

The Princess Alexandra Hospital **Police Beat**

An evaluation by the Crime and Misconduct Commission



February 2007

CRIME AND
MISCONDUCT
COMMISSION



QUEENSLAND

CMC vision: To be a powerful agent for protecting Queenslanders from major crime and promoting a trustworthy public sector.

CMC mission: To combat crime and improve public sector integrity.

© Crime and Misconduct Commission 2007

ISBN: 1 876986 45 X

Apart from any fair dealing for the purpose of private study, research, criticism or review, as permitted under the *Copyright Act 1969*, no part may be reproduced by any process without permission. Inquiries should be made to the publisher, the Crime and Misconduct Commission.

Crime and Misconduct Commission
140 Creek Street, Brisbane, Queensland, Australia 4000

GPO Box 3123
Brisbane Qld 4001

Tel: (07) 3360 6060

Fax: (07) 3360 6333

Email: mailbox@cmc.qld.gov.au

Contents



Preface	vii
Acknowledgments	vii
Abbreviations	viii
Summary	ix
Chapter 1: Introduction	1
What is beat policing?	1
Beat policing in Queensland	1
Background to the PAHPB	3
The proposal	3
Criteria for selection of beat site and model	3
QPS environmental scan	4
The launch of the PAHPB	5
The role of the CMC in the evaluation	6
Structure of the report	7
Chapter 2: Evaluation methodology	8
Impact evaluation	8
Data sources	9
QPS calls for service	9
QPS CRISP	9
Patrol logs	10
PAHPB daily logs	10
PAH focus groups	11
Key stakeholder interviews	11
QPS and PAH operational and procedural documentation	12
Surveys	12
Data analysis	14
Limitations of the data	15
Considerations and challenges in the evaluation	16
Summary of Chapter 2	17

Chapter 3: Service provision	18
Responding to calls for service and incidents of crime	18
Frequency of calls for service and offending	18
Roster analysis	19
Job types	21
Beat officers' daily activities	22
Beat officers' daily logs	22
Problem-solving	24
Responding to hospital inquiries	27
Metropolitan South Region patrol logs	27
South Brisbane District Inquiry Office patrol logs	27
Working with other security providers	29
Hospital security	29
Retailer security	32
Summary of Chapter 3	33
Chapter 4: Perceptions of safety	34
Level of awareness of the PAHPB	34
Visibility	37
Police visibility	37
Security visibility	38
Perceptions of safety before and after the PAHPB	38
General safety	38
Factors associated with perceptions of safety	39
Perceptions of the roles of PAHPB officers and of hospital security	41
Identifying the most suitable service provider	41
Protective Behaviours program	43
Summary of Chapter 4	46
Chapter 5: Stakeholder satisfaction	48
Measures of satisfaction	48
Quality of service provided and professional conduct of the PAHPB officers	49
Courteousness, amount of information and timeliness of response	50
Quality of information provided	51
Accessibility	52
Ideal service	55
Barrier to an ideal service: conflicting roles	56
Job satisfaction among beat officers	57
Summary of Chapter 5	60

Chapter 6: Conclusions	61
Key evaluation questions	61
Service provision	61
Findings	61
Suggestions for future improvements	62
Perceptions of safety	63
Findings	63
Suggestions for future improvements	64
Stakeholder satisfaction	64
Findings	64
Suggestions for future improvements	65
Final comments	65
Appendix: Breakdown of data from beat officers’ daily logs during trial period	67
References	71

Preface

The CMC has been at the forefront of advocating beat policing in Queensland for well over a decade. From modest beginnings with just two beat sites, to 100 beats currently operating across the state, the Queensland Police Service (QPS) has managed a remarkable transformation towards the adoption of this highly successful model of policing.

The Princess Alexandra Hospital Police Beat (PAHPB) is another chapter in the QPS's commitment to beat policing. The establishment of a beat in a hospital is a first for Queensland and is unprecedented in other Australian policing jurisdictions. This model presented some unique challenges for the service, particularly in relation to the size of the hospital and surrounds, the high traffic flow, and the divergent needs of the hospital and the retail precinct. Despite these obstacles, we believe the PAHPB provides a positive example of what can be achieved, even within a complex environment such as a hospital.

Acknowledgments

This report is the product of a comprehensive evaluation undertaken by a small team of researchers from the CMC's Research and Prevention Unit. Research officer Jennifer Epps was responsible for managing the project and writing the report. Special thanks go to Dennis Budz, Kim Adams, Anna Sheehan and Alexa Van Straaten for their important contributions. The report was prepared for publication by the CMC Communications Unit.

During the evaluation of the PAHPB trial the CMC benefited greatly from the participation of a number of police officers, whose contribution was essential to the completion of this report. We would especially like to acknowledge the contribution of Katherine Goodwin, who was responsible for collating the QPS administrative data for the report. We also formally thank senior officials from the QPS including Assistant Commissioner Kathy Rynders, Detective Superintendent Gayle Hogan and Inspector Les Hopkins, who provided support for the project. Additionally, special thanks go to the officer in charge of the PAHPB, Senior Sergeant Phil Edwards, and his beat officers whose willingness to share their insights and experiences of beat policing made this evaluation possible.

We thank the staff at the Princess Alexandra Hospital (PAH), in particular Kay Toshash and Rita Forni, for their contribution to the distribution of the hospital surveys; and we thank Peter Frew, Charlie Grugan and Toni Connolly for their assistance.

We also thank the staff of the PAH and Buranda retail district who provided valuable input and contributed to our understanding of the needs of the PAHPB community.

Abbreviations

ANOVA	analysis of variance
CFS	calls for service
CJC	Criminal Justice Commission
CMC	Crime and Misconduct Commission
CRISP	Crime Reporting Information System for Police
ED	Accident and Emergency Department
ICU	Intensive Care Unit
LAC	Local Area Command
MHU	Mental Health Unit
MSR	Metropolitan South Region
PAH	Princess Alexandra Hospital
PAHPB	Princess Alexandra Hospital Police Beat
QPS	Queensland Police Service
SBD	South Brisbane District
SIU	Spinal Injuries Unit

Summary



In October 2005 the Queensland Police Service (QPS) established a police beat on the Princess Alexandra Hospital (PAH) campus. The beat footprint was extended beyond the hospital grounds to include the immediate surrounds — a predominantly retail precinct. This is believed to be the first model of a police beat operating in a hospital environment in Australia. The Crime and Misconduct Commission (CMC) has extensive expertise in evaluating police beats in Queensland; the QPS therefore approached us to conduct an evaluation of the Princess Alexandra Hospital Police Beat (PAHPB) over a six-month trial period. A joint evaluation framework was established, with the CMC taking primary responsibility for the evaluation. This report documents our key findings.

Chapter 1: Introduction

The first chapter of this report looks at beat policing in general, as well as specifically in Queensland. It provides some background to the PAHPB, and describes the role played by the CMC in the evaluation of its effectiveness.

Chapter 2: Evaluation methodology

A wide range of sources were used to examine the implementation of the PAHPB and to assess its success in achieving its objectives. An impact evaluation was conducted to answer three primary questions:

- 1 Has the PAHPB improved the management of calls for service to the PAH (and become the primary provider of police services to the beat community)?¹
- 2 Has the PAHPB improved perceptions of safety for hospital staff and Buranda retailers?
- 3 Are stakeholders satisfied with the PAHPB?

Data sources used in the evaluation include:

- » QPS Calls for Service (CFS)
- » QPS Crime Reporting Information System for Police (CRISP)
- » Metropolitan South Region (MSR) patrol logs
- » South Brisbane District (SBD) Inquiry Office patrol logs
- » PAHPB daily logs
- » PAH focus groups (key hospital staff groups)
- » Key stakeholder interviews (police, hospital staff, retailers)
- » QPS and PAH operational and procedural documentation (e.g. rosters)
- » PAHPB hospital and retailer surveys (before and after the trial).

¹ This key evaluation question was later broadened to incorporate a wider range of duties undertaken by beat officers during the trial within the entire beat area.

In framing the evaluation, researchers have taken into consideration a number of factors that could influence the effectiveness of the trial, including:

- » the length of the trial
- » the beat environment
- » the size of the hospital campus
- » the capacity of the beat
- » staff turnover.

Chapter 3: Service provision

This chapter assesses the extent to which the PAHPB achieved its goal to improve the management of calls for service originating from the designated beat area, and in addition to become the primary provider of policing services to the beat community. The key conclusions are that:

- » consistent with QPS South Brisbane District data, there has been no significant change in the number and types of calls for service and reported crime during the trial
- » the level of staffing and normal operating hours of the beat were appropriate to meet the calls for service and crime reporting demand
- » operating hours and rostering were strongly supported by hospital stakeholders
- » the activities undertaken by the PAHPB have included a high proportion of inquiry work, administrative tasks and proactive patrolling; of possible concern is the low proportion of officers' time attributed to community policing activities — specifically, a lack of identifiable problem-solving strategies employed by PAHPB officers in the retail community
- » during the trial there was a downward trend in the time spent at the hospital, and in time spent travelling to and from the hospital, for Metropolitan South Region general duties officers and officers working in the South Brisbane District Inquiry Office; beat officers took up the primary hospital inquiry role for the police service within the PAH
- » a good relationship has been established between hospital security and the PAHPB.

Chapter 4: Perceptions of safety

The second objective of the PAHPB evaluation was to assess the extent to which the beat improved the perceptions of personal safety and security among hospital staff and retailers within the beat area. Surveys were carried out with these groups before and after the trial, and a series of interviews and focus groups were conducted throughout the trial.

The results indicate that, in general, the PAHPB has made hospital staff and retailers feel more safe during the six-month trial. In particular, there were substantial increases in police visibility at the PAH, and increases in hospital staff's awareness of the beat. This was largely due to the beat officers' patrolling, inquiries work, and involvement in new staff inductions and presentations to the hospital. Slight increases in police visibility were also perceived by the retail community, but not to the same extent as by the hospital staff. Low awareness among retailers may be explained by confounding factors including the temporary closure of a number of retail establishments for refurbishment during the trial, the location of the beat office within the PAH, and the very limited amounts of time the PAHPB officers spent outside the hospital environment.

By and large, perceptions of safety among hospital staff have improved substantially since the introduction of the PAHPB, among both those working during the day and those working after dark. There were gender differences, with male staff feeling safer than their female counterparts overall; this is consistent with fear-of-crime literature. Interestingly, however, female hospital staff in the sample, while feeling more fearful of victimisation than males generally, also showed statistically significant improvements in perceptions of safety since the introduction of the PAHPB.

Retailers also perceived themselves to be safer generally since the introduction of the PAHPB. Unfortunately, limited sample sizes precluded further meaningful analysis.

Chapter 5: Stakeholder satisfaction

This chapter explored the level of stakeholder satisfaction with the delivery of policing services over the course of the PAHPB trial, using a range of data including pre- and post-trial surveys, interviews and focus groups.

Overall, hospital staff (including senior management) and retailers reported high satisfaction with PAHPB service delivery. Survey findings indicated that:

- » the majority of hospital staff and over half of all retailers considered the quality of service provided by beat officers to be above average
- » all groups considered the professional conduct of officers to be mostly above average
- » the majority of hospital staff and retailers were satisfied with the level of courteousness of the beat officers
- » most were satisfied with the amount of information provided to them by the beat officers
- » many rated the quality of information provided by the beat staff as highly satisfactory
- » response times were considered good, with a high percentage of stakeholders satisfied with the time it took for PAHPB officers to respond
- » most felt that PAHPB officers were often or always accessible/available.

Two main sources of dissatisfaction with the PAHPB service emerged. The first related to the difficulties some stakeholders experienced in accessing the beat office during the trial period. It is important that the beat officers engage with the beat community in order to ensure visibility, awareness and access to the services they provide.

The second problem related to the sharing of confidential patient information, and the conflicting roles and competing interests of the police and hospital in this. In the interest of establishing and maintaining a good working relationship, it is essential that specific procedures and guidelines are developed and formalised, and these provisions communicated to the relevant stakeholders.

The PAHPB officers themselves were also considered stakeholders in the trial, and in-depth interviews took place in which they were questioned about their satisfaction with their work. Officers demonstrated enthusiasm throughout the trial, and their morale was consistently high. They expressed high levels of job satisfaction and all felt they were strongly supported by management. The beat officers were advocates of training for future beat staff, and of consistency in staffing.

Chapter 6: Conclusions

The sixth and final chapter summarises the main findings of the evaluation and concludes that the project has achieved a great deal in a very short period. However, there are a number of changes that could be made to maximise the impact of the PAHPB over time. Suggestions are made below under the three main primary evaluation areas.

The PAHPB could improve the management of calls for service, and become the primary provider of policing services to the beat community, by:

- » ensuring that PAHPB officers are encouraged to increase their engagement with the beat community, including the retailers, and have the time to do so; establishing a rapport with individuals working in the beat will be crucial to any effort made by beat officers to develop and implement problem-solving strategies
- » minimising the time officers expend on routine inquiry tasks; one possible solution might be to provide beat officers with the services of an administrative officer, even if it was only on a part-time basis
- » providing beat officers with the appropriate beat officer training (discussed further below).

To have a greater positive impact on the PAHPB community's perceptions of safety, the PAHPB should consider:

- » conducting proactive patrols of the entire beat area regularly and frequently, to improve visible presence and awareness of the services they provide
- » expanding the number and frequency of the protective behaviour programs they facilitate; continuing to incorporate presentations about the purpose of the beat at inductions for new hospital staff; and opening up protective behaviour programs to the broader PAHPB community outside the hospital campus (e.g. retailers)
- » carrying out patrols at times when, and in places where, members of the PAHPB community have reported feeling less safe (e.g. when working alone, or walking to public transport after dark)
- » devising strategies to help groups who have reported lower levels of perceived safety (e.g. female hospital staff, emergency department staff) feel safer.

To enhance stakeholders' satisfaction with PAHPB services the PAHPB could:

- » provide clear and detailed information to stakeholders (i.e. hospital staff, retailers), explaining the roles and functions of the PAHPB and the protocols surrounding contact with PAHPB officers
- » develop protocols for sharing patient information between hospital staff and PAHPB officers.

Should the QPS decide to continue the PAHPB on the basis of this evaluation, the challenge will be to build on the strengths of the current approach, while at the same time allowing the beat to incorporate more of the characteristics normally associated with beat policing. These features include providing public access to the beat office, offering a wider range of policing services to beat area clients, and encouraging beat officers to engage in problem-solving.

Chapter 1: Introduction



This report presents the key findings of an evaluation conducted by the Crime and Misconduct Commission (CMC) in partnership/collaboration with the Queensland Police Service (QPS). The evaluation covers the trial of the Princess Alexandra Hospital Police Beat (PAHPB), conducted between 29 October 2005 and 30 April 2006.

What is beat policing?

The CMC has previously defined beat policing as ‘... an operational strategy designed to make individual police officers responsible for the community’s policing needs in a defined geographical area called ‘the beat’ (CMC 2003, p. 1).

In addition to the importance placed on beat officers taking ‘ownership’ of a particular area, beat policing also incorporates four key elements of community policing (Edwards 2005; Segrave & Ratcliffe 2004):

- » an emphasis on community-based crime prevention
- » expansion of the role and duties of the police officers into non-emergency interactions with the public
- » calls for service that do not necessarily involve criminal matters
- » establishment of community partnerships and mechanisms for community feedback.

A much broader range of policing functions is expected of beat officers than of general duties officers (Bond & Gow 1997; CMC 2003). General duties officers are expected to patrol within a division and to respond to calls for service as directed by police communications, whereas beat officers are expected to *regularly patrol and engage with the community within a defined area* to acquire local knowledge and build relationships.

They are expected to use the local knowledge they acquire to help the community identify problems, and then formulate and implement problem-solving strategies to deal with them.

Beat policing in Queensland

Beat policing became well established in Queensland in the 1990s after successful trials of police beats in Toowoomba and West End. Two common models of beat policing



Beat officers regularly patrol and engage with the community within a defined area.

can be found operating in Queensland — neighbourhood police beats and police beat shopfronts (CMC 2003). Currently, there are 50 neighbourhood and 49 shopfront beats operating in locations across the state. There are distinct differences between these two models, and variation within them.² However, a common feature is an emphasis on officers maintaining responsibility for a defined beat area, and long-term ownership of it, as well as taking a problem-solving approach combined with relentless follow-up of repeat calls for service.³ Table 1.1 describes the main aims of the neighbourhood and shopfront models.

Table 1.1: Comparison of the aims of neighbourhood and shopfront police beats

Aims	Neighbourhood model	Shopfront model
Reduce calls for service	✓	
Encourage problem-solving	✓	
Develop Problem Oriented and Partnership Policing (POPP) strategies	✓	
Increase police–community interaction and information flow	✓	✓
Reduce the incidence of specific types of crime and undesirable behaviour	✓	
Increase community satisfaction with police	✓	
Increase job satisfaction for beat officers	✓	
Increase public’s sense of safety	✓	✓
Win acceptance of beat policing from other police	✓	
Contribute to the QPS Strategic Plan	✓	✓
Reduce the community’s fear of crime	✓	✓
Raise the perception that offences will be detected		✓

Ideally, both the community and the police will benefit if these aims are achieved. Benefits should include:

- » a reduction in calls for service and crime rates
- » a decrease in the potential for conflict between police and the public
- » a reduction in fear of crime
- » better information flow, as a result of improved interactions between police and the public
- » an increased capacity to solve problems collaboratively (Segrave & Ratcliffe 2004).

² For example, the West End Neighbourhood Police Beat is a split-force model (CJC 1996).

³ Details are available from the QPS: <http://www.police.qld.gov.au/programs/crimePrevention/p_beat/> (viewed 22 May 2006).

