioner of Police and from the station commander of Queenstown Community Service Centre. Participants were contacted and the study was explained to them. A consent form was signed prior to interviews taking place. Participants volunteered to participate and were informed that they may withdraw at any stage of the research process.

The participants were recruited through purposive sampling which is the technique frequently used in qualitative research with a small number of interviews being the norm. A qualitative research method was utilised for this study in order to provide richness and in-depth information. Data was gathered using semi-structured interviews with participants who, according to the judgement of the researcher, possessed the information required about the phenomenon under study. Tesch's eight step method of data analysis was employed. The study examined the lived experiences of police officers in a rural town in the Eastern Cape Province.

3.3 CHARACTERISTICS OF PARTICIPANTS.

Ten interviews were conducted at the Queenstown Police Community Service Centre in the Eastern Cape. Police officers who met the eligibility criteria were included and interviewed. Although five males and five females participated, this was not typical of the South African police force as there are more males than females in the police force. Interviewing lasted for two days due to the fact that there was a large number of individuals to interview as well as a shortage of personnel at the community service centre. The sample included police constables, a community relations officer and police inspectors. They were all adults ranging in age from 25 to 48 years. All spoke both Xhosa and English fluently. This meant that the researcher was able to conduct the interviews in English. All participants were black South Africans. All police officers reported that they had experienced interactions with mentally ill persons while executing their duties. Their experience in the police service ranged from one year to 23 years. Participants were mentally alert and able to converse coherently with the researcher.

The interviews were transcribed verbatim and analysed. Three themes with sub-themes describing police officers' experiences emerged from the data and are listed in table 3.1 and will be discussed after the table.

Table 3.1 Themes and sub-themes of the experiences of police officers interacting with mentally ill persons.

THEMES	SUB-THEMES
Theme 1: Police officers may be called to a community venue to deal with a person behaving in an erratic manner.	Sub-theme 1.1: When police officers were called to a scene they found it difficult to communicate with people involved in the situation. Sub-theme 1.2: The mentally ill person may present with unacceptable behaviour such as being violent or destructive. Sub-theme 1.3: Through their behaviour, family members often made it more difficult for police officers to take effective action.
Theme 2: Police officers expressed diverse emotions related to handling mentally ill persons in the community	Sub-theme 2.1: Police officers felt vulnerable at not being able to utilise normal police procedures. Sub-theme 2.2: Police officers experienced that emotional demands were made on them when they had to interact with mentally ill persons. Sub-theme 2.3: Police officers experienced empathy towards mentally ill persons and their families.
Theme 3: Police officers were expected to take action and deal with mentally ill persons, the family and the community in the course of their work.	Sub-theme 3.1: The police officers were not sure of their actions as they lacked a clear description of their function in interacting with the mentally ill persons. Sub-theme 3.2: It would seem as if most police officers were not aware of the contents of section 40 of the Mental Health Care Act, no.17 of 2002. Sub-theme 3.3: Police officers do not know how to handle the mentally ill person. Sub-theme 3.4: Police officers expressed a need to be trained in managing mentally ill persons.

3.4 DISCUSSION OF THEMES AND SUB-THEMES

Themes and sub-themes were developed for a better understanding of the diverse fundamental elements of data. Three themes with sub-themes describing the experiences of police officers interacting with mentally ill persons emerged. These themes and sub-themes will be discussed in the following paragraphs. The first theme reflected on police officers being called to a community venue to deal with a person behaving in a volatile manner. The second theme entailed the various emotions communicated by police officers related when they were interacting with mentally ill persons in the community. Theme three explored the experiences of police officers in relation to them being expected to intercede and interact with mentally ill persons, the family and the community in the course of their work. The themes will be discussed below

3.4.1 THEME 1: POLICE OFFICERS MAY BE CALLED TO A COMMUNITY VENUE TO DEAL WITH A PERSON BEHAVING IN AN ERRATIC MANNER.

Theme one dealt with both positive and negative experiences of police officers related to dealing with mentally ill persons in the community. This theme described how the police officers experienced coming across mentally ill patients in the community and how the individual behaved. It also described the response of the families and the intervention of police officers at the scene where a mentally ill person was experiencing a crisis. Although police officers did encounter mentally ill persons when they were just moving around in the community; most often their contacts happened when they were called to intervene in a situation.

When police officers were called to deal with a disturbance in the community, they were not always informed about the nature of the situation. This meant that they did not know what to expect or what kind of help will be required from them. They also did not know if they would receive help such as support from family members or other community members. The police officers reported that at times they were tempted to ignore such calls which meant that the mentally ill individual would not receive any help. The participant indicated that police officers found it very difficult to communicate with mentally ill persons. They could not understand the person in order to determine what the problem was and could not get their own messages

across. The meaning of the theme will be further clarified by the sub-themes which will be discussed in the following paragraphs.

3.4.1.1 Sub-theme 1.1: When police officers were called to a scene they found it difficult to communicate with people involved in the situation.

The participants had difficulty communicating with both the confused mentally ill persons as well as their family members. By the time police officers were called to a scene the mentally ill person might be confused or may not be able to respond to logic. The family members exacerbated the situation as they were already stressed and agitated, which hindered the process of communication. Nevertheless when police officers arrived at the scene they found it difficult to interact with the mentally ill person who might already be acting in a violent manner towards everybody who approached him/her, including the participants. The problem was not only the mentally ill person not being able to communicate, but the family may also be unwilling to share information on the mentally ill person or on the situation as will be discussed in sub-theme 3.4.1.3 below.

> *"The mentally ill patient does not know what is going on, so now we need to take all our effort on trying to do what we want while we don't know anything about the patient" (Participant : B).*
>
> *"You come to the scene and you will find out that when you are interviewing the patient, trying to find out what is happening, only to discover that you are called at a time when the patient is already upset, is not acting logically and may be violent already" (Participant :K).*
>
> *"Once they see us* (police officers) *arriving on the scene, even before we start talking they fight with us as if we are enemies" (Participant: E).*

Participants explained that it was customary that they were summoned by the community at a stage when a mentally ill person was in a state of crisis making it impossible to interview the person. As the nature of the crisis was concealed from the police officers when they were called to a scene, they entered the scene without understanding what was happening. The arrival of police officers at the scene often heightened the stress experienced by the mentally ill person as they tended to

associate law enforcement with incarceration. Participants cited that should they insist on communicating with mentally ill person that could instigate violence.

Research conducted in Australia by Short, MacDold, Luebbers, Ogloff and Thomas (2014:336) on the nature of police involvement in mental health transfers stated that communication between police and mentally ill persons were complex and potentially dangerous. According to Short et al.(2014:336), police officers often interacted with people in an acute mental health crisis and who, at that stage, were unable to communicate. The authors further stated that a noticeable portion of these interactions included persons threatening to injure or kill themselves, or having a drug related problem meaning that the person may be agitated, uncooperative and refusing to talk (Short et *al.,* 2014:337). Police officers were frequently called to a scene at the stage when a mentally ill person is experiencing a crisis, hindering communication. The study revealed that police were often unable to communicate with aggressive mentally ill individuals and were only interested in transferring the mentally ill person to the health establishment. Australian police are reported to fear the risk of injury whilst interacting with mentally ill persons and this further hindered the communication process between the mentally ill persons and the police officers. Police officers frequently were not able to make contact with the health care workers when trying to summoning them to provide some kind of professional help (Short et al*.,* 2014:336).

Watson, Draine and Ottati (2008:368), in a study in the United States of America on improving police response to persons with mental illness, indicated that police officers had trouble with their interaction and the situation was more likely to result in an assault on either the mentally ill person and/or police officers. The authors further stated that police officers were aware that their intervention could aggravate the condition as they were perceived to be a threat by mentally ill persons. Bonfide, Ritter and Munetz (2014:342), in a study in United States of America on police officer's perceptions of the impact of a crisis intervention team, are of the opinion that a police officer's stance regarding the origin of mental illness would define how they communicated with mentally ill persons. Mentally ill persons are often seen as menacing by the general public, including police officers, which negatively affects communication between the mentally ill and police officers. Watson et al. *(2004) in* Bonfide, *et al.* (2014:342) further state that police officers have a limited

understanding of the pathology of mental illness, which contributes to the communication difficulties experienced at the scene.

Short, MacDold, Luebbers, Ogloff and Thomas (2014:336) state that communication between police and mentally ill persons are complex and potentially dangerous. According to Short et al.(2014:336), police officers often interact with people in an acute mental health crisis and at that stage they are unable to communicate. The authors further state that a noticeable portion of these interactions include persons threatening to injure or kill themselves or with a drug related problem, meaning that the person may be agitated and confused and illogic (Short et al., 2014:337) Police officers are frequently called at a stage when a mentally ill person is experiencing a crisis and as such is difficult to communicate with. The study revealed that police officers lack the skill to communicate with the aggressive mentally ill, as such all that they do is to transfer the mentally ill person to the health establishment. Australian police officers are reported to fear the risk of injury whilst interacting with mentally ill persons, which hinders the communication process between the mentally ill persons and the police officers. Health care workers are often unavailable to provide support to police officers at the scene (Short et al., 2014:336).

Watson, Draine and Ottati (2008:368), in a study in United States of America on improving police response to persons with mental illness, indicate that police officers' interactions are more likely to result in assault of the mentally ill person and/or police officers.

3.4.1.2 Sub-theme 1.2: The mentally ill person may present with unacceptable behaviour such as being violent or destructive.

All participants mentioned that most of the community calls they dealt with involved a person causing disruption. Often when they arrived on the scene, they found that one of the people involved in the situation was a mentally ill person who was acting in a violent or destructive manner. Participants reported that they found it difficult to intervene in such situations. The mentally ill person may be screaming, shouting, swearing or carrying dangerous weapons and be threatening to injure the family, community or police officers. Threatening behaviour occurred when the mentally ill person acted aggressively, which might be verbal or physical in nature. The mentally ill person would often direct their aggression towards the police officers or

community members such as relatives or neighbours and may be in possession of dangerous weapons.

Occasionally police officers were summoned by concerned community members as the mentally ill persons walked around the streets aimlessly, disturbed the smooth running of the traffic, threatened to harm themselves and others, and perhaps damaged peoples' property. Police officers found it difficult when the mentally ill person was wandering in the street as there was no one to give background information on the condition of the person. Participants reported that in a few situations they came across a depressed mentally ill person who threatened to commit suicide. They further indicated that in those isolated cases of depressed persons, they did not do much but rather referred the person or called in the help of social workers, as they had insufficient skills to defuse the situation.

> "*In my experience there are cases where you find a mentally ill person chasing people with an assegai, a knife or an axe. Sometimes you find and see the damage the person has already done and you can easily determine that the person is seriously injuring other people and will be assaulted by the community" (Participant : K).*
>
> "*He (police officer) lost his finger as he was approaching a mentally ill patient who had a panga" (Participant: A).*
>
> *"They will swear and they will do all kinds of stuff, they will even try to scare you (police officer) with some weapons" (Participant E)*
>
> *"Those that wander around in streets, we only act if they cause chaos in town, breaking peoples cars, disturbing the traffic, then we had to arrest and transport them to the hospital" (Participant: G).*

Participants asserted that in most instances they were called when the mentally ill person was already violent, carrying dangerous weapons, destroying property or being uncooperative. According to the participants (police officers), the behaviour of the mentally ill person was out of control and directed at anyone in the vicinity of the situation, including the participants. Some participants cited instances where a colleague sustained injuries whilst interacting with mentally ill persons. Through their

behaviour the mentally ill persons may cause damage to property, or pose a danger to self and others.

Hoffman, Hirdes, Brown, Dubin and Barbaree (2016: 1) did a study in Canada on the use of a tool called a brief mental health screener to enhance the ability of police officers to identify persons with mental illness. The authors state that when a mentally ill person is in a state of crisis, police officers are often called to neutralise the condition and have to decide whether criminal charges are justified or whether it is necessary to transport the person to a mental health facility. The authors further declare that a person with mental illness can be disruptive, dangerous or display a criminal behaviour. However police officers, who are often the first on the scene, found themselves as the key role players to resolve the mental health crisis. The ability of police officers to precisely recognise behaviours linked to mental illness is considered a legal requirement by the Mental Health Act of Canada. This Act also affects the manner in which they comprehend and react to persons subjected to a mental health crisis. The preceding description relates to another country's Mental Health Act but the same directive is not found in the South African Act.

