

Cops are from Mars and Shrinks are From Venus

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Conflicting expectations: the culture clash between police organizations and mental health systems

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When governments have contemplated the downsizing of psychiatric facilities, a variety of community supports and agencies have been considered or developed in order to address the needs of people with mental illnesses who will be residing in the community. Needs for community based housing, assertive treatment services, crisis lines, medical care, shelters, recreation centres and supportive work environments have been identified and implemented. However, one community service that has been significantly affected by changes in the health care system, but is not generally considered in the context of community mental health planning, is the police service. This is surprising because the police are de facto part of the mental health continuum. To quote a coroner's inquest resulting from the police shooting of a mentally ill person by police in Toronto, Canada, "the police are the front line extension of the mental health system." Nonetheless, this is not a role that police have typically been trained for, and is a role that is often greeted with ambivalence by the police. This is notwithstanding that an estimated 10-20% of police calls in Canada involve persons suffering from significant mental illness.

It is to some extent obvious that as more people with mental illnesses are residing in the community, rather than in institutions, that there will of course be increased numbers of contacts between those with mental illnesses and the police. In other words, the fact that there are more people with mental illnesses residing in the community will increase the number of contacts between PMI (people with mental illnesses) and police. But there are a variety of other factors specific to this population about why the police might have more frequent contact with this population,. For instance, police may encounter people with mental illnesses resulting from:

- apprehensions under the mental health act
- arrests in which the perpetrator turns out to have or appear to have a mental illness
- calls from the public requesting assistance with an individual who may or may not have committed a crime but in which case the primary nature of the calls relates to the existence of behaviour which seems to reflect a mental illness
- crimes in which the victim suffers from a mental illness.

The latter category is worthy of some note in that PMI are more likely to be the victims of crime than the general population.

In some cases, the course of action open to the police is obvious, but in many cases, it is less so. Should a mentally ill person be arrested, hospitalized or perhaps no intervention at all should take place? The situation is further complicated by the fact that even when police officers feel that treatment may be appropriate it is not within their purview to ensure that this happens. Those mental health professionals who work with police officers know that in places like Canada where individual rights and freedoms are of paramount importance, it is difficult to admit or treat someone against their will. Probably the single largest source of frustration experienced by the police in their work with the mentally ill relates to the difficulty of accessing treatment for them. There are endless and almost legendary stories of police officers sitting in their vehicles still completing paperwork only to see the person that they brought to the emergency room leaving and either heading home or back to the streets. This is particularly frustrating when it is preceded by the officer spending hours sitting in the hospital waiting for that person to be seen and assessed.

In contrast, one finds psychiatrists, psychologists and other mental health professionals (MHPs) frustrated by the apparent tendency of the police to arrest PMI who appear to these health care workers as harmless. The perception is that police, at times, unnecessarily lock up those who may be ill but do not pose a risk, or that they unreasonably use force on persons who are out of touch with reality and who are not responsible for their actions.

In other words, the police and MHPs sometimes appear to work at cross purposes. They often view the same case and the same situation in very different ways, and they often do not have a great deal of respect for the skills and knowledge of the other profession. In extreme situations, they might appear to be blue collar thugs versus ivory tower academics or pie in the sky theorists versus Rambo or power hungry shrinks versus...well...power hungry cops. These simplifications perhaps overstate the day to day situation but they do to some extent capture the flavor of the fundamental differences as they are perceived by the participants.

There is no doubt that there are real differences in the way that MHPs and police look at the same situation. Consider the work of Inspector Frank Trovato of the Toronto Police Service. As part of his research for his masters degree thesis, Inspector Trovato asked almost 500 police officers how they would respond to a variety of cases which involved mentally ill persons. The same questions were later asked to a much smaller group of 32 MHPs. The question was: how do you think the police should manage the following situation? (Below is one of several scenarios in the survey):

The Hitchhiker: Carl is a typical middle-class, white, 38-year-old male bookkeeper:

Details: Carl was driving on a highway when he picked up two hitchhikers. One hitchhiker sat in the back seat and the other in the front seat. The rear passenger was fast asleep during this episode. However, Carl believed the passenger in the front seat kept looking at him and smiling. Conversation between them was casual. Carl became very suspicious when the hitchhiker asked what form of recreation Carl enjoyed. Other movements, which made Carl scared, are described as follows: while the passenger was reaching in his pocket, Carl believed the passenger was touching a knife, or gun. Carl also believed that the hitchhiker, while placing a cassette tape in the car stereo, deliberately touched him with his hand causing Carl to believe the hitchhiker was homosexual. Carl also became convinced both hitchhikers were going to hurt him. As a result, Carl pulled the vehicle off the highway, went around to the passenger side of the car, jerked the

door open, grabbed the hitchhiker in the passenger seat and started to punch and kick him about the head and body. When the police arrived, Carl convinced he was going to be executed, started to scream, spit, and yell that his blood was splattered against the interior of the car and roadway.

Background: Carl had a difficult childhood losing his parents while he was two years old in a car accident. Carl had been in and out of school since grade seven. He used illicit drugs, primarily marihuana, but had also been hospitalized for alcoholism a year ago. After Carl spent three days in jail for a minor marihuana arrest, he attempted suicide by slashing his wrists. He spent two weeks in a psychiatric hospital. Carl's wife mentioned these problems began five to ten years ago. Other than the current drinking problem, Carl is described as a good husband and father to a three-year-old child.

Q. Which police decision do you agree most with in handling Carl's case?

1. **Seek Medical Attention**
2. **No Action**
3. **Arrest**

The differences between the police and MHPs were notable. Whereas 82% of police officers thought it was appropriate to arrest in this case, only 22% of MHPs thought this was the preferred option.

In a case in which someone is clearly mentally ill and also clearly dangerous, in the final assessment, MHPs act like MHPs, and police act like police. It is not that the police do not recognize the mental illness just as it is not that MHPs do not recognize the danger. Rather, it is more likely the priorities of each profession which are different.

How does one resolve such a dilemma? There are a variety of parts to the ideal solution, many of which are outside the scope of this discussion, but part of the solution is to develop a clear understanding of the culture in which each profession operates, the basic principles that drive their action and decisions and the role that each plays in society. The work of the police and the work of mental health professionals often appear to be at odds with each other--and taken at face value this may indeed be the case. But if one looks at some of the underlying assumptions, responsibilities, and knowledge that drive each profession, it becomes clear that the differences, if properly interpreted, make the professions complementary rather than conflicting.

In essence, we are talking about cultural differences. A culture can be defined as the socially shared and transmitted knowledge of a society as reflected in its norms, beliefs, and practices. There is often and inevitably a clash when two different cultures come into contact and neither understands or appreciates the norms, practices and beliefs of the other. The outcome can be similar to "racism" in which irrational dislike and distrust, based on a lack of knowledge, emerge. But by increasing the level of understanding and the familiarity with a culture, the barriers can be reduced and the two cultures can better cohabitate. This is the goal of this paper.

There are four areas of principle difference between the police organizations and police personnel on the one hand, as opposed to mental health systems and mental health workers, on the other. These include:

1. ***Guiding principles*** which direct the work of each profession, derived from codes of ethics, societal expectations, organizational goals and missions, and legislation;
2. norms in terms of the ***personality characteristics*** which are typical of members of each profession
3. ***behavioural priorities***: the differences in the immediate demands of the situations within which these individuals find themselves operating.
4. the ***organizational structures*** within which these individuals operate and which both generate and support the beliefs, practices and norms.

Of note is that there are many similarities between these two groups. Both are people-oriented, altruistic, logical, investigative and attract people generally looking for a better world. Both are also traditionally male dominated. However, this paper will focus on the differences since they are where our understanding and effort is required.

1. Guiding principles/codes of ethics:

Both police and MHPs are bound by various codes of ethics. The sources can vary; principles may be codified in forms ranging from organizational missions and goals, oaths, legislation, codes of ethics, professional standards. Again, if one reviews these sources, many similarities are evident. But there are two areas that are different which are relevant in our context:

a. Who is the primary object of concern--the individual versus society as a whole, the rights of the individual versus the rights of the collective?