Background to the PAHPB

The proposal

The initiative for a police beat in the Dutton Park Division arose from analysis conducted by the QPS South Brisbane District for the 2003 Metropolitan South Region Operational Performance Review. District calls-for-service data consistently indicated that the PAH campus, the Centro Buranda shopping centre and surrounding street addresses had the highest number of calls for service (Interview, QPS senior management, no. 1). The Dutton Park Division was also continually among the top four divisions for the highest number of recorded offences (QPS 2004a).

The inspector in charge of the Dutton Park Local Area Command decided that a proactive, collaborative partnership approach between the QPS and the PAH was required to lower the calls for police attendance and handle the offending behaviour and safety concerns in the area.⁴ In informal discussions with hospital staff, including the hospital Security Manager, the viability of providing a permanent police presence within the hospital grounds was discussed. The view that was consistently expressed was that police should be based at the hospital.

The inspector then in charge of Dutton Park had previous involvement on the working committee of the Toowoomba beat trial and had experience overseeing the West End Beat. The inspector proposed that beat policing be considered as an option for achieving effective liaison between police, hospital staff and local retailers, as well as reducing the time general duties officers spent conducting inquiries and responding to calls for service at the hospital. In November 2003 the inspector presented the District Manager at the PAH with a proposal to examine the feasibility of establishing a police beat within the hospital grounds (Interview, QPS senior management, no. 2).

Negotiations and preparations for a police beat trial followed. The CMC, because of its extensive experience and expertise in establishing and evaluating beat policing schemes in Queensland, was invited by the QPS to participate in the PAHPB steering committee for the project. Subsequently, a CMC representative attended a few meetings in an advisory capacity with other key QPS and PAH management staff.

Criteria for selection of beat site and model

It is important to select a site for a police beat that will maximise the opportunity for local ownership of the beat. According to criteria adopted by the QPS, a neighbourhood police beat should be positioned in a primarily residential area that is small enough for adequate patrol by foot. The site should place a sufficient demand on police services and be within defined statistical and local area collection boundaries. Like neighbourhood beats, beat shopfront sites also require evidence of sufficient demand on police services. Other key criteria include public prominence, accessibility and affordable lease arrangements.

⁴ Communications with Metropolitan South Region staff confirmed that the term ‘Local Area Command’ and title ‘Local Area Commander’, although not commonly used within the QPS, are accepted convention within that region.

A feasibility study was conducted by the Dutton Park project team to decide the best model and site for the proposed beat. Four options were initially considered:

- » a beat office within the PAH campus
- » a shopfront within the Centro Buranda shopping centre
- » a shopfront within the strip retail area adjacent to the PAH campus and Centro Buranda
- » mobile patrols in a defined area operating from the Dutton Park Division.

These options were extensively reviewed in the QPS environmental scan released in December 2004 (QPS 2004b).⁵

QPS environmental scan

The environmental scan demonstrated that calls for service at the proposed site had increased significantly between 2002 (802 calls) and 2004 (1033 calls). An increase in the need for police services was seen across most call offence categories, with the greatest increases for absconders, disturbances and community assistance (QPS 2004b). Due to the predominance of non-residential property and the resultant transitory population within the PAHPB boundaries, a neighbourhood police beat strategy was considered inappropriate. The large number of police inquiries from the hospital (e.g. summons; coronial matters) also ruled out a shopfront police beat. The following statement from the Metropolitan South Region environmental scan illustrates some of the thinking about the establishment of the beat:

The proposed beat area presents unique policing challenges that have little in common with the standard retail or neighbourhood beats currently in operation throughout the State. There is little commonality between Calls for Service in the proposed beat area and those of other established neighbourhood and retail based beats and the established nexus between the PAH and policing operations presents a situation where value adding in police resource allocation is possible in addition to the conventional aims of crime reduction and prevention. (p. 4)

The environmental scan documented the range of criteria used to decide the most appropriate model and site for the proposed beat. These criteria included demographics of the area, crime and calls for service statistics, operational objectives, and costs to the QPS and Queensland Health.

Analysis of crime statistics and calls for service showed a constant demand on police services, justifying a beat model detached from local area stations. Operational interaction between the hospital and police was particularly high and resource-intensive, due to matters such as Emergency Examination Orders, sudden deaths, and various forms of police-related hospital inquiries. Since a major objective of establishing a beat was to expedite current police processes in dealing with these types of inquiries, the decision was made to operate the beat from within the PAH campus. It was judged that locating the beat within a retail area would compromise the capacity of police to deal with hospital inquiries, because it would attract high levels of walk-in public traffic that would be better diverted to Dutton Park or Annerley police stations.

⁵ A copy can be obtained by contacting the QPS.

Accordingly, the QPS recommended that a police beat be established in the PAH campus and incorporate the nearby retail precinct. In the same month, December 2004, senior management at the PAH provided in-principle support for the establishment of the police beat within the hospital grounds (QPS 2005a).⁶

The 'closed door' model

During discussions to determine the appropriate beat model for within the hospital, senior management at the PAH and in Queensland Health raised concerns that a highly visible and accessible shopfront operating within the hospital campus might attract a lot of walk-in traffic (i.e. staff and public) and could also discourage some members of the public from seeking health services. It was therefore decided that a 'closed door' beat, located in a relatively discreet low-traffic area of the hospital, would be the most appropriate model.

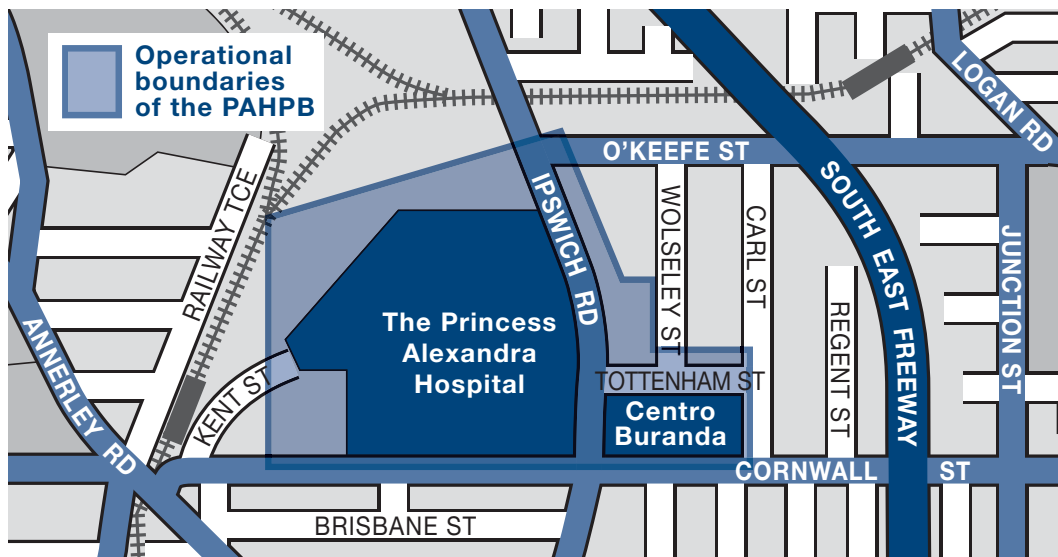
The launch of the PAHPB

The PAHPB became operational on 29 October 2005 and was officially opened on 16 November 2005 by the Honourable Judy Spence, Minister for Police and Corrective Services, and the Honourable Stephen Robertson, Minister for Health.

The operational boundaries of the PAHPB (see Figure 1.1) were:

- » PAH campus, Ipswich Road
- » Brisbane Metropolitan Linen Service (within the PAH campus, and listed as a Critical Infrastructure Site for the Metropolitan South Region), Ipswich Road
- » Centro Buranda shopping centre, Ipswich Road
- » strip retail area adjacent to the PAH campus and Centro Buranda, Tottenham Street.

Figure 1.1: Area within which the PAHPB operated during the trial



⁶ A copy of the QPS project plan can be obtained by contacting the QPS.

There does not appear to be anything similar to the PAHPB model operating in any other police jurisdiction in Australia. The PAH campus lies 4 kilometres from the Brisbane Central Business District and services a population of 1.6 million. Over 4500 staff are employed at the PAH to provide services that include all adult specialties except gynaecology and obstetrics. The PAH's statewide services consist of an acquired brain injury outreach service, the Queensland amputee limb service, a spinal outreach team and a transitional rehabilitation program. In March 2004 a 64-bed Adult Acute Psychiatric Unit was officially opened as part of a \$310 million redevelopment of the hospital. At the time of this evaluation the PAH had a 727-bed capacity.⁷



There does not appear to be anything similar to the PAHPB operating anywhere in Australia.

The role of the CMC in the evaluation

In September 2005 the CMC was approached by the Assistant Commissioner, Metropolitan South Region, to assist the QPS with an evaluation of the PAHPB for a six-month trial period starting on 29 October 2005. A joint evaluation framework was established, with the CMC taking primary responsibility for the evaluation. Table 1.2 outlines the responsibilities of the CMC and QPS.

Table 1.2: Evaluation responsibilities

CMC	QPS
Overall management and direction for the evaluation	Collection and analysis of calls for service (CFS) data
Surveys of hospital staff and businesses within the PAHPB area	Collection and analysis of CRISP data
Interviews and focus groups with stakeholders	Assistance to CMC in the collection and analysis of daily log data
Assistance in the development and analysis of daily log data	Assistance to CMC with section of the report relating to CFS and CRISP data
Analysis of relevant operational and procedural documents	Access for CMC to PAHPB officers and senior police management in Metropolitan South Region
Interviews with beat officers and senior management in Metropolitan South Region	Assistance to CMC with any other data management tasks as required
Preparation of final report in collaboration with key stakeholders	
Delivery of final public report	

⁷ Data provided to the CMC by the PAH Corporate Services Team, 19 May 2006.

Structure of the report

This report is divided into six chapters. Following the current chapter, **Chapter 2** describes the aims set out in the original QPS PAHPB proposal and the evaluation methodology used by the researchers to conduct this research. It includes an overview of the key evaluation questions, data sources, analysis tools, limitations of the administrative data, and evaluation challenges.

Chapter 3 presents a range of data on the policing services provided by the beat officers. An analysis of calls for service, crime reports and patrol logs is used to describe the distribution, frequency and workload type. This chapter includes a section on beat officers' responses to beat community needs and presents two case studies as examples of beat officers' problem-solving strategies.

Chapter 4 examines the extent to which the PAHPB had an impact on hospital staff and retailers' perceptions of safety. The data used for this chapter are mainly derived from surveys distributed to a sample of hospital staff and retailers before and after the trial. The surveys were designed to measure any meaningful change over time in the level of awareness of the PAHPB, visibility of the police, perceptions of safety, frequency of contact with police and security, and continuation or initiation of protective behaviours.

Chapter 5 explores stakeholder satisfaction with the trial. A number of issues were canvassed in post-trial surveys, focus groups and interviews. PAHPB service is assessed through measures of stakeholders' satisfaction with quality, professional conduct, courteousness, amount and quality of information provided, timeliness and accessibility. Specific challenges for the PAHPB are discussed, as well as levels of satisfaction of the beat officers themselves.

The final chapter, **Chapter 6**, summarises key findings of the evaluation, and suggests ways in which the QPS might improve the effectiveness of the police beat model.



The Centro Buranda shopping centre is within the operational boundaries of the PAHPB.

Chapter 2: Evaluation methodology



This chapter outlines the evaluation methodology developed by the CMC and used in partnership with the QPS.

Impact evaluation

Like previous Queensland beat-policing evaluations conducted by the CJC/CMC, the PAHPB evaluation is essentially an impact evaluation. This means that the evaluation is conducted to determine whether a project's impact on a selected population or environment is in accordance with its initial aims (CMC 2003). Impact evaluations will therefore also reveal any unintended and unanticipated effects of a trial.

The QPS Project Plan for the PAHPB trial details the following broad aims (QPS 2005a):

- » Enhance community safety.
- » Improve service delivery and use of resources.
- » Improve communications between the QPS and PAH.
- » Reduce calls for service (CFS) and time taken to respond.
- » Use problem-solving strategies.
- » Improve and streamline coronial and mental health inquiries.

The CMC used three primary evaluation questions, based on these aims, to examine the extent to which the PAHPB achieved these aims.

The questions were:

- 1 Has the PAHPB improved the management of calls for service to the PA Hospital (and become the primary provider of police services to the beat community)?⁸
- 2 Has the PAHPB improved perceptions of safety for hospital staff and Buranda retailers?
- 3 Are stakeholders satisfied with the PAHPB?



One of the aims of the PAHPB is to improve communications between the QPS and PAH.

⁸ This key evaluation question was later broadened to incorporate a wider range of duties undertaken by beat officers during the trial within the entire beat area.

Data sources

Data from multiple sources have been used to gauge the impact of the PAHPB trial. In the main, the information was obtained from major stakeholders including QPS senior management, beat officers, PAH senior management, staff and local retailers.

QPS calls for service

Calls for service are the calls made by the public directly to a local police station or by dialling triple zero to request police assistance (Guidi, Townsley & Homel 1997). Calls are directed to or received by QPS police communication centres, where staff record details of the caller, the nature of the incident and the address that police may be required to attend. Calls are prioritised and then assigned to a crew to respond. Calls for service that fall within the boundaries of a police beat area within a division are typically assigned to the officers within that beat, provided they are available to take the job at the time of the assignment. The PAHPB operates seven days a week between the hours of 8 am and 10 pm.



The PAHPB operates seven days a week between 8 am and 10 pm.

The calls-for-service data used for this report covered three distinct spans of time: the actual trial period (29 October 2005 – 30 April 2006), and the equivalent period in the two years preceding the trial (2003–04 and 2004–05).

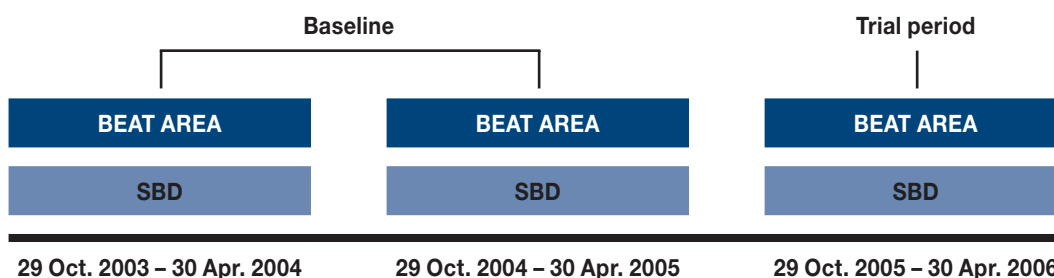
Data were also collected for the entire South Brisbane District (SBD) and separately within the beat area to monitor trends over time and to enable comparisons between the district and the beat. The categories of data captured included area, job category, day received and time received. Over 127 000 calls for service records for the SBD and over 1 700 for the beat area were analysed.

QPS CRISP

CRISP (Crime Reporting Information System for Police) is a database that the QPS uses to capture details of reported crime. Police officers contact data entry staff from the QPS Information Management Division to have crime records logged in CRISP. Each offence is electronically entered, classified and counted. Records of offences are usually generated by calls for police service, but not exclusively — for example police may come across someone in the act of committing an offence when out on patrol (QPS 2005b). The statistics on crime used in this evaluation were derived from CRISP.

The CRISP data were extracted for the same three periods as the calls-for-service data: the actual trial period (29 October 2005 – 30 April 2006) and the equivalent period in the preceding two years (see Figure 2.1, next page).

Figure 2.1: Data collection areas and timeframe



Data were collected for the entire South Brisbane District (SBD) and separately within the beat area, to enable comparisons and reveal yearly trends. The CRISP fields for time of offence, earliest committed date of offence⁹ and crime types were included in this analysis. A total of 43 720 crime records for the SBD and 515 crime records for the beat area were analysed.

Patrol logs

Officer patrol logs for the Metropolitan South Region and the South Brisbane District Inquiry Office (based in the Morningside Police Station) were used to determine the amount of time police officers spent at the PAH, including travel to and from the hospital. Two periods were analysed, one before the trial, from 6 August 2005 to 28 October 2005, and the second during the trial, from 3 December 2005 to 24 February 2006. The analysis did not include the time officers spent on jobs after returning to their home stations.

PAHPB daily logs

Calls for service and offence data do not capture the full range of PAHPB officers' activities during a shift. For example, the beat officers attended regular collaborative meetings with hospital stakeholders. In order to capture the broadest possible range of duties engaged in during the trial, daily activity logs were coded into an occurrence sheet format. For each month of the trial the same beat officer used a coding scheme to assess the beat's daily logs and documented activity counts in a monthly spreadsheet.¹⁰ The officer also recorded a list of factors that might have influenced occurrences, and documented them in a monthly report to accompany the spreadsheets. For example, when hospital inquiries decreased from 151 in November to 135 in December the officer noted that the drop was due to the start of the holiday season, when there are usually fewer administrative requests.

⁹ 'Earliest committed date' refers to the earliest date when the offence could have occurred. For example, if someone returns after a weekend away to find their house broken into, the earliest committed date would be the date they departed. The latest committed date would be the day they returned and discovered the robbery.

¹⁰ To ensure data integrity, coding guidelines were developed by the CMC in collaboration with a beat officer who took responsibility for interpreting the daily logs for the duration of the trial.

PAH focus groups

In the final month of the trial a total of five focus group meetings were held with hospital staff working in areas that had elicited frequent contact with general duties and PAHPB officers. Selected groups included staff from the Mental Health Unit (MHU), Spinal Injuries Unit (SIU), Accident and Emergency Department (ED), Intensive Care Unit (ICU) and Switchboard/Reception. Between six and ten people attended each session, the length of which ranged from 30 to 90 minutes.