Short, Macdold, Leubbers, Ogloff and Thomas (2014:341) indicated that a mentally ill person may be in a mental health crisis presenting with psychotic symptoms, including aggression. The authors state that a mental health crisis may be triggered by family arguments, relationship problems and substance intoxication as well as arrest by the police officers. Psarra, Sestrini, Santa, Petsas, Gerontas, Garnetas, and Kontis (2008:77) describe that police officers relate that they often fear interaction with violent mentally ill persons. According to the authors, a mentally ill person may indicate that they are uncertain about what to expect from the police officers but they often fear that they will be arrested. Not knowing what awaits them, the mentally ill person tries to cope by acting in a manner that may cause harm to all involved. The authors further state that communities commonly label the mentally ill personas aggressive. In this study it was found that the majority of participants report that when dealing with mentally ill persons, most often the person will exhibit aggressive behaviour; they rarely come into contact with mentally ill persons who behave in a calm manner.

Watson et *al. (*2014:351) indicate that police officers frequently come across mentally ill persons who are in a crisis situation. They try to evaluate the condition of the mentally ill person as quickly as possible with little or no knowledge on identifying symptoms of aggression. The police officers are expected to deal with the situation and to choose from a wide range of options. Police officers are expected to come up with the best solution on how to curb the crisis to ensure the safety of all people involved. Research was conducted in the United States of America by Watson, Swartz, Bohrman, Kriegel and Draine (2014:355), where the authors tried to explore how police officers think about mental disturbance calls. The findings were that police officers associate the mentally ill persons with a high risk for injury and that it is often a complex situation to attend to. The study findings also links the level of danger to characteristics such as substance abuse, gender and age; it was stated that males were often more hostile than females. They also indicate that people of a younger age tended to react more with anger and violence.

3.4.1.3 Sub–theme1.3: Through their behaviour, family members often make it more difficult for police officers to take effective action.

The mentally ill person's family are often part of the problem. They summon help but when police officers arrived on the scene, they are not always helpful or prepared to assist the police in dealing with the situation. Most participants attributed improper cooperation to ignorance or misunderstanding. Participants experienced that the family members did not take responsibility for the behaviour of their family members. Some participants were of the opinion that families were sometimes responsible for the odd behaviour displayed by the mentally ill person by not supporting their ill relative or by prodding and teasing the person. When the police arrive on the scene, thementally illperson may already have been destructive to property, may have threatened to harm the family members or may have already attacked family members. According to participants the family members seem to be scared of the mentally ill person.

> *"Uh, the family always call the police because the person is destroying property, is violent, so they need assistance so that you can take the mentally ill (person) to the hospital". (Participant C)*

“Family pose problems during the time of disability grant, because they take the patient’s money, leading to fights and then later call the police to report that the patient is violent without telling the whole story to the police”(Participant K).

“Whereby the family called us that there was a mentally ill patient but they never told us that the particular person is violent.” (Participant B)

“Yes, the other thing is when the police arrive at the scene or to that particular person the family distance themselves, whereby they give the police officers difficulties to work with that particular person“(Participant : B).

“The family members are not willing to take part as they are scared of the patient’. (Participant: D)

Most participants reported that they experienced problems when they were called to attend to a mentally ill person experiencing a health crisis. Most of the time the problems were related to the family withholding information related to the behaviour of the patient. In some instances the family may be dishonest about the mentally ill person’s violent behaviour, putting the lives of both the mentally ill person and the police officers at risk of injury. Participants implied that the family did not want to assist them whist interacting with the mentally ill relative in times of mental health crises. This posed a great challenge for the participants who did not know what to expect when they arrived on the scene. The mentally ill person might be threatening to harm family members or have attacked family therefore the family may be scared of the mentally ill person. Often the family refused to talk to police officers. This resulted in police officers having to deal with the situation in the dark, as they did not know the condition of mentally ill person and what had already happened.

Makgothu, Du Plessis and Koen (2015:1), in a South African study on the ability of families to support mentally ill family members,are of the opinion that sometimes the burden of caring for the mentally ill person at home causes much distress to the families. The families of a mentally ill person are often expected to take responsibility for the care of the mentally ill person, whether they are ready for it or not. Caring for a mentally ill person at home poses a heavy responsibility on the families as it takes time, is expensive and tends to drain energy. The family of a mentally ill person may experience psychological problems and an impaired quality of life as they often have

to support the mentally ill person alone, without professional support. Often they do not receive help from other family members or from the community (Makgothu, Du Plessis and Koen, 2015: 1).

Participants in the current study stated that the family members were usually aware of the dangers of non-compliance of the mentally ill person. However, should the mentally ill person decide not to take his/her treatment or refuse to attend the clinic, they feel helpless and do not intervene. Most of the time the family was not able to force the mentally ill person to comply with his/her treatment plan as they were scared of the person. This meant that the family did not ensure that treatment was continued. When the police arrived on the scene, the family did not inform them about the mental illness or the non-compliance. Participants revealed that they struggled to understand how a situation developed as they were not given the necessary information about the mentally ill person from the bystanders or family members.

> *"You are called in that situation and you ask the family and you find that they know that he (patient) stopped taking treatment three months ago, he last visited the clinic five months ago but they have done nothing" (Participant: K).*

A mentally ill person' treatment plan usually includes compliance to pharmacotherapy as well as psychotherapy in order to maintain his/her condition at acceptable functional levels. Participants were of the opinion that families of the mentally ill persons did not support the mentally ill relatives to comply on the treatment regimen. Family members waited until the mentally ill person goes into a state of crisis, which may often include being aggressive.

It is the role of the primary health care clinic to do a follow up visit to the home of the patient if the person does not arrive for appointments as arranged. Baumann (2011:243) states that at the moment the primary health care system is under such pressure due to a high workload and staff shortages that this is not done. The poverty-stricken population, especially from rural background, may be unable to reach the health facilities where their sick family member has to attend due to distances that must be travelled or lack of transport (Baumann, 2007:643). According to Watson, Marabito, and Ottati (2008:265), the families often did not have any contact with available community resources that could help them or the mentally ill

person. Families were often unable to effectively interact with the mentally ill persons. This meant that intervention was often postponed leading to a mental health crisis. Due to the non-compliance, the person's mental condition deteriorates causing problems such as destruction of property or aggression. This is often the background when police officers are summoned by the family or community members to assist in handling aggressive mentally ill persons.

According to Magadla and Kolwapi (2013:168), the integration of mental health care into the primary health care system puts extra responsibility on the family to care and support their mentally ill relatives in the community. Families are often not educated on how to care for a mentally ill person. They experience the person as an emotional and financial burden that causes them to become despondent. This in turn causes them not to act before a crisis occurs. Watson and Fulambarker (2013:77) did a study in the United States of America on the utilisation of a Crisis Intervention Team to respond to similar situations. The authors describe that when families discuss plans for a crisis intervention meeting with an intervention team, they express frustration with both the police and the mental health care team due to the ineffective collaboration between the two parties and the family. The mentally ill person tends to dominate the entire family, threatening violence and destruction. Families often react with fear and helplessness. Often these families are themselves in desperate need for support and understanding. Families may feel despondent and may only be seeking for temporary relief from taking care of the mentally ill person.

According to Makgothu, Du Plessis and Koen (2015:1) in a South African study, the family members are often unable to cope due to their limited understanding of the dynamics related to mental illness. Draine, Zabow (2008), in Makgothu, Du Plessis, and Koen (2015:4), assert that agitated relatives are not always sensible when it comes to making a sound decision when a crisis occurs, hence they require support and guidance from the health professionals. Some families approach traditional or faith healers and only consult the mental health care system when the unconventional fails them.

3.4.2 THEME2: POLICE OFFICERS EXPRESSED DIVERSE EMOTIONS RELATED TO HANDLING MENTALLY ILL PERSONS IN THE COMMUNITY.

Police officers reported that responding to calls for help from the community and coming across mentally ill individuals triggered a number of negative emotional responses. An emotion can be described as a complex feeling state with psychological, physical and conduct elements; emotions are often exhibited externally (Sadock & Sadock, 2015:387). Police officers expressed these emotions by using words such as frustration, anger and feeling scared. These emotions were frequently expressed non-verbally. The participants often did not name the specific emotion but described the situation from which it can be deduced how they felt. In her field notes the researcher listed these observations and made references to emotions expressed on faces.

Most of the participants reflected on the emotional experiences they had while interacting with mentally ill persons and their families. Participants displayed a diverse range of emotions during interviews such as frustration, anger, fear, anxiety, feeling sorry for the mentally ill individual or they expressed empathy towards the person. Other emotions that were also noted included agitation, apprehension, concern, feeling troubled, discouraged or complaining about a situation. Police officers also expressed displeasure about certain aspects of their interaction with mentally ill persons.

The three sub-themes identified dealt with feeling vulnerable, feeling that unnecessary demands were made of them and experiencing empathy towards mentally ill individuals. These sub-themes will now be discussed.

3.4.2.1 Sub-theme 2.1: Police officers felt vulnerable at not being able to use normal police procedures.

Vulnerability is a state of feeling exposed to the possibility of being harmed, either physically or emotionally (Oxford Dictionary, 2007:1319). Most participants verbalized that they experienced feeling vulnerable. Although this is not an emotion one would often associate with a police officer, the participants considered themselves vulnerable as they were required to interact with mentally ill persons and were unsure of what to expect of a situation. As already explained, mentally ill

individuals often present with agitation, aggressive behaviour that is out of control. Participants stated that not being able to use their normal methods of controlling aggressive individuals, they felt helpless and vulnerable. These methods included pepper spray or firearms. Participants knew that they were not dealing with criminals but with vulnerable mentally ill individuals who were not to be harmed. They were scared that interacting with a mentally ill person could lead to the person being harmed. In most of the quotes reflected here the participants do not mention the emotion but it is implied in their non-verbal communication as described in the field notes.

> *"It's frustrating at times as the police get injuries in the struggle of trying to hold the patient unarmed" (sounded vulnerable). (Participant: C).*
>
> *"If that were to happen (a patient harmed or killed) I'm sure that policeman will lose their job, go to jail or the government will be sued. That is the challenge that we confront once we are called to a violent situation" (Participant: K)*
>
> *"Unfortunately what is happening in South Africa, there is this thing of everything that is done by the police get photographed, even by cell phones" (Participant: K).*

Participants alluded to the fact that they are often at risk of physical injury when interacting with a mentally ill person, especially one who is armed. A policeman will go into a situation armed with a firearm; however, they are not allowed to use it on a vulnerable member of the public, especially one who is a mentally ill person. Participants expressed frustration at being unable to use firearms and not having anything else to protect themselves with when interacting with mentally ill persons, as in the past some of the mentally ill persons sustained physical injuries in the process of controlling them.

Watson *et al. (2014:352)* assert that responding to calls associated with individuals involved in a mental health crisis can cause the police officers to feel very unsafe and vulnerable. Police officers commonly describe persons with mental illness as dangerous, therefore they felt a need to be able to use force, which is not permissible whist dealing with mentally ill persons.

"In terms of the law we can be sued or arrested when we try and take a mentally ill patient because every time you take someone for instance into a police van people and even court see that as an arrest"(Participant : K).

"Our problem is when you are approaching a mentally disturbed person you don't have anything to defend yourself with if he is going to stab you, you can't protect yourself. (Participant: A)

"With the resources we have we can injure them (mentally ill person) the use of pepper spray, because we do not have a choice, because you can't get into contact without using one of the resources we have" (Participant F)

Participants stated that they were trained to use force to resolve violent circumstances even if it meant killing someone in order to save the lives of an entire community. When interacting with mentally ill persons these procedures could not be used. They feel unsure of how they are supposed to act as they had never received any training on how to manage the situation. Being unable to use the methods they are used to increases their feelings of being vulnerable.

Ellis (2014:10) states that police officers interact with mentally ill persons in crisis situations in spite of not being able to intervene effectively. This commonly leads to the application of severe or fatal force towards the vulnerable mentally ill persons. This exposes the lives of the mentally ill person as well as community members and police officers to danger. Short, Macdold, Luebbers, Ogloff and Thomas (2014:10) reveal that when police officers react to the unknown, they sometimes do not have the option to prepare a diplomatic reaction or to consider former reports about the person to help direct their risk assessment and various opinions. This may lead to confusion and questionable decisions and actions.

