Factors Associated With Police Attitudes Towards Mentally Ill People in Lusaka Urban

By

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DEDICATION

To my dear wife Helen and my lovely children Edith, Eddie and Erica.

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A project of this nature is virtually impossible to complete without the input of several people. While it is very difficult to mention by name all those who contributed towards the completion of this research project, I would particularly like to thank the following people:-

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ABSTRACT

Objective: The main objective of the study was to determine factors associated with Police attitudes towards mentally ill persons in the streets and Police Cells of Lusaka urban.

Design: This was a case control study involving 220 consenting Police Officers, randomly selected, out of which 110 with negative attitudes constituted cases and the other half with positive attitudes were controls.

To be considered a case, an Officer had to score less than 70% on an attitude scale, while any Officer who scored 70% and above was a control.

Main Outcome Measure: Police attitudes towards mentally ill persons was the main outcome measure seen as positive or negative.

Setting: The study covered all Police Stations and Posts in Lusaka urban where sampled subjects were to be found.

Results: Because two analyses were done, instead of considering the 5% significant level, 2.5% was considered as a cut off point for statistical significance. Thus, a p-value of 0.025 was considered significant at 95% level of confidence.

The median (Q_1,Q_3) ages in years for those with negative attitudes and those with positive attitudes were 30 (27,34) and 29 (26,35) respectively (p=0.014).

There was statistically no significant difference in the median length of stay at work for the two groups ($p=0.144$). Those with positive attitudes had significantly (t-2.330; $p=0.021$) spent more years in school, than those with negative attitudes. There was an association between sex and attitude ($p=0.017$) as well as between marital status and attitude ($p=0.253$).

Some significant difference ($p<0.001$) was noted in marital status between males and females in the total sample.

Some association ($p=0.026$) was observed between handcuffing and Police attitudes towards mentally ill persons.

Another significant association ($p<0.001$) noted was between the conviction that mentally ill people must be locked up in Chainama Hills Hospital and Police attitudes towards mentally ill persons.

A listing of signs and symptoms (in category 1: violent, restless, talkative, nakedness or torn clothes) was significantly ($p<0.001$) higher among Officers with negative attitudes.

Suggestion among Police Officers that they needed further training in skills on how to deal with mentally ill persons was significantly ($p=0.024$ associated with their attitudes towards mentally ill persons.

An association between the conviction that breast-feeding mentally ill mothers should be allowed to breastfeed and attitude was observed ($p=0.025$). After adjusting for confounding factors, breast-feeding was the only factor independently associated with the outcome.

Officers who stated that mentally ill breast-feeding mothers should be allowed to continue breast-feeding were 28% (95% CI; 0.55,0.94; p=0.015) less likely to have negative attitudes towards mentally ill persons.

Conclusion and Recommendations: We conclude that there was an association between socio-cultural belief (e.g. breast-feeding, marrying a person with history of mental illness) related to mental illness stigma, and Police attitude towards mentally ill persons. There was no association between training, education, personal experience in dealing with mentally ill persons and attitude.

The report concludes with a recommendation that health education targeting socio-cultural beliefs of the Police regarding mentally ill persons should be introduced quite early in their training and this must be on going even after graduation.

This should be augmented by the introduction of a training module/component in their curriculum, which involves visits to practical sites like Chainama Hills College Hospital Board.

ABBREVIATIONS

AIDS	Acquired Immuno Deficiency Syndrome
CBoH	Central Board of Health
OR	Odds Ratio
RFA	Research Foundation of America
UK	United Kingdom
USA	United Stated of America
UN	United Nations
WFMH	World Federation of Mental Health
WHO	World Health Organisation
ZAMBAT	Zambia AIDS Related Therapy

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CERTIFICATE OF COMPLETION OF DISSERTATION

I Edward Mbewe hereby certify that this dissertation is the product of my own work and, in submitting it for my MPH programme, further attest that it has not been submitted in part or in whole to another University.

Signature:..... Date: 9 June 2003
(Student)

I/we Dr. S. Sinkala having supervised and read this dissertation, am/are satisfied that this is the original work of the author under whose name it is being presented. I/we confirm that the work has been completed satisfactorily and is ready for presentation to the examiners.

Signature/Supervisor:..... Date: 9 June 2003

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DECLARATION

This dissertation is the original work of Edward Mbewe. It has been prepared in accordance with the guidelines for \MPH dissertations of the University of Zambia. It has not been submitted elsewhere for a degree at this or other University.

Signature:..... Date:.....9 June 2003

CHAPTER ONE

1.0 Background

The Mental Disorders Act (CAP 539 of the laws of Zambia) empowers the police to:

> *...remove to a place of safety a person whom they find in a public place who appears to be suffering from mental disorder and to be in immediate need of care and control in his own interests or for the protection of others.*

It should be emphasised that, when the Act mentions place of safety, this does not necessarily mean the police cells where most psychiatric patients are often locked up with crime suspects before being taken to mental health institutions. Despite the Act being non specific, the ideal situation is that in each case, the police should arrange for the transfer of the patient to the nearest place of safety, where he/she can be medically examined and suitable arrangements made for his/her care. This implies that the police must have reliable criteria for assessing people whom they deem to be mentally ill, besides their mere appearance.

Unfortunately, our police officers lack objective criteria for identifying a person as truly mentally ill. This shows that the police have to work under a wide range of assumptions when dealing with persons assumed to be mentally ill. Therefore, it is not uncommon to observe that the victims of mental illness are detained

without food for lengthy periods in police cells (Mbewe, 1998; unpublished). Patients are brought to psychiatric institutions like Chainama after beatings, in handcuffs and with signs of physical deterioration.

To this effect the Inspector General of Police in 1995, acknowledged in the press that, the police needed to change its tactical approach from being a force, to a service providing institution. Indeed for their services to be of any benefit to the community, several changes need to be made. One such change should be in their attitudes towards mentally ill persons found in the streets and police cells of our communities in Zambia. This is compounded by a situation where mental health services in Zambia are mainly hospital based. Chainama Hills College Hospital is the only 3rd referral hospital for mental health services, supported by a network of psychiatric units in seven provincial general hospitals. These units located at Ndola Central Hospital, Mansa, Kasama, Kabwe, Chipata, Mongu and Livingstone General Hospitals are expected to provide 2nd referral services. There are about 560 psychiatric beds across the country, with about 200 beds also available in general hospitals. According to the Central Board of Health (CBoH) document entitled *Situation Analysis of Mental Health Services in Zambia (2002)*, a comprehensive picture of the incidence and prevalence of mental and neurological disorders per 10,000 population in Zambia is not well known. However, available records from Chainama Hills College Hospital show that acute transient psychotic states have a high incidence and prevalence rate, of 2.11 and 3.61, respectively. Schizophrenia, substance misuse, epilepsy and dementia

follow in that order. In terms of average length of stay in hospital, schizophrenic patients stay longer, close to four weeks or more. In-patient data according to quarters for the year 2002, obtained from Chainama Hills College Hospital, show a steady increase of new cases. For instance in the first quarter of 2002, a total of 433 patients were admitted compared to 489, 496, and 535 patients who were admitted during subsequent quarters respectively. This brought the annual total number of mentally ill people who were admitted to Chainama to 1952, for the year 2002. The exact number of mentally ill patients that roam the streets of Lusaka although not fully established, still causes a lot of concern to the public.

Apart from hospital care, we also have two rehabilitation centers. One is Nsadzu in the Eastern province with 120 bed capacity and the other is Kawimbe in Northern province with bed capacity of up to 40.

1.1 Problem Statement

The problem focused upon in this study dealt with factors that were associated with police negative attitudes towards mentally ill patients in the streets and police cells of Lusaka urban. It was assumed that during their training, police officers were taught relevant skills on how to deal with mentally ill patients in the community. Besides, it should be pointed out that even the Mental Health Act CAP 539 of the laws of Zambia is in the process of being reviewed. This will be in line with the Mental Health Policy document, which is equally being developed at this moment. This therefore, entails that the Police need not have negative attitudes towards mentally ill persons. However, in a small study by Mbewe

(1998, unpublished) it was found that 96% of all Police Officers interviewed in five major stations in Lusaka (Lilayi, Matero, Central, Chelstone and Chilenje), did not have the full realisation of the existence of the Mental Health Act, as well as their stipulated obligations. It was equally evident that the Police portrayed behaviour, which depicted social stigma, when it came to dealing with mentally ill patients. For instance, mentally ill patients are still being locked up with suspected criminals, not fed, bathed nor availed with immediate medical attention, which they need in most cases. Therefore, if we ask what could be the factors that are associated with attitude of Police Officers when it comes to dealing with the mentally ill? There is no straightforward answer to this question; save to state that several factors could be contributory. It was the aim of this study to try and delve into this situation in order to search and come up with factors that directly contribute to the negative attitude of Police Officers towards dealing with the mentally ill in the streets and Police cells of Lusaka Urban.