The following key points were discussed:

- » a typical day or week in the department
- » the level of contact with QPS officers before the trial
- » awareness of the PAHPB trial
- » level and type of contact with PAHPB officers
- » key police-related issues for the department
- » personal safety and security
- » level of satisfaction with PAHPB officers.

Key stakeholder interviews

A schedule of interviews was also maintained during the trial. Informal face-to-face interviews were conducted on a weekly basis with beat officers, regarding the day-to-day running of the beat, their experiences and their job satisfaction. In the final months of the trial a series of semi-structured interviews were held with senior QPS and PAH staff. Table 2.1 lists the key stakeholders interviewed.

Table 2.1: Key stakeholders interviewed

Senior PAH staff	Senior QPS staff	QPS PAHPB officers
Acting District Manager	Acting Superintendent/ Inspector LAC Dutton Park	Senior Sergeant, Officer in Charge
District Solicitor	Detective Superintendent State Crime Operations	Senior Constables (2)
Executive Manager Mental Health Unit (MHU)	Senior Sergeant, Officer in Charge, Dutton Park	Constables (3)
Manager of Fire and Security	Senior Sergeant, Crime Prevention Unit	
Director of Emergency Department		
Director Complaints Management Unit		
After Hours Nurse Coordinator		
Executive Director Corporate Services		
Director of Medico-Legal Office		
Director of Patient Administrative Services		

The specific questions varied according to the role of the individual and their length of involvement in the trial. Beat officers were questioned about their specific attitudes to beat policing, impressions of the level of management support for the beat project, level of job satisfaction, and thoughts on the necessity for training. Senior management in the QPS were asked about the derivation of the beat, key issues for management, value for money, sense of satisfaction among the target community, and strengths and weaknesses of the model. Senior management in the hospital were consulted about their involvement in initial liaison, funding arrangements, key issues, sense of satisfaction among the broader hospital community, and the usefulness of the beat during the trial period.

QPS and PAH operational and procedural documentation

A range of relevant operational and procedural documents were retained for analysis to give a greater understanding of how closely the implementation phase of the trial conformed to its initial design. The documents included the QPS PAHPB Project Proposal, Metropolitan South Region PAHPB Environmental Scan, various media statements, internal hospital memorandums, beat officer rostering sheets and activity logs.

Surveys

Hospital

Pre- and post-trial surveys were developed by the research team in consultation with the QPS and the PAH.¹¹ The purpose of the pre-trial instrument was to capture baseline data regarding staff contact and experiences with PAH security and QPS police officers, and to ascertain staff views on personal safety and security while working on the hospital campus. The post-trial instrument was designed to reveal any meaningful changes in hospital staff's perception of safety since the introduction of the beat, and their level of satisfaction with the services provided by the beat officers.

Pre-trial surveys were administered to participants by internal mail at about the time the PAHPB was introduced (14 November 2005) and post-trial surveys six months later (1 April 2006).¹² The target sample for both surveys was 500 hospital staff, 100 from each of the key police contact areas (ED, MHU, SIU and ICU) and 100 additional staff selected by the PAH Corporate Management Unit. The surveys enabled staff to remain anonymous, took approximately 20–30 minutes to complete, and were collected on a 2–3 week turnaround. The response rate was higher for the pre-trial survey (56%, providing 281 surveys for analysis) than for the post-trial survey (39%; 196 surveys).

Table 2.2 (facing page) provides a breakdown of demographic variables across both samples.



The post-trial survey gauged hospital staff's satisfaction with the police beat.

¹¹ A copy of the survey instruments can be obtained by contacting the CMC.

¹² The pre-trial surveys were conducted in mid-November, after the beat had been operational for a fortnight, due to unavoidable delays with development of the survey instrument. It is believed that this timing will not affect the results, since the beat was only newly established.

Table 2.2: Demographic characteristics within PAHPB hospital surveys

Demographic variables		Pre-trial		Post-trial	
		%	<i>n</i>	%	<i>n</i>
Gender	Male	20.2	56	22.9	44
	Female	79.8	221	77.1	148
Age category	Under 25	17.2	48	14.1	26
	25–34	25.1	70	33.2	61
	35–44	24.0	67	26.1	48
	45–54	25.1	70	18.5	34
	55 and over	8.6	24	8.2	15
Work area	ED	15.4	42	14.8	28
	MHU	21.0	57	9.5	18
	SIU	12.5	34	22.8	43
	Other	51.1	139	52.9	100
Work status	Full-time	73.4	204	76.6	147
	Part-time	24.5	68	20.8	40
	Casual	2.2	6	2.6	5

Source: PAHPB hospital surveys (November 2005, April 2006)

Notes:

- Totals for each variable may not add up, due to some random missing data.
- Percentages may not add up to 100, due to rounding.
- ‘Other’ work areas included various wards, Administration, Surgical, Neurosciences, Quality Improvement, Security, Executive, Switch, Rehabilitation, Pathology and Radiology.

Retailers

Surveys of retailers within the beat area were also conducted before and after the trial.¹³ Like the hospital survey, the pre-trial instrument (10 November 2005) was developed to capture baseline data on retailers’ perceptions of safety and security and their experiences with police while working at Buranda. The post-trial survey (8 May 2006), distributed six months later, was designed to measure any changes in retailers’ perceptions of safety and security and their experiences with PAHPB officers during the trial.¹⁴

Surveys were distributed by hand to retailers within Centro Buranda and the adjacent Buranda strip retail area. All retailers were given five days to complete the surveys, which were collected at the end of this time. To allow for staff absences on the day of collection, retailers who could not hand over the survey were given reply-paid envelopes in which to return it. Given the size of the sample (less than 40 retail establishments), participants expressed some concern about being identified. In acknowledgment of these concerns, this report does not present any demographic characteristics that would make it possible to identify them.

¹³ A copy of the survey instruments can be obtained by contacting the CMC.

¹⁴ See footnote 12.



Like the hospital survey, the post-trial survey of retailers was designed to measure any changes in their perceptions of safety and security, and their experiences with PAHPB officers during the trial.

Unfortunately, the trial coincided with a major refurbishment of the Centro Buranda shopping precinct. This inevitably had an impact on the responsiveness of retailers, because some establishments closed down before the trial concluded, and about 10 new retailers opened in the final months of the trial. A total of 31 surveys were returned in the pre-trial sample and 35 in the post-trial survey.¹⁵

Data analysis

QPS calls for service, crime reporting and patrol log data have been presented at the beat area, district and regional levels over time to enable pre- and post-trial comparisons. Additionally beat officer daily log data were coded during the trial period to provide a quantitative representation of officers' workload. Descriptive statistics have been used to examine the types of calls for service to the hospital and surrounds, common offences committed, time spent on inquiries work and the nature of the police response, as well as the daily activities of beat officers.

¹⁵ Due to the refurbishment of Buranda Plaza, exact counts of retailers are confounding and response rates have therefore not been included.

Survey data were examined using descriptive statistics to provide frequencies, means, standard deviations¹⁶ and percentages. Statistical testing was performed on variables of interest (e.g. gender) across pre- and post-trial measures to assess significant changes in participants' perceptions and experiences after the introduction of the PAHPB. T-tests or analysis of variance (ANOVA) were used to compare the mean scores of different groups (pre-trial and post-trial), provided there were at least 30 participants in each group.¹⁷ In view of the small number of participants in the post-trial survey of retailers (for questions relating to satisfaction with the beat officers), only the frequency of responses will be reported.

Qualitative data from interviews, focus groups and informal discussions were collated, and general themes extracted. In order to provide an accurate and comprehensive evaluation of the PAHPB trial, these data were triangulated with the results of surveys and administrative data.

Limitations of the data

The calls-for-service data reported in this evaluation are based on reported, not verified, data. Reported data record the code assigned by the operator on first receipt of the call, whereas verified data are captured when the attending police officer contacts police communications to verify the nature of the incident. Reported data were used because of the delay in obtaining verified data. However, it is important to be cautious in interpreting calls-for-service data relating to specific job categories, because reported categories can change once a police officer responds to a job and verifies the nature of the incident. For example, a disturbance call may turn into a domestic violence call once police arrive on the scene and verify the circumstances.

Calls-for-service data also have limitations in capturing officers' activities as directed by police communications. A few months into the trial, beat officers realised that not all calls for service received from within the beat area during normal hours of operation were being directed to them by police communications. This was because the police communications system had not been sufficiently updated to incorporate the PAHPB as the primary unit of response to calls within the beat area. Therefore, although all calls for service to the PAHPB during the trial period have been reported in this evaluation, calls incorrectly assigned to surrounding stations in the beginning months of the trial cannot be reported separately. To correct the problem for the purpose of this evaluation, a number of other administrative data have been used to give an indication of beat officers' workload. This triangulation also made it possible to capture activities initiated by beat officers that do not appear in calls-for-service data.

¹⁶ A measure of variability that provides an index of the dispersion of the distribution.

¹⁷ Given a medium to large effect size, 30 participants should lead to about 80% power (the minimum suggested power to be able to detect a statistically significant difference between groups) (Cohen 1988).

Considerations and challenges in the evaluation

There are some factors that could have substantial impact on the effectiveness of the trial, and which have been taken into consideration by researchers in framing the evaluation of the PAHPB:

- » The hospital is extremely large. During the six-month evaluation period it had over 4500 staff, a 727-bed capacity at a 90 per cent occupancy rate, and over 19 000 same-day discharges.¹⁸ The beat area also incorporates a high-traffic, highly populated area including the Centro Buranda shopping centre. The suburb of Dutton Park is ethnically diverse, with the highest proportion of young people (aged 0–14 years) in Brisbane’s inner-city region, and is relatively unstable. Very few residential tenancies are located within the beat boundaries. This population, combined with the size of the hospital, made it difficult for officers to achieve community policing objectives.
- » During the trial, at full capacity the PAHPB operated with one senior sergeant, two senior constables and three constables. Considering the size of the PAH campus and associated workload, the relatively small size of the beat may have limited the scope for the beat officers to be fully effective.
- » The tendency of stakeholders to overestimate the potential impacts of a trial in its early stages is a relevant consideration that has been well documented in previous beat reports (CJC 1995, 1996). The length of the PAHPB trial was only six months, with monitoring beginning on the first day of operation. Given that it took some time to set up the beat office with the appropriate equipment to enable the officers to do their job (e.g. desktop and laptop computers), the beat only really operated to its full potential in the remaining 3–4 months of the trial.
- » As mentioned previously, a large-scale renovation to the Centro Buranda shopping precinct made it difficult to distribute the survey instruments. It also limited the ability of officers to make initial contact with retailers, to establish community partnerships (e.g. the major supermarket was closed for a month for renovations).
- » Due to the nature of staffing for a trial, with officers seconded from other stations for a set period, PAHPB staff started to turn over in March 2006, including handover of the Officer in Charge position at the end of March, before the conclusion of the trial. This had an impact on established partnerships with hospital staff and interfered to some extent with the overall performance of the beat.



Major renovations to the Centro Buranda shopping precinct limited the ability of beat officers to make initial contact with retailers.

¹⁸ Data provided to the CMC by the PAH Corporate Services Team (19 May 2006).

Summary of Chapter 2

The links between the evaluation questions, the aims of the trial, measures and data sources are summarised in Table 2.3 below.

Table 2.3: Overall PAHPB trial evaluation strategy

CMC evaluation questions	QPS PAHPB aims	Measures	Data sources
Has the PAHPB improved the management of calls for service to the PA Hospital (and become the primary provider of police services to the beat community)?	<ul style="list-style-type: none"> » Improve service delivery. » Improve the use of resources. » Reduce calls for service and time taken to respond. » Improve and streamline coronial and mental health inquiries. » Use problem-solving strategies. 	<ul style="list-style-type: none"> » Assess changes in QPS administrative data (CFS, CRISP, logs) over the course of the trial. » Analyse rostering of beat officers. » Assess daily activities of beat officers during trial. 	<ul style="list-style-type: none"> » QPS CFS » QPS CRISP » MSR patrol logs » SBD inquiry office patrol logs » PAHPB daily logs and rosters » Interviews » Focus groups » Case studies
Has the PAHPB improved perceptions of safety for hospital staff and Buranda retailers (owners/ employees)?	<ul style="list-style-type: none"> » Enhance community safety. 	<ul style="list-style-type: none"> » Analyse survey data for significant changes in perceptions. » Assess stakeholders' comments. 	<ul style="list-style-type: none"> » Hospital surveys (pre- and post-trial) » Retailer surveys (pre- and post-trial) » Interviews » Focus groups
Are stakeholders satisfied with the PAHPB?	<ul style="list-style-type: none"> » Improve communications between the QPS and PAH. 	<ul style="list-style-type: none"> » Analyse stakeholders' feedback. » Analyse survey data on satisfaction measures. » Assess stakeholders' comments. 	<ul style="list-style-type: none"> » Interviews » Focus groups » Hospital surveys (pre- and post-trial) » Retailer surveys (pre- and post-trial) » QPS and PAH operational and procedural documentation

Chapter 3: Service provision



This chapter deals with the first of the CMC's evaluation questions: 'Has the PAHPB improved the management of calls for service to the PA Hospital?'

Although it was assumed that the trial would have a limited short-term impact on the levels of crime and victimisation within the beat area, there was an expectation that the PAHPB would become the primary provider of police services to that community. This would alleviate the need for officers from other divisions to attend to calls for service, inquiries and investigations in or around the PAH. In that capacity, beat officers would be responsible for several traditional policing activities previously undertaken by general duties police in the district, as well as undertaking a community beat policing role.

To give a complete picture of the role played by the PAHPB officers, the chapter presents data on calls for service and incidents of crime, beat officers' daily activities, their response to hospital inquiries and their relationship with security providers.

Responding to calls for service and incidents of crime

Frequency of calls for service and offending

Table 3.1 (facing page) compares calls for service and crime report data in the PAHPB trial period with two equivalent periods (and beat boundaries) before the introduction of the beat. Data for the South Brisbane District (SBD) are also presented, to provide a context for the demand for police services to the area. The table shows that the number of calls for service originating from the beat area has remained consistent over this three-year period. A similar trend is observed when using crime data.

As a proportion of the total number of calls for police assistance in the SBD, calls to the beat area represent less than 2 per cent of the calls received each year. Similarly, the number of crimes in the beat area in proportion to the district is just over 1 per cent — a figure that remained unchanged in the trial period.

Table 3.1: Trends in calls for service and CRISP – within beat area, compared with South Brisbane District (SBD)

Period	Number of calls for service			Number of crime reports		
	SBD	Beat boundaries	% within beat	SBD	Beat boundaries	% within beat
29 Oct. 03 – 30 Apr. 04	37 788	550	1.5	15 256	178	1.2
29 Oct. 04 – 30 Apr. 05	41 235	574	1.4	13 990	170	1.2
Trial period 29 Oct. 05 – 30 Apr. 06	48 468	581	1.2	14 474	167	1.2

Source: QPS calls-for-service and CRISP data.

Notes:

- Percentages have been rounded.
- Specific fields were extracted from raw data to replicate the beat boundaries for the periods presented. SBD totals include the beat area totals.
- Calls for service within the trial period are those calls made within the beat area boundaries, not all of which were attended to by the beat officers. All calls go to the police communications centre and are assigned to a crew. Due to problems experienced in the first half of the trial (in which the PAHPB was not listed as the primary or secondary response unit on the police communications system), not all jobs received within beat operating hours were assigned directly to the PAHPB. This situation has since been rectified; however, as a direct result, these data may not accurately reflect PAHPB workload.

Roster analysis

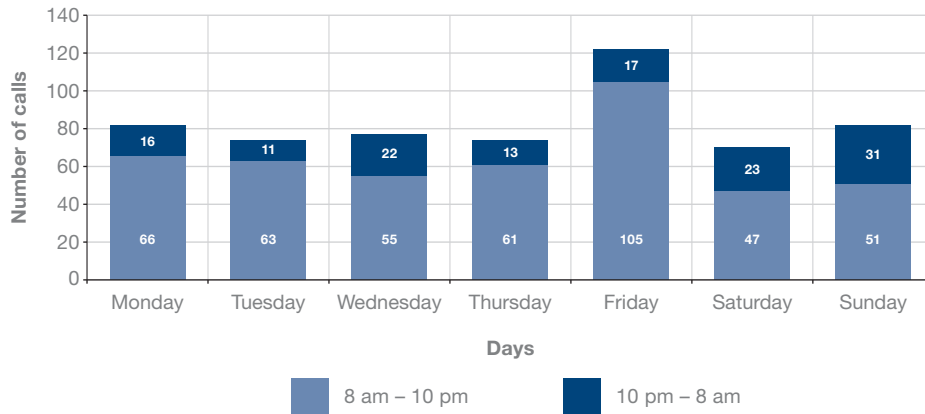
The following analysis was conducted in order to assess the appropriateness of the operating hours selected for the beat and of the number of beat officers rostered to cover the calls for service and reported crime demand within the beat area. During the trial the PAHPB operated seven days a week and was staffed between the hours of 8 am and 10 pm. Figure 3.1 (next page) shows that the majority of calls for service (77%) were received within the beat’s normal working hours, with a peak in the number of calls on Fridays (21%). In total, six beat officers (one senior sergeant, two senior constables and three constables) worked a split-shift roster system with two shift options — 8 am until 4 pm and 2 pm until 10 pm — seven days a week. An analysis of the proportion of calls for service across the two shifts indicated a relatively equal distribution of calls, with 57 per cent of calls (254) occurring during the ‘afternoon’ shift when beat officers were normally on duty.¹⁹



The majority of calls for service were received during the beat’s normal working hours.

¹⁹ As there is overlap between the two shifts, the break point of 3 pm was used to present distribution of calls (i.e. 8 am – 3 pm and 3 pm – 10 pm).