3.4.2.2 Sub-theme 2.2: Police officers experienced that emotional demands were made on them when they had to deal with mentally ill persons.

All police officers affirmed that, as members of law enforcement, interacting with mentally ill persons is an unfamiliar responsibility which leads to emotional discomfort. In response to the demands made of them, police officers experienced emotions such as anger and frustration, fear and anxiety, as well as feelings of rejection.

Amongst other emotions reflected were anger and frustration. Anger and frustration usually occur concurrently. In this study police frustration was one of the most prominent emotions reflected by police officers with most of their interactions with the mentally ill person. Police officers found interaction with mentally ill persons frustrating as this is a difficult facet of work that they regard as the responsibility of the healthcare workers.

> *"As I said it before it is very difficult we need more power" (Sounded angry and frustrated)*
>
> *(Participant J)*
>
> *"When you get to the scene the family leave everything to the police and do not want to do their part". (Complaining, sounding frustrated). (Participant C).*

Frustration is a deep chronic sense or state of insecurity and dissatisfaction arising from unresolved problems or unfulfilled needs (https://www.merriam-webster.com, accessed online on 21/11/16). Frustration arises from a perceived resistance to the fulfilment of an individual's will or goal and is likely to increase when the will is denied. People with low frustration tolerance tend to experience more frustration than those who have high frustration tolerance (Branch and Wilson, 2010:225). Maclean and Marshall (2010:65) reveal that police officers tend to be frustrated when experiencing difficulties to connect the mentally ill person with services such as health care or social welfare. Wells and Schafer (2006), in a study done in United Sates of America on officer perceptions of police responses to persons with mental illnesss, indicate that one of the frustrations police officers experienced was the frequency with which they interacted with mentally ill persons as well as the amount of time and effort they have to spend on dealing with the mental health crisis (Wells & Schafer, 2006:1)

All participants reflected a feeling of anger towards the mentally ill persons, the families and community members for not getting cooperation when they arrive on the scene. Finding that the situation is not what was expected, may lead to an emotional reaction. Occasionally anger was directed at family members for not warning them about what to expect. Anger is a psychological reaction to a risk or a feeling of powerlessness, a recurrent automatic reaction (Kneisil &Trigobff, 2013 756).

"It's frustrating you know because if injuries occur to the patient the police will be blamed" (Looked angry). (Participant: C).

"It is not easy even at the hospital to hand over, they take time to assist you, as a result of a it may take you about 3 to 4 hours attending that one complaint, it's really frustrating" (Looked angry as well as frustrated) (Participant:C).

Most participants expressed feelings of anger related to interacting with aggressive mentally ill persons where there is a high probability that the mentally ill patient might injure self and/or others. Police officers expressed anger about the length of time spent whilst interacting with mentally ill persons.

According to Branch and Wilson (2010:225), anger is a familiar human emotion and is regarded as a healthy emotion if expressed in an acceptable manner. However, if not controlled, it could become an emotional problem. Anger can be detrimental to one's relationships, health status and self–confidence (Branch & Wilson, 2010:225). Police officers related experiences such as anger in some facet of their interaction, especially whilst the encounter challenges actions in accessing services for the mentally ill persons

The participants feared being confronted by family of the mentally ill person or their superiors about harming a patient, which could lead to disciplinary action. As stated previously, the public take pictures or even video recordings of the contact between police officers and the public which can be used by the media, portraying police officers in a bad light. Participants revealed feeling vulnerable due to the fact that when a mentally ill person is injured, police officers may be sued and their jobs may be on the line.

Anxiety is a physiological reaction that helps people to prepare to either run away from a situation or to physically fight and defend themselves (Nejad & Volny, 2008:10). Anxiety can also be described as an emotion that prompts a physical response that allows us to react quickly to a real or a perceived threat (Nejad & Volnyl, 2008:2). Fear is the psychological condition consisting of neuropsychological changes in response to a realistic hazard (Sadock & Sadock, 2015:387). All participants looked uneasy or apprehensive or even agitated in certain aspects of the

interview, especially where they were deliberating on their experiences with regard to violent mentally ill persons.

> *"Then sometimes if that person got hurt the family can come back and it's gonna be a civil claim that can be lodged against us (police officers) whereas we were acting in the capacity just to help". (Anxious and fearful look) (Participant: G)*
>
> *"Our problem is when you approach a mentally disturbed person you don't have anything to defend yourself; if he is going to stab you can't protect yourself whereas you can't handcuff the person". (Looked fearful and anxious). (Participant: D)*
>
> *"In most cases there will be someone that will be injured or even killed" (Looked scared and anxious) (Participant: K)*
>
> *"Sometimes, when you get to the scene these patients become wilder and fight everybody including the police(Looked fearful). (Participant C).*

Participants experienced anxiety when they were not able to utilise normal methods to control aggression even in the face of violent mentally ill individuals. The fact that some participants sustained injuries whilst approaching an armed mentally ill person bare-handed with nothing to protect themselves from the threatening injury made them to feel fear for their lives when attending calls related to a mental health crisis.

Anxiety is not a common emotion that a police officer will easily confess to. Anxiety is a common experience and people differ in their ability to endure anxiety. Anxiety is a personal feeling regarding the stressors and assists people to cope with risky situations. Anxiety affects people of all socio economic levels. Anxiety is classified into four stages namely; mild, moderate, severe and panic (Kniesl & Trigoboff 2013:393). No reference could be found related to police officers experiencing anxiety.

Rejection is the feeling where you are not accepted (Weller, 2009:344). Participants felt rejected especially by the mentally ill persons, family, medical staff in the health facilities and the community in the process of dealing with mentally ill persons. Police regarded their service as secondary to that of the healthcare workers and therefore felt they deserved assistance in times of need. However, they often found

themselves at the forefront yet not appreciated by the mentally ill or their significant others.

> *"Yes the thing is when police arrive on the scene or to that particular person the family distance themselves, whereby they give the police officers difficulties to work with that particular person". (Voice sounded as if feeling rejected). (Participant L).*

> *"Sometimes when we get at the scene, the patients become wilder and fight everybody including the police, so that is when we apply force and even call more police officers for assistance". (Expressed a feeling of rejection). (Participant C).*

Participants experienced feelings of rejection as they entered the field with the intention to help the mentally ill person and the family, and then found that surprisingly the family distance themselves from the situation. This led to ineffective interaction between the participant, the mentally ill person and the family. Sometimes the violent behaviour displayed by the mentally ill persons contributed to the feelings of rejection on the part of participants who did not understand the pathology of mental illness.

Magadla and Kolwapi (2013:169) agree with the current study that previously police were regarded as brutal, impartial and as protected by the state, and were accused of undermining the interests of the public. This created a distance between the police officers and the general community, hence the rejection of police officers by the mentally ill persons, families as well as the community at large. In the past the role of South African police officers involved punishment of the criminals and brutality was interpreted as cruelty by the public. Therefore it should be borne in mind that the stigma of the new South African police officers of being labelled as cruel by the communities cannot be wiped off momentarily. (Magadla & Kolwapi, 2013:169).

3.4.2.3 Sub-Theme 2.3: Police officers experienced empathy towards mentally ill persons and their families.

A few police officers demonstrated feeling empathic and understanding of the mentally ill person. Therefore, when interacting with mentally ill persons, police officers tried to listen to and understand the problems from the mentally ill person's

perspective. Some police officers were aware that if they approached the mentally ill person in a calm way, being prepared to listen to his/her story then they are more likely to understand the situation and to come up with more effective solutions to the crisis situation. Police officers emphasised that mentally ill persons should not be treated as criminals, instead one should put oneself in the shoes of the mentally ill person. All police officers acknowledged that they lacked information related to interacting with mentally ill persons, giving rise to an absence of empathic understanding amongst police officers. According to the participants, an empathic response would only be observed in a few police officers, those who went an extra mile in performing their duties and who do their best in whichever situation that comes their way.

Empathy is the ability to perceive what others perceive and react to and comprehend the experience of others on their terms (Kniesl and Trigoboff, 2013:43). Police officers stated that most interactions where police officers were empathetic had successful interactions with fewer injuries to all parties involved.

> *"Those that are walking in town, we interview and listen to what they say and you put yourself in his shoes and treat him like normal people. Then they will give you what you want" (Participant: L).*
>
> *"We can't handcuff those mentally ill, you see, because they are not criminals they are mentally disturbed" (Demonstrated understanding) (Participant D).*
>
> *"We have to keep calm. You don't have to raise your voice when talking to them" (Participant B).*
>
> *"The only thing that I have seen that works is if you are able to get through to the person and speak with the person and listen to the patient. That is the only winning solution" (Participant K).*
>
> *"The only thing I have seen work is, if you are able to get through to the person and speak with the person and listen to the patient. You need to sit and calm him down before you take him to the van" (Participant K).*

Participants demonstrated that they endeavoured to understand the mentally ill person, indicating that they did not view these individuals as criminals. Therefore the application of restraints was deferred. By acting in a calm manner when talking to the

mentally ill, the participants temporarily put their personal interests aside and responded to the mentally ill person's needs. Participants learnt to be sensitive to the mentally ill person's needs by showing understanding of what a mentally ill person went through and therefore they cannot be harmed.

Empathic presence involves listening, silence, support though accepting and encouraging the expression of feelings allowing pain to be expressed and responding in a noncritical, non-judgemental way (James & Gilliland, 2013:436). Maclean and Marshal (2010:66), in a study conducted in United Kingdom on police perspective of mental health issues and services, state that police officers show empathy towards mentally ill persons. The authors reveal that police officers express empathy towards the demands of mentally ill persons and are sensitive to the outcome that police interaction could have against them. Several positive effects were mentioned and most participants conveyed great interest to assist mentally ill persons. The positive drive to assist seems to be the common response for police officers interacting with mentally ill persons who are in a state of crisis (Maclean & Marshal, 2010:66).

3.4.3 THEME 3: POLICE OFFICERS WERE EXPECTED TO TAKE ACTION AND DEAL WITH MENTALLY ILL PERSONS, THE FAMILY AND THE COMMUNITY IN THE COURSE OF THEIR WORK

All participants articulated that their primary function as police officers was to combat crime in the communities. They had a job description of what they were supposed to do and it did not include managing mentally ill individuals. However they did have a duty to care for and interact with the community. One of these duties was to maintain law and order and to help communities deal with crises. This meant that at times they needed to interact with mentally ill persons, their families and members of the community in an effort to maintain law and order. Participants were trained to deal with criminals, not with individuals with special needs, such as the mentally ill. Therefore at times police officers were unsure what was expected of them; there were no distinct guidelines to follow on how to act when in contact with the mentally ill. Three sub-themes emerged from the data namely uncertainty regarding what their role and function was, their lack of knowledge regarding what Section 40 of the Mental Health Care Act, act no 17 of 2002 entails and an awareness that they lacked

knowledge and skill in dealing with the mentally ill. These sub-themes will now be discussed.

3.4.3.1 Sub-theme 3.1: The police officers were not sure of their actions as they lacked a clear description of their role and function in interacting with the mentally ill persons.

The participants explained that dealing with mentally ill individuals was outside the activities that were normally required of a police officer. The participants indicated that they were trained on how to deal with criminals, how to deal with aggression and how to subdue an aggressive criminal. Although they tended to use the same methods when interacting with mentally ill individuals they realized that these methods may be detrimental to the person. The problem experienced by the participants was that they could not use the same methods if the person they were dealing with was a non-offender whom they were not supposed to harm. This caused them to be unsure of how to act and what their role and function were when dealing with the mentally ill person and his /her family. They stated that having to deal with a mentally ill person was time consuming and increased the pressure of work in the police service, as they could not fulfil their primary duty of law enforcement and public safety. Their primary duty was disturbed by the calls related to mentally ill patients. Police officers experienced the role of interacting with the mentally ill person as too clinical in nature and not related to their job description.