1.2 Purpose

The main purpose of this study was to investigate the major contributing factors towards the negative attitude of the Police in dealing with mentally ill patients.

No similar study has been carried out in Zambia before. This study was aimed at redressing the issues that hinge on stigma towards mental illness by Police Officers. In the past no much efforts have been made to come up with long lasting solutions in dealing with stigma towards mentally ill persons in Zambia.

1.3 Justification

The knowledge gained from this study would contribute to the existing body of knowledge, and thus, assist in reshaping the attitude of the Police when dealing with the mentally ill. This will help reduce the social stigma attached to mental illness by Police Officers.

1.4 General Objective

The general objective of this study was to investigate the contributing factors to negative attitude of the Police towards the mentally ill patients in the streets and police cells of Lusaka urban.

1.5 Specific Objectives

1.5.1. To determine if there was any association between the level of education and attitudes of Police towards mental illness.

1.5.2 To find out if the training of Police Officers was associated with the attitudes they showed when dealing with mentally ill patients in the community.

1.5.3 To determine the socio-cultural beliefs attached to mental illness among Police Officers were associated with the attitudes they displayed when dealing with mentally ill patients.

1.5.3 To find out if individual experiences among Police Officers in dealing with mentally ill patients were associated with the development of attitudes toward mentally ill patients.

1.5.4 To come up with intervention strategies for assisting in changing the attitudes of Police officers in dealing with the mentally ill patients

1.6 Hypothesis

It was hypothesised at 95% level of confidence that the attitude shown by the Police in dealing with the mentally ill is related to:

- Level of education
- Type of training
- Socio-cultural belief systems
- Individual past experience(s)

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Historical Perspective:

Goffman (1963) said stigma was an attribute that according to prevailing societal attitudes is deeply discrediting and reduces a person to one who is in some way tainted and can therefore be denigrated. He also said that people can internalise stigmas applied to them by others. Researchers, therefore, differentiate between the "felt" stigma a person perceives and "enacted" stigma, which refers to actions upon the individual expressed through various forms of discrimination. For instance, mentally ill people are labelled according to the institution, which offers them treatment like Chainama Hills Hospital, in Lusaka, as "Chainama".

"Enacted stigma perpetuates public health problems and prevents societies from addressing health care issues at community and national levels with appropriate delivery, funding and support of research, health care services and legal and educational interventions" (Goffman, 1963). The stigma attached to mental illness and its sufferers has been in existence for a long time. History has shown that despite long enduring attempts to eradicate it, the stigma attached to mental illness, still appears to be as strong as ever.

It is Hippocrates, the father of medicine who first entertained the thought that mental illness could have an organic cause, contrary to the pre-existing notion, which was based on the belief that mental illness was caused by demons. As a result, he advanced a more humane approach to the treatment of mentally ill persons. His recommendation was that mentally ill persons should be treated in an asylum, which was a "secure and safe retreat from chaos pressures and impure environment of crowded urban centers rather than having persons with mental illness whipped in public or incarcerated in dungeon-like buildings" (Shorter, 1997; Rabinow, 1991).

Little did Hippocrates realise that his approach would give rise to the institutionalisation syndrome and perpetuate social stigma against mentally ill persons. This is due to the fact that, community involvement was absent, and nobody was willing to welcome any discharged person from mental asylums.

In the second century AD, Soranus of Ephesus who lived in Rome and belonged to the "Methodist" School of Physicians (related to the philosophers Heraclitus and Epicurus), advanced the idea that the human body was made up of atoms which were in constant motion. He then argued that it was when the motion of these atoms was disturbed that one became diseased. This brought him closer to the current view that some mental illnesses such as Schizophrenia have a genetic basis (Gelder et al, 1996; Mental Health Issues-USA, 2002).

Soranus went further to argue that as a result of this, the treatments of his time were futile. These treatments included:- locking the patient into a dark room, flogging, starving, making drunk, causing deep sleep with opium and other drugs. Instead of this approach, he recommended that mentally ill patients should be kept in safe dim, but adequately lit rooms, with simple exercises, diet, and always on the ground floor to avoid suicide attempts and when necessary, to be restrained with soft materials, with use of hands instead of clubs or iron instruments (Mental Health Issues, 2002; Amnesty International, 1999).

Ironically, we still observe that even in the 21st century, mentally ill patients are still being confined to cells, seclusion rooms, starved, with restraint mostly by the use of handcuffs in case of police or wire in case of the public at large. This is the common scenario in Zambia, for instance, where the use of wooden handcuffs is in use in Kasama.

It was in 450 BC, when Aristotle defined not only the legal principle of informed consent unchanged to this day but also the two essential powers of democracy that are now influencing us through our colonial masters, underlining the two legal justification for civil commitment of some mentally ill persons. Looking at the government's roles in any society, Aristotle was of the view that these were the resulting two basic powers:- "*police* power to protect its citizens from danger and harm and *parens patriae* power (to use a legal term applied to this idea by the

Romans) to help those in need of parental type of care (Amnesty International, 1999; Shorter, 1997; Rabinow,1991).

In this case the government is seen as an overall parent of the citizens whose nation it governs. This notion underlies the traditional modes of voluntary admission and detention as a means of holding mentally ill persons for care.

In ancient Greece and Rome it was the responsibility of family members to care for their mentally ill relatives. Later on, "civil commitment became a formalised governmental procedure to isolate socially undesirable persons, and only later to treat mental disability as an illness per-se" (Mental Health Issues, 2002)

It is in these circumstances that until 16th century, civil commitment was largely taken to be a government policy in some western countries. The inclusiveness of the mentally ill in the confinement of persons known as undesirables, which society condemned or sought to correct by force, caused people to stigmatise the mentally ill even more. Thus, the 16th century is at times referred to as era of the *great confinement* in the west. For instance, in 1575 in England parliament enacted a law allowing the government to punish vagrants and confine the poor or mentally ill to institutions called houses of correction.

In1606 beggars were being whipped in public squares in France while in 1630, stigmatisation increased in England through a commission that sought to

vigorously enforce the "poor laws", which applied also to all persons with mental illness. It was not until 1656, that a decree to help the poor military invalids and the sick by King Louis XIII of France saw an opening into public hospitals to the above category of people for the first time. In England, a decree of 1697, established the institution of Justice of the Peace. This became responsible for the creation of numerous houses of correction. Through out the 17th century, mentally ill persons were never segregated in any way from those who were poverty stricken, unemployed, idle, social-deviants or debilitated (Shorter, 1997; Rainbow, 1991; Mental Health Issues, 2002).

Despite the assurance of hospital solace the horrors of these hospitals were several and punitive, based on theories and beliefs surrounding mental illness. In this era, the image of a mentally ill person was largely that of an animal, which could feel neither pain nor cold but seemed to thrive under such conditions. Indeed, some schizophrenic patients do harm to themselves and display no effects of pain. It is no wonder that Shakespeare described a mentally ill person of his time as a homeless person who was not more but a poor, bare, *two legged* animal meant to be whipped from *village to village* and stock-punished and imprisoned (my italics).

In mid 19th century, the mentally ill became a spectacle to be watched through asylum windows by the public as they were restrained in chains. For instance, in England one could pay a penny in order to watch these scenes. It was Benjamin

Franklin, president of United States of America (USA), who authorised the establishment of general hospitals to receive and care for mental illness as well as the sick in the mid 18th century. This saw a turn in the approach of treatment of mentally ill persons. For the first time governments and society in the west were accepting responsibility for care and treatment (Mental Health Issues, 2002).

Today, a document by the World Health Organisation (WHO) entitled *Mental Health Global Action Programme* (mhGAP; 2002) observes that around the world, many persons with mental disorders are victimised due to their illness and become targets of unfair discrimination. The document further argues that, "suffering, disability and economic loss are bound to continue as long as there is stigma. Stigma and discrimination are further perpetuated by inaccurate information about mental disorder, such as the notion that people with mental disorders are often violent or bewitched in some way, or that mental disorders are untreatable". WHO (2002) document entitled *World Report on Violence and Health* observes that violence is difficult to define, as it is an extremely diffuse and complex phenomenon. The report states that ideas of what is acceptable or not in relation to behaviour, as well as what constitutes harm, are culturally influenced and constantly under review due to constantly evolving values and social norms. To this effect, WHO (2002) defines violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation".