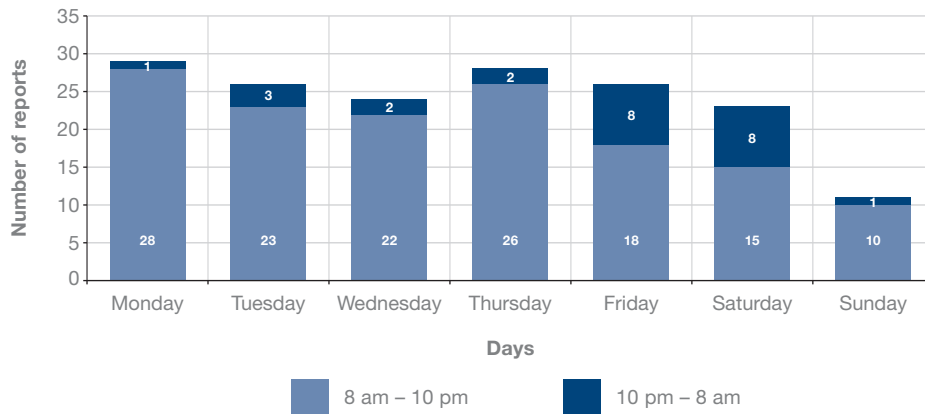
Figure 3.1: Calls for service to beat area during trial by time and day reported



Source: QPS calls-for-service data, 29 October 2005 – 30 April 2006

Similarly, reported crime generates significant workload for beat officers. An analysis of the QPS CRISP data indicated that, of the 167 reported crimes that occurred within the beat boundaries during the trial, 85 per cent (142) occurred during beat operating hours (see Figure 3.2). Modest differences in the number of incidents are observed between weekdays, with the highest numbers recorded on Mondays and Thursdays (17% in each case).²⁰ Just over 60 per cent of these crimes were committed during the beat’s day shift.

Figure 3.2: Reported crime during trial period by time and day reported (earliest committed)



Source: QPS crime report data, 29 October 2005 – 30 April 2006

²⁰ For the purpose of time of day analysis this report uses the ‘earliest committed day’ recorded for each crime. In most cases the earliest committed date and latest committed date are the same.

It was also common practice for two officers to be rostered on during the afternoon, with the exception of Sundays, when it was typical for only one officer to be rostered on. Thus it seemed, from the level of analysis conducted, that the coverage of hours provided by the beat was appropriate, and reflected the distribution of calls for service and crime reports to the area.²¹ The following comments, made during interviews with hospital management, provide additional evidence of the general satisfaction with the operating hours of the beat.

The majority of traffic that's going to be around the PA starts dying out about 8 o'clock in the evening when visiting time stops ... Emergency Department will still be busy as it normally is busy at that time of the evening, but that's monitored, I mean they've got CCTV cameras in those areas ... (Interview, hospital, no. 6)

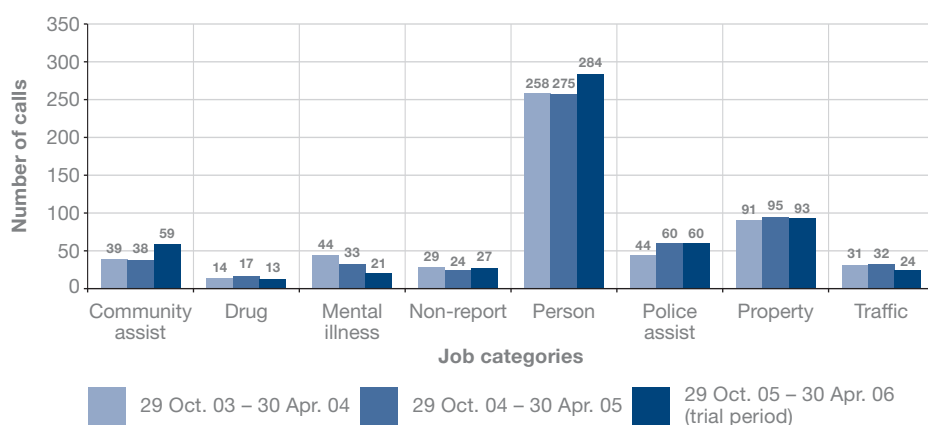
I don't think there's any particular demand to have the hours altered ... I know people would like to have twenty-four seven, everybody likes that ... but I don't see a problem with it ... most of our work that happens on this site happens between 7 am and about 7 to 8 pm ... I think the hours are okay. (Interview, hospital, no. 1)

Hospital staff and retailer satisfaction with the spread of beat office hours is discussed in greater detail in Chapter 5.

Job types

The highest proportion of calls for service originating from the beat area over the past three years fall within the job category 'person' (see Figure 3.3). This category includes absconders from the hospital, assaults, disputes, disturbances, domestic violence, sudden deaths, and threats against the person. There have been no significant changes in the types of jobs originating within the beat area during the same period over the last three years.

Figure 3.3: Trends in calls for service – job categories originating in beat area

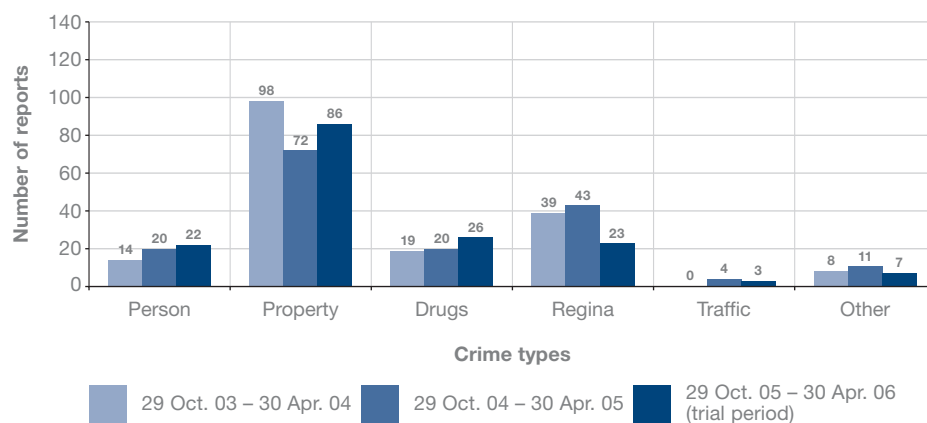


Source: QPS calls-for-service data

²¹ Data to enable complex roster analysis (e.g. time and activity attributions) are not available, and are outside the scope of this evaluation.

As Figure 3.4 shows, there was also little change in crime-report data for the beat area over the three-year period. Half (49.7%) of all crimes reported over the selected periods were property crimes.²²

Figure 3.4: Trends in crime reporting – crime types in beat area



Source: QPS crime report data

Beat officers' daily activities

Beat officers' daily logs

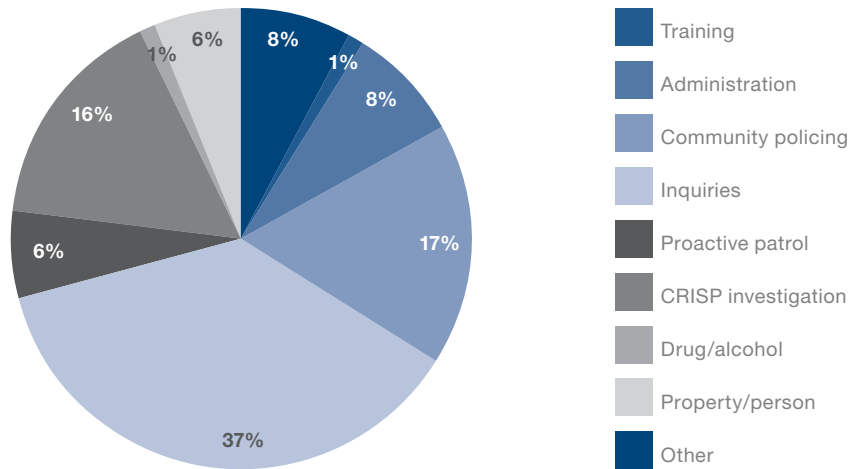
For the duration of the trial, one beat officer was assigned responsibility for generating a quantitative representation of the beat officers' daily activity logs. A coding scheme was devised at the beginning of the evaluation and all activities from the daily logs were assessed, coded and included in a monthly spreadsheet. Monthly occurrence sheets were used to reduce a range of 43 activities to nine categories of beat officer activity for examination (for a full range of activity codes and counts, see Appendix).

Beat officers spent the largest proportion of their time during the evaluation period (37%) conducting 'inquiries work' within the hospital (see Figure 3.5, next page). The activities categorised as inquiries included:

- » serving summonses and subpoenas on people required for court
- » obtaining statements and medical records required for court
- » conducting a traffic accident investigation, including obtaining traffic accident versions from people involved and obtaining blood or breath samples
- » completing 'authority to release information' forms from Medico-Legal (a department within the hospital) and executing warrants to provide medical records
- » instigating a coronial investigation or obtaining records on a coronial file on behalf of the investigating officer
- » obtaining information in response to a request from another police crew.

²² Note that Regina offences include the following categories: drug; good order; prostitution; trespassing and vagrancy; gaming, racing and betting; liquor licensing; unlawful possession; use and/or handling of weapons; against justice procedures; against government and security operations.

Figure 3.5 Occurrences recorded in beat officers' daily logs



Source: Data from beat officers' daily logs, 1 November 2005 – 30 April 2006

When categories are examined for two three-month periods (Table 3.2), it can be seen that, as the trial progressed, the number of activities increased. The only substantial exception to this trend is found in the Community Policing category.²³ Community policing, in this context, includes activities such as general liaison, lectures and talks, attending formal meetings with stakeholders, responding to 'counter' inquiries,²⁴ and attending to community-based policing projects. That said, of the 192 activities counted as community policing, 58 per cent (112) were attendance by beat officers at stakeholder meetings.

Table 3.2: Breakdown of activities from beat officers' daily logs during trial period

	November–January	February–April
Training	62	105
Administration	235	238
Community policing	129	63
Inquiries	493	603
Proactive patrol	240	252
CRISP investigation	113	133
Drug/alcohol	7	18
Property/person	125	121
Other	17	6

Source: Data from beat officers' daily logs, 1 November 2005 – 30 April 2006

²³ The category 'Property/person' showed only a small decline (4 counts).

²⁴ Although the beat office did not contain a 'counter' as such, on occasion hospital staff would request assistance by dropping in at the office.

The number of community policing activities decreased in each month of the trial (from 51 in November to 35 in January, to 12 in April). Given the importance of community policing tasks in a beat policing model, it had been expected that there would be a steady increase in these activities over time, but this turned out not to be the case (see Appendix for full breakdowns by category and subcategory). Possible reasons for the decrease may be:

- » a notable increase in inquiry tasks, from 493 in the first three months to 603 in the final three months
- » a high percentage of time spent performing administrative tasks throughout the trial (16%)
- » an initial period of intensive liaison (especially meetings) during the establishment of the beat.

It will be important to keep track of the changes in these activities over time, to ensure that officers set aside sufficient time from hospital inquiry and administrative tasks to engage adequately with the beat community. See Chapter 5 for additional discussion of this issue.

Problem-solving

As stated in the introductory chapter of this report, beat policing is defined by an expansion of the traditional policing role to incorporate a particular emphasis on meeting the needs of the beat community. Beat officers are therefore expected to engage with the beat community, acquire local knowledge, and help the community formulate and implement problem-solving strategies.²⁵

Senior police management pinpointed problem-solving as a key policing strategy that separates beat policing from general duties policing, and integral to the PAHPB.

The officer in charge of the beat explained the process beat officers used to present him with an identified problem:

How it happens is that if somebody identifies an issue within this group then they approach me and they normally would say well okay in the case of [specific street address] do you mind if I do something in relation to it? [If] I agree with them, they put forward their case. [If] I agree it's an issue and it's a problem that needs to be addressed I give them all the support that they can possibly have to address it whatever that means. [Officer X] is in the middle of doing a project on the [insert specific business] so that's just another example of people identifying what they would like to attack as a project and the whole idea is to make it a better environment for us and to reduce our workload. Make a better environment for the hospital staff and the surrounding area in our footprint. (Interview, beat officer no. 1)

Two case studies are presented here (see next two pages) as examples of the PAHPB officers' efforts to use a problem-solving approach in responding to problems within the beat area. One example arose from repeat calls for service in the business area of the beat; the other came from within the hospital.

²⁵ Details are available from the QPS at: <http://www.police.qldgov.au/programs/crimePrevention/p_beat/>.

Case study 1

Background

A business premises in the beat area had a long history of police involvement, regularly generating calls for service. A PAHPB officer analysed the calls over a six-month period, and found that over 70 calls were made.

Beat officers' response

Beat officers consulted with various individuals from the beat community, other agencies and police from local stations.

Nature of the problem

The business owner was having problems managing the establishment, creating an atmosphere that continually promoted further trouble on the premises.

Strategy

The beat officer:

- » examined relevant legislation to establish possible breaches by the business owner (e.g. *Residential Tenancies Act 1994*)
- » informed and worked with other relevant agencies (e.g. Rental Tenancies Authority; Queensland Fire and Rescue Service; the local council) to formulate a response
- » developed a fax-back system with the business owner (for matters that didn't need to be dealt with immediately), to reduce the number of calls for service made.
- » contacted the QPS District Crime Prevention Coordinator to inform them of the potential of this project to be realised as a 'Problem Oriented and Partnership Policing' (POPP) initiative
- » in collaboration with the District Crime Prevention Coordinator, developed a short questionnaire to add to the end of an existing survey (for the QPS Boggo Road busway project); the 'PAH' section of the survey contained questions to examine the perceptions of PAH staff, patients and visitors of safety and security in the beat area
- » conducted some basic descriptive analysis (e.g. percentages) on the survey data.

Outcome

This strategy was only in the early stages of implementation at the end of the trial period.

Case study 2

Background

A permanent patient residing in the hospital was identified as presenting a constant threat to the nurses responsible for the patient's care. The patient has anger-management problems and a history of illegal non-prescription drug use in the hospital grounds.

Beat officers' response

PAHPB officers consulted with key staff at the hospital about the patient's case management and their concerns with the patient's behaviour. Beat officers also consulted with the patient.

Nature of the problem

The patient is a ward of the state in full-time palliative care due to injuries. As a result of violent and abusive behaviour towards staff, the patient is rotated through different wards each month so that staff share the responsibility of case management.

Strategy

PAHPB officers thought the best way to deal with the situation was to provide a visible presence on the ward and visit the patient on a regular basis. They also provided the patient with a means of contacting them directly, and one beat officer established a relationship whereby the patient, if a (non-medical) problem arose, could contact the PAHPB office and the officer would come to the ward — which would usually defuse the situation.

Outcome

This worked well with the patient for the first few months of the trial, but deteriorated when the patient broke the law and was caught with drugs, once again threatening hospital staff. The PAHPB took criminal action, which effectively dissolved their relationship with the patient. Although this patient continues to be difficult to manage, the beat officers and hospital staff feel they have now established a good working relationship — one that will assist in helping staff to manage this and other difficult patients in the future.

In choosing case studies to demonstrate a problem-solving approach, it was hard to find many examples that showed the level of collaboration with the community that might be expected of a police beat model. Of particular concern was the lack of any examples involving the formation of a collaborative partnership with members of the retail community. This suggests that beat officers and police management need to strengthen their commitment to problem-solving and make it a clearer focus of the PAHPB.

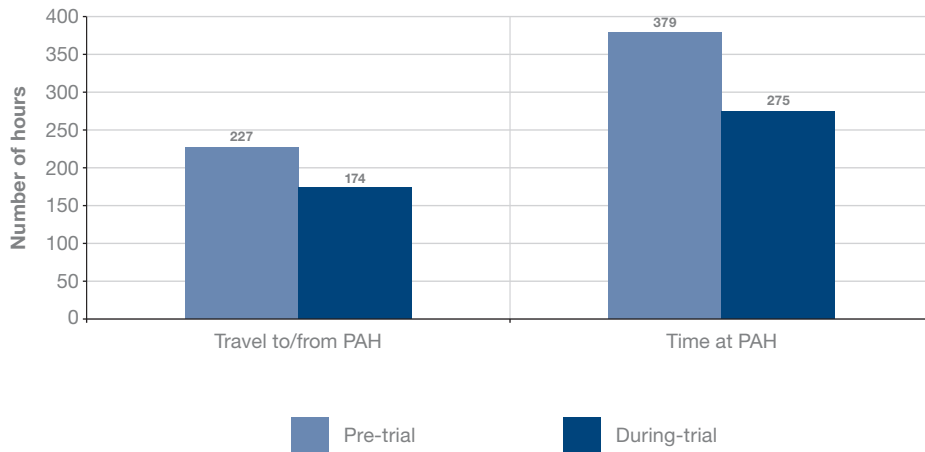
Responding to hospital inquiries

Metropolitan South Region patrol logs

For a period of 24 weeks — 12 weeks before the PAHPB trial and 12 weeks during it — officers in charge of stations and divisions within the Metropolitan South Region (MSR) were required to monitor all incidents attended at the PAH that were recorded in station and division patrol logs.²⁶ Over the pre-trial 12-week period, officers spent a total of 227 hours travelling to and from the PAH and a further 379 hours at the hospital. Since the implementation of the PAHPB, a substantial downward trend can be seen for both travel time and time spent at the hospital (see Figure 3.6).

On average, police in MSR spent 19 hours per week (SD = 9.0)²⁷ travelling to and from the hospital before introduction of the PAHPB and 15 hours per week doing so once it was operating (SD = 5). Similarly, officers spent an average of 32 hours per week (SD = 14) at the hospital before the trial and 23 hours per week (SD = 12) during it.