> *"It's difficult to deal with mentally disturbed persons. It's not our job but we are doing it for the sake of helping the community" (Participant C).*

> *"Our challenge is when we get to the institution (the mental health care facility), they also give us problems of not wanting to take responsibility for the mental patient (and the policemen have to wait until the patient is sequestered)" (Participant K.*

Dealing with the mentally ill person is a grey area and who should be responsible for what is not well designated. The participants indicated that a lack of training made it difficult for them to deal with the mentally ill person. If necessary they may try to bring in additional help such as backup support from their law enforcement team, ambulance services, members of public, relatives of the person or even neighbours who had a good relationship with the patient. The participants indicated that in most

instances they received help from the law enforcement team and very little help from health services, as these were often not available or were not willing to come to their rescue.

After a mentally ill individual has been restrained, the police officers were able to take the person to a health care facility. The participants indicated this activity may also lead to problems. They were also unsure about the extent of their involvement in the care of the mentally ill persons as the health care facility may expect them to spend lengthy waiting periods with the mentally ill person, keeping control of his/her behaviour while they waited for the person to be admitted to a ward. Medical staff expected them to keep control of the mentally ill person during this waiting period. This caused them frustration as they were aware that time spent at the health care facility meant that they were neglecting their normal law and order duties.

The South African Police Act no. 68 of 1995 (South Africa, 1995) describes the role of the South African Police Service as the conservation of the internal security of the country, maintaining law and order, the examination of any offence or alleged offence and the prevention of crime, to protect and help community members. According to van den Brink *et* al. (2012:1), in many countries the police officers are authorised to render assistance to citizens who are in need of assistance yet unable to take care of themselves. Therefore police officers adopt a frontline professional role in the care of people with mental illness who suffer a crisis. The Mental Health Care Act no. 17 of 2002 (South Africa, 2002) authorises police officers to transport mentally ill individuals who need to be transported from a community location to a health care facility or between psychiatric facilities. The Act does not prescribe a specific role such as managing the mentally ill or delivering the mentally ill persons to the ward when they arrived at the hospital

Hoffman, *et al. (*2016:1), in a study in Canada on the use of the brief mental health screener tool to enhance the ability of police officers to identify persons with serious mental disorders, indicate that various provincial mental health acts across Canada furnish authority for police officers to arrest a person who they believe to be mentally ill and who may be a danger to themselves or others and to transport the mentally ill person to the health establishment for assessment or treatment. The ability of police officers to accurately recognise behaviours related to a mental illness is seen as

essential by the Canadian authorities for police officers to be able to safeguard themselves, the public and the mentally ill individual (Hoffman, *et al.,* 2016:1).

According to van den Brink *et al. (2012:1),* police officers were at the forefront in dealing with mental health crises whereas their primary duty was law enforcement. In many countries police officers are constitutionally mandated to offer support to the residents of the country who were in need of such support. Of special interest was the fact that in any community situation, in approximately half of the cases they managed to resolve the crisis themselves without contacting any health care services. Police officers calmed the mentally ill person or involved the family members in looking after him. Police officers in other countries such as United Kingdom interact with the mentally ill person in addition to their primary role of maintaining law and order (van den Brink *et al., 2012:1).* The involvement of the participants in the care of the mentally ill persons should be clarified between the Department of Health and the Department of Justice as participants believe that they are performing the responsibilities of the health care workers (Magadla and Kolwapi, 2013:174).

3.4.3.2 Sub-theme 3.2: It would seem as if most police officers were not aware of the contents of section 40 of the Mental Health Care Act no.17 of 2002.

The Mental Health Care Act no. 17 of 2002 (South Africa, 2002), section 40 mandates that if a police officer, according to his judgement believed, from personal assessment or from information received from a health care provider that a person by virtue of his/her mental illness is likely to inflict harm on self and others, that person should be arrested. Police officers have to ensure that the mentally ill person is transported to the relevant health establishment. The mentally ill person should be handed over for further management to the relevant health establishment or any person appointed by the establishment to accept such mentally ill persons (Baumann, 2011:581).

Most police officers were unaware of section 40 of the Mental Health Care Act no. 17 of 2002 (South Africa, 2002) since it was not included in their basic training. A few of the participants stated that they were aware of this Act as they had accessed the information from elsewhere and studied the content. Section 40 of the Mental Health

Care Act no.17 of 2002 (South Africa, 2002) should be used to guide policemen on their role in dealing with the mentally ill persons. Most of the participants lacked knowledge about how to handle mentally ill patient according to the indications in section 40. All police officers expressed a need for training on section 40 of the Mental Health Care Act no.17 of 2002 (South Africa, 2002) in managing the mentally ill persons in the community.

> *"I never heard anything related to section 40 and that is what I want to know" (Participant: I).*
>
> *"I don't know anything about section 40; we were never told about it at the college and in the field, nothing at all" (Participant C).*
>
> *The Health Act was explained in relation to dealing with mentally ill patients, there is a regulation that is put, which clarifies how we must proceed with the mentally ill patient (Participant: K).*
>
> *"We get a little bit of information when we are busy with them, get to these institutions they give us the green light about the section" (Participant F).*

Magadla and Kolwapi, (2013:174) affirms that the authority given to police by section 40 of the Mental Health Care Act no.17 of 2002 (South Africa, 2002) constitutes a strange practice in which one state department endorses an announcement which has to be effected by components from another state department. Magadla and Kolwapi (2013:175) concur with another study that all police officers required training with regard to the handling of mentally ill persons. Bonfine, *et al.* (2014:341), in the study in United States of America on police officer perceptions of the impact of crisis intervention team programmes, are of the opinion that police officers are commonly placed as frontline reactors to mental health crises; as such a police based programme should be instituted to magnify their knowledge in relation to interacting with mentally ill persons.

3.4.3.3 Subtheme 3.3: Police officers do not know how to handle the mentally ill person.

This subtheme was shared by all participants. In executing their duties police officers would from time to time attend to mental health crises in the course of their work. The police officers lacked information about the symptoms of mental illness and

information about what behaviour to expect from a mentally ill individual. Being unsure of how to act in situations related to mental illness, police officers occasionally treated the mentally ill person like a criminal. Mentally ill persons presented with behaviour which may be viewed negatively by police officers. The officers also do not know how to handle mentally ill persons who exhibit behaviour such as undressing in public, wandering in the streets, swearing at people, destroying property, who may be depressed, who refuse to talk, who threaten to commit suicide and who may be running around carrying dangerous weapons. As a last resort minimal force can be implemented, such as physically grabbing and holding the person down anyhow as well as applying handcuffs. All these actions should be done while taking the necessary precautions to avoid injuring the mentally ill person. A knowledge deficit caused police officers to treat the mentally ill individuals in an erratic manner.

> *"So we had to respond by throwing stones as well to keep him inside the house but reaching the door" (Participant F)*
>
> *"As a way of handling the patient, we try to scare the patient such as shouting at him ordering him to correct his behaviour" (Participant: E)*
>
> *"We get a little bit of information when we are busy with them get to these institutions they give us green light about the section" (Participant I).*
>
> *"(Sometimes) there will be someone who will be seriously injured or even killed" (Participant: K)*

Participants reported that in the event of a crisis they execute various methods of trying to defuse the situation in an effort to resolve the crisis. The strategies used carry danger for the mentally ill person or for the people in the vicinity as well as the police officers. The information that police officers possess is insufficient to help them improve their practice. Only a few of the participants verbalised that they had limited knowledge on how to deal with mentally ill individuals.

Mclean and Marshal (2010:66) indicate that police officers are aware that a violent mentally ill person can be injured by the normal methods used in trying to restrain the person. Police officers are often perceived as a threat by such persons. However, police officers often find themselves in a situation where they are the only

service professionals available to assist mentally ill patients in crisis. Wells and Schafer (2006:580) state that police officers in the United States of America act as gatekeepers, deciding during an interaction where to place the mentally ill person. This is done based on their assessment of the symptoms or behaviour the person exhibited. The options are imprisonment for severe crises, and this was the most preferred option. Other options are using the family as custodian, “diesel” therapy whereby the person is loaded in a bus to be dropped off away from his jurisdiction to be on his own. The last option is too harsh as the confused mentally ill individual is away from home and will not be able to enter health services; this means that the person’s condition will probably become worse (Wells & Schafer, 2006:580).

3.4.3.4 Sub-theme 3.4: Police officers expressed a need to be trained in managing mentally ill persons.

In the police college training focused on controlling criminal behaviour. However, the police officers were also made aware that they have a responsibility to protect the public. All participants shared the same sub-theme. It was difficult for the participants to deal expertly with mentally ill persons as the police officers had not received training on how to deal with such behaviour. The participants were expected to go into a situation without the knowledge and skill of how to observe and what to look out for. They are also not trained on how to handle the problems they come across. Consequently the participants stated that they did not know how to manage.

> *“It also gives us a problem that we don’t have much information on how to handle mentally ill patients” (Participant: L).*
>
> *“I don’t want to lie, madam, we never received any training even at the college concerning the mental patient even at the station. I would like the department of health to come and train us, we might end up doing the wrong things” (Participant D).*
>
> *“We look at what the seniors do, asking them how things are done. There is no workshop or training. Even at the college we never received any training on this” (Participant: L).*
>
> *“We are not trained or specifically prepared, if this is a mentally ill person and he is violent this is how you should deal with him” (Participant: K).*

"There is no specific way in which police officers are equipped to interact with mentally ill persons". (Participant: K)

Participants viewed their interaction with mentally ill persons as an area which required specialised training on how to interact with mentally ill persons. They regarded the type of work as dangerous and posing a risk to self and others. They indicated that they were not trained in communicating with a person who might be psychotic, anxious, threatening to commit suicide or who is depressed.

Ellis (2014:11) states that the crisis intervention team should be introduced to link the inequality gaps between the health care providers and the police service systems. Mclean and Marshal (2010:336) indicate that police officers are aware that a violent mentally ill person can be injured by the methods used during their encounter and that they were perceived as a hazard. Police officers often find themselves in a situation where they are the only service available to assist mentally ill patients in crisis.

Other authors such as Magadla and Kolwapi (2013:170) indicated that police officers in South Africa were not trained for their role in looking after mentally ill patients, implying that police had a knowledge deficit regarding such interactions. Consequently some of them disregarded calls related to the mentally ill persons, leaving them at risk of injuring themselves and others. The authors are of the opinion that police officers are working in the dark as they had not received sufficient training. Furthermore, Magadla and Kolwapi (2013:170) state that the training of police officers to recognise and handle a mental health crisis could lead to significant improvement in police officers' referral of mentally ill persons who defaulted on their treatment.

3.5 DISCUSSION

The study explored the experiences of police officers interacting with mentally ill persons in a rural town in the Eastern Cape Province. To the researcher's knowledge, the study is one of very few in the Eastern Cape that focused specifically on the police officers' experiences of mentally ill persons within a police interview context.

It would seem as if participants only took notice of the aggression experienced by mentally ill persons during a mental health crisis. The participants discussed the aggression they observed almost exclusively and did not really describe other forms of erratic behaviour. Initially the researcher thought more would be said about their contact with the homeless mentally ill individuals wandering around the town but even on re-interviewing participants they still focused on how aggressive the mentally ill person was. Participants reported that the wandering patients were not their main concern as they were usually walking around quietly without disturbing the smooth running of town. Police intervention on wandering mentally ill persons was even more complex, as the person might not want to speak and there was no family present.

Occasionally they notified the Department of Social Development to take care of the needs of the mentally ill persons, to reach a decision whether to trace the families, provide food services, organise a shelter, employment or arrange for institutionalisation. Police officers only seem to be called when a mentally ill person displays odd behaviour such as shouting or threatening people, disturbing traffic flow, undressing in public, destroying people's property. Considering the study performed by Magadla and Kolwapi (2013) on the knowledge and skills police officers need to manage mental health care users, it was found that police officers were not favoured by the community. As previously cited, police officers lacked the knowledge related to interacting with mentally ill persons. The need for police training has been highlighted by virtually all participants. Police officers require training related to section 40 of the Mental Health Care Act, 2002 (South Africa, 2002). The findings of the present study unveiled that there is lack of knowledge related to mental illness resulting to sub-standard interaction between police officers and mentally ill persons.