Contained in Figure 2 are a variety of excerpts and quotes from various mission statements, codes of behaviour, standards of conduct and the like for police officers on the one hand and MHP.¹

This principle might be illustrated through an anecdote. Several years ago, when I first established a joint liaison committee at a psychiatric hospital where I worked, a committee which included members of the criminal justice system as well as the health care system, included high ranking members of two different police services. These two police services, for whatever reason, did not get along well. At one point in the meeting, tension arose between the representatives of the two police agencies. One of the officers, in an attempt to smooth the waters, said, "Well, there really is no reason to get in lather about this. After all, we are all here for the same purpose—and that is to ensure the protection of the public." The statement did indeed serve the purpose of diffusing the tension between the police officers, but it nearly caused those of us in the mental health professions to fall off our chairs. Protection of the public is NOT what is first and foremost in the minds of

¹ For the purposes of this paper, I am focusing on psychologists and psychiatrists.

MHPs. In fact, it is about #9, somewhere after carbon paper, as Dilbert would say. MHPs are tasked with concern about the welfare and best interests of their individual patients, protecting their rights and advocating for them. This is the mind set that MHPs act from when facing a person with a mental illness. They are not totally unaware of public protection issues—but it is not their primary mandate—just as police officers are not totally unmindful of the welfare of the individuals they encounter—but they are driven primarily by public safety issues.

The second area of difference in terms of guiding principles relates to the expected default position for the two professions--in other words, how you "get in trouble" in policing versus mental health. Police often get in trouble by NOT doing something; MHP get in trouble by DOING something.

b. errors of omission versus errors of commission (police are often reported or disciplined for not taking action (see Figure 3 for excerpts from codes of ethics etc highlighting these differences)

MHPs often ask police why they just cannot leave a situation alone-- if a person is not dangerous, not certifiable under a mental health act and has not committed a noteworthy offense. Why cannot the police simply leave the situation alone? Police report that they rarely have that option, and that the neighbor who phones because Fred is yelling at a fire hydrant will not respond well to the failure of the police to take action. Indeed, they expect a complaint about their failure to take action to be made the next day by the neighbor.

In psychiatry, on the other hand, there is a long history of taboo, and of illicit use of psychiatry as a social control mechanism. For instance, it is a method some governments have used, and likely still use, for the political control of dissenters. Thus Canadian society has little tolerance and significant social disapproval of restraint and involuntary treatment; there is an emphasis on avoiding the imposition of treatment, ensuring consent, respecting autonomy and individual determinism even when it does not appear to be in best interests of patient. It is not the "call" of the service provider to determine whether a person "should" receive treatment. I am reminded of an incident that occurred in my early career, when I was young and naïve, of arguing before a civil commitment review board that a person should be detained in hospital and treated--and being admonished by legal counsel that I should not let my concern for the patient's best interests interfere with my duty to protect his legal rights. In other words, the patient has the legal right to be ill and untreated.

So police are expected to be proactive and MHPs are expected to be reactive.

Of course, both professions can err in both ways. Police do get in trouble for responding and taking action when they shouldn't have or people would have preferred they didn't, just as MHPs get in trouble for refusing to provide treatment or simply not offering it—but the default positions seem to be opposite.

2. Personality differences:

If one attempts to review the literature and research about personality differences between police and MHPs, one finds at least 250 published studies about desirable and undesirable characteristics

for police officers—and two for MHPs. Basic personality is a very important selection criterion for police whereas MHPs are selected almost entirely on the basis of grades in school. One might suspect from this that police have much better social skills than MHP.