Figure 3.6: Travel time and time spent at PAH by MSR general duties officers



Source: QPS MSR patrol log data, pre-trial 6 August – 28 October 2005; and during trial 3 December 2006 – 24 February 2007

South Brisbane District Inquiry Office patrol logs

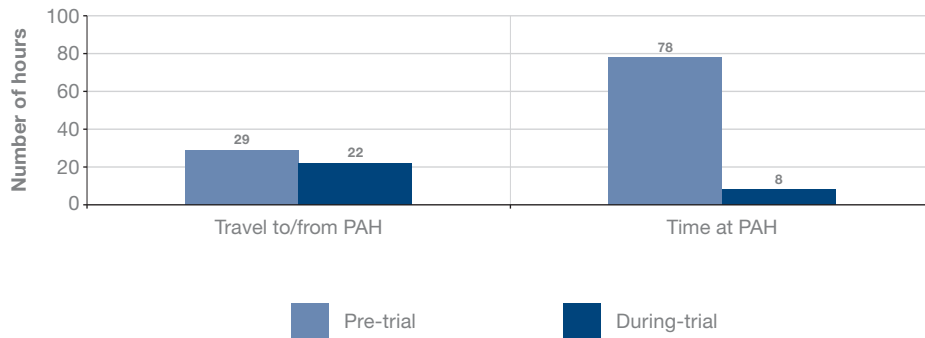
Equivalent data were collected by the South Brisbane District (SBD) Inquiry Office (based in the Morningside Police Station) during the same 12-week period. This hospital liaison office manages police inquiries (coronial statements, court statements, summons etc.) in all South Brisbane hospitals including the Mater Public and Private, Mater Children's, Queen Elizabeth II, Belmont Private, Sunnybank Private and Greenslopes Private. Before the PAHPB trial this office was also responsible for PAH inquiries.

²⁶ This was an initiative of the Assistant Commissioner MSR, implemented by the MSR Projects Unit. Raw data were subsequently made available to the CMC for the purpose of this evaluation.

²⁷ SD (standard deviation) is a statistical measure of variability that reflects the standard distance of scores from the mean (or the standard amount by which scores in the distribution differ or deviate from the mean).

As Figure 3.7 shows, there was some evidence of a downward trend in travel hours to and from the hospital (although the numbers were small to begin with) and a substantial decline in hours spent at the PAH during the trial.

Figure 3.7: Travel time and time spent at PAH by officers of SBD Inquiry Office



Source: QPS SBD Inquiry Office patrol log data, pre-trial 6 August – 28 October 2005; and during trial 3 December 2006 – 24 February 2007

A considerable reduction in hours spent at the hospital by general duties officers provides evidence of the beat’s success in expediting work arising from inquiries. As intended, the beat officers have taken on the relatively time-consuming role of attending to inquiries originating from the hospital. This confirmed the view expressed by most officers that a large proportion of their time was spent dealing with inquiries within the hospital:

At the moment the inquiries work in itself seems to be so busy that it keeps us ... it keeps our days very full. But does still allow for us to get out and about and meet people and turn people over. So it sort of seems to be a good balance at this stage ... We’re getting to know a lot of the specialist areas because of our inquiries work ... we’ve been able to expedite a lot of the inquiries work because of that working relationship, that’s been really good. Sort of increasing our knowledge and our ability to respond quickly ... Yeah, inquiries work is something I’ve never done before. And I’ve learnt a lot about it. Significantly that’s probably the majority of the work that we’re doing. (Interview, beat officer no. 5)

The bulk is a lot of inquiries ... in general duties, you hardly ever do any inquiries work. By inquiries work [I mean] replying to doctors’ statements, doing freedom of information applications, summoning doctors and sending subpoenas in for medical records, and search warrants for medical records, and general duties might do that once in a blue moon but here it is done every day. (Interview, beat officer no. 4)



A large proportion of beat officers’ time was spent dealing with inquiries from within the hospital.

The beat officers had very little if any previous experience with hospital inquiries, with the exception of the officer in charge and one constable who was seconded to the beat from the SBD Inquiry Office. This officer brought a range of skills and knowledge of systems to the beat:

[I] knew how to request statements, the processes of finding doctors, who to go and see, who to go and speak to, so I was able to put that in and show the other guys here how to do a lot of that and I guess we've just developed that to suit the fact that we now work on campus ... I guess that's a bit of a benefit that you are right on campus so if you need to type up something quickly or a statement comes in last minute, you can quickly go down and grab it because you are nice and close. Certainly inquiry work is different to doing general duties and I guess a lot of the guys are getting used to it. It's very paperwork and very, I guess, labour intensive ... because there are a lot of phone calls and just chasing things, and it's a lot of problem-solving too with inquiry work because there is never really a set way that everything is done. (Interview, beat officer no. 6)

Working with other security providers

Hospital security

The PAH employs public servants as hospital security officers. These officers have delegated powers under the *Health Services Act 1997* to provide fire, safety and security services to all staff and visitors to the hospital and external grounds. The PAH Security Department provides 24-hour operational cover with five officers on day shifts, five on night shifts and six on afternoon shifts. Before the introduction of the PAHPB, hospital security staff generally reported any detected offences to local off-site police. Hospital security management were involved in the initial consultations with the QPS to plan for an on-site police presence, and draft PAHPB and fire and security service protocols were established, within the first month of the trial, to outline the division of roles and responsibilities (and probable crossover) between the two service providers.

Since the introduction of the beat, the role of the security officers has continued relatively unchanged, except that the officers now report any offences directly to the on-site beat. The officer in charge of the beat and the security manager also hold monthly meetings, and engage in frequent informal discussion. The overwhelming majority of key stakeholders from the hospital and QPS management indicated, when interviewed, that the beat officers and security staff had established a successful collaborative relationship, and this was one of the strengths of the trial:

... The rapport, the understanding of each other's business and everything would actually make ... the security staff feel that, you know, they had a good backup support because our mental health area for example is growing rapidly. Some nights it's quite extraordinary, the type of people and the amount of people that just turn up. I guess they feel they have some backup too that would assist them in dealing with matters and to date that seems to be very successful. I haven't had one negative comment. (Interview, hospital, no. 8)

The procedures that were put in place right at the very beginning, that took place between the security PA coordinator and myself and the Senior Sergeant in charge of Dutton Park and the Inspector of Dutton Park LAC, have made that transition quite easy, because we all know our roles and we're working on

the same page so people that are at the hospital know we're pushing a particular means of how they should call for service — whether they want security or police to come. The first port of call is security. Security then finds if it's a police issue, then they contact police. Security and/or police, that's the message they're giving to everybody in the hospital and it's working quite well. Every now and then you'll get somebody who's been missed out of the information sessions, I guess, and try to get in touch with us directly but that doesn't happen very often. But then we'll deal with it if it's a police issue but we'll bring to their attention the correct procedures that should be followed through security. (Interview, beat officer no. 1)

To understand the impact of the introduction of the PAHPB on the hospital security arrangements, a section about contact with security was included in the surveys of hospital staff and retailers at the beginning and end of the trial. Hospital staff were asked whether they had contacted police and/or security staff about any matter in the past 12 months.

As Figure 3.8 (facing page) shows, substantially more participants had made contact with security than with police in the preceding 12 months. However, as might be expected, there was a subtle increase in the proportion of participants who had contacted police since the introduction of the PAHPB, and a corresponding decrease in those who had contacted security.

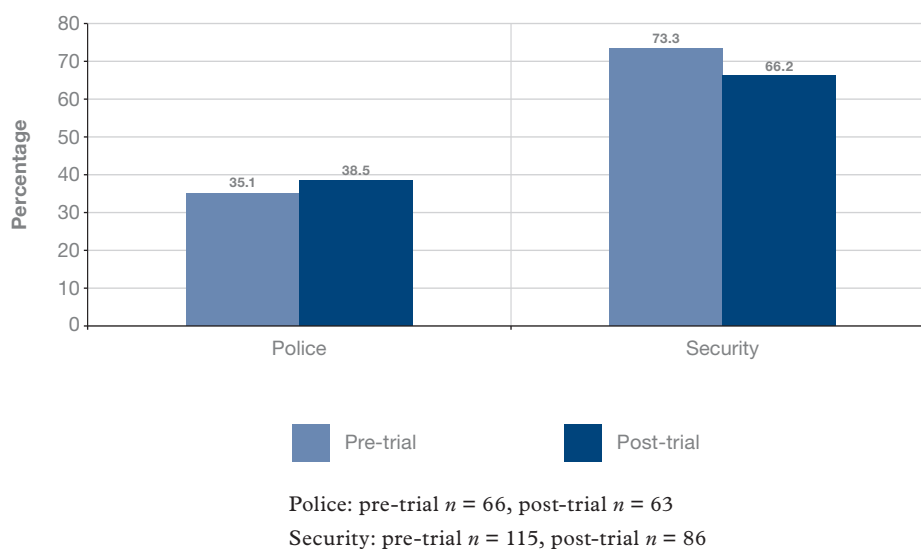


The collaborative relationship established between beat officers and security staff was seen as one of the strengths of the trial.

In terms of the reasons for contact, since the introduction of the PAHPB in the hospital, staff more often contacted police about suspicious activity (14%), for advice (16.3%) and about protective behaviour training (2.3%). Similarly, police from the beat were more likely to contact staff (27.9%) than were police before there was a beat in the hospital (20.7%). As was indicated in Figure 3.5 (p. 23), during the trial PAHPB officers spent on average 37 per cent of their time conducting hospital inquiries work, which may account for the increase in police contact with hospital staff. Proactive patrolling of the beat area (17%) could also contribute to this increase. While there was no meaningful change from pre-trial to post-trial in the number of staff contacting police to report a crime (14.9% and 14% respectively) or a disturbance (8% and 9.3% respectively), there was a substantial decrease in the number of staff contacting police to report some other problem (pre-trial, 46%; post-trial, 16.3%).

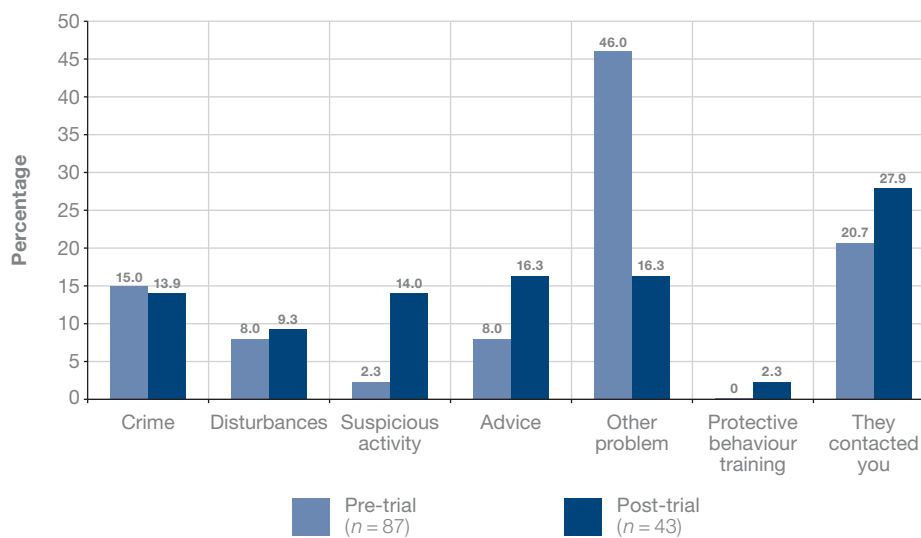
As can be seen in Figure 3.9 (facing page) and Figure 3.10 (p. 32), since the introduction of the PAHPB, hospital staff were not only more likely to contact PAHPB officers, but also more likely to contact security to report suspicious activity (24.3%), for advice (12.2%) and to receive protective behaviour training (4%). It is possible that internal hospital promotion of the PAHPB (for example in the hospital newsletter, or via word of mouth) encouraged staff to use the services offered by beat officers and security.

Figure 3.8: While working have you contacted the police or security about any matter in the last 12 months?



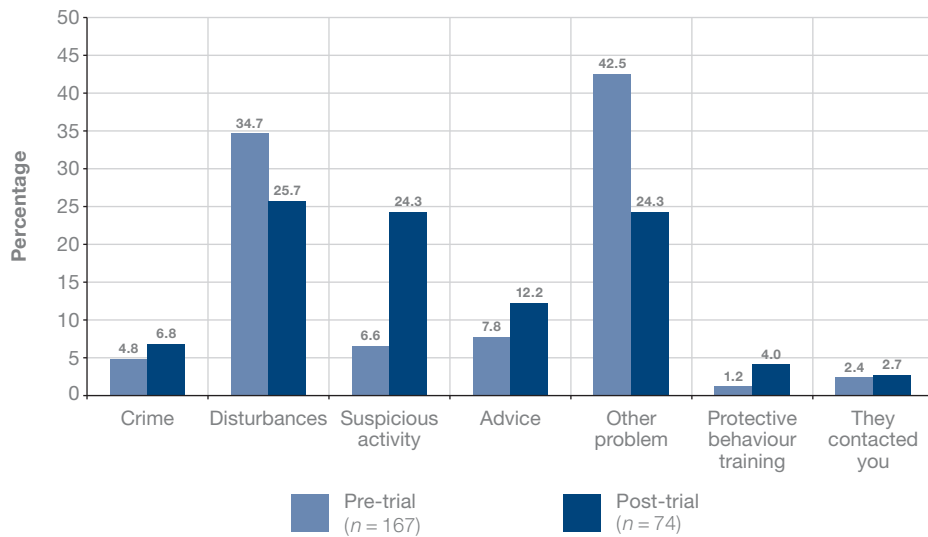
Source: PAHPB hospital surveys (November 2005, April 2006)

Figure 3.9: Last time you had contact with a police officer while working, what was it about?



Source: PAHPB hospital surveys (November 2005, April 2006)

Figure 3.10: Last time you had contact with a security officer while working, what was it about?



Source: PAHPB Hospital Surveys (November 2005, April 2006)

Retailer security

At the outset of the trial, and before the shopping centre was refurbished, retail security was employed to conduct daily random patrols of the centre and car parks. Security is also employed on an ad hoc basis by individual retailers within the centre and at the adjacent retail strip on Tottenham Street, depending on their specific requirements and private or corporate lease agreements.

Unfortunately, although the same questions were asked of retailers as of hospital staff, small sample size precludes any meaningful analysis of the impact of the police beat on relationships between police and security contacts in the retail context. It should be noted, however, that there was a reduction in the number of contacts between retailers and police from pre-trial (69%; $n = 20$) to post-trial (45%; $n = 9$). Frequency of contact also declined, with the average number of times retailers contacted the police in the preceding 12 months going from 3.38 pre-trial ($n = 21$) to 2.60 post-trial ($n = 7$). Once again, it is of concern that these measures were not in the expected direction, given the importance of a commitment from PAHPB officers to establish relationships with the local community.

Summary of Chapter 3

To give a complete picture of the role played by the PAHPB officers, this chapter has presented data on the ways in which they:

- » respond to calls for service and incidents of crime
- » carry out their daily activities
- » respond to hospital inquiries
- » work with other security providers.

We found no change in the types of calls for service or reported crime originating from the PAHPB area. Our analysis of beat officer rosters showed that the majority of calls for service made to police communications were being received during the beat's normal operating hours. Similarly, QPS CRISP data indicated that the majority of reported crimes were being committed during beat operating hours. Furthermore, the evaluation found high levels of support for the spread of hours during which the beat was in operation.

Not surprisingly, PAHPB officers spend a large amount of time on inquiry work, administrative tasks and proactive patrolling. However, of possible concern is the low proportion of officers' time attributed to community policing activities overall, and the decline in these activities over the course of the trial.

The case studies presented in this chapter are two examples of problem-solving by the PAHPB officers during the six-month trial. Given the lack of identifiable problem-solving strategies undertaken with the retail community by the PAHPB officers, we suggest that a stronger commitment to problem-solving should be adopted by the beat officers and police management to ensure that it becomes a greater focus of the PAHPB. The establishment of community partnerships and mechanisms for community feedback are integral to a beat policing model.

The analysis of patrol log data from Metropolitan South Region and the South Brisbane District Inquiry Office indicates an encouraging downward trend in the amount of time spent by general duties and inquiry officers travelling to and from the PAH, and at the PAH, since the introduction of the beat. As might be expected, beat officers' daily logs show a rise in inquiry work during the course of the trial, as the beat officers take on the primary hospital inquiry role for the police service within the PAH.

Introduction of the PAHPB seems to have had no adverse effect on working relationships between hospital staff and security officers. A good collaboration between the PAHPB and hospital security has been established, with the role of security remaining relatively unchanged, as expected.

Chapter 4: Perceptions of safety



This chapter deals with the second of the CMC's evaluation questions: 'Has the PAHPB improved perceptions of safety for hospital staff and Buranda retailers?'

Pre-trial surveys were issued in November 2005,²⁸ and post-trial surveys in April (hospital) and May (retailers) 2006. They were designed to:

- » determine the level of awareness of the beat and assess the extent of police visibility within the beat area
- » identify any meaningful change in perception of safety with the introduction of the PAHPB
- » compare the perception of the role of a PAHPB officer with that of a security officer
- » ascertain the extent to which hospital staff engage in protective behaviours.

In addition to reporting the perceptions of beat area retailers and hospital staff, as determined from survey data,²⁹ this chapter includes comments made during interviews and focus groups that provide further insight into stakeholders' perceptions of safety and security since the introduction of the PAHPB.