However, the report is quick to acknowledge that different ways of defining violence do exist. For instance a definition for the purposes of arrest and conviction, used by Police Officers, will be quite different from the one for social service interventions. It is also important to note that the aspect of intent as implied in the WHO definition, may not be easy to demonstrate among patients with mental illness due to the fact that behaviour that results into violent acts, may be due to psychotic conditions marked by delusions and hallucinations.

The issue of violence needs a closer scrutiny as some signs of mental illness may involve violent acts which cause people to generally fear and run away to avoid mentally ill persons. For instance in Germany, in a large study on mentally ill offenders, the risk of homicide was found to be slightly higher in those suffering from schizophrenia compared to the general population (Boker and Hafner, 1977). In Sweden Lindqvist and Allebeck (1990) undertook a study of 790 mentally ill (schizophrenic) persons aged above 15 years, and discovered that despite crime rates among schizophrenic males being similar to that of the general public, the rate of violent offences was four times higher in the former. However, the violence was almost always of minor severity.

In the same vein Gelder *et al* (1996) advanced some hypotheses in an attempt to understand causes of violence. Three main ideas were suggested as follows: (1) aggression as a fundamental instinct which may be expressed in undesirable aggressive acts as well as socially acceptable ways; (2) aggression as the result of

a frustration in goal-directed behaviour; (3) aggression as learned behaviour resulting either from experiences in which aggression was awarded, or from observation and modelling of the aggressive behaviour of other people. Whether a person is aggressive in a particular situation will depend on several factors which include: personality, the immediate social group, the behaviour of the victim, disinhibiting factors like noise, and social pressure, physiological factors like hunger, fatigue, and lack of sleep, and the presence of mental illness. According to Taylor (1993) violence is associated more often with personality disorder among mentally ill suspects, than with the mental illness per-se. In Zambia aggression is seen as self-defence, if a person is restrained and is afraid, there is a tendency to fight back.

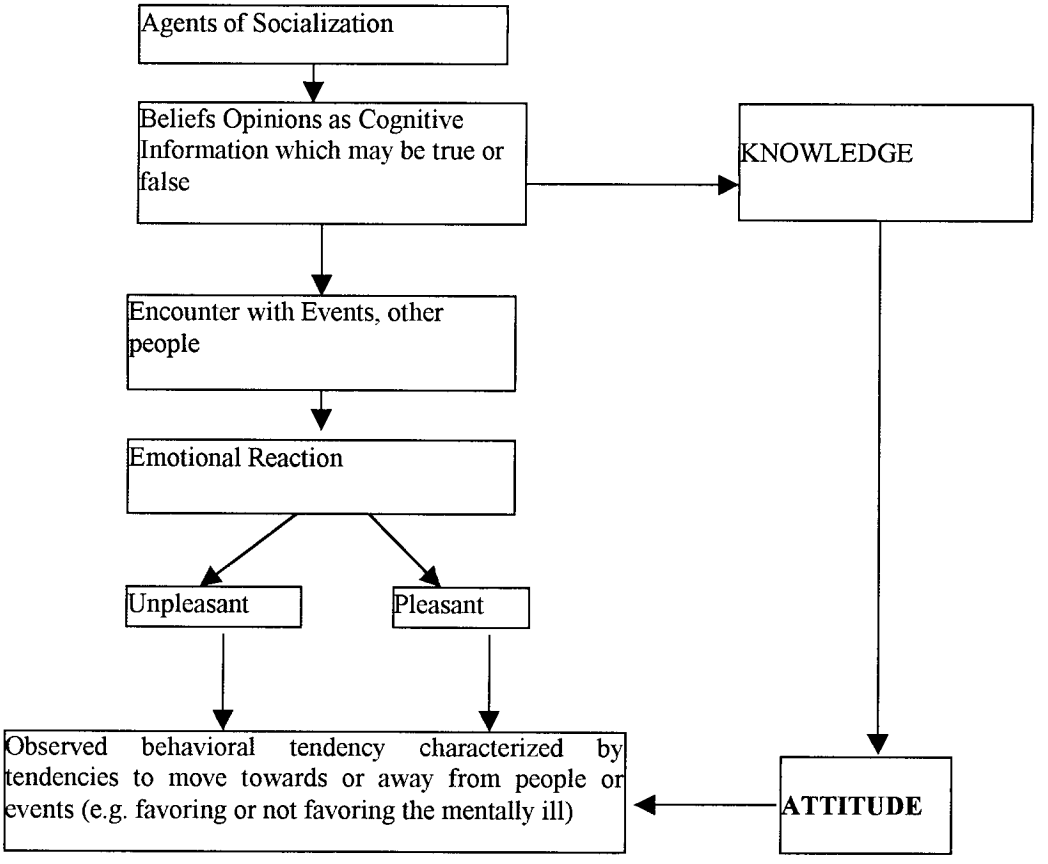
2.2 Conceptual Frame Work:

Attitudes are described by Fishbein (1967) as learned dispositions to respond to an object (or concept), or to a class of objects (or concepts) in a favourable or unfavourable way. In the same vein an elaborate view of attitudes is given by Shaw and Wright (1967) as, a relatively enduring system of affective, evaluation reactions based upon and reflecting the evaluative concepts or beliefs which have been learned and about the characteristics of a "social object" or class of social objects, including of course the people with whom the individual is associated. To this effect Witting and Williams (1984) argued that all of us react to other people and events around us in three ways. Thus, we firstly call up beliefs or opinions, which may or may not be true; secondly, we respond emotionally with

great or less intensity due to pleasant or unpleasant affects; thirdly, we react with observable behavioural tendencies, tendencies to move toward or away from the event or people. These three components make up our attitudes. In this study, the word attitude is taken to mean a combination of beliefs, emotions and behavioural tendencies fastened to specific people like the mentally ill.

Attitude formation is seen to largely depend on the knowledge we initially obtain through agents of socialisation towards some events. Therefore the underlying assumption is that there is a sequential relationship between knowledge and attitudes as seen in figure 1.

Fig. 1: **A Conceptual Framework on the Relationship between Knowledge and Attitude Formation.**



Lundman (1980) pointed out that Police Officers in democratic societies are members of organisations intended to serve the public at large. Among the norms that are supposed to guide police actions in a democratic society is an expectation that police be equitable in their treatment of citizens. It is therefore expected that Police Officers in the community will not abuse their powers of arrest by discriminating against certain citizens in favour of others. The case in question is the unfair way in which some Police Officers in our society deal with issues relating to mentally ill patients. It is obvious from observations in our society that frequently the police maintain negative images of powerless citizens like the mentally ill and that these images encourage discriminatory policing.

Bunch (2001) stated that police are looking for new methods to deal with consequences resulting from an increased number of mentally ill persons with emotional disturbance found roaming the streets. This is based on the way the police have been dealing with mentally ill people on the streets of Los Angeles.

For instance in May 1999 two policemen moving aimlessly spotted a 54 year-old homeless African American woman with history of mental illness. She never seemed to be a threat to public safety as she pushed her belongings in a shopping trolley. The officers questioned her whether the trolley was a stolen one. In response she produced a screwdriver and threatened them. The response from the police officers was rapid and deadly. One officer shot the woman in the chest, killing the college educated woman who had worked for a bank before she started

hearing voices and took to the streets. In another related situation in Memphis-United States of America (USA), police shot a knife wielding mentally ill male patient in what were termed as controversial circumstances. In New York city, a man wielding a hammer was shot and killed as he faced six police officers, while in Los Angeles another mentally ill person was shot at 38 times by sheriff's deputies, who said he threw a knife at them (Bunch, 2001; Amnesty International, 1999). In spite of the above incidents attracting several protests, most police commissioners insist that officers are in order to act the way they did. To this effect several human rights groups, Amnesty International for instance, have complained that police officers in several American cities are ill-equipped to deal with mentally ill people found on the streets of our communities.

The developments discussed above saw an increasing number of police departments introducing a 40 hours special training for volunteer officers, on mental health issues. This prepares them to respond appropriately each time a crisis arises involving mentally ill persons. Several criminologists seem to have welcomed this novel approach. It is pointed out that in over 60 trials involving police shootings of mentally ill persons in the USA, in all of them, the "cops screwed up in the first 90 seconds," meaning that the initial response taken by the Police on confronting a mentally ill suspect is very crucial; in that while they are challenging a mentally ill person whom they happen to have met for the first time, what might be going on in their mind might not necessarily be the impression that they equally need to take into consideration the aspect of the presence of mental

illness in the individual (Bunch, 2001). Thus, instead of the normal reaction of obeying orders from the Police, the individual may appear to be challenging those orders, resulting into the Police taking a confrontational and aggressive role.

This reflects negatively on their attitudes and behaviour towards mentally ill persons.

Experts argue that one reason why police find themselves acting apprehensively when confronting the mentally ill, is largely due to the form of their training. Their training has been in dealing with criminals who generally respond rationally by dropping the weapon on officer's commands for instance, than a suspect who is supposed to be mentally ill.