The most obvious difference falls along the introversion/extroversion continuum. Police officers are generally extroverts—outwardly oriented, action oriented, attuned to other people, not terribly internally reflective and more socially focused. On the other hand, people who manage to stay in school for all the years that it takes to acquire an MD or a PhD tend to be introverts—inwardly oriented, focused, reflective and relatively attuned to principles and ideas rather than to people. Introverts typically seem distant, cold, a bit unfeeling and rude to extroverts (may not actually be the case but is often the appearance). In practice, this means that in Canada, all police seem to play hockey. It is rare that I interview a police candidate who does not play hockey. The women even play hockey. Yet, I cannot think of a single psychiatrist or psychologist I know who plays hockey. They bicycle, bird-watch, hike, kayak—but do not often engage in group or team sports.

Other differences are more demographic:

Police, historically, have more often been blue collar, predominantly male, marry young, and have less education. (This is, however, beginning to change.)

Versus

MD/PhD: who more often comes from a white collar background, are more likely to be female (compared to police), marry older, have much post secondary education

If one examines the typologies on the interest inventories that we all took in high school to figure out what we should do when we grow up, we find that police fall into the categories presented by the terms “realistic, enterprising, and social” which are associated with the personality characteristics of emotional stability, dominance, social boldness, lack of sensitivity, lack of apprehension, lack of anxiety and independence

Psychologists and psychiatrists, on the other hand, fall into the categories of “investigative, artistic, and social” which are associated with reasoning, abstractedness, openness to change, introversion, lack of rule consciousness, lack of toughness, independence, social boldness

So both groups are characterized by independence, and boldness, and maybe are not as sensitive as they might be--so both feel confident about expressing their opinions and thinking they are right--but otherwise they do tend to look at things differently.

3. Behavioural Priorities:

Notwithstanding that both police and MHPs provide a social service, it is perhaps a little obvious to comment that police and MHP have very different jobs. But aside from the content of the jobs themselves, the priorities of the jobs are also very different. Consider, for example, the actions that are expected of and/or trained into the two groups with respect to a specific situation. Perhaps a mentally ill person is creating a disturbance in his home. Things are being thrown out the windows and doors and he is yelling loudly that he doesn't need these items any more because he won't be around much longer. He does not have a history of violence but has quite a history of scaring the

neighbors and of threatening suicide every time anyone does something he does not like. The police are called. So is his psychiatrist. The police will want to immediately apprehend and stabilize the situation to ensure the safety of all concerned, whereas the psychiatrist will suggest they leave it alone, see if things settle and remind him of his appointment next week, all the while wondering what set the person off this time!

The police and the psychiatrist are, in this situation, driven by very different behavioural priorities. Compare for example...

Police vs MHPs

Action versus analysis

Focus on behaviour versus focus on feelings, thoughts and emotions

Intervention versus treatment

Control versus understanding

Fast decision making versus thoughtful introspection

definition of “immediate:” within minutes versus over the course of hours of days

custody versus rehabilitation

power versus knowledge

The last of these is often the most problematic for situations in which police and MHPs interact. Often, police have little appreciation of how little power MHPs actually have in terms of providing and forcing treatment. In most jurisdictions, there is almost no ability of MHPs to make anyone do anything. They can not remove a person, impose treatment or hospitalization, impose conditions, contact family members etc--without the consent of the individual. Police on the other hand have a fair bit of power by virtue of the various authorities of the state they are entrusted with—but in the case of PMI, they may have little in the way of specific tools or techniques (e.g. they cannot provide counseling or medication, may not be able to assess intent or work from any diagnostic perspective given the fact that they likely have little background information available about the individual in question. A prime example of this involves those very frustrating cases in which the police bring a person they perceive to be suicidal (such as in the situation above) to a hospital emergency room, to find once again that the “patient” is out walking the streets before the officer has finished the paper work. The risk of suicide may be real and the officer uses the power he has to bring that person to the hospital. But the MHP who sees that individual may well recognize the presence of a borderline personality disorder and may know that contrary to what is apparent to the police officer, admitting the person to hospital may well increase, rather than decrease, the eventual likelihood of suicide. However, the net effect of what may well be a series of appropriate decisions by both police and MHP is conflict and hostility between the two groups.