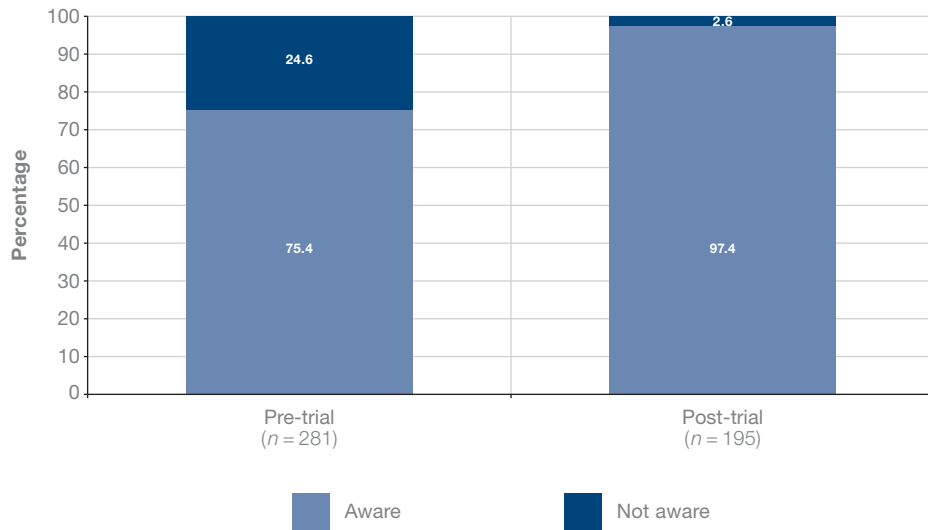
Level of awareness of the PAHPB

Hospital staff and retailers were questioned on their awareness of the existence of the PAHPB at the hospital or campus. As shown in Figure 4.1 (facing page), there has been a statistically significant increase (from 75.4% to 97.4% over the course of the trial) in hospital staff's awareness of the existence of the beat. Given the short timeframe of the evaluation, this is a very encouraging result. It is important that the PAHPB strive to maintain this very high level of awareness. One of the ways in which this could be accomplished is to continue to be involved in the induction of new hospital staff.

28 The pre-trial surveys were conducted in mid-November, after the beat had been operational for a fortnight, due to unavoidable delays with development of the survey instrument. It is believed that this timing will not affect the results, since the beat was only newly established.

29 The total survey sample size reported may vary slightly, due to some missing data. Missing values were scattered randomly throughout the data and therefore are not reported.
Hospital sample size: pre-trial $n = 281$; post-trial $n = 196$.
Retailers sample size: pre-trial $n = 31$; post-trial $n = 35$.

Figure 4.1: Are you aware of the new PAHPB? (hospital staff)



Source: PAHPB hospital surveys (November 2005, April 2006)

In an effort to establish relationships with retailers within the beat area, beat officers introduced themselves to most retailers and issued them with a QPS ‘Keyholders Index’ form at different periods during the trial. The Keyholders Index is a QPS initiative aimed at enabling police to gain quick access to private premises in the event of burglary, storm damage, fire and wilful or accidental damage.³⁰ Details of after-hours contacts, keyholders and contactable private security for each establishment are kept on a central register at the beat.



Beat officers introduced themselves to most retailers within the operational area of the PAHPB.

³⁰ A copy of the QPS Keyholders Index form can be obtained by contacting the QPS.

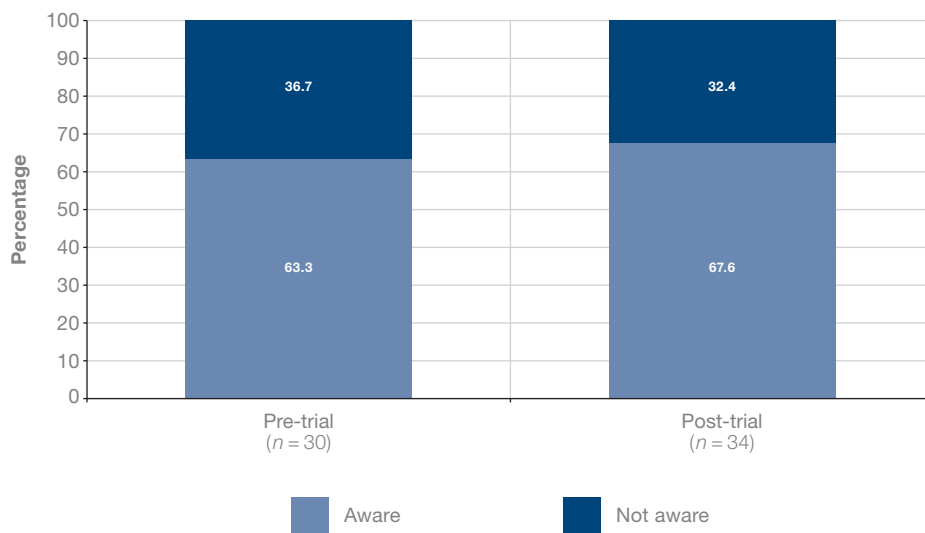
Despite these efforts, only a slight increase in awareness of the PAHPB among retailers by the end of the trial period was achieved, and it was not statistically significant (see Figure 4.2 below). There are some plausible explanations of why the increase in awareness among retailers was less than expected. For example:

- » The refurbishment and redevelopment of the Centro Buranda shopping centre during the trial resulted in the temporary closure of a number of businesses and the introduction of a number of new retailers to the district, possibly limiting the beat officers' opportunity to make or maintain contact with some retailers.
- » The way in which the beat operated, with no front counter, and situated on the hospital campus (thus removed from the retail area), was a barrier to retailers who wanted access to the services provided by PAHPB officers. When retailers were asked what they liked least about the PAHPB, they consistently mentioned its location at the hospital, its lack of accessibility, its 'invisibility', difficulties in finding it, and difficulties in making contact.³¹
- » PAHPB officers had limited time available to spend in areas outside the hospital grounds. When asked how often they spent time in the retail areas, they said:

I'd like to say every shift [proactive patrolling], but it's just not happening, I'd probably, personally I'd be going over once or twice a week. It's not very much but ... because with the phones in here they ring constantly and you are always doing paperwork and chasing up correspondence, so often you are not over there [at the retail precinct] unless there's a job. (Interview, beat officer no. 4)

There is more inquiries stuff here [compared to general duties]. Little bit of general duties thrown in with over the road [retailers, businesses] ... But generally speaking you'd have to say because most of it's correspondence related with the [hospital] warrants and you know getting statements and that sort of thing. (Interview, beat officer no. 3)

Figure 4.2: Are you aware of the new PAHPB? (retailers)



Source: PAHPB retailer surveys (November 2005, May 2006)

³¹ Source: PAHPB retailer survey (May 2006)

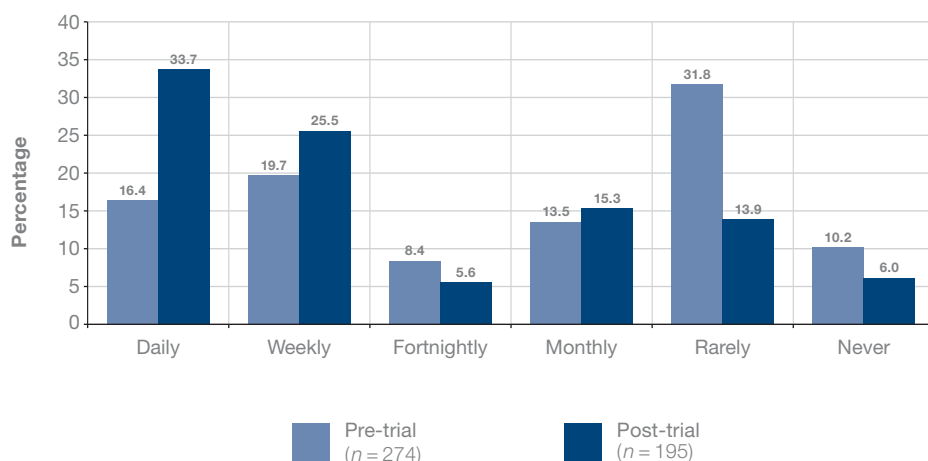
This does not necessarily mean that changes are needed to the beat model, or to the location of the beat office, however. It simply reinforces how important it is for beat officers to engage in additional and frequent non-emergency interactions with retailers and clients outside the PAH campus.

Visibility

Police visibility

Since the introduction of the PAHPB, the visibility of police around the hospital has substantially increased. In the pre-trial survey 36 per cent of hospital staff recalled seeing police at least weekly. This rose to 59 per cent in the post-trial survey (see Figure 4.3). In view of the substantial reduction in the time spent by general duties officers at the hospital during the trial (as reported in Chapter 3), it is probable that this increased visibility can be attributed to the presence of the beat officers.

Figure 4.3: While working or studying at the hospital or campus, how often do you recall seeing a uniformed police officer (not a security officer)? (hospital staff)



Source: PAHPB hospital surveys (November 2005, April 2006)

In the focus groups and interviews, hospital staff expressed reassurance at knowing that the police were on-site, and associated feeling safer in their work environment with a permanent police presence:

... and just knowing they're actually on the campus is good. Yeah, for your own sense of ... just knowing they're there. (Focus groups, hospital, no. 3)

... I know, because of the clientele in the mental health area, they may often not sort of like police because of dealings they've had outside. However, there's a large portion of people there including the patients that feel much safer because, you know, they see the uniform if it's security or police, and it gives them some reassurance as well. (Interview, hospital, no. 4)

The question about seeing uniformed police was an item added to the post-trial survey of retailers. Of 34 respondents, about 40 per cent (41.2%) recalled seeing a police officer while they were working at least weekly during the trial, whereas almost a third of retailers (32.3%) reported that while they were at work they rarely or never saw a police

officer.³² This further reinforces the importance of beat staff increasing their presence outside the hospital grounds.

Security visibility

The majority of hospital survey respondents recalled seeing security staff at least weekly before and after the trial (pre-trial, 93.5%; post-trial, 84.7%).³³

This result was expected, since the role of security officers includes controlling and providing parking, issuing staff with identification tags, monitoring CCTV, providing staff with escorts, and patrolling the hospital grounds.



Since the introduction of the PAHPB, the visibility of police around the hospital has substantially increased.

Security guards are also employed by Centro Buranda shopping centre and by individual stores within the centre on an ad hoc basis, depending on their specific needs and private or corporate agreements. Just over 60 per cent of retailers (61.7%; $n = 34$) who were asked at the end of the trial recalled seeing a security officer at least weekly while working and just over a third (35.3%) said that they rarely or never saw a security officer.

Perceptions of safety before and after the PAHPB

General safety

Hospital staff who had contact with the PAHPB about any matter during the trial were asked to indicate their perception of their personal safety since the introduction of the beat, using a five-point scale ranging from 'extremely safe' to 'extremely unsafe'.³⁴ A low score indicates a higher level of perceived personal safety. The number of staff who indicated a high level of perceived personal safety in the workplace after the introduction of the PAHPB increased by more than one-third (from 43.8% to 78.4%).

Only 1 per cent of staff felt unsafe in the workplace after the introduction of the beat (see Figure 4.4, facing page).

Although retailers also indicated an increased perception of safety since the introduction of the beat (from none to just over 60% safe) the number of retailers who responded was too small to allow any meaningful conclusions to be drawn from the data.³⁵

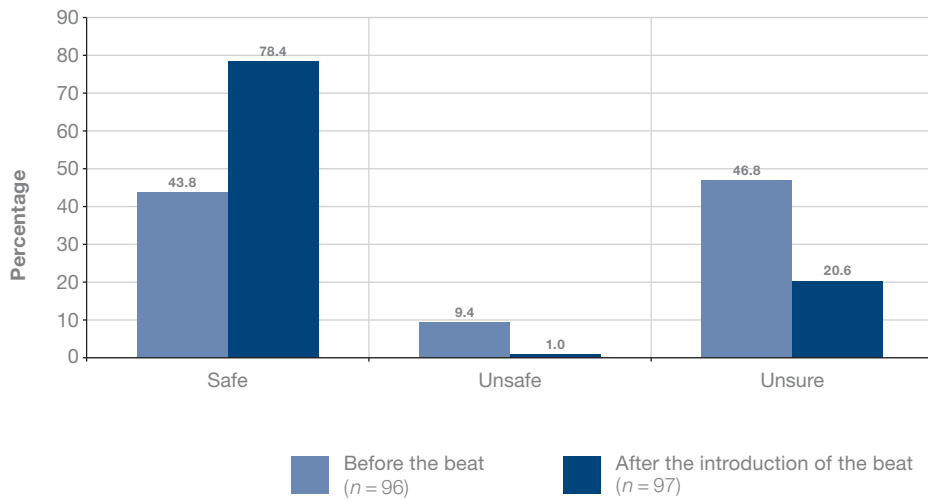
³² The size of the sample was small, making the result less meaningful; however, the survey is representative of the retailers as only a small proportion approached did not complete the survey.

³³ The slight decline in the proportion of hospital staff who recalled seeing security staff on a daily basis is not a significant change. Pre-trial $n = 278$, post-trial $n = 196$.

³⁴ Five-point Likert scale response options: 1 = extremely safe; 2 = very safe; 3 = unsure; 4 = very unsafe; 5 = extremely unsafe.

³⁵ Pre-trial $n = 12$, post-trial $n = 13$. The 60 per cent reported was a rise from no retailers (0%) to eight retailers (61.5%).

Figure 4.4: How safe did you feel in your workplace before and after the introduction of the beat? (hospital staff)



Source: PAHPB hospital surveys (November 2005, April 2006)

Factors associated with perceptions of safety

There was an expectation that beat officers would have a positive influence on hospital staff and retailers' perception of safety. This effect would be the result of beat officers providing an increased police presence, better access to police services and greater opportunity for contact with the police. Participants in the survey did report feeling safer since the introduction of the PAHPB. However, because general perceptions of safety can be influenced by gender, age and environmental factors such as a person's location (Grabosky 1995), hospital staff and retailers were further questioned regarding their perception of safety at various stages during and after their work day. Statistical tests were performed to determine whether there were significant differences in responses as a function of age, gender, current work area and work groups. Tables 4.1 and 4.2 (pp. 40, 42) show the results of this analysis.

As can be seen in Table 4.1 (p. 40), there were higher levels of perceived safety (the lower the mean the greater the perceived safety) after the introduction of the beat in all eight situations. Five of the eight increases were found to be statistically significant (e.g. when working during the day and walking to transport after dark).



Hospital staff and retailers reported feeling safer since the introduction of the PAHPB.

Table 4.1: Indicate in general how safe you feel when ... (hospital staff)

Situation	Pre-trial	Post-trial
Working during the day	1.7 (0.93)	1.4*** (0.61)
Working after dark	3.1 (1.2)	2.5*** (1.4)
Working alone during the day	2.1 (1.02)	1.8*** (0.84)
Working alone after dark	3.6 (1.2)	3.1*** (1.3)
Walking to transport during the day	1.9 (0.98)	1.8 (0.89)
Walking to transport after dark	3.8 (1.2)	3.5** (1.3)
Walking to transport alone during the day	2.04 (1.05)	1.89 (0.93)
Walking to transport alone after dark	4.0 (1.2)	3.8 (1.2)

Source: PAHPB hospital surveys (November 2005, April 2006)

Notes:

- The top number in each case is the mean; the lower number (in parentheses) is the standard deviation.
- Sample size varied for pre-trial from 272 to 277, and for post-trial from 185 to 191, due to some random missing data.
- Lower mean equals higher perceived safety.
- Means have been rounded.
- **p < .01; ***p < 0.001

Further analysis of the hospital survey items revealed other significant findings, including strong gender differences.³⁶ Literature on fear of crime indicates that females are frequently more fearful of possible victimisation than are males (Grabosky 1995). The findings of our evaluation are consistent with the literature, irrespective of the time of the survey. It is not surprising, therefore, to find that male staff in the sample reported significantly higher levels of perceived safety than female staff members across almost all measures, including:

- » working after dark***
- » working alone during the day***
- » working alone after dark***
- » walking to vehicle/public transport during the day**
- » walking to vehicle/public transport after dark***
- » walking to vehicle/public transport alone during the day***
- » walking to vehicle/public transport alone after dark***³⁷

³⁶ Caution needs to be taken in interpreting these findings, because of gender differences in general levels of self-disclosure. For example, a meta-analysis of 205 studies involving 23 702 participants found that women tend to disclose slightly more than men (Dindia & Allen 1992).

³⁷ **p < .01; ***p < 0.001

Interestingly, further analysis of gender differences revealed that female hospital staff in the sample, while feeling more fearful of victimisation than did males generally, also showed statistically significant increases in perceptions of safety after the introduction of the PAHPB. They felt safer working during the day and after dark, working alone during the day and after dark, and walking to transport after dark.³⁸ The only exceptions were when walking to transport during the day and walking alone to transport during the day and after dark. In contrast, males only felt significantly safer working during the day since the introduction of the beat to the hospital grounds.³⁹

A few additional significant differences between hospital staff groups were found. Emergency staff (mean = 2.0) reported significantly lower perceptions of safety during the day than did staff from the spinal injuries unit (mean = 1.49) or 'other' areas (mean = 1.49), as did staff members who worked in the evening (mean = 1.64) compared with staff who did not work in the evening (mean = 1.45).⁴⁰ These findings can probably be explained by the fact that emergency staff are considered 'the front line'. Generally hospital emergency wards are extremely busy and sometimes chaotic environments, often associated with high levels of aggression and violence. Emergency staff (mean = 2.17) also reported a lower level of perceived safety than did staff from 'other' areas (mean = 1.81) when walking to their vehicles or public transport during the day. Approaching statistical significance was the finding that staff who worked in the evening also reported a lower level of perceived safety (mean = 1.92) than did staff who did not work in the evening (mean = 1.75) while walking to public transport during the day.

These findings show the value of beat police familiarising themselves with the safety concerns of hospital staff, and focusing their strategies (such as proactive patrolling) on specific times, places and/or staff types to improve perceptions of safety.