However, some studies have shown that in Memphis, USA, where re-orientation of police on mental health issues was done, the police were less likely to arrest mental suspects. Instead, they were more prone to refer them for treatment to relevant institutions. Above all the rate of injuries on police officers called to deal with such cases was noted to have declined. (Shane, 1980)

The situation where police officers needed special training in handling the mentally ill was discussed earlier by Khan (1963). He saw the role of the police in relation to helping the mentally ill as a very active one. He observed that police were major case locators; they were major channels for members of the public concerned with reporting situations they had encountered but which they

were not sure where to turn. To this effect Kan stated that the role of the police thus; involved a referral service in the overall mental health system. He puts his argument as follows:

> *''The issue is not whether police should be screening and exercising some discretion but rather how much they can and should do...Brief screening and more complete evaluation and case referral are part of the same process and require the same basic qualities and attitudes. Proper referrals whether to a guidance clinic for personality help, to a community centre for club contact, or to a court as a preliminary step toward institutionalisation also presuppose a good working knowledge of community resources and agencies''*

In related circumstances, it is important to note that in countries like Britain, Italy and the USA, the closure of most mental health institutions in preference to community based care, has lead to an increase in the number of mentally ill people on the streets. This implies that the criminal justice systems of such countries have to shoulder much of the workload once carried out by mental health institutions before they were closed. For instance in a University of Miami report, it is noted that in the big cities of the USA, as many as 7% of all police calls involve the mentally ill. In a related situation, Birmingham (2002) stated that in the United Kingdom, a new draft mental health bill was published in July 2002, that introduced a new legal framework for the compulsory treatment of people with mental disorders in hospitals and in the communities. From the very

day of its introduction, the bill was reported to have received condemnation as it was perceived to be little more than a scheme for detaining dangerous mental patients, who recently included those with a diagnosis of personality disorder. Birmingham further pointed out that the white paper on reforming the Mental Health Act that preceded the draft bill attracted a great deal of attention because of its over-riding emphasis on public safety. The draft bill makes provision for treatment without consent. It is explained that despite such treatment breaching the physical integrity, the view of the British government was that it could be justified under the European Convention on Human Rights Article 8(2) on the basis that the law, is proportionate, and is in the interests of the public safety or to protect health or moral standards.

The emphasis on enforcing psychiatry treatment in the community has not only been a feature of the United Kingdom alone, but has also been observed in Australia, NewZealand, Italy, and the United States of America as Preston (2002) observed.

In the meantime, in most parts of Africa, people's attitudes towards mental illness are still strongly influenced by traditional beliefs (Gureje and Alem, 2000). Some of these beliefs often lead to unhelpful or health -damaging responses to mental illness, stigmatisation and reluctance in seeking appropriate care for this problem. Such beliefs equally affect the provision of health care services as well as the manner in which the mentally ill may be regarded by the police. Gureje and his

colleague (2000) strongly argued that this had led to policy makers having the opinion that mental illness is largely incurable or, at any rate, unresponsive to orthodox medical practices.

Another observation by Gureje and Alem (2000) is that the legal provisions for issues relating to mental illness in African countries are often outdated and needing thorough revision. Former colonisers passed down the majority of such provisions. These former colonial governments have subsequently revised their laws to incorporate modern views on the nature of mental illness. This is factual when we compare the Laws of Zambia pertaining to mental illness and the UK. The Zambian Version of 1957 has never been revised since independence in 1964, while by 1992, people like Turner et al (1992), were criticising section 136 of the Mental Disorders Act (1983) of the UK, stating that, this section needed to be revised in order to take into account the legal provision for treatment of mentally ill persons beyond the hospital grounds.

It therefore goes to show that the police in most African countries are still being driven by the mentality embedded in the inherited laws like the Mental Health Act Cap 539 of the laws of Zambia, which contains a lot of derogatory terminology, by the standards of our era. To this effect Gureje and his colleague (2002) clearly argued that, the outdated legal provisions did not recognise the rights of the mentally ill, nor did they recognise the nature of their illness in regard to culpability for offences which could be committed.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Study Design

This was a case control study. One group with negative attitudes towards mentally ill persons constituted cases, while the other with positive attitudes comprised the controls. Sample units were assigned to their respective groups after indicating their answers on an attitude scale consisting, which comprised positive and negative premises towards mentally ill persons. In order to score, respondents had to select and circle their choice (answer) on a five-point scale, ranging from strongly agree to strongly disagree. A case was anybody who scored below 70% while a control was one who scored 70% and above.

3.2 Sample Size Determination

220 Police Officers were selected to participate in the study ,out of which 110 were cases and 110 were controls. Under the limitation of lack of the prevalence of the exposure variable of interest (P_1,P_2 on the factor of interest between cases and controls) which could not be fully determined before the study, the sample size was determined after a pilot study using 60 respondents, 30 cases and 30 controls. It was envisioned that since double analysis was implied, the final analysis would consider a significance level of 2.5% instead of 5%. Pocock's formula was used to determine the final sample size (Pocock, 1982):

$$n = \frac{(P_1q_1 + P_2q_2)\ f(\alpha,\beta)}{(P_1 - P_2)^2}$$

Where:

n, represents the sample size in each group

P_1, represents the proportion in one arm. E.g. the incidence of personal experience in handling a mentally ill person among cases.

$q_1 = 100 - P_1$

P_2 represents the proportion of same exposure in the second arm. i.e. incidence of personal experience in handling a mentally ill person among controls.

$f(\alpha, \beta)$ represents the function of alpha, beta, which is 7.85 for $\alpha = 5\%$, power = 80%

Nominal lists, indicating names, ranks, and staff number of each Police Officer obtained from their Headquarters were used to construct a sampling frame. A scientific calculator was used to generate random numbers followed by matching the selected numbers with names on the sampling frame. Only at one station did the in-charge refuse to cooperate resulting in two selected Officers being scared of going contrary to their boss and these Officers were not included. In order to fill this gap, two other Officers from another station were selected using the technique mentioned above.

3.3 Ethical clearance

Preliminary preparations involved obtaining an ethical clearance from the ethics committee and another clearance from the Inspector General of Police through the Directorate of Research at Zambia Police Service Headquarters. A message was then circulated to all Police Stations and Posts in Lusaka urban. This made it possible for the research team to find all involved stations expectant and ready to participate. Further consent was obtained from selected sample units who had to remain anonymous. Individual informed consent was obtained before the respondents could be given the self administered questionnaires. Due to the nature of their job, it was very difficult to completely avoid passing through their immediate supervisors. This however could not have adversely affected their individual choices and answers to the questionnaires.

3.4 Data collection

Selected Officers were then followed to their respective stations and questionnaires were distributed through their In-charges. Apart from circling their chosen answers, respondents were also requested to write down what they thought were signs and symptoms of mental illness according to their training, as well as their suggestions towards improvement of their attitudes towards the mentally ill persons. Two concealed Police Officers (in plain clothes, from Service Headquarters) were trained and used as research assistants to administer questionnaires, which had to be filled in and returned on the spot.

3.5 Data Analysis

After the questionnaires were filled in, cleaning was done to check for completeness and correct entries. Written answers were then cleaned, categorised, and post-coded before they were entered into Epi-info6 for analysis. During univariate analysis frequencies were done and to check for missing variables and correct entries. In bivariate analysis a t-test was used to determine the difference in the mean of a continuous variable which was normally distributed between cases and controls. The Kruskal-Wallis test was used to compare the distribution of a continuous variable that was not normally distributed between Police Officers with negative attitude and those with a positive one. The χ^2 was used to determine associations between exposures and the outcome. An Odds Ratio (OR) was calculated in order to ascertain the extent and likelihood of associating one's exposure in form of type of training, experience of handling a mentally ill patient, use of handcuffs on the mentally ill, marrying an ex-mentally ill patient, social cultural beliefs on one hand, and his/her attitude towards the mentally ill on the other hand. Bivariate analysis was followed by multivariate analysis using forward logistic regression in SPSS, in order to determine factors, which were independently associated with the outcome. Because two analyses were done, instead of considering the 5% significant level, 2.5% was considered as a cut off point for statistical significance. Thus, a P-value of 0.025 or less was considered significant at 95% level of confidence Factors considered in the final analysis are presented in table 1.