3.6 CONCLUSION:

The study indicated that police officers lack knowledge related to interacting with mentally ill persons. Mentally ill people living in the community experienced an intensification of the physical symptoms of their mental condition when they were stressed. Should their condition become worse and their symptoms increase, they present with psychotic symptoms such as hallucinations and delusions or emotional

symptoms such as anxiety, aggression or depression and may sometimes threaten to commit suicide. All the symptoms prevent mentally ill persons from being able to think logically, thus they behaved in an erratic manner. These behaviours may include restlessness, undressing in public, wandering around aimlessly, as well as destroying property.

CHAPTER 4

CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

Research findings related to the experiences of police officers interacting with mentally ill persons were discussed in Chapter Three. A literature control was performed and similarities to the research were discussed. Chapter Four concentrates on the conclusion, limitations and recommendations of the study on how police officers can be better prepared to handle mentally ill persons.

4.2 THE AIM OF THE STUDY

The aim of the study was to explore and describe the experiences of police officers interacting with mentally ill persons in a rural town in the Chris Hani District Municipality. Recommendations will be made to the SAPS and the Department of Health on how police officers can be better prepared to handle mentally ill persons. The researcher is of the opinion that the aim of the study was attained.

The experiences of police officers interacting with mentally ill persons in the rural town in Chris Hani district municipality were explored and described in chapter three. Based on these findings recommendations to assist the police officers to interact with mentally ill persons effectively will be discussed in this chapter.

4.3 CONCLUSIONS OF THE STUDY

The researcher drew conclusions from the findings as discussed in chapter three. According to Grove, *et al*. (2015:597) conclusions are a synthesis of findings.

- **Unable to communicate with the mentally ill person**

The interaction between police officers and mentally ill persons has increased with most mentally ill individuals now living in the community. Chronically mentally ill persons sometimes stop taking their prescribed medication. There has also been an increase in substance abuse. If one adds these two groups to individuals who become acutely mentally ill, there is the chance of police officers often coming in contact with a mentally ill person experiencing a mental health crisis. Consequently police officers, being members of law enforcement, find themselves at the forefront

in these events. Police officers are expected to intervene when the public asks for help in controlling a situation where an individual is acting in an unacceptable manner. In South Africa this happens regardless of the fact that police officers are unfamiliar with the pathology of mental illness and are subsequently not able to manage the behaviour displayed by these mentally ill persons. The participants reported that police officers found dealing with a mentally ill person as one of the most difficult facets of their job. Police officers lacked information on how to communicate with the mentally ill persons, how to de-escalate the mental health crisis or how to deal with the person's resultant behaviour. As such police officers found it very difficult to deal with situations the public expected them to resolve.

When police officers were called to the scene where an individual was acting in an unacceptable manner they found it difficult to interact with the mentally ill person who was often already aggressive and acting in a violent manner. They found that the mentally ill person did not want to communicate with them and that trying to engage him/her in a conversation sometimes escalated the violent behaviour. The police could neither understand the person nor convey their own message to the mentally ill person. That was the reason police officers exhibited an unwillingness to attend community calls associated with mental health crises.

- **Poor collaboration between police officers and family members.**

There is often poor collaboration between the police officers and family members with regard to intervening in a mental health crisis. Frequently police officers were summoned by the family to deal with the mentally ill person. However, the police officers found that the family tended to withdraw from the situation and may also withhold information related to the person's mental health crisis. This meant that police officers would enter a scene at a venue in the community basically not knowing what to expect. The family distanced themselves from the situation and refrained from assisting police officers who are trying to abate the situation. The people, such as family members or neighbours, do not want to become involved in the crisis by explaining what gave rise to it. There was no cooperation between the family and the police while mental health personnel were also often on the scene.

- **Police officers had to deal with negative emotions**

Dealing with mentally ill persons elicited negative emotions in police officers such as feeling vulnerable, frustrated, angry and afraid. Each of these emotions will be discussed below:

- **Vulnerability**: Communicating with a person they could not understand and who did not respond to their overtures already made police officers feel vulnerable as they trained to handle criminals and not aggressive mentally ill patients. Police officers were aware that they were dealing with the general public and could not use weapons to control a situation. This means that they did not know how to handle the mentally ill individuals without resorting to using weapons. Being unable to use pepper spray or firearms whilst interacting with aggressive mentally ill persons made them feel vulnerable. The problem escalated when the mentally ill person were armed. The officers were only aware of being at risk of physical injury. Police officers revealed that they also felt vulnerable due to the fact that, should the mentally ill person sustained injuries during the interaction, they may be sued and their jobs may be on the line.
- **Frustration:** Police officers expressed a feeling of frustration when interacting with a mentally ill person as they did not view this as part of their duties. They regarded mentally ill persons as the responsibility of the mental health care workers. Police officers also reported that they became frustrated being called to a crisis in the community and not knowing the details of what is happening (as already explained). Police officers also became frustrated when they had to transport a mentally ill individual to a health facility and then had to deal with the health service personnel. They often found that the staff at hospitals would not take possession of the mentally ill person until his admission had been processed and the person could be either treated (sedated) or put in a seclusion facility. The police officers want to take the patient to the health facility and leave (to get on with doing their law enforcement duties) while the mental health staff expect them to keep the aggressive patient under control until his condition could be managed with medication/seclusion.

- **Anger:** Police officers affirmed that it made them angry to be expected to interact with mentally ill persons without being formally prepared to do the job. Police officers also experienced anger whilst interacting with aggressive mentally ill persons who would often direct their violence towards the police officers. Police officers would also become angry at the family members of mentally ill persons who, when they called police to assist them to deal with a mental health crisis, then distanced themselves from the situation and expected the police officers to intervene.
- **Fear:** Police officers reported being afraid in those situations where they were expected to deal with an unstable situation involving an aggressive mentally ill person whose behaviour was out of control and who may even be armed. They did not know how to communicate with the person, how to de-escalate the crisis or how to get the weapon from the person. Some of the participants reported that in the past some of their colleagues were injured whilst interacting with mentally ill persons. Not knowing what to expect from a situation also made them experience fear.
- **Empathy**: In spite of their anger and fear, the police officers still had empathy for the mentally ill person, who they realized was confused and who was probably also experiencing anger and fear. Some of the participants explained that if police officers were better prepared to deal with the mentally ill, this empathy would be expressed by more officers and may be used to help develop a positive attitude in police officers towards the mentally ill.

- **Section 40 of the Mental Health Care Act, no 17 of 2002 (South Africa, 2002)**

Participants lacked information related to section 40 of the Mental Health Care Act,no.17 of 2002 (South Africa,2002) This act refers to the role police officers are expected to play when they come across a mentally ill person or when they needed to transport a mentally ill person from a community venue to a health facility. However, during their training police officers were never informed of the contents of this section of the Act. Only a few of the participants had managed to access this information from elsewhere such as the Internet. This caused friction between police

officers and health personnel as each party expected the behaviour from the other that was regulated by the Act. This study showed that there is an urgent need for police officers to be informed about this aspect of the Act. Health staff should also be aware of what the section states to prevent them from having unrealistic expectations of police officers.

- This may prevent frustration in the police officers who are often expected to waste time standing around in health facilities, not being able to leave until mental health care staff are satisfied that the mentally ill person is controlled. Police officers felt this kept them from their primary duties of law enforcement.

4.4 RECOMMENDATIONS

In this study the experiences of police officers interacting with mentally ill persons were explored and described. Based on the findings of the study the researcher made recommendations under the following headings namely in practice, in education as well as in research.

4.4.1 Practice

- The family, health personnel from community health services and other mental health team members should look out for the mentally ill person. When a mental health crisis develops, the family or the member of the mental health team could involve the police officers and emergency technicians, especially as transport may be needed. However, the family as well as health care workers calling police officers should be prepared to provide assistance as needed during the crisis. It is especially important that families should be trained to stay with the mentally ill person and supply police officers with information.
- A mental health crisis intervention team should be established. Instead of police officers, this team should be called to the scene and should deal with the mentally ill person and the family. They can decide whether it is necessary to involve police officers in the situation. They may initially need to train police officers on how to assess and identify a mental health crisis and how to intervene effectively. This strategy can help to strengthen police officers' competence to intervene in a crisis, identify possible signs of a mental health

crisis, gather the necessary information and they can be taught how make appropriate referrals.

Kniesl and Trigoboff (2013:751) agree with Bonfide *et.al.* (2014:341) that mental health crisis teams need access to their own vehicles to transport mentally ill individuals. These teams can consist of psychiatrists, psychiatric nurses, substance abuse counsellors, psychologists, psychiatric social workers or child welfare workers. The advantages of the crisis unit are that they can intervene in a crisis without delay, supply increased community access to services and they can evaluate the condition of mentally ill persons in the individual's own familiar environment which may make the mentally ill person less agitated. This may prevent unnecessary admissions to hospital and simplify the process of hospitalisation or detoxification as needed. It will also prevent unnecessary arrests and the trauma the mentally ill person may experience. Such a team can act as the liaison with law enforcement and can collaborate with the mentally ill person, the family and the community network.

It was clear from the literature that Kniesl and Trigoboff (2013:751) and Bonfide *et.al.* (2014:341) agree that police officers would intervene more effectively if they received training from other members of the crisis team. Consequently when the crisis intervention team is fully functioning police officers will interact more effectively with the mentally ill persons.

- If one takes into consideration the negative feelings and experiences reported by participants, it is necessary for them to be debriefed after an incident. They should also be offered counselling to discuss the bad experiences they had.

4.4.2 Educational

- The role of police officers in managing mentally ill persons should form part of their basic training at the police college. The police college should consider including the following topics in their curriculum: the symptoms of mental illness, assessing an individual to determine mental status, how to handle emotions in individuals they come across such as anger, fear, sadness and cognitive states such as confusion, delusions and hallucinations. The police officer should be made aware of how to deal with an aggressive mentally ill

person, a person experiencing a mental health crisis including how to deal with suicidal persons.

- Police officers should be taught basic communication skills, including how to communicate with a person who is agitated, angry, confused or out of contact with reality. This includes communicating with (often hostile) family members.
- The police officers should also be informed regarding the contents of section 40 of the Mental Health Care Act no.17 of 2002 (South Africa, 2002). The police officers should understand what is expected of them and what is not.
- As police officers had apparently not been informed regarding the above topics, staff at police stations should include these topics in their in-service training programmes to ensure that all police officers know how to act effectively and safely when dealing with mentally ill individuals.

4.4.3 **Research**

- The study can be duplicated to a wider area such as the Chris Hani District Municipality or in the Eastern Cape to explore the experiences of police officers interacting with mentally ill persons in different contexts.
- A similar study can be done in an urban area to determine if the experiences of police officers are similar.
- A study could be conducted on the experiences of mentally ill persons interacting with police officers so as to get to know the mentally ill person's perspective on the phenomenon.
- A study can also be done on experiences of families of the mentally ill persons interacting with their mentally ill relative or with police officers.

4.5 LIMITATIONS

Limitations are imperfections in a study that may limit the generalizability of findings. All studies have limitations which may be theoretical or related to the research methods used.

- The study was limited to one rural town, and the results cannot be generalised to other communities. Due to a lack of funding, the researcher could only afford to move around the one rural town to gather data and therefore focused

on police officers who were associated with the Community Service Centre situated in the rural town centre.

- Participants dwelt more on the aggression they observed in the mentally ill person's behaviour and not on any other problems related to the mentally ill individual. They seemed to focus on this one type of behaviour, which may be an indication of how scared they are of dealing with mentally ill persons. Even on re-interviewing to try to get a more balanced view on the mentally ill persons, they still maintained that most of the time they are called to an individual experiencing a mental health crisis that presents as aggression. This means that the views described in this study may be skewed.
- Experiences of families and community members interacting with mentally ill persons were not obtained so as to acquire a more complete mental image of what other parties experience regarding the phenomenon under study. It would have been more insightful to have obtained the other parties' perspectives of the phenomenon. On the other hand, it may be a true reflection of what police officers have to deal with when their paths cross those of the mentally ill.
- There was not enough literature on the phenomenon especially from a South African perspective. There was only one quantitative study done in the entire Eastern Cape Province, so further research and publication is needed.

4.6 CONCLUSION

In accordance with the findings of the study as discussed in chapter three, the researcher deduced that police officers interact with aggressive mentally ill persons as part of their daily duties. Police officers are expected to act but are not sure how to act, exposing their lives and the lives of the mentally ill to danger. Police officers experience an emotional demand to interact with mentally ill persons without using the normal police procedures. Police officers experience negative emotions such as anger and frustration, fear and anxiety and a feeling of rejection Police officers therefore need training related to interacting with mentally ill persons. Recommendations were made according to the three headings of practice, education and research as discussed above.