As can be seen in Table 4.2 (next page), there were higher levels of perceived safety after the introduction of the PAHPB in four out of the eight situations (during the evening, alone during the day and during the evening, and walking to transport during the day). However, due to limited sample sizes (some as low as 14 respondents), these findings are not statistically significant. Unfortunately, small sample size also precludes any further meaningful analysis.

Perceptions of the roles of PAHPB officers and of hospital security

Identifying the most suitable service provider

From a list of ten services, participants were asked to indicate whether PAHPB officers, hospital security officers or both should provide these services. There were no statistical differences among responses for nine of the ten services. The average response (collapsing across pre- and post-trial) for the nine services is provided in Table 4.3 (next page).

38 During the day $p < .01$; after dark $p < .001$; alone during day $p < .01$; alone after dark $p < .001$; walking to transport after dark $p < .02$.

39 Working during the day $p < .01$.

40 'Other' work areas included in the sample: various wards, Administration, Surgical, Neurosciences, Quality Improvement, Security, Executive, Switch, Rehabilitation, Pathology and Radiology.

Table 4.2: Indicate how safe you feel when ... (retailers)

Situation	Pre-trial	Post-trial
Working during the day	2.26 (0.58)	2.03 (0.98)
Working during the evening	2.79 (0.82)	2.84 (1.57)
Working alone during the day	2.63 (0.81)	2.90 (1.68)
Working alone during the evening	3.29 (0.73)	3.82 (1.85)
Walking to transport during the day	2.26 (0.58)	2.25 (1.37)
Walking to transport during the evening	3.24 (0.74)	3.46 (1.42)
Walking around the mall during the day	2.0 (0.58)	1.8 (1.08)
Walking around the mall during the evening	2.9 (0.74)	2.23 (1.61)

Source: PAHPB retailer surveys (November 2005, May 2006)

Notes:

- The top number in each case is the mean; the lower number (in parentheses) is the standard deviation.
- Sample size varied for pre-trial from 14 to 31, and for post-trial from 24 to 35, due to some random missing data.
- Lower mean equals higher perceived safety.
- Means have been rounded.

Table 4.3: What services do you think police officers from this beat should provide, and what services are the responsibility of hospital security officers?

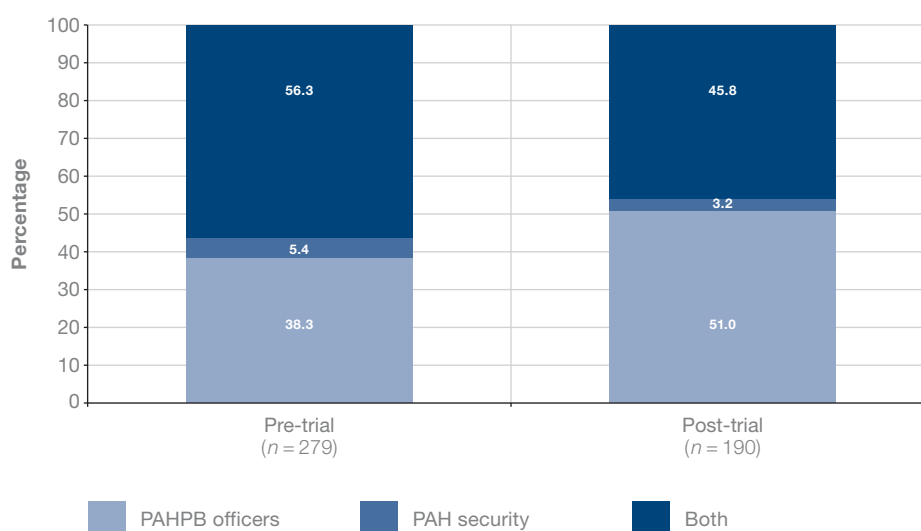
	PAHPB officers %	PAH security %	Both %	Total % (n)
1 Patrolling hospital grounds	2.2	49.7	48.2	100 (463)
2 Dealing with disturbances	10.8	26.8	62.3	100 (462)
3 Dealing with vandalism/property damage	41.9	11.5	46.6	100 (461)
4 Assisting staff who need information/advice on personal safety and security matters	9.6	39.7	50.7	100 (469)
5 Providing staff with an escort to their vehicle/ public transport after dark	0.4	94.5	5.1	100 (467)
6 Recovering stolen property	63.4	4.7	31.9	100 (467)
7 Taking a crime report	83.1	1.1	15.8	100 (467)
8 Taking a report about a suspicious activity	28.8	20.5	50.7	100 (469)
9 Responding to an emergency situation	7.8	11.2	81	100 (464)

Source: PAHPB hospital surveys (November 2005, April 2006)

Note: Sample size varies, and some percentages do not total 100 due to some random missing data.

The tenth service, responsibility for ‘assisting staff, patients or visitors who have been witness to or victim of a crime in the hospital grounds’, was scored significantly different across the two periods (Figure 4.5). After the PAHPB had been in operation for six months, there was an increase of more than 10 per cent in the number of hospital staff who felt that the beat officers held this responsibility. There was a slight decrease in the number of hospital staff who felt that both police beat officers and hospital staff should perform this service.

Figure 4.5: Service provision: ‘assisting staff, patients or visitors who have been witness to or victim of a crime in the hospital grounds’



Source: PAHPB hospital surveys (November 2005, April 2006)

Protective Behaviours program

The QPS Protective Behaviours program is designed to help people improve their problem-solving and communication skills, encourage them to identify situations that are potentially unsafe, and teach them to develop strategies to counter these situations.⁴¹ During the trial, one of the PAHPB officers, a trained Protective Behaviours facilitator, gave a series of presentations to staff at the hospital.⁴²

... It's an ongoing thing over a fair period of time [i.e. the Protective Behaviours presentations] because there's 5500 staff here and it'll reach a point where they'll want us to do presentations at their [hospital staff] inductions. We do a presentation at inductions but it's of a limited variety and these lectures that we are giving now in relation to protective behaviours, they are too big to be included in the initial inductions. (Interview, beat officer no. 1)

41 Details are available from the QPS: < <http://www.police.qld.gov.au/programs/protectiveBehaviours/>>.

42 The Protective Behaviours program was conducted on the hospital grounds and was not offered or promoted to beat area retailers.

Hospital staff were asked whether or not they had attended a Protective Behaviours program presented by police during their time working at the hospital. Within the sample it was found that the number of staff participating in a program doubled in the first six months of the opening of the police beat in the hospital (pre-trial, 7.3%; post-trial, 15.1%).

I think part of the presentations that the police officers did for us on the personal protection sort of stuff, and the big impact of that was actually just telling people what's in our local area; you know what are the hotspots if you like, or the danger points, and you think, 'Oh, I'm definitely not walking to my car at night time now.' Yeah, so I think [the presentations] really sort of hit home. (Focus groups, hospital, no. 5)

Hospital staff were also provided with a list of activities that some people engage in to enhance their personal safety. Staff were then instructed to indicate whether or not they had engaged in any of these for the purpose of working at the hospital. Averaging across the two survey periods, the most commonly used protective behaviours by hospital staff were:

- » avoiding unsafe areas during the night because of crime (82.5%)
- » using lighted walkways, even if this means going out of my way (74.1%)
- » regularly checking people's identification if they are unfamiliar (72%)
- » parking my vehicle on hospital property (designated property; 69%)
- » avoiding unsafe areas during the day because of crime (58.9%)
- » walking to transport in groups during the evening (55.3%).

The survey revealed that less than 20 per cent of staff had limited or changed their daily activities in the past year because of crime (18.7%), started carrying something to defend themselves (12.4%), or used the hospital's safe to lock up valuables (11.8%). While just over one-fifth of staff (22.2%) walked to their transport in groups during the day, nearly 30 per cent (28.7%) of staff said that they had learnt more about self-defence.

As can be seen in Table 4.4 (facing page), tests for significant differences in the engagement of protective behaviours after the introduction of the PAHPB revealed the following significant differences:

- » There was an increase from pre-trial (25.3%) to the end of the trial (32.1%) in the proportion of staff learning more about self-defence.
- » There was an increase of approximately 10 per cent from the beginning of the trial (12.8%) to the end of the trial (23.2%) in the proportion of staff using the hospital's shuttle bus.
- » From pre- to post-trial, the proportion of staff attending a Protective Behaviours program run at the hospital by police approximately doubled (from 7.3% to 15.1%).

Table 4.4: Extent of engagement by hospital staff in personal protective behaviours

Protective behaviour:	Pre-trial			Post-trial		
	Yes	No	Consi- dered/ plan to	Yes	No	Consi- dered/ plan to
I have learnt more about self-defence.	25.3	57.6	17.1	32.1 ^{▲**}	39.4	28.5
I avoid unsafe areas during the day because of crime.	58.9	38.1	3.0	58.8	37.3	3.9
In the past year I have limited/changed my daily activities because of crime.	18.7	79.4	1.9	18.6	77.3	4.1
I walk to my transport in groups during the evening.	55.0	39.9	5.0	55.6	34.9	9.5
I regularly check people's identification if they are unfamiliar.	68.4	25.9	5.7	75.6	18.1	6.2
I use the hospital's shuttle bus service.	12.8	83.8	3.4	23.2 ^{▲*}	71.1	5.8
I have attended a Protective Behaviours program run at the hospital by police.	7.3	87.2	5.5	15.1 ^{▲**}	68.2	16.7
I have started carrying something to defend myself.	11.8	84.9	3.3	12.9	79.4	7.7
I avoid unsafe areas during the night because of crime.	82.0	16.5	1.5	82.9	13.5	3.6
I walk to my transport in groups during the day.	21.9	0.0	77.7	22.4	75.0	2.6
I use lighted walkways even if this means going out of my way.	72.9	25.9	1.1	75.3	21.6	3.1
I use the hospital's safe to lock up my valuables.	10.1	89.1	0.7	13.5	85.0	1.6
I park my vehicle on hospital property (designated parking).	64.9	33.2	1.9	73.1	25.3	1.6

Notes:

- Percentages reported. Percentages may not total 100 due to some random missing data.
- Sample size varied for pre- to post-trial due to some random missing data.
- *p < 0.005; **p < .01; ***p < 0.001 (t-tests)

Summary of Chapter 4

An important aim of the PAHPB was to improve the perceptions of safety for hospital staff and retailers. Focus groups and interviews were conducted, and pre- and post-trial surveys were designed to examine a number of factors including:

- » stakeholders' level of awareness of the PAHPB
- » visibility of the police officers
- » perceptions of safety among hospital staff and retailers
- » the roles of the beat officers and security officers
- » the extent to which hospital staff were engaging in protective behaviours since the introduction of the beat.

Overall, hospital staff's perceptions of safety had improved over the course of the six-month trial period. By contrast, it was a matter of concern that retailers' level of awareness of the PAHPB had increased less than expected, and this might have had an impact on their overall perceptions of safety working in the beat area. For this reason, it is important that PAHPB officers focus on communicating and forming relationships with the retailers and clients outside the hospital campus.

The key findings from this chapter are summarised in Table 4.5 below.

Table 4.5: Summary of key findings

Measures	Hospital staff	Retailers
Level of awareness	There was a significant increase in awareness of the PAHPB among hospital staff since the start of the trial (from 75% aware to 97% aware).	A slight increase in retailers' awareness of the PAHPB since the start of the trial (from 63% aware to 67% aware).
Visibility	Substantial increase in visibility of police at the hospital. Pre-trial 36% reported seeing police at least weekly; this increased to 59% by the end of the trial.	Post-trial, 41% saw police at least weekly and 32% rarely or never saw police.
General perception of safety	A 34.6% increase in perceptions of personal safety since the introduction of the PAHPB (from 44% safe to 78% safe).	The PAHPB appeared to increase perceptions of safety; however, sample size was too small for conclusions to be drawn from the data.
Specific measures: – working during the day/after dark – working alone – walking to transport	Significant improvements in safety were found post-trial for staff working during the day; working after dark; working alone during these times; and walking to transport after dark. Higher levels of safety were also found for staff walking to transport during the day; walking to transport alone during the day; and walking to transport alone after dark. Strong gender differences were observed, with male staff reporting significantly higher levels of perceived safety than females across most measures.	Higher levels of perceived safety for staff working and walking to transport during the day, walking around the mall during the day and in the evening; however, limited sample size precluded further meaningful analysis.

(Continued)

Table 4.5, continued

Measures	Hospital staff	Retailers
Suitable service provider	<p>Overall staff felt that both PAHPB and security officers should be responsible for patrolling; dealing with disturbances; dealing property-related incidents; assisting staff and providing personal safety advice; taking a report about suspicious activity; and responding to an emergency. Security officers were seen as exclusively responsible for providing escorts to transport, and the PAHPB for recovering stolen property and taking a crime report.</p> <p>Significant change over the course of the trial for one service was observed: a 10% increase in the number of staff who felt beat police should be responsible for assisting people who had been witness to or victim of crime.</p>	Questions were not included on the retailer survey.
Protective behaviours	<p>Significant differences in the engagement of protective behaviours from pre- to post-trial included an increase in the number of staff learning about self-defence (from 25% to 32%); a 10% increase in proportion of staff using hospital shuttle buses (from 13% to 23%); and participation in the Protective Behaviours program increased from 7% to 15%.</p>	Questions were not included on the retailer survey.

Note: Percentages have been rounded.



There was a significant increase in awareness of the PAHPB among hospital staff over the course of the trial.

Chapter 5: Stakeholder satisfaction



This chapter deals with the third of the CMC's evaluation questions: 'Are stakeholders satisfied with the PAHPB?'

It was envisaged that there would be an improvement in clients' level of satisfaction with the delivery of policing services over the course of the PAHPB trial. The chapter explores the responses of hospital staff and retailers to survey questions about the services provided by the police beat, and how they might be improved. It examines qualitative data collected in interviews and focus groups with QPS beat officers, QPS and PAH management, hospital staff and retailers. This assessment will help the PAHPB to determine the areas of service delivery that need to be targeted for improvement.

Measures of satisfaction

At the end of the PAHPB trial, those participants who had had contact with beat officers about any matter since its opening were asked to indicate their level of satisfaction with the service they provided. For the purposes of this project, satisfaction was defined as the extent to which hospital staff and retailers were satisfied with:

- » quality of service
- » professional conduct
- » courteousness
- » amount of information provided
- » timeliness of service
- » quality of information provided
- » accessibility/availability.

Participants were also asked to compare the current service provided by the PAHPB with what they perceived would be the ideal service. Statistical tests were applied, to determine whether there were significant differences in responses as a function of gender, age, current work position, work area, work status, and whether or not work was performed in the evening. The only significant differences were found for current work position within the hospital and hospital work area (but none identified for age, gender or work status).

The retailers sample became too small for statistical tests to be performed when retailers who had not had any contact with beat police during the trial period were excluded. (The sample was reduced to less than half.) Each dimension of satisfaction is explored in greater detail in the sections that follow.⁴³

⁴³ Dimensions with the same scale have been grouped together within the chapter, to avoid unnecessary duplication.

Quality of service provided and professional conduct of the PAHPB officers

Hospital staff and retailers were asked to comment on the **quality of service** provided by PAHPB officers and their **professional conduct** on a five-point scale ranging from ‘far above average’ (1) to ‘far below average’ (5).⁴⁴

Three-quarters of hospital staff indicated that the quality of service provided by the PAHPB was above average (see Table 5.1). Staff from the Mental Health Unit (mean = 1.5) and the Spinal Injuries Unit (mean = 1.7) gave a slightly higher rating to the quality of service than did staff from ‘other’ areas (mean = 2.3).⁴⁵

The following comment provides a concrete example that clearly illustrates the professional approach taken by officers working at the beat:

I have been extremely impressed by the skill and by the sensitivity ... by their ability to assess the situation in a very practical way and come up with very soft shoe practical solutions ... (Focus groups, hospital, no. 2)

Of the 13 retailers who had contact with police during the trial, nearly two-thirds felt the quality of service provided by the PAHPB was above average. No retailers considered the quality of service to be below average. Their comments included the following:

The officers were friendly, professional, prompt and very helpful ... it’s improved the quality of working life at Buranda. (Retailer survey, respondent no. 33)

Police from the PAH beat have come over to introduce themselves and make sure we know they’re there. Very good service! (Retailer survey, respondent no. 1)

Table 5.1: Respondents’ satisfaction with service quality and professional conduct

Satisfaction dimension	Respondents	Above average %	Average %	Below average %	Total n
Quality of service	Hospital staff	75	24	1	94
	Retailers	61	39	0	13
Professional conduct	Hospital staff	85	15	0	95
	Retailers	61	39	0	13

Source: PAHPB hospital survey (post-trial: April 2006) and retailer survey (post-trial: May 2006)

Notes:

- Sample size varies due to some random missing data.
- Caution must be taken interpreting results of retailer survey given small sample size.
- Percentages have been rounded.

44 Five-point Likert scale response options: 1 = far above average; 2 = above average; 3 = average; 4 = below average; 5 = far below average. A lower mean indicates a better quality of service and a higher level of professional conduct.

45 $p < .001$; ‘other’ work areas included in the sample: various wards, Administration, Surgical, Neurosciences, Quality Improvement, Security, Executive, Switch, Rehabilitation, Pathology and Radiology.

A total of 85 per cent of hospital staff indicated that they felt the level of professional conduct of the PAHPB officers was above average, and no staff considered it to be below average. Allied Health Staff (e.g. physiotherapy, speech therapy; mean = 1.2) perceived the level of professional conduct to be slightly higher than did staff from the 'other' category of positions (predominantly nurses; mean = 1.8).⁴⁶

Well over half of retailers (61%) felt the level of professional conduct shown by the PAHPB officers to be above average, and all of the rest (39%) felt it was average. No retailers reported feeling that the level of professional conduct was below average.