4. Organizational differences:

Most of the above information has focussed on differences between individual officers and individual MHPs. Indeed, since many of the encounters are one to one this is often the actual focus. But in addition, there is need for the systems to interact. And like the individuals, the systems are often different.

The nature and organization of an institution dictates the way in which it responds to situations. One key difference between people in police organizations versus those in mental health systems has to do with self-regulation. Although police are required to work independently and exercise judgment and discretion, in the end they work in a hierarchical system and are required to follow orders. Police officers are accountable to, and responsible to, their superior officers directly and their community indirectly in virtually all ways. MHPs on the other hand may be administratively responsible to a manager in a hospital setting but clinically they are self-regulating and report to their regulatory body or College as we call them in Canada. MDs and PhDs typically earn more money than their immediate superiors who are likely “managers” of some sort. Thus, there is the appearance of a hierarchy but it is in many ways a false hierarchy. The implication of this is that it is hard for the two systems to do business because MHPs may assume the police have more flexibility than they do, and police assume that will provide service according to proscribed patterns and that they will follow clear direction from administration.

Anyone who has ever worked with a psychiatrist or psychologist knows that they do not necessarily do that. Each one seems to do their own thing, by and large. One of the risks, therefore, is that single situations get dealt with on a case by case basis and that some MHPs and some police work out functional patterns of interaction. However, there may well be no structural change or consistent change in patterns of interaction across the system(s). Consider the role of chief of police for example. If a chief dictates a certain way of handling the mentally ill, it is difficult for an officer to ignore or contradict it. But it is relatively easy for an ER doctor or an admitting psychiatrist to set his or own standards for certification and admission—as long as they are not clearly in violation of the law or his professional standards. What the hospital might or might not like is often of little concern to the doctor.

Additional organizational problems have to do with simply knowing who to talk to or contact in an organization. One useful model to consider in looking at organizational cultures derives from the typologies identified by Harrison and Handy; they have identified four main types of organizations :(see figure)

- Power
- Role
- Task
- Person

Police culture is traditionally a power culture in which the chief and the governance authority set the tone. Reporting relationships are clear and coordinated; individuals are to perform their assignments, and important decisions may be influenced by sources far beyond the individual officer. The greatest strength of power cultures is their ability to react quickly and cohesively.

Hospital culture on the other hand is a cross between role type and person type. A role culture is bureaucracy but the different streams are relatively independent and may not know much about what each other do. Such a system is flexible and values individual autonomy but lacks central control. Similarly, a person culture is more of collective—such as a group of MDs who share a group practice. Essentially, the members set their own rules.

There are a variety of other typologies of organizations that have been proposed and to make a long story short, no matter which typology you use, police organizations and health care system operate differently. The simple implication of this is that members of each culture have a hard time accessing the other because they may not correctly identify the centres of power and decision-making and may invest in developing programs and procedures with people who do not have the power to enact them.

Implications...

The primary need for both police and MHPs is to understand and appreciate the cultural differences and relative strengths of each other's professions. Think of it as a multicultural experience. Employ the concept of 'acculturation' whereby change results from continuous first hand contact between two distinct cultural groups. This change can take place at the individual or the group level. It is to be contrasted with assimilation in which one culture gives up its ways in favor of the ways of the other culture—or separation, in which case the two cultures become estranged, or marginalized, in which one culture is simply not interested in interacting with the others. (Police services and mental health system each have a long history of marginalization but this has changed in recent decades. The advent of contemporary, or community-policing, has forced police to move from their traditional isolationist position, just as the de-institutionalization of people with mental illnesses has forced psychiatric care into the mainstream.) The final option is integration in which one tries to make the best of other worlds and maintain one's own heritage while interacting regularly with the other culture.

Studies in social psychology have certainly suggested that integration is the strategy with the best outcomes—but it is probably a foreign concept to both police and mental health systems each of which have a strong tradition of relative isolation from other groups. In the case of the police, "police culture" is well ingrained into the system and considered by many police officers as desirable. Police have traditionally seen themselves as different and separate from others and have relied strongly on internal supports. For example, many police officers; socialize with other police officers, may be involved only in police activities and feel the need to limit their contact with outside groups.