4.7 CHAPTER SUMMARY

Chapter Four contributed evidence that the objectives were met, the research findings were interpreted and deliberations on limitations were presented. The recommendations of the study were imparted to encourage the authorities of the two departments to collaborate and come up with customer-based programmes.

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ADDENDUM A: REC-H FORM

Nelson Mandela Metropolitan University
for tomorrow

APPLICATION FOR APPROVAL
NMMU RESEARCH ETHICS COMMITTEE (HUMAN)

TO BE FILLED IN BY A REPRESENTATIVE FROM THE FACULTY RTI COMMITTEE:					
Application reference code:	**H** HUMAN	..... YEAR	Health Sciences..... FACULTY	Nursing Science..... DEPARTMENT	..... NUMBER
Resolution of FRTI Committee:	☐ **Ethics approval given** ☐ **Referred to REC-H** (if referred to REC-H, electronic copy of application documents to be emailed to Kirsten.Longe@nmmu.ac.za)				
Resolution date:					
Faculty RTI representative signature:					

BEFORE YOU FILL IN THIS FORM please read the following documents:

"Research Ethics (Human) Application Process" (http://www.nmmu.ac.za/default.asp?id=4619&bhcp=1)

"Code of Conduct for Researchers at NMMU" (Students: http://portal.nmmu.ac.za/default.asp?id=71&sp=0&bhcp=1 or Staff: http://my.nmmu.ac.za/default.asp?id=308&bhcp=1).

WHO NEEDS TO FILL THIS FORM IN?

Any project in which humans are the subjects of research (hereafter called a *study*) requires completion of this form and submission for approval first to their Faculty RTI Committee (FRTI). The FRTI will refer projects to the Research Ethics Committee (Human) (REC-H) where deemed necessary.

WHEN SHOULD THIS FORM BE HANDED IN?

The research proposal should first have been approved by the FRTI before Ethics approval may be given. It should also have first been reviewed by the FRTI for **Ethics** clearance before it is referred to the REC-H.

HOW TO FILL THIS FORM IN:

1) Complete Sections 1 to 8 in typescript (Tab between fields, select from pull-downs, information may be pasted from existing Word® documents), and save (filename must contain your name). Handwritten forms will not be accepted.

2) Use the "Save as" option to save the application form with a filename containing your name (e.g. "**J Smith** REC-H Application Form.doc").

3) Complete Sections 1 to 8 in typescript (Tab between fields, select from pull-downs, information may be pasted from existing Word® documents), and save (filename must contain your name). Handwritten forms will not be accepted.

4) Append the necessary information e.g. Research methodology, Informed consent form, Written information given to participant prior to participation, Oral information given to participant prior to participation (examples of these may be found on the Research Ethics webpage: (http://www.nmmu.ac.za/default.asp?id=4619&bhcp=1)

5) **Electonic copy:** Email all the files (including any appendices) to kirsten.longe@nmmu.ac.za.

6) **Hard copy, signed:** Print the document, get each page initialled on the lower right hand corner and get Sections 9 and 10 signed by the relevant parties. **Hand the signed hardcopy and attachments in** at the Department of Research Capacity Development, 13th Floor, Main Building, South Campus (ATT: Ms K Longe).

Please delete this instruction block before you save and print for the final time.

1. GENERAL PARTICULARS

TITLE OF STUDY

a) Concise descriptive title of study (must contain key words that best describe the study):
Experiences of police officers interacting with mentally ill persons in the Chris Hani District

PRIMARY RESPONSIBLE PERSON (PRP)

b) Name of PRP (must be member of permanent staff. Usually the supervisor in the case of students):
Prof J. Strumpher

c) Contact number/s of PRP: **0415042617**

d) Affiliation of PRP: Faculty **Health Sciences**; Department (or equivalent):**Nursing**

PRINCIPLE INVESTIGATORS AND CO-WORKERS

e) Name and affiliation of principal investigator (PI) / researcher (may be same as PRP):
N.M.Mjali Gender: **Female**

f) Name(s) and affiliation(s) of all co workers (e.g. co-investigator/assistant researchers/supervisor/co-supervisor/promoter/co-promoter). If names are not yet known, state the affiliations of the groups they will be drawn from, e.g. Interns/M-students, etc. and the number of persons involved:
Dr D.Morton

STUDY DETAILS

g) Scope of study: **Local**

h) If for degree purposes: **Masters**

i) Funding : **No specific funding**
Additional information (e.g. source of funds or how combined funding is split)

j) Are there any restrictions or conditions attached to publication and/or presentation of the study results? **NO**
If YES, elaborate: (Any restrictions or conditions contained in contracts must be made available to the Committee)

k) Date of commencement of data collection: **1 July 2016** Anticipated duration of study: **4 years**

l) Objectives of the study (the major objective(s) / Grand Tour questions are to be stated briefly and clearly):
To Explore how how police officers experience interacting with mentally ill persons during their everyday duties

m) Rationale for this study: briefly (300 words or less) describe the background to this study i.e. why are you doing this particular piece of work. A few (no more than 5) key scientific references may be included:
The researcher worked as a psychiatric nurse in a psychiatric Hospital in the Chris Hani District Municipality and observed that police officers regularly brought mentally ill persons for admission. However, the mentally ill persons were dealt with in a harsh and demeaning manner which raised concerns. The researcher seeks to explore how police officers experience interacting with mentally ill persons during their everyday duties.

METHODOLOGY

n) Briefly state the methodology (specifically the procedure in which human subjects will be participating) (the full protocol is to be included as *Appendix 1*):
the researcher will use a qualitative, explorative, descriptive and contextual design, to explore the experiences of police officers interacting with mentally ill persons.The population of the study will be all trained police officers, working in the community service centres of a rural town in the Chris Hani District Municipality who in their line of duty interact regularly with mentally ill individual.The researcher will make use of in depth interviews and field notes, as a way of gathering data. Tesch's eight steps of content analysis will be used to identify themes. Data will be analysed by the researcher and the independent coder. The researcher will utilise the following strategies to ensure rigor, namely credibility, transferability, dependability, and confirmability.

o)

p) State the minimum and maximum number of participants involved (Minimum number should reflect the number

of participants necessary to make the study viable)	Min: **10**	Max: **12**

2. RISKS AND BENEFITS OF THIS STUDY

a) Is there any risk of harm, embarrassment or offence, however slight or temporary, to the participant, third parties or to the community at large? **NO**
If YES, state each risk, and for each risk state i) whether the risk is reversible, ii) whether there are alternative procedures available and iii) whether there are remedial measures available.
Not applicable

b) Has the person administering the project previous experience with the particular risk factors involved? **NO**
If YES, please specify:

c) Are any benefits expected to accrue to the participant (e.g. improved health, mental state, financial etc.)? **NO**
If YES, please specify the benefits:

d) Will you be using equipment of any sort? **YES** If YES, please specify: **Audio recorder**

e) Will any article of property, personal or cultural be collected in the course of the project? **NO**
If YES, please specify:

3. TARGET PARTICIPANT GROUP

a) If particular characteristics of any kind are required in the target group (e.g. age, cultural derivation, background, physical characteristics, disease status etc.) please specify: **Police officers should have been working at the rural town's community service centre for at least one year.**
Should have had contact with mentally ill individuals in the past.

b) Are participants drawn from NMMU students? **NO**

c) If participants are drawn from specific groups of NMMU students, please specify:

d) Are participants drawn from a school population? **NO** If YES, please specify:

e) If participants are drawn from an institutional population (e.g. hospital, prison, mental institution), please specify:
Not applicable

f) If any records will be consulted for information, please specify the source of records: **Not applicable**

g) Will each individual participant know his/her records are being consulted? **NO**
If YES, state how these records will be obtained:

h) Are all participants over 21 years of age? **YES** If NO, state justification for inclusion of minors in study:

4. CONSENT OF PARTICIPANTS

a) Is consent to be given in writing? **YES** If YES, include the consent form with this application [Appendix 2].
If NO, state reasons why written consent is not appropriate in this study.

b) Are any participant(s) subject to legal restrictions preventing them from giving effective informed consent? **NO**
If YES, please justify:

c) Do any participant(s) operate in an institutional environment, which may cast doubt on the voluntary aspect of consent? **NO** If YES, state what special precautions will be taken to obtain a legally effective informed consent:

d) Will participants receive remuneration for their participation? **NO** If YES, justify and state on what basis the remuneration is calculated, and how the veracity of the information can be guaranteed. **NA**

e) Do you require consent of an institutional authority for this study? **YES** If YES, specify: **Station Commissioner of Police**

of participants necessary to make the study viable)	Min: **10**	Max: **12**

2. RISKS AND BENEFITS OF THIS STUDY

a) Is there any risk of harm, embarrassment or offence, however slight or temporary, to the participant, third parties or to the community at large? **NO**
If YES, state each risk, and for each risk state i) whether the risk is reversible, ii) whether there are alternative procedures available and iii) whether there are remedial measures available.
Not applicable

b) Has the person administering the project previous experience with the particular risk factors involved? **NO**
If YES, please specify:

c) Are any benefits expected to accrue to the participant (e.g. improved health, mental state, financial etc.)? **NO**
If YES, please specify the benefits:

d) Will you be using equipment of any sort? **YES** If YES, please specify: **Audio recorder**

e) Will any article of property, personal or cultural be collected in the course of the project? **NO**
If YES, please specify:

3. TARGET PARTICIPANT GROUP

a) If particular characteristics of any kind are required in the target group (e.g. age, cultural derivation, background, physical characteristics, disease status etc.) please specify: **Police officers should have been working at the rural town's community service centre for at least one year.**
Should have had contact with mentally ill individuals in the past.

b) Are participants drawn from NMMU students? **NO**

c) If participants are drawn from specific groups of NMMU students, please specify:

d) Are participants drawn from a school population? **NO** If YES, please specify:

e) If participants are drawn from an institutional population (e.g. hospital, prison, mental institution), please specify:
Not applicable

f) If any records will be consulted for information, please specify the source of records: **Not applicable**

g) Will each individual participant know his/her records are being consulted? **NO**
If YES, state how these records will be obtained:

h) Are all participants over 21 years of age? **YES** If NO, state justification for inclusion of minors in study:

4. CONSENT OF PARTICIPANTS

a) Is consent to be given in writing? **YES** If YES, include the consent form with this application [Appendix 2].
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b) Are any participant(s) subject to legal restrictions preventing them from giving effective informed consent? **NO**
If YES, please justify:

c) Do any participant(s) operate in an institutional environment, which may cast doubt on the voluntary aspect of consent? **NO** If YES, state what special precautions will be taken to obtain a legally effective informed consent:

d) Will participants receive remuneration for their participation? **NO** If YES, justify and state on what basis the remuneration is calculated, and how the veracity of the information can be guaranteed. **NA**

e) Do you require consent of an institutional authority for this study? **YES** If YES, specify: **Station Commissioner of Police**

I **AM NOT** **aware of potential conflict(s) of interest which should be considered by the Committee.** If affirmative, specify: **NA**
05 December 2017 SIGNATURE: **Prof J. Strumpher** (Primary Responsible Person) Date
05 December 2017 SIGNATURE: **N.M.Mjali** (Principal Investigator/Researcher) Date

10. SCRUTINY BY FACULTY AND INTRA-FACULTY ACADEMIC UNIT

This study has been discussed, and is supported, at Faculty and Departmental (or equivalent) level. This is attested to by the signature below of a Faculty (e.g. RTI) and Departmental (e.g. HoD) representative, neither of whom may be a previous signator.

NAME and CAPACITY (e.g. HoD)	SIGNATURE	Date
NAME and CAPACITY (e.g. Chair:FacRTI)	SIGNATURE	Date

11. APPENDICES

In order to expedite the processing of this application, please ensure that all the required information, as specified below, is attached to your application. Examples of some of these documents can be found on the Research Ethics webpage (http://www.nmmu.ac.za/default.asp?id=4619&bhcp=1). You are not compelled to use the documents which have been provided as examples – they are made available as a convenience to those who do not already have them available.