Table. 1. Factors considered as associated with Police attitudes towards the mentally ill

Age	In years
Sex	Male, Female
Education	09-12, 13-16
Marital status	Married, Single, Widowed
Training	Criteria for identifying signs/symptoms of mental illness, listing of signs and symptoms as per training, how to handle mentally ill suspects (e.g. handcuffing, use of force), where to detain mentally ill persons, approved length of stay in cells
Personal Experience	Ever handled a mentally ill suspect, results of previous experience, how an Officer expected his fellow officers to treat him/her after recovering from mental illness
Socio-cultural	Marrying a person with previous history of mental illness, can mentally ill breast feeding mothers continue to do so? Can people with previous history of mental illness be allowed to become chiefs in some villages?
Improvements	What Police Officers suggested to be done in order to improve their attitudes towards the mentally ill

CHAPTER FOUR

4.0 RESULTS

4.1 Sociodemographic Factors

The sample comprised of 220 respondents, 110 with negative attitudes and 110 with positive attitudes towards mentally ill patients. The median (Q_1, Q3) ages in years for those with negative and those with positive attitude towards mentally ill people were 30 (27,34) and 29 (26,35) respectively (p=0.014). There was a statistically significance difference in the median length of stay at work between the two groups (p=0.144). Those with positive attitudes had significantly (t=2.330;p=0.021) spent more years in school, than those with negative attitudes. The majority (80%) of the respondents were males. Among those with negative attitudes, males comprised 70% of the total (110), while 86% among (110) those with positive attitudes, were males. There was an association between the sex of respondents and attitudes towards mentally ill people (p=0.017). Out of 110 cases 59 (53.6%) were constables by rank compared to controls who had 52 (47.3%) constables. There was no association between rank and attitudes, as these percentages were not statistically different (p=0.085)

The majority 170 of the respondents were married, 45 were single, and 5 were widowed. Among those who were married, 84(76.3%) were in the group with negative attitudes and 86(78.2%) were in the one with positive attitudes towards

the mentally ill. Among the singles, 24 (21.8%) were in the group with negative attitudes, while 21(19.1%) had positive attitudes. 2 of those who were widowed had a negative attitude. A significant difference ($p<0.001$) in the distribution of marital status was noted between males and females, with a higher rate of singleness and widowhood among females. However, there was no association between marital status and attitudes towards mentally ill persons ($p=0.253$).

4.2 Training Factors

Out of 110 cases the majority 93(84.5%) were trained at Lilayi while the rest trained at Kanfinsa, compared to 98(89.1%) among the controls who were trained at Lilayi with rest at Kanfinsa. There was no association between training at a particular Police Training College and attitudes towards mentally ill people ($p=0.319$). There was no association between stating that their training provided them with some criteria of identifying mentally ill people and attitudes of Police Officers towards the mentally ill ($p=0.053$).

Among the 110 cases 66(59.1%) stated that they were trained to handcuff mentally ill people, and out of 110 controls only 48(42.5%) indicated the same. These percentages denoted some association between handcuffing and Police attitudes towards mentally ill people ($p=0.026$). There was no difference of any statistical significance between cases 81(72.0%) and controls 79(71.8%) in claiming that their training equipped them with the knowledge of where to keep suspected mentally ill people ($p=0.048$). However, there was an association

between the conviction that mentally ill persons must be locked up in Chainama Hills College Hospital Board and attitudes towards mentally ill persons (p=0.001).

Out of 110 cases the majority 80(72.7%) stated that mentally ill people should be kept in cells between 12-23 hrs compared to 88(80.0%) controls who stated the same. These percentages were not statistically different (p=0.591).

When writing down the signs and symptoms of mental illness according to their training, a listing of signs and symptoms in category 1 (violent, restless, talkative, nakedness or torn clothes); was significantly (p<0.001) higher among Police Officers with negative attitude towards mentally ill persons, than those with a positive attitude; as in table 2.

Table. 2. Categorised Signs and Symptoms of Mental illness: n=220

Category	Cases	Controls	Chi-square	P Value
1: Violent, Restless, Talkative, Naked or torn clothes, Dirty	107	78	28.57	<0.001
2: Idle, Wondering, Eating rubbish, Isolated, forgetful	03	32		

There was some association (p=0.036) between stating that their training equipped them with knowledge and skills on how to deal with mentally ill persons, and negative attitudes among Police Officers.

4.3 Social Cultural Factors

The majority 79(71.8%) of those with negative attitudes had previous experience of handling a person suffering from mental illness in relation to 87 (79.1%) among controls who had the same experience. No association was observed between previous experience in dealing with mentally ill persons, and negative attitudes (p=0.112). There was some association between the conviction that, if an Officer became mentally ill and recovered, s/he would be laughed at and feel isolated by fellow officers, and negative attitudes towards mentally ill persons (p=0.026).

The majority 94(85.5%) of those with negative attitudes indicated that in their villages and tribes a person with past history of mental illness could not be allowed to become a chief, and 86(78.2%) among those with positive attitudes were of the same opinion. These percentages were not statistically different (p=0.213). About half (54%) of Officers with negative attitudes differed significantly (p=0.025) with those who had positive attitudes (84%) towards mentally ill persons, in relation to the conviction that breast feeding mothers who become mentally ill should be allowed to continue breastfeeding their babies. Those with negative attitudes did not approve of the above statement while Officers who had positive attitudes were of the opinion that mentally ill mothers could continue breastfeeding.

When asked to suggest ways of improving police attitudes towards mentally ill persons, an association (p=0.024) was observed between the desire to be further trained in handling of mentally ill persons and Police attitudes as 74% among those with positive attitudes indicated that they needed special training in handling of mentally ill suspects.

4.4 Multivariate Analysis

After adjusting for confounding variables breastfeeding was the only significant factor associated with the outcome (attitudes towards mentally ill persons). Police Officers who said mentally ill breastfeeding mothers should continue to do so, were 28% (95%CI 0.55,0.94;p=0.015) less likely to have negative attitudes towards mentally ill persons.

CHAPTER FIVE

5.0 DISCUSSION

5.1 Limitations

Limitations to this study may be due to the fact that there were few incidences where some In-charges of police stations were uncooperative, such incidences were less than 1%. It could also have been possible for some officers to share their experiences with those who were yet to answer the questionnaires, due to the fact that all stations had received the information concerning the study on the same day; while the research team took longer to follow up sampled officers in their respective stations.

Another shortcoming could have arisen from the fact that no much choice was left for all those who were sampled as the letter from the Inspector General literary informed them to cooperate. In some instances, Police Officers who were research assistants and operating under-cover, were easily recognised, a situation that could have been possible to put some of the respondents under pressure to cooperate, despite their unwillingness emotionally, hence some might not have been telling the truth in some of their responses. However, we feel that most of these shortcomings could not have significantly biased the results.

It should equally be pointed out that despite several efforts to have current empirical literature with relevant materials, not much have been found. However, several researches on stigma against epilepsy in Africa -Zambia have been called for by Research Foundation of America (RFA). In Zambia, Zambia AIDS Related Therapy (ZAMBART) has also carried out research regarding stigma on AIDS. Efforts to retrieve data from international libraries through the Internet yielded less significant results when searching for empirical literature.

5.2 Stigma Against Mentally Ill - Portrayed through Negative Attitudes

Stigma against mentally ill persons is displayed through negative attitudes that prevail among affected Police Officers. Our conceptual framework assumes that attitudes are learnt and re-enforced through the process of socialization. To this effect, education, training, individual encounters with mentally ill persons, information from families and friends, working environment, and mental health institutions, all take part in influencing the way in which Police officers will behave towards mentally ill persons in our society. For instance, in this study most of the Police Officers with lower education levels fell in the group, which was more likely to have negative attitudes. Training confounds socio-cultural beliefs in shaping Police attitudes towards mentally ill persons. This is propagated through the use of sources of learning materials which contain derogatory terms when describing mentally ill patients, such as: morons, idiots, imbeciles, and insane according to the Mental Disorders Act Cap 539 of the Republic of Zambia.

5.3 Influence Of Training

Training can influence in a negative or positive way in the formation of Police attitudes. Burch (2002) argued that one reason why police find themselves acting apprehensively when confronting the mentally ill is largely due to the form of their training. Their training has been in dealing with criminals who generally respond rationally by dropping the weapon on officer's commands for instance, than a suspect who is supposed to be mentally ill.

However, some studies have shown that if trained in a specific way, the police can change their attitudes for the better towards mentally ill persons. For instance, in Memphis-USA, where re-orientation of police on mental health issues was done, the police were less likely to arrest mental suspects. Instead, they were more prone to refer them for treatment to relevant institutions. Above all the rate of injuries on police officers called to deal with such cases was noted to have declined (Shane, 1980)

The listing down of signs and symptoms of mental illness in category 1(violent, restless, talkative and nakedness) was significantly higher among Officers with negative attitudes, compared to those with positive attitudes who scored higher in category 2(idle, wondering, eating rubbish, isolated and forgetful). Eliasson (1995) argued that sequences of events that culminate in acts of violence usually have fear as a driving force. The persons involved want to prevent something threatening and frightening from becoming a reality. An attempt is made to flee

from being abandoned, losing control of one's emotions, appearing weak, wavering self-esteem, and lack of trust and security increase vulnerability in social relationships. This accords with Gelder *et al* (1996), who viewed aggression as a learned behaviour resulting either from experiences in which aggression was awarded, or from observation and modelling of aggressive behaviour of other people. Gelder and his colleagues (1996) further suggested that violent behaviour could be resulting from visual hallucinations and paranoid delusions suffered by mentally ill persons.