A previous study of "what do police want from the mental health system," for example, suggests that police would like education and information from MHPs but are not keen on joint operations or joint training. They do not want to spend time in a psych hospital for training, for example. MHPs often arrive at the same point of separateness but by different routes. "Mental hospitals" are historically separated geographically from other facilities. The stigma of mental illness extends to those who work with the mentally ill. The public approach is to avoid psychiatric hospitals, avoid the mentally ill, and indeed avoid MHPs for fear that they will be analyzed by them, judged or

found lacking in some way. Physicians in particular like to talk to members of their own discipline and even shy away from other MHPs when it comes to education. Thus we are talking about the attempt to integrate two groups who have not only major cultural differences but also have significant traditions that discourage acculturation

The necessary strategies? First is recognizing that the clash exists. Second, accepting that there is good reason to try to overcome it in the interests of the work undertaken by both groups. Third, crossing the threshold—studies indicate that the best training for police in dealing with people with mental illnesses is to conduct joint training between police and MHPs, acknowledging that they both have things to learn from each other—and getting people in the same room at the same time. There is evidence that familiarity does not breed contempt. For example, in attitude studies and the aforementioned survey conducted by Inspector Trovato, MHPs working in forensic services tended to display attitudes and choices that fell between those of other MHPs and police. In other words, it appears that when MHPs are more familiar with the criminal justice system, they come closer to seeing things the way that police do..

In studies and reviews of successful police/mental health liaison programs, the common factor which contribute to success is regular meetings with all the parties involved--getting the players together, face to face, on a regular basis. However, frequently, one hears of systems that are running well then fall apart. Such failures generally arise for one of three reasons:

1. the arrangements were not negotiated or supported by the people holding the “real” power in the organization—which speaks to the need to understand how organizations work
2. once the system was running it was not sufficiently supported by regular and ongoing meetings between the players. That is, a lack of sustained communication. Calling a meeting when there is a conflict is obvious; having a meeting when nothing is going wrong is equally important but not as obvious particularly given every one’s time constraints
3. lack of appreciation at the individual and first responder level about the obligations, goals and cultures of the groups of professionals.

The fact that these problems are not immutable suggests that in the end, the partnerships can work well—if we want them to.

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Figure 2

Mental health professionals...duty to the individual...

"a physician shall act only in the patient's interest...."

"a physician owes his patients complete loyalty...."

"the health of my patient will be my first consideration..."

"Psychologists strive to benefit those with whom they work and take care to do no harm."

"Psychiatrists.. have a long tradition of being committed to placing the patient's well-being above all else"

"a physician shall regard responsibility to the patient as paramount"

"the health of my patient will be my first consideration..."

Police...responsibility to society

"ensuring that police are accountable to the public...."

"the fundamental duties of a police officer include serving the community..."

"law enforcement officials shall at all times...serve the community and protect all persons..."

"officers will strive to obtain maximum cooperation from the public"

"..exists for the purpose of protecting life and property and maintaining social order"

"in partnership with the community...to secure a safe and secure environment..."

Figure 3

Errors of Commission versus Errors of Omission

Mental Health Professionals:

A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless,

(a) he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent;

"voluntary patients...are entitled to the same rights and responsibilities as patients in any other medical setting. Limitation of freedom...should reflect concern for the patient's safety and well being."

Before you (the patient) accept or refuse treatments, a doctor must tell you what the treatment is, what it's for, what the side effects are, what alternatives there are, and what might happen if you accept or refuse the treatment. You can then give "informed consent". Only you can decide on treatment, unless a doctor believes you are unable to understand the treatment or the consequences of your decision.

THE GENERAL RULE STILL IS:
adults can be given health care only with their consent.

Versus

Police:

“accept the duty to act...”

“to serve and protect...”

“shall ensure the full protection of the health of persons...and shall take immediate action to secure medical attention...”

“no call too small”

"misconduct: withholding services..”

Officers, while on duty, shall respond without delay to all calls for Police service.