APPENDIX 1: Research methodology

Attach the full protocol and methodology to this application, as "Appendix 1" and include the data collection instrument e.g. questionnaire if applicable.

APPENDIX 2: Informed consent form

If no written consent is required, motivate at 4a). The intention is that you make sure you have covered all the aspects of informed consent as applicable to your work.

APPENDIX 3: Written information given to participant prior to participation

Attach as "Appendix 3". The intention is that you make sure you have covered all the aspects of written information to be supplied to participants, as applicable to your work.

APPENDIX 4: Oral information given to participant prior to participation

If applicable, attach the required information to your application, as "Appendix 4".

APPENDIX 5, 6, 7: Institutional permissions

Attach any institutional permissions required to carry out the research e.g. Department of Education permission for research carried out in schools.

ADDENDUM B: PERMISSION TO CONDUCT THE RESEARCH FROM THE FACULTY OF POST GRADUATE RESEARCH COMMITTEE (H16-HEA-NUR-018)

Nelson Mandela Metropolitan University
for tomorrow

Copies to:
Supervisor: **Prof J Strumpher**
Co-supervisor: **Dr D Morton**

Summerstrand South
Faculty of Health Sciences
Tel. +27 (0)41 504 2956
Fax. +27 (0)41 504 9324
Marilyn.Afrikaner@nmmu.ac.za

Student number: 213498863

Contact person: Ms M Afrikaner

10 August 2016

MS N MJALI
PO BOX 9381
QUEENSTOWN
5310

RE: OUTCOME OF PROPOSAL SUBMISSION

QUALIFICATION: MCur Advanced Psychiatric Nursing Science Coursework

FINAL RESEARCH/PROJECT PROPOSAL:
EXPERIENCES OF POLICE OFFICERS INTERACTING WITH MENTALLY ILL PERSONS IN A RURAL TOWN IN THE CHRIS HANI DISTRICT COMMUNITY IN THE EASTERN CAPE PROVINCE

Please be advised that your final research project was approved by the Faculty Postgraduate Studies Committee (FPGSC) subject to the following amendments/recommendations being made to the satisfaction of your Supervisor/s:

COMMENTS/RECOMMENDATIONS:

1. Title
   Title is too long – Can delete "in the Chris Hani District community".
2. Table of Contents
   - References should not be numbered. Insert proper page numbers.
   - Start "Annexures" on a new page and number separately. Number 14 (Annexures) was not indicated in the Table of Contents, and was incorrectly numbered.
3. Goals and objectives
   There is no difference between the research aim and the research objective. The research aim can be phrased like a goal which indicates an end state, a desired outcome.
4. Measuring instrument and validity (reliability)
   These are embedded in the explanation of data analysis process, however validity/reliability constructs need to be clarified explicitly.
5. Time schedule:
   Explain "DRC" – it is the official abbreviation for "Democratic Republic of the Congo".
6. Many editorial corrections to be made – no spaces after full stops, no spaces between words, American versus British English, etc.
7. REC-H Form:
   1 d) Delete "Specify here, if "other""

4 f) Capital letter – Commissioner of Police – From Eastern Cape or where?

Please be informed that this is a summary of deliberations that you must discuss with your Supervisors.

FPGSC grants ethics approval. The ethics clearance reference number is **H16-HEA-NUR-018** and is valid for three years.

We wish you well with the project.

Kind regards,

Marilyn Afrikaner
FPGSC Secretariat
Faculty of Health Sciences

ADDENDUM C:REQUEST TO CONDUCT RESEARCH FROM STATION COMMISSIONER OF QUEENSTOWN COMMUNITY SERVICE CENTRE

Nelson Mandela Metropolitan University

Port Elizabeth

22 August 2016

The Station Commissioner of police

Queenstown Community Service Centre

Queenstown

Sir

APPLICATION TO CONDUCT RESEARCH STUDY

My name is Ntombekhaya Mildred Mjali, and I am a master's student at the Nelson Mandela Metropolitan University (NMMU). I am conducting research on Experiences of police officers interacting with mentally ill persons in the Chris Hani District community under the supervision of Professor J. Strumpher at the department nursing Science in NMMU.The aim of the study is to explore and describe the experiences of police officers interacting with mentally ill persons in a rural town in the Chris Hani District Municipality. Recommendations will be made to the South African Police Service and the Department of Health on how police officers can be better prepared to handle mentally ill persons.

Research Plan and Method

Permission will be sought from police officers prior to their participation in the research. A purposive sampling technique will be utilised which will be based on the inclusion and exclusion criteria and on the judgement of the researcher The researcher will conduct the interviews using one open ended question with follow up questions to facilitate communication. All information collected will be treated in strictest confidence and neither the community service centre nor individual police officers will be identifiable in any reports that are written. Participants may withdraw from the study at any time without penalty. The role of the community service centre is voluntary and the area commissioner of police may decide to withdraw the participation at any time without penalty. Attached for your information are copies of Participant Information Statement and Consent Form.

Thank you for taking the time to read this information.

Signature: Prof J Strumpher (Supervisor) Date: 22.08.2016

Signature N.M.Mjali (Researcher) Date: 22.08.16

ADDENDUM D: PERMISSION LETTER GRANTED BY STATION COMMISSIONER

SOUTH AFRICAN POLICE SERVICE

SOUTH AFRICAN POLICE SERVICE

P.O. Box 76

Facsimile: 045 8382603

Your reference Student nr213498869

0FFICE OF THE STATION COMMANDER
SOUTH AFRICAN POLICE SERVICE
QUEENSTOWN
2016-09-01

Enquiries BRIGADIER M M KOPOLO
Telephone 045 808 6021

DEPARTMENT OF NURSING SCIENCE
NELSON MADELA METROPOLITAN UNIVERSITY
PORT ELIZABETH

RESEARCH CONDUCTED AT SAPS: QUEENSTOWN: MRS N.M MJALI

1. *On 1st September 2016 permission was granted to Mrs Ntombekhaya Mildred Mjali to conduct research on experiences of Police Officers interacting with mentally ill person in the rural Queenstown Area.*

Kind Regards

..... BRIGADIER

STATION COMMANDER: QUEENSTOWN

M M KOPOLO

ADDENDUM E: REQUEST TO CONDUCT RESEARCH FROM PROVINCIAL AREA COMMISSIONER OF POLICE BISHO

Nelson Mandela Metropolitan University

Port Elizabeth

22 August2016

The Provincial/National Commissioner of police

Eastern Cape

Bisho

Sir

APPLICATION TO CONDUCT RESEARCH STUDY

My name is Ntombekhaya Mildred Mjali, and I am a master's student at the Nelson Mandela Metropolitan University (NMMU). I am conducting research on Experiences of police officers interacting with mentally ill persons in the Chris Hani District community under the supervision of Professor J. Strumper at the department nursing Science in NMMU.The aim of the study is to explore and describe the experiences of police officers interacting with mentally ill persons in a rural town in the Chris Hani District Municipality. Recommendations will be made to the South African Police Service and the Department of Health on how police officers can be better prepared to handle mentally ill persons.

Research Plan and Method

Permission will be sought from police officers prior to their participation in the research. A purposive sampling technique will be utilised which will be based on the inclusion and exclusion criteria and on the judgement of the researcher The researcher will conduct the interviews using one open ended question with follow up questions to facilitate communication. All information collected will be treated in strictest confidence and neither the community service centre nor individual police officers will be identifiable in any reports that are written. Participants may withdraw from the study at any time without penalty. The role of the community service centre is voluntary and the area commissioner of police may decide to withdraw the participation at any time without penalty. Attached for your information are copies of Participant Information Statement and Consent Form.

Thank you for taking the time to read this information.

Signature: Prof J Strumpher (Supervisor) Date: 01.09.16

Signature N.M.Mjali(Researcher) Date: 01.09.16

ADDENDUM F: PERMISSION GRANTED BY PROVINCIAL COMMISSIONER BISHO

SOUTH AFRICAN POLICE SERVICE **SUID-AFRIKAANSE POLISIEDIENS**

Postal Address

Reference	3/34/2
Enquiries	**Brig N Klaas** Lt Col Dyosini
Telephone	040 - 608 8439
Fax Number	040- 608 8525

OFFICE OF THE PROVINCIAL HEAD
ORGANISATIONAL DEVELOPMENT AND
STRATEGIC MANAGEMENT
PRIVATE / BAG X 7471
KING WILLIAM'S TOWN
EASTERN CAPE
5600

2017-11-14

The Provincial Commissioner
EASTERN CAPE

PERMISSION TO CONDUCT RESEARCH ON EXPERIENCES OF POLICE OFFICERS INTERACTING WITH MENTALLY ILL PERSONS IN A RURAL TOWN IN THE CHRIS HANI DISTRICT COMMUNITY IN THE EASTERN CAPE PROVINCE: MRS. N M MJALI

Appended herewith an application to conduct research in terms of the National Instruction 1 of 2006 (Research in the Service), including the recommendations in support of the research initiative received from the supervisor Prof J Strumpher for Faculty of Health Sciences at Nelson Mandela Metroplitan University.

.....BRIGADIER
PROVINCIAL HEAD: OD & STRATEGIC MANAGEMENT
EASTERN CAPE
N KLAAS

PERMISSION TO CONDUCT RESEARCH ON EXPERIENCES OF POLICE OFFICERS INTERACTING WITH MENTALLY ILL PERSONS IN A RURAL TOWN IN THE CHRIS HANI DISTRICT COMMUNITY IN THE EASTERN CAPE PROVINCE: MRS. N M MJALI

RECOMMENDED/ NOT RECOMMENDED

_____

_____

_____

LIEUT GENERAL
PROVINCIAL COMMISSIONER: EASTERN CAPE
L E NTSHINGA

ADDENDUM G: REQUEST PERMISSION TO CONDUCT RESEARCH FROM PARTICIPANTS

Department of Nursing Science

Nelson Mandela Metropolitan University

21 June 2016

Queenstown Community Service Centre

Queenstown

Dear Participant

REQUEST FOR PERMISSION TO INTERVIEW PARTICIPANT

You are being asked to participate in a research study. I am a student pursuing Master's Degree in Psychiatric Nursing Science at Nelson Mandela Metropolitan University (NMMU) in Port Elizabeth. You may be eligible for the study if you have been working at Queenstown community service centre for at least one year, and have had contact with mentally ill individuals in the past. The title of the study is; Experiences of police officers interacting with mentally ill persons in Chris Hani District community in the Eastern Cape. The aim of the study is to explore and describe the experiences of police officers interacting with mentally ill persons in Queenstown. The study will benefit the entire community as recommendations will be made to the South African Police Service and the Department of Health on how police officers can be better prepared to handle mentally ill persons.

The research will be conducted under the supervision of Professor J. Strumpher at the Department of Nursing Science at NMMU. Participation in research is completely voluntary. If you do partake, you have the right to withdraw at any given time, during the study without penalty or loss of benefits. Please feel free to ask the researcher to clarify anything that is not clear to you. To participate, it will be required of you to provide a written consent that will include your signature, date and initials to verify that you understand and agree to the conditions. Telephone numbers of the researcher are 082 9980 286. The ethical integrity of the study has been approved by the Research Ethics Committee (Human) of the university. Privacy and confidentiality will be ensured by safeguarding information fromunauthorised persons, through use of passwords on the electronic documents.

For any query do not hesitate to contact the supervisor or the researcher.

Yours sincerely

N.M.Mjali

RESEARCHER

ADDENDUM H: INFORMED CONSENT

NELSON MANDELA METROPOLITAN UNIVERSITY

INFORMATION AND INFORMED CONSENT FORM

RESEARCHER'S DETAILS	
Title of the research project	**Experiences of police officers interacting with mentally ill persons in a rural town in the Eastern Cape**
Reference number	**H16-HEA-NUR-08**
Principal investigator	
Address	**No 20 A Strelitzia Street Queenview Park Queenstown**
Postal Code	**5319**
Contact telephone number (private numbers not advisable)	**0829980286**

A. DECLARATION BY OR ON BEHALF OF PARTICIPANT		*Initial*
I, the participant and the undersigned	(full names)	
ID number		
OR		
I, in my capacity as	(parent or guardian)	
of the participant	(full names)	
ID number		
Address (of participant)		

A.1 HEREBY CONFIRM AS FOLLOWS:		Initial
I, the participant, was invited to participate in the above-mentioned research project		
that is being undertaken by	(name of researcher)	
from	(affiliation e.g. department/school/faculty)	
of the Nelson Mandela Metropolitan University.		