Taylor (1993) had suggested earlier on that violence was associated more often with personality disorder rather than mental illness per-se. The World Federation for Mental Health (2000) document talks of several myths attached to mental illness one of which is myth number 8, which states that mentally ill and mentally restored individuals are dangerous or violent. The document redresses this by pointing out that the vast majority of these individuals are not dangerous or violent. In the same vein a document of the Inns Court School of Law entitled *Criminal Litigation and Sentencing (1998)* stated that, it was very important to realise that there was no necessary connection between mental disorder and dangerousness. It further argues that, violent offenders, terrorists and so fourth, are clearly dangerous, but may well not be mentally disordered at all. In this case, offences committed by the mentally ill, which are mostly property in nature, should not cause them to be regarded as more dangerous than any other offender who commit similar offences. This still accords with Walsh and Fahy (2002)

argument that current evidence contradicts the conviction that the closure of large psychiatric institutions in some developed nations like USA and UK over the past 30 years could have meant that a larger proportion of societal violence can be attributed to people with mental disorder. They stated that the contribution of mental disorder to homicide statistics in the United Kingdom seems to be falling rather than increasing. They further pointed out that in Australia's Victoria County, violent acts committed by mentally ill persons [schizophrenics] had risen since the shift to community care. However, this increase paralled that of the general population. The authors emphasised that even among patients who had already been seriously violent, reconviction rates had fallen over the past 20 years.

In this study, what is interesting is that the conviction that mentally ill persons were violent, was listed first among signs and symptoms in category 1. Unless they are provided with basic criteria of assessing and identifying signs and symptoms of mental illness, the Police are most likely to continue with such assumptions, which could make them act more in form of self defence and fear; as they handle mentally ill persons. This may be one of the underlying reasons giving rise to handcuffing and locking up of mentally ill persons. To this effect Gelder *et al* (1996) suggested that for a person to be aggressive, several factors come into play such as "noise, social pressure, hunger, fatigue, lack of sleep, and presence of mental illness", all which may be found among mentally ill suspects.

Anecdotal evidence has shown that most often than not those mentally ill suspects who are brought to mental institutions in handcuffs from police cells, end up being very cooperative upon arrival. When the Police are told to unhand-cuff these persons, they are almost always reluctant to do so, and show some element of fear. Eliasson (1995) suggested that this happens in any circumstance, which evokes anxiety.

Direct observation in some of the Police Stations, showed that when being detained, mentally ill suspects were locked up with criminal suspects, kept hungry, and delayed in being taken to a mental health institution. In this regard the way in which most of the mentally ill persons were being treated, indicated some infringement on their rights. Haworth (2000) emphasises that any laws relating to the detention of mentally ill persons or any other person in general, should consider the principles agreed to in the United Nations (UN) document of 1991, which safeguards against undue discrimination and infringement of human rights. It is worth noting that in the same vein a WHO (1996) document entitled *guidelines for the promotion of human rights of persons with mental disorders,* outlines fundamental freedoms and basic rights of which two and three are essential to mention in full.

Number two states that all persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person. As previously stated, our Zambian Mental

Disorders Act, which dates as far back as 1957, does not guarantee this. Number three states that all persons with a mental illness, or who are being treated as such persons, have the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment. Unless our police are given the right information and an enabling environment, within which to operate while upholding these basic rights, nothing can change their attitudes in relation to dealing with mentally ill persons.

5.4 Social-cultural Aspects and Individual Experience

No association between previous experience in dealing with mentally ill persons and negative attitudes was observed. In the same vein, Police Officers with negative attitudes towards mentally ill persons were of the conviction that, once they became mentally ill, upon recovery, they would be stigmatised by fellow Officers. This accords with the document of the World Federation of Mental Health (WFMH, 2000), which pointed out that persons with disabilities-especially psychiatric disabilities-face great difficulties in obtaining equal opportunities. They often must overcome environmental, legal, institutional and attitudinal barriers to finding employment.

Akin to this phenomenon, is the fact that in Africa, mentally ill persons are still being stigmatised by their own families and communities, to the point of being neglected or being beaten to death. This is in accordance to a BBC radio discussion of *30th November 2002*, where the plight of mentally ill people was

being discussed. It was revealed that in Ghana, a certain family lost its relative, a single young man who was suffering from mental illness. The sister to the deceased narrated that when he was still alive, her brother was not allowed to eat or stay in their house. As a result, people would throw water and any rubbish on him. He would constantly suffer from beatings, which he sustained from people as he begged for food. Unfortunately, one day these beatings became fatal and he died after being brutalised. She believes that had he not been so much stigmatised and neglected, her brother would not have died at the hands of the merciless community within which he lived. Similar revelations came from Uganda, Tanzania, and Nigeria to mention just a few.

All told, mental illness produces a heavy burden of human suffering, social exclusion, discrimination against the mentally ill and their families and high economic costs. The WFMH (2000) document further reveals that many individuals who have had a mental illness report that coping with the discrimination of mental illness is often worse than dealing with the illness itself. It is therefore very important to note that within the Police ranks there exists an element of fear of getting mentally ill due to the consequences that would follow. One thing that this study did not explore directly was the number of those Officers who had fallen mentally ill but had recovered, and were now back in employment. However, it would be interesting to note that many professional workers who either resign a job or take a medical leave of absence related to a mental illness

episode, experience difficulty maintaining a working, discrimination-free relationship with their employer.

It is plausible to argue that experience among Police Officers in dealing with fellow Officers with previous records of mental illness, shows that those returning to the same work environment upon discharge from mental health institutions, often discover that their performance and behavioural difficulties that initially interrupted work have negatively influenced colleagues' and employer perceptions of their professional responsibilities (WFMH, 2000).

Another observation made by this study is that there was some association between some cultural beliefs and negative attitudes among Police Officers. For instance, Officers who came from a cultural background, which tolerated a person with previous history of mental illness to become chiefs in their villages, were less likely to have negative attitudes. Similarly, Officers who stated that they would not allow any of their close relatives to marry any individual whom they previously handled with history of mental illness were more likely to have negative attitudes. These two factors also confounded the belief related to sudden weaning of all babies whose mothers became mentally ill.

Gureje and Alem (2002) argued that in most parts of Africa, people's attitudes towards mental illness are still strongly influenced by traditional beliefs, some of which often lead to unhelpful or health-damaging responses to mental illness,

stigmatisation and reluctance in seeking appropriate care for this problem. As stated above, this study discovered that a strong belief exists (in the general public) that permeates among Police Officers with negative attitudes, in terms of instant weaning of any child whose mother suffers from mental illness. It is believed that breast milk from mentally ill mothers is contaminated, hence possible to transmit mental illness to the baby. This is further strengthened by other convictions that say that mental illness runs in families, and mentally ill persons do not fully recover.

Problems which equally arise from this belief include, strengthening of enacted and felt stigma against mentally ill people, and the breaking of the formation of social-psychological bonding process between the mentally ill mother and her baby. This may be further linked to the development of emotional instability in the baby as it grows. Depending on several other factors the major one of which is socio-economic status of the family, the baby is highly likely to end up with malnutrition.

It is therefore imperative that our Police Officers be equipped with adequate knowledge that includes a serious consideration of the welfare of both mother and baby as they deal with the aspect of mental illness in the mother. For instance, no permanent separation should be created even if the mother seems violent and is under detention. What ought to be done is to see to it that the baby is constantly brought to its mother at regular intervals for breastfeeding under

very close observation. In this regard, health workers need to work closely with the police as well as the public to ensure that they offer their expert advice.

However, it is rather unfortunate to note that traditional beliefs that give rise to social stigma against mentally ill people, does not only exist among the ranks of Police Officers, but permeates through the medical personnel as well. Anecdotal evidence shows that it is not uncommon for medical staff to isolate a baby from its mother once they suspect her to be mentally ill. In the same vein Sartorius (2002) observed that another form of stigma of mental illness exists, which he calls *iatrogenic stigma*, as it begins with behaviour and attitudes of medical professions. To this effect Sartorius stated that the public and health professionals often have negative attitudes to people with mental illness and will behave accordingly once they are told that a person has an illness about which they have prejudice. He also blamed health services, which did not seem to have mechanisms for appropriate protection of patients once certain diagnoses, which carry stigma, had been made. Sartorius cautioned that being conscious of the power of diagnosis and of the labelling process might contribute to a wiser use of diagnoses, but removing the diagnosis by itself would not eliminate stigma.