THE FOLLOWING ASPECTS HAVE BEEN EXPLAINED TO ME, THE PARTICIPANT:					Initial
2.1	**Aim:**	The investigators are studying the experience of police officers interacting with mentally ill persons in the Chris Hani District community in the Eastern Cape Province. The information will be used /for study purposes and recommendations will be made andrecommendations will be made to the South African Police Service and the Department of Health on how police officers can be better prepared to handle mentally ill persons.			
2.2	**Procedures:**	I understand that			
2.3	**Possible benefits:**	As a result of my participation in this study police officers may be better prepared to handle the mentally ill persons.			
2.4	**Confidentiality:**	My identity will not be revealed in any discussion, description or scientific publications by the investigators.			
2.5	**Access to findings:**	Any new informationor benefit that develops during the course of the study will be shared as follows:			
2.6	**Voluntary participation /refusal/discontinuation:**	My participation is voluntary	YES	NO	
		My decision whether or not to participate will in no way affect my present or future care / employment / lifestyle	TRUE	FALSE	

3. THE INFORMATION ABOVE WAS EXPLAINED TO ME/THE PARTICIPANT BY:								Initial
(name of relevant person)								
in	**Afrikaans**		**English x**		**Xhosa x**		**Other**	
and I am in command of this language, **or**it was satisfactorily translated to me by								
I was given the opportunity to ask questions and all these questions were answered satisfactorily.								

4.	No pressure was exerted on me to consent to participation and I understand that I may withdraw at any stage without penalisation.	

5.	Participation in this study will not result in any additional cost to myself.	

A.2 I HEREBY VOLUNTARILY CONSENT TO PARTICIPATE IN THE ABOVE-MENTIONED PROJECT:		
Signed/confirmed at	on	20
Signature or right thumb print of participant	Signature of witness:	
	Full name of witness:	

A. STATEMENT BY OR ON BEHALF OF INVESTIGATOR(S)									
I,	Ntombekhaya Mildred Mjali,			declare that:					
1.	I have explained the information given in this document to			(name of patient/participant)					
	and / or his / her representative			(name of representative)					
2.	He / she was encouraged and given ample time to ask me any questions;								
3.	This conversation was conducted in	**Afrikaans**		**English**	x	**Xhosa**	x	**Other**	
	And no translator was used								
4.	I have detached Section D and handed it to the participant			**YES**		**NO**			
Signed/confirmed at				on				20	
Signature of interviewer	Signature of witness:								
	Full name of witness:								

B. IMPORTANT MESSAGE TO PATIENT/REPRESENTATIVE OF PARTICIPANT

Dear participant/representative of the participant

Thank you for your/the participant's participation in this study. Should, at any time during the study:

- an emergency arise as a result of the research, or
- you require any further information with regard to the study, or
- the following occur

(indicate any circumstances which should be reported to the investigator)

Kindly contact	Mrs N.M.Mjali
at telephone number	0829980286

ADDENDUM I: INTERVIEW GUIDE

An interview guide

Main question

- Tell me your experiences about interacting with mentally ill persons?

The follow up questions may include the following;

Follow up questions

- Tell me how you interact with mentally ill persons displaying hostile behaviour?
- Briefly tell me your understanding of Section 40 of the Mental Health Care Act?
- Tell me about the training you received on interacting with mentally ill patients?

ADDENDUM J: TRANSCRIPTION OF AN INTERVIEW

24. 09. 16 Participant (K)

Researcher: Good morning Sir

Participant: Morning Ma'am

Reseacher: How are you today?

Participant: Good,Thanx how are ma'am

Researcher: Please have a sit

Researcher: Are you comfortable the way you are sitting? Please relax, and feel free to ask questions as we continue with the interview if you don't understand something. Can we start with our interview?

Participant:Yesmaam, go ahead

Researcher: Thank you sir

Researcher: Tell me your experiences about interacting with mentally ill persons?

Researcher: I have my own personal experiences in assisting actually the family of the mentally ill patient.

Researcher: Mmh

Participant: We only assist if that patient is violent, so as to minimise the risk of other people being injured, may be being involved in danger with that person that is aggressive ,

Researcher: Mmh

Participant: somebody who is absconding from treatment just to but it's not really our duty you see

Participant: Mmh We assist that family to take care of that person but it is very difficult, where the family is not known, it will be only presumption from us that this person is ill or information from passbys that this person is ill yet they are not related to the person, you have to take that person to frontier hospital for medical examination, then from to be transferred to any mental institution,

Researcher: Mmh

Researcher: How do you experience that as an individual police

Participant:It is not a nice thing but we do because we are human beings and sometimes we take the mentally ill person because there is no one to attend to the mentally ill individual. And we are forced to take that person to a place of safety I would say.

Researcher: Can you tell me more experiences about this? … As you have indicated that it is not your duty but you end up doing it.

Participant: In some instances you take this person, may be this person already injured someone then you don't have the right resources or right transport mode may be to transport this person and is already injured but sometimes you are forced to take this person may be quicker to the hospital then he is gonna be attended there for the injuries and also for this other thing the mental thing, he acted he is not in sober senses like a drunk person,

Researcher:Uh-huh

Participant:Then sometimes if that person got hurt or may be whatever the family or whatever can come back and is gonna be a civil claim that can be lodged against us whereas we were acting may be in a capacity just to help that person sincerely

Researcher:Uh-huh

Participant: Sometimes you are exposed in danger of being sued because you can be sued by the family

Researcher: Uh- huh

Participant: how do you transport that patient because I don't know if the minister can approve that may be we have ambulance to do that job and we escort the ambulance

Researcher: Mmh

Participant The ambulance to take this casualty and we will go together the hospital or wherever then it's much better

Researcher: Mmh

Participant: But where we have only closed bakie to handcuff that person and put him there and if there is blood it's not us that is supposed to treat that, so we are not trained to do that job

Researcher: Mmh

Participant: But it's a casualty and the very same is a perpetrator but is also a casualty because he got injured before our arrival,

Researcher: Uh-huh

So I think may be those are the problems we are exposed to,

Researcher: Mmm

Participant: Sometimes we end up not taking that person at all if he is injured because it is beyond our control unless not injured, you check yourself this person is not injured then you can transport him to that our police van or something.

Researcher: Mmm, what you are saying is sometimes if you found the patient already hurt in the scene you end up not involving yourself.

Participant: Yes, unless may be you escort seeing to it that this person is not in the scene to the hospital also from the information they will tell you that this person is not drunk not taking any drug or anything but he is a mentally ill person then you have to assist and check sometimes the ambulance too is in danger because if they load that person to ambulance and he is still violent he can destroy everything there

Researcher: Uh-huh,

Participant: then may be we will be forced, then in that instance to load in a van, but those ambulance people would be there, may be to sedate him or what,I don't know, may be to calm him if he is still aggressive.

Researcher: Are there more experiences that you would like to share with me.

Participant: If really a person is mentally ill it's much better if the family is involved because it's the family that will help us in this fashion,

Researcher: Mmh

and we know this person because to my own understanding if a person is mentally ill he cannot hate everybody from the family

Researcher mmh

Participant: there will be the one that will he will come closer, or will understand that person but for us if are wearing uniform we are coming out of the police van,

Researcher: Mmh

Participant: sometimes even if he was aggressive you will think again because think again because you are involved, so sometimes you will think that the family is lying about the condition of the patient that he is aggressive he was assaulting every person because when we arrive he will be calm.

Researcher: Mmm

Participant: So that's where may be we doing our job on daily basis if there is a mental case person we go there we assess the situation we see that we can control we do because at the end of the day we have to execute our duties.

Researcher: Mmm, I hear you

Researcher: Can you tell me how you handle mentally ill persons displaying hostile behaviour?

Participant: If really it's a hostile situation then it means if somebody else if he is the only person that we know he is not ok we still minimise the risk because if other people say may be for example we once had one and this one was holding an axe with a new born child and that if we force ourselves in he was going to cut the throat of that child and any move, he was holding it like this and the child was on his arms, there we ended up opening one of the door without disturbing him from what he was doing. Without him knowing we were already inside the premises then we managed to rescue that little child, and we took him because it was a mentally ill patient case that was a hostage one but we managed to come out with the child

Researcher: Tell me more

Participant: We opened one of the doors it was a two roomed flat and he was sleeping on top of the bed, holding that child with a sharp axe, so we saw him through the window and we kept on talking disturbing him that he must concentrate on the window where people were and fortunately one of the rooms the second door I think it was a kitchen or something we managed to open one of the windows there and we entered through that window to go to the room the we forced ourselves he wouldn't concentrate on the new-born child we manage to apprehend and took him the hospital we could not even open up a criminal case to that person at that stage because he was acting at his capacity .

Researcher: Alright, its good to hear that , lets now move to the next question

Researcher: Briefly tell me your understanding of Section 40 of the Mental Health Care Act?

Participant: Is the one that they are using in the mental institutions, I do a bit its giving us a right to act if really somebody in danger then we have to if it comes to a push we cannot threat one that mentally ill person to kill somebody else then we act on that one that one gives us the right but its at the hospital

Researcher: Mhm

and if is a patient from hospital it's a state patient Morse that person so every person who is a mental patient is supposed to get treatment under that institution so if he is outside we call that person absconded or what relapsing and not in sober senses.

Researcher: Tell me about the training you received on interacting with mentally ill patients?

Participant: Never received a formal training just from the basic training but all these other things we got on the field, its also to assist when somebody is killing someone you have to be there, you have to apprehend that person as a state patient, we cannot run away from that its our duty if we need arises we can even kill that person if he does not stop what he is doing as a last resort if we cannot stop that person from doing what he is doing.

Researcher: Mmm

Participant: This is my personal opinion, mostly in Queenstown I've been working here for seven years now, if the care workers, can try to have good relations that is , doctor's nurses and paramedic, whoever to be available, as we are the first people to arrive as they are trained, if we don't get the right information we might act wrongly. We don't know whether patient is really mentally ill or not. I t could be better if they are the first one to arrive, because this is their patient, as police we do not know what is going on, they know.

Researcher: So if I heard you well you say you would appreciate it if the health care workers are involved whilst you are attending the mentally ill person

ADDENDUM K: GUIDELINES FOR ANALYSIS TO INDEPENDENT CODER

Tesch's eight steps of content analysis were used to develop the codes as follows;

- Get the sense of the whole by carefully reading all transcripts to get and record concepts that dawn to your mind as you read.
- Chose one transcript that seems to stimulate your interest or the one that is on top of the others, probably the shortest one and read it. Reflect on it searching for the underlying meaning and record the ideas that come to your mind as you read at the margin.
- The researcher to continue reading several transcripts and make a list of themes that emerged. Group similar themes into columns. Arrange as major, unique, and leftover topics.
- The researcher should go back to the data base with the list above. Abbreviate the themes as code. Record codes next to appropriate segments of the text. Establish if new themes come out.
- Find the most definitive wording for your themes and return them into class. Decrease total list of categories by putting together categories related to each other. Sketch lines between categories to indicate similarities.
- A final decision should be reached on arranging, abbreviating, and codifying each category.
- Gather data material belonging together to each category in one place and conduct a preliminary analysis.
- If there is a need the researcher should recode the prevailing data (Creswell, 2014:198).

ADDENDUM L: DECLARATION: LANGAUGE EDITOR

Address:

24 Justin Road

Broadwood

Port Elizabeth 6070

Tel: 074 3209463

Email Address: aileenk@absamail.co.za;

03 December 2017

Editor's Certificate

To whom it may concern

This is to certify that I, Aileen Gail Klopper, have proofread the document titled:

Experiences of police officers interacting with mentally ill persons in a rural town in the Eastern Cape Province

MS NM MJALI (213498863) submitted in partial fulfilment of the MASTER OF NURSING in Advanced Psychiatric Nursing Science in the Department of Nursing Science in the Faculty of Health Sciences at the Nelson Mandela University.

I have made all the necessary corrections or, where I was not able to do so, I have highlighted options for the author to address. According to my perceptions the document is ready for presentation to the destined authority.

Yours faithfully

Associate KLO001: Professional Editors Guild