Similarly, it is not surprising that Officers in this study could not allow any of their relatives to marry ex-mental patients. They also dreaded the idea of falling mentally ill due to the fact that they would be stigmatised by their colleagues and the public at large. All this emanates from the knowledge base which harbours strong beliefs as stated above, which in turn evoke unpleasant emotions, whose

congruent behaviour displays a tendency to treat mentally ill persons unfavourably; thus, displaying negative attitudes towards them.

The conviction that mentally ill people cannot totally recover is at variance with WHO (2001) press release of *4th October 2001*, entitled *Mental Disorders Affect One in Four People;* which said that despite the chronic and long-term nature of some mental disorders, with proper treatment, people suffering from mental disorders could live productive lives and be a vital part of their communities. It further goes to point out that above 80% of those suffering from schizophrenia can be free of relapses at the end of one year of treatment with relevant medication and family intervention.

One might say that with lack of up to date legislation, mental health policy and political commitment, we are likely to observe treatable cases of mental illness progressing into chronicity and wrongly conclude that, mentally ill people cannot totally recover. WHO (2001) further bemoaned the lack of commitment to action among concerned communities and their governments by emphasising the fact that "responsibility for action lies with governments; as currently, more than 40% of countries have no mental health policy and over 30% of countries allocate less than 1% of their total health budgets to mental health, with another 33% spending just 1% of their budgets on mental health."

Here we are arguing that the process of eliminating stigma needs some concerted efforts. For instance, we cannot entirely put the burden upon the police alone but upon all concerned parties, which includes; policy makers, politicians, religious leaders, medical personnel, communities at large, concerned families, and the patients themselves. If stigma against mentally ill people is to be reduced and eliminated there must be a deliberate effort by the government and politicians, that points towards combating social stigma against mental illness in our society. Unless stigma against mental illness is dealt with actively, it will be very difficult for the mentally ill to be entrusted into the hands of law enforcement officers, especially where community mental health activities are concerned. If we are going to advocate for community participation in the care of the mentally ill persons, we have to ensure that mechanisms are in place to assist concerned relatives in the care of their mentally ill relatives.

Although community care has been advocated for, for sometime now, it is important to note that we cannot entirely close all mental health institutions in the country in favour of community mental health approach. This should be done with caution due to several reasons cited above. The major one being that legislation needs reviewing to empower both medical and law enforcement officers to deal with mentally ill persons effectively, in the community, without any infringements on their individual rights. In a related situation, Preston *et al* (2002), in Australia, an epidemiological study on the assessment of compulsory psychiatric treatment in the community revealed that both subjects and their

matched controls had reduced inpatient admissions and bed days. Subjects had significantly more outpatient contacts. Multivariate analysis indicated that being placed on a community order was associated with increased out patient contacts in subsequent year compared with the control group. The researchers concluded that the introduction of compulsory treatment in the community did not lead to reduced use of health services. The only weakness of their study could have lied in the validity of their measuring instruments. Applied to the Zambian situation, one finds that community mental health services should exist and run parallel to institutional care, strengthened by new legislation that will spell out the new roles of the police and psychiatric personnel. Above all if all that has been said is to be meaningful, stigma against mentally ill persons must be tackled vigorously.

5.5 Conclusions and Recommendation

We conclude that there was an association between social-cultural belief (e.g. breast feeding, marrying an ex-mental patient) related to mental illness stigma, and Police attitudes towards mentally ill persons. Education; training, and individual experiences were not significantly associated with attitudes towards mentally ill people among the Police in Lusaka urban. This study recommends that:

- Health education and orientation to mental health issues should start early and run throughout the training of Police Officers, in order to counteract the soci-cultural beliefs related to mental illness stigma that these Officers enter their training with.

- Materials and methods that are used to train Police Officers in handling people with mental illness, help to enforce negative attitudes, by containing derogatory terminology, and emphasising on handcuffing and detaining mental suspects in cells with criminal suspects. The knowledge and skills given to Police Officers strengthen the pre-existing cultural beliefs concerning mental illness hence influence the way an Officer is likely to handle a mentally ill person once confronted with one. Breastfeeding mothers who become mentally ill and fall under police custody, should be encouraged to continue breastfeeding under close supervision at regular intervals. Sudden weaning must be discouraged at all costs.
- The study does agree with Haworth (2002, unpublished) in recommending that the Police should have a training module/component in their syllabus, which uses humane approaches in dealing with the mentally ill, and upholds their individual rights to community treatment. This should be based on the current draft of the proposed Mental Health Policy (2002).
- A brochure with standard basic criteria for identifying mental illness among suspects should be developed alongside medical and legal lines and be availed to the Police.
- The training of Police Officers should include practical-educational visits to Chainama Hills College Hospital and other institutions dealing with mental health issues.
- An ongoing mental health education campaign should be introduced and strengthened among the Police through the Victim Support Unit. This should

be in conjunction with other stakeholders like, Chianama College of Health Sciences, Mental Health Association of Zambia and all relevant stake holders.

- Breastfeeding mothers who become mentally ill and fall under police custody, should be encouraged to continue breastfeeding under close supervision at regular intervals. Sudden weaning must be discouraged at all costs.

REFERENCES:

Amnesty International Rights for All: *Race, Rights, and Police Brutality.* NARPA USA. 1999:4

Birmingham L. (ed) Detaining Dangerous People with Mental Disorders. *British Medical Journal* 2002; **325**:2-3

Boker W, and Hafner H. Crimes of Violence by Mentally Disordered Offenders in Germany. *Psychological Medicine.* 1977; **7**:733-6

Bunch K. *Living better Content Emotionally*: WebMD Medical News Article-2001; 1674.51398

CBoH *Situation Analysis of Mental Health Services in Zambia:* Directorate of Public Health and Research. 2002

Chainama Hills College Hospital Board *Report on Clinical Services.* 2003

Eliasson E. P. *Men, Women and Violence: Understanding and Changing Violent Behaviour.* Stockholm: Bokforlag 1995:24

Fishbein M. (ed.) *Readings in Attitude Theory and Measurement.* New York: John Wiley,. 1967:257

Gelder M, Dennis G, Mayou R, and Cowen P. (ed.) *Oxford Textbook of Psychiatry.* Oxford: Oxford University Press. 1996:761

Goffman E. *Stigma; Notes on the Management of Spoilt Identity.* 1963:3

Gureje O, and Alem A. Mental Health Policy Development in Africa. *Bulletin of the World Health Organisation.* Geneva: 2000 **79** (4): 475

Haworth A. A Study on Street Kids in Lusaka Zambia. Unpublished

Haworth A. The Impact of Human Rights upon Mental Health Care. *Health in the Commonwealth-Sharing Solutions.* Commonwealth Secretariat: Kensington Publications Ltd. UK. 2000:83-86

Inns of Court School of Law, *Criminal Litigation and Sentencing.* London: Blackstone Press Ltd. 1997/98:326

Jewkes R. (ed) Preventing Domestic Violence Most Women Welcome Inquiries, but Doctors and Nurses Rarely Talk about it. *British Medical Journal.* 2002; **324**:253

Khan. (1963) *Role of the Police in the community* In: Wilson, Q.J. *Varieties of Police Behaviour.* Oxford: Oxford University Press, 1969:44

Lindqvist P, and Allebeck, P. Schizophrenia and Crime. *British Medical Journal* 1990; **157**:345-50

Lundman J.R. (ed) *Police Behaviour: A Sociological Perspective.* Oxford: Oxford University Press, 1980:168

Mbewe E. Knowledge Attitude and Beliefs of Police Officers Towards Mentally ill People in Lusaka. Unpublished

Mental Health Act, Cap 539 of the Laws of Zambia

Mental Health Issues Outpatient Civil Commitment: A Brief History. USA. 2002

Pocock S.J. Statistical Aspects of Clinical Trial Design. *The Statistician* 1982; 31:1

Preston J.N, Kinsley S, and Xiao J. Assessing the Outcome of Compulsory Psychiatric Treatment in the Community: epidemiological Study in Western Australia. *British Medical Journal.* 2002; **324**:1244-6

Rainbow P. (ed.) *The Foucault Reader: an Introduction to Foucault's Thought.* Middlesex. England. 1991:124-41

Shakespeare. *King Lear Act 3, Scene 4.* Oxford: Oxford University Press

Shane G.P. *Police and People: A Comparison of Five Countries.* Toronto: The C.V. Mosby Co.. 1980:43

Shorter E. *A History of Psychiatry From the Era of Asylum to the Age of Prozac.* New York : John Wiley & Sons Inc. 1997:33

Shaw M.E, and Wright J.M. *Scales for the Measurement of Attitudes.* New York: McGraw-Hill Book Co. 1967:479

Taylor P.J. *Violence in Society.* Royal College of Physicians. London. 1993

Witting F.A, and Williams, U.G. *Psychology: An Introduction.* New York: McGrow-Hill Book CO. New York. 1984:567

WHO World Health Report: *Mental Health New Hope.* 2001

WHO Mental *Health Global Action Programme* (mhGAP). 2002

WHO *World Report on Violence and Health.* 2002

WHO *Guidelines for the Promotion of Human Rights of Persons with Mental Disorders.* Division of Mental Health and Prevention of Substance Abuse. WHO: Geneva 1996

Sartorius N. (ed) Iatrogenic Stigma of Mental Illness Begins with Behaviour and Attitudes of medical Professionals, Especially Psychiatrists. *British Medical Journal* 2002; **324**:1470-71

The World Federation for Mental Health. Alexandria V.A. USA. 2001

Walsh E. and Fahy T. (eds) Violence in Society Contribution of Mental illness is Low. *British Medical Journal.* 2002; **325**:507-8

APPENDIX 1

Questionnaire

QUESTIONNAIRE

ID

□

SECTION A:

DEMOGRAPHIC DATA

1. Age at last birth day:_____
2. Date of birth: ____/___/_____

3. Sex: Male

   Female

4. Rank:_____

5. Number of years in service:_____
6. Marital Status: 1. Married
   2. Single
   3. Divorced
   4. Cohabiting
   5. Separated
   6. Widowed
7. Number of years spent in school_____

8. Highest level reached in education:
   1. Junior Secondary
   2. Senior Secondary
   3. College
   4. University
9. Where did you receive your police training?:_____

SECTION B

INSTRUCTION:
Circle your answers

10. Everybody is potentially mentally ill
    i. Strongly agree ii. Agree iii. Don't know iv. Disagree v. Strongly disagree

11. The most suitable place for all mentally ill people is Chainama Hills Hospital
    i. Strongly agree ii. Agree iii. Don't know iv. Disagree v. Strongly disagree

12. It is true that all mental illnesses run in families
    1. Strongly agree ii. Agree iii. Don't know iv. Disagree v. Strongly disagree

13. Mentally ill people are very dangerous
    i. Strongly agree ii. Agree iii. Don't know iv. Disagree v. Strongly disagree

14. You could equally suffer from mental illness at any time just like you do with malaria
    i. Strongly agree ii. Agree iii. Don't know iv. Disagree v. Strongly disagree

15. Mentally ill patients deserve to be locked up due to their dangerous behaviour
    i. Strongly agree ii. Agree iii. Don't know iv. Disagree v. Strongly disagree

16. It is very risky to think that mentally ill people totally recover from their madness
    i. Strongly agree ii. Agree iii. Don't know iv. Disagree v. Strongly disagree

17. The best way to deal with all mentally ill patients is to handcuff them and take them to Chainama.
    i. Strongly agree ii. Agree iii. Don't know iv. Disagree v. Strongly disagree

18. Mentally ill patients can possibly recover
    i. Strongly agree ii. Agree iii. Don't know iv. Disagree v. Strongly disagree

19. Mentally ill patients deserve a better treatment just like any body else
    i. Strongly agree ii. Agree iii. Don't know iv. Disagree v. Strongly disagree

SECTION C

20. Does your training provide you with some basic criteria of identifying mental illness in people?
    (1) yes
    (2) no (go to question 22)

21. Write down four main signs of mental illness according to your training

    (1)_____

    (2)_____

    (3)_____

    (4)_____

22. Are you trained to handcuff a person you suspect to have mental illness?
    (1) Yes
    (2) no
    (3) no idea

23. Does your training equip you with the knowledge of where to keep suspected mentally ill persons?
    (1) yes
    (2) no
    (3) no idea

24. Where should a mentally ill suspect be detained?
    (1) Police cells
    (2) Church
    (3) Chainama Hills Hospital Board
    (4) Any where

25. How long should a person suspected to be mentally ill be kept at any police station?
    (1) 12 hours
    (2) 24 hours
    (3) 48 hours
    (4) 72 hours
    (5) Over 72 hours

26. Have you handled a person suffering from mental illness before?
    (1) yes
    (2) no

27. From your personal experience would you say:
    (1) you are now more scared of the mentally ill people
    (2) you are more understanding and willing to assist all people with mental illness
    (3) you are unsure of how to handle any person suspected to have mental illness

28. In your village can people with history of mental illness be allowed to become chiefs?
    (1) yes
    (2) no
    (3) no idea

29. What would your employers and work-mates say if you became mentally ill but recovered?
    (1) Welcome you
    (2) Isolate and laugh at you
    (3) retired you on medical ground
    (4) no idea

30. If you're close female relative wants to marry a man whom you once detained with history of mental illness what would you do?
    (1) advise her against it
    (2) let her go ahead and marry
    (3) no idea

31. Should mentally ill mothers who are breast-feeding be allowed to continue breast feeding their babies?
    (1) yes
    (2) no
    (3) no idea

32. Any further suggestions on how Police Officers can improve their attitudes towards mentally ill persons?:.....

APPENDIX 2

Consent Form

CONSENT FORM

Dear respondent,

You are one of the officers selected to participate in a study on Factors Associated with Police Attitudes towards mental illness. You are kindly requested to answer all questions as sincerely as you can. Do not write your identity number or name. Be assured that all information that you are going to give will be treated with strict confidence.

Kindly indicate by signing at the end of this information your willingness to participate, thank you.

I am willing to participate:.....

APPENDIX 3

Permission From The Office of The Inspector General

Telephone 252872

Telegrams: INSOFPOL, RIDGEWAY

In reply please quote

No

REPUBLIC OF ZAMBIA

OFFICE OF THE INSPECTOR-GENERAL

ZAMBIA POLICE HEADQUARTERS
P.O. BOX 50103
RIDGEWAY
LUSAKA

All Officers in Charge,
Police Stations,
Lusaka Division.

1st March 2002

RE: INTRODUCTION LETTER ON RESEACH BEING CONDUCTED.

I wish to introduce Mr. Mbewe, a student pursuing a Masters Degree in Public Health at the School of Medicine, Ridgeway Campus, Lusaka. His research is on factors associated with police attitudes towards mentally ill people in Lusaka Urban.

This research is in partnership with the Research and Planning Unit at Service Headquarters.

Please give him the necessary cooperation he needs because command has already been granted him permission.

Thank you,

S.N. ULAYA BA ED (UNZA).
for/DIRECTOR OF RESEARCH

ZAMBIA POLICE
EMMASDALE
POLICE STATION
14.03.02
OFFICER IN-CHARGE
BOX 31549, LUSAKA

07/1C

APPENDIX 4

Ethical Clearance

THE UNIVERSITY OF ZAMBIA
Research Ethics Committee

Telephone: 252641
211440 (UTH) 254824 (Pre-Clinical) Ridgeway Campus
Telegrams: UNZA. LUSAKA.
Telex: UNZALU ZA 44370

Fax: + 260-1-250753

DEAN'S OFFICE
P.O. box 50110
Lusaka. Zambia.

Your Ref.:
Our Ref.:

1st October 2001

Mr Edward Mbewe .
Department of Communiity Medicine
UTH LUSAKA

Dear Mr Mbewe

The Research Ethics Committee reviewed your proposal on 12th of September 2001 and was approved. Congratulations!

Title of research proposal: **"Factors associated with police attitudes in dealing with mentally ill suspects in the streets and cells of Lusaka Urban".**

Please keep the committee informed on the progress of your research project.

Yours faithfully

Signed:.....
E NKANDU(MRS)
SECRETARY, RESEARCH ETHICS COMMITTEE

APPENDIX 5

Departmental Recommendation Letter

THE UNIVERSITY OF ZAMBIA
School of Medicine

Telephone: 252641
Telegram: UNZA, Lusaka
Telex: UNZALU ZA 44370

Fax: + 260-1-250753

Dean's Office
P.O. Box 50110
Lusaka, Zambia

Your Ref:

Our Ref:

18th April 2001

TO WHOM IT MAY CONCERN

Re: **EDWARD MBEWE**

The above mentioned is a Masters of Public Health (MPH) student with the University of Zambia, School of Medicine. Kindly assist him with the information he may need from your organisation even as he conducts research.

Yours sincerely

Dr C Chiwele
HEAD, DEPARTMENT OF COMMUNITY MEDICINE