Courteousness, amount of information and timeliness of response

Hospital staff and retailers were asked to indicate, on a five-point satisfaction scale ranging from 'very satisfied' (1) to 'very dissatisfied' (5),⁴⁷ their level of satisfaction with the courteousness, amount of information provided, and time it took PAHPB officers to respond to queries. Key findings include the following (see also Table 5.2, facing page):

- » Nearly all hospital staff (91%) and retailers (85%) were satisfied with the level of courteousness of the PAHPB officers. This view was also shared by participants of the focus groups and interviews, the majority of whom found PAHPB officers to be friendly and polite.
- » Most PAH staff (80%) were satisfied with the amount of information provided to them by officers from the PAHPB. Staff from the Emergency Department (mean = 1.6), Mental Health Unit (mean = 1.2) and Spinal Injuries Unit (mean = 1.5) were slightly more satisfied with the amount of information provided by the PAHPB than were staff classified as 'other' (mean = 2.2).⁴⁸ This finding was expected, as the three units named were identified before the trial as having the highest frequency of contact with police, and were therefore approached by PAHPB officers when the trial started and provided with information about the role of the beat in the hospital.
- » Just over three-quarters of retailers (77%) were satisfied with the amount of information provided by the PAHPB officers. Less than 10 per cent of retailers (8%) were dissatisfied with the amount of information shown by officers from the beat (however, the sample size was small).
- » About two-thirds of retailers (66.7%) were satisfied with the response time of the PAHPB officers. No retailers reported dissatisfaction with the response time. Approximately three-quarters of hospital staff (73%) were satisfied with the amount of time it took for the PAHPB to respond to queries. Only 3 per cent of hospital staff were dissatisfied with the response time of PAHPB officers. Staff from the Mental Health Unit (mean = 1.2) and the Spinal Injuries Unit (mean = 1.6) were slightly more satisfied with the response time of the PAHPB officers than were staff classified as 'other' (mean = 2.2).⁴⁹

46 Position categories included: student, allied health, support services, external contractor, technician, scientist and 'other' (93% of the 'other' category were nurses; 7% were administrators and doctors).

47 Five-point Likert scale response options: 1 = very satisfied, 2 = satisfied, 3 = neither satisfied nor dissatisfied, 4 = dissatisfied and 5 = very dissatisfied. Low scores indicate a higher level of satisfaction.

48 $p < .002$

49 $p < .005$

A staff member from the Mental Health Unit provided insight into situations in which a timely and appropriate police response is of particular importance to staff:

There have been times when visitors have been bringing ... there's been drug activity, you know, with visitors and coming into the ward, and things like that, and the police beat has certainly been involved and have been very responsive ... I think very responsive. Very quickly, and have done a very good job, very efficient, done in a really good way. That's probably the biggest advantage that we're seeing, from the police beat, for our service, yeah. There's that fast response too ... To all those sorts of situations, and look, it's that fast response that de-escalates a lot of the anxieties of a lot of our patients as well. In past times it could have been a 24-hour response. In that time the anxieties have escalated to a point where, you know, patients need to be compensated or there could be further activities, mental activities, as a result. (Focus group, hospital, no. 3)

Table 5.2: Satisfaction with courteousness, amount of information provided and timeliness of response

Dimension	Respondents	Satisfied %	Neither %	Dissatisfied %	Total n
Courteousness	Hospital staff	91	7	2	97
	Retailers	85	15	0	13
Amount of information	Hospital staff	80	15	5	98
	Retailers	77	15	8	13
Timeliness of response	Hospital staff	73	24	3	91
	Retailers	67	33	0	12

Source: PAHPB hospital survey (post-trial: April 2006) and retailer survey (post-trial: May 2006)

Notes:

- Sample size varies, due to some random missing data.
- Caution must be taken interpreting results of retailer survey, given small sample size.

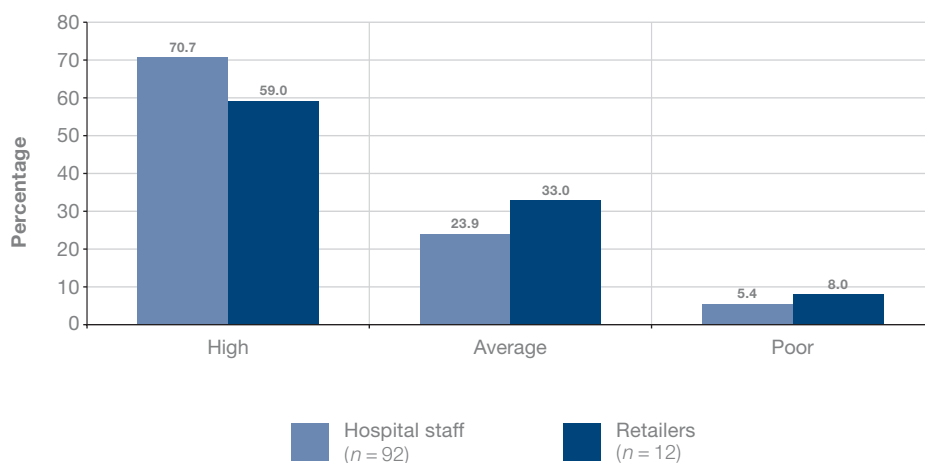
Quality of information provided

Survey respondents were questioned on their perception of the quality of information provided by officers from the PAHPB on a five-point scale from 'very poor quality' (1) (information vague and unhelpful) to 'very high quality' (5) (very helpful; gave clear instructions).⁵⁰ High scores indicate a higher quality of information provided. As Figure 5.1 (next page) shows, while just over 70 per cent of hospital staff (70.7%) reported that the quality of information provided by beat staff was of high quality, nearly a quarter (23.9%) indicated that the quality of information provided was average. Staff from the Spinal Injuries Unit (mean = 4.2) perceived the quality of information provided to be slightly higher than did staff classified as 'other' (mean = 3.6).⁵¹ Well over half of retailers (59%) felt the quality of information was of high quality, and less than 10 per cent of retailers (8%) felt the quality of information was poor.

⁵⁰ Five-point Likert scale response options: 1 = very poor quality; 2 = poor quality; 3 = average quality; 4 = high quality; 5 = very high quality.

⁵¹ $p < .02$

Figure 5.1: Satisfaction with quality of information provided by PAHPB officers



Source: PAHPB hospital survey (post-trial: April 2006) and retailer survey (post-trial: May 2006)

Accessibility

Using a six-point scale ranging from ‘always’ (1) to ‘never’ (5),⁵² hospital staff were asked to indicate how readily accessible officers from the PAHPB were if staff needed to contact them. Low scores indicate higher accessibility. The overwhelming majority of staff felt that the police were readily accessible (see Table 5.3). Only 4 per cent of staff felt that police officers were rarely or never accessible. Staff from the Spinal Injuries Unit (mean = 1.7) reported a slightly higher level of accessibility than did staff from the category ‘other’ (mean = 3.3).⁵³ Retailers also indicated satisfaction; however, due to small sample size, the respondents would not constitute a representative sample.

Table 5.3: Satisfaction with accessibility/availability of PAHPB officers

Dimension	Respondents	Often/always %	Sometimes %	Rarely/never %	Total n
Accessibility/availability	Hospital staff	85	11	4	74
	Retailers	83	0	17	6

Source: PAHPB hospital survey (post-trial: April 2006) and retailer survey (post-trial: May 2006)

Notes:

- Total n is slightly smaller because this question was not applicable for 20 hospital staff participants (21.3%) and 5 retailers who were advised not to contact the PAHPB directly.
- Caution must be taken in interpreting the results of the retailer survey, given small sample size (17% represents only one respondent).

⁵² Six-point Likert scale response options: 1 = always; 2 = often; 3 = sometimes; 4 = rarely; 5 = never; 6 = ‘Not applicable — I was advised not to directly contact the PAH Police Beat.’

⁵³ p < .02

At the beginning of the trial it was decided that, in keeping with a ‘closed door’ beat model, hospital security staff would remain the primary point of contact between hospital staff and the PAHPB. Communications to hospital staff reiterated this arrangement. For example, an article in *WhisPAH* (hospital staff newsletter), stated:

Hospital Security remains the primary point of contact for staff, patients and members of the public using the hospital facilities and all inquiries relating to issues or incidents occurring on the hospital campus should continue to be directed to Security as usual. (PAH 2005)

In spite of the high levels of satisfaction expressed by staff in the surveys, participants in focus groups and interviews expressed confusion about the accessibility of the beat. Participants were not confident in their recall of the exact spread of beat office hours, the number of beat staff, the location of the beat, or how to contact it. Some staff had been given the direct phone number, unbeknown to others.

There was some debate surrounding the role of security staff since the introduction of PAHPB; some staff said they had been informed that the role of hospital security had not changed and it remained the ‘first port of call’, while others believed there were exceptions to this rule and the beat could be called directly. Overall, staff were unclear of the protocols directing their interactions with PAHPB officers, and felt dissatisfied with the piecemeal way in which information about the beat had been distributed to them by the hospital before and during the trial. There was a general feeling that inconsistent and often ambiguous information about the purpose of the police beat hampered their efforts to establish working relationships with beat officers. For others, lack of communication had direct implications for their work, impeding their ability to do their job efficiently.

The following is an example given by a hospital employee who received a request from a beat officer on the day of the interview:

Like today, we had the police beat officer ring up and wanted to page one of the doctors that was away on leave because he’s had a summons to court, to appear in court tomorrow, and of course we can’t do that, because we’ve been told, you know, you can’t just put it back through to the beat office, which is silly for us. I mean the police beat officer wants a doctor in the hospital. The simple way is for us to page the doctor on his pager and leave a message for him to call back on the police beat number ... But we’re not allowed to do that. So what do we do? Do we page that doctor back to Dutton Park, and Dutton Park doesn’t know what he’s talking about? (Focus group, hospital, no. 4)

Staff expressed a need for clear and detailed information, and well-defined protocols, about when the PAHPB could be contacted and the appropriate way to do it.

I think one of my frustrations too was this assumption that I would always contact the wrong person, so as an adult working in a fairly intense environment, I’m not able to make a reasonable decision, or might even be redirected if I’ve made the wrong decision. So, yeah, that really ticked me off. (Focus group, hospital, no. 5)

In addition, some staff believed that the way the beat had been set up (closed beat model) was contradictory to their views of what a PAHPB should be:

I think we had this initial image of like the police beat in Queen Street Mall, where they’re out there, open and present. If you want to inquire, why can’t that

still happen, even if someone did come up with an inquiry that they need to direct back to their own local police station? Surely they can just be told to do that? ... It's called the police beat ... but this one, it's a police hide-out. That's what I feel it is. It's not a police beat, it needs a different name. (Focus group, hospital, no. 5)

Perhaps from an organisational point of view, we felt with an open door system there was some concern ... Will some people be deterred from using the hospital for accessing health care service? Applying a bit of logic, I doubt that very much. If you're sick, no matter who's present, you're going to go and get health care ... Let's give [an open door system] a try, see what happens. (Focus group, hospital, no. 4)

Another factor that influenced communication was clarity about the beat officers' role. PAHPB officers were new to beat policing and had no similar models of beat policing in the Queensland or national context to guide them. Staff perceived that the beat officers were unfamiliar with the role they would play in the hospital:

One of them [beat officer] came up. I showed him around and he was very keen to know about how the unit worked and how they could possibly fit in, but I think in those early stages, they weren't really sure about how they were going to fit in either, and their understanding was that they wouldn't be a first port of call. It would be Security first, who would then direct them appropriately to the police, so they were never directly in the chain from an early start. (Focus group, hospital, no. 5).

The issue of the accessibility of beat officers to hospital staff is multifaceted. High levels of satisfaction were observed among those staff members surveyed who *had* contact with the PAHPB during the trial. However, many staff in the focus groups expressed confusion or dissatisfaction with the model of policing selected, and about communication regarding this model. The decision to have a closed model on campus meant that the communication strategy used by the hospital and the beat needed to be broad-reaching, to inform staff of their responsibilities while also taking care not to overwhelm PAHPB officers with staff and public interest. Not only would this change the nature of the work of the beat on the campus; it could also discourage potential patients from seeking medical treatment. The following comments were made by beat officers:

... Generally speaking, if it was a shopfront beat because of the increase of traffic into the office there wouldn't be as much proactive work and I think that would sort of go against the ideal of what we're trying to achieve out of this beat. In that we're trying to increase the awareness and sort of increase the perception of safety. So if we're stuck in the office we're not out of the office doing our job ... that's the problem I think ... If you were to make it a shopfront, then you'd be looking at, I think, an increase in staff even so you could allow for someone permanently at the counter. (Interview, beat officer no. 5)

I think in this case here because they have a million people a year passing through it ... not just that but the hospital staff would see that any issues that they'd have in their home or wherever they might live. It would interfere with the operations. You would never get out of the office because you'd be sitting on the counter full time. (Interview, beat officer no. 1)

Finally, as was shown in Table 5.3 (p. 52), only a small number of retailers ($n = 6$) had any contact with the PAHPB during the trial. Although this group is too small to be

representative, comments from the larger sample (including those retailers with no contact with the PAHPB) reflected frustration with the beat’s location on the hospital campus. In an open-ended question, respondents were asked what they ‘liked least about the PAHPB service’. Comments included the following:

That we can’t call directly. By the time I get transferred from Dutton Park to wherever else they send me it is often too late. (Retailer survey, respondent no. 32)

It’s secretive. I had trouble finding it in the hospital. (Retailer survey, respondent no. 33)

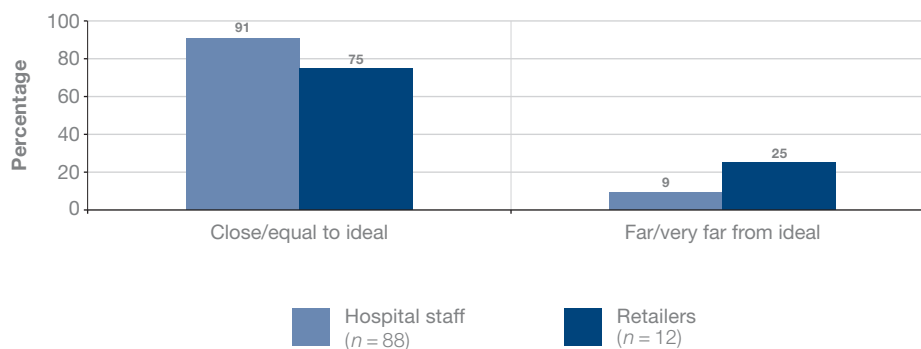
Needs to be more visible. (Retailer survey, respondent no. 34)

Ideal service

The final scaled satisfaction question on the survey read: ‘... How far from your ideal was the service you received?’ Responses were on a five-point scale from ‘very far from ideal’ (1) to ‘equal to ideal’ (5), with higher scores indicating a better service provided by the PAHPB.⁵⁴ Results revealed that nearly all hospital staff (90.9%) and retailers (75%) felt that the current service provided by the beat officers was close to or equal to the ideal service. Less than 10 per cent of hospital staff (9.1%) and 25 per cent of retailers felt that the service provided by the PAHPB was far from or very far from ideal (see Figure 5.2).

Staff from Allied Health (mean = 4.3) felt that the service was more ideal than did staff from Support Services (mean = 3.1).⁵⁵ Furthermore, staff from the Mental Health Unit (mean = 4.3) and Spinal Injuries Unit (mean = 4.2) felt the service provided by the PAHPB was closer to their ideal than did staff from ‘other’ work areas (mean = 3.3).⁵⁶ The reasons for these differences are unclear; however, higher satisfaction may be related to higher levels of contact with the beat officers.

Figure 5.2 Closeness to ‘ideal’ service provided by PAHPB officers



Source: PAHPB hospital survey (post-trial: April 2006) and retailer survey (post-trial: May 2006)

⁵⁴ Five-point Likert scale response options: 1 = very far from ideal; 2 = far from ideal; 3 = close to ideal; 4 = very close to ideal; 5 = equal to ideal.

⁵⁵ $p < .04$

⁵⁶ $p < .001$

Barrier to an ideal service: conflicting roles

It is clear that service users were satisfied with the service being provided by the PAHPB officers, rating it close to ideal. However, during informal discussions, focus groups, stakeholder meetings and interviews, the issue of patient information disclosure was discussed at length. It is fair to say that police requests for the disclosure of confidential patient information has presented an operational challenge for hospital administration and staff, as well as for PAHPB officers, since the beginning of the trial. The main problem identified is the tension created by the conflicting roles and competing interests of police and hospital staff. Put simply, the PAHPB officers require the release of specific confidential patient information to perform their investigative role and to assist other police, whereas hospital staff have a responsibility to only release patient information in accordance with strict provisions that have been designed to protect the confidentiality of such information.⁵⁷

Beat police and senior police management stated that they respected the hospital's existing procedures; however, they believed that the police were acting in the best interests of the public in the course of their duty. In contrast, hospital management, while recognising the importance of establishing a collaborative working relationship with beat police, felt strongly that it was necessary to maintain a system of tight control on patient information.

We've been hearing a lot of positive things about the relationship, but equally well, I think, there is inevitably a bit of tension between doctors and the police, because we've got our patients' interests as the primary concern ... (Focus group, hospital, no. 5)

Of course they just want their information and I understand that ... but they have to understand that a hospital is bound by legislation as well. We can't release it in certain circumstances ... And the consequences for the hospital, should we become more relaxed about certain legislation, is that we can be sued ... we can lose our jobs, we can have disciplinary action taken against us, and we can be charged with an offence if it is pursued. There are ramifications for our staff ... by breaching the rules ... So staff have an awareness of this and act accordingly. (Interview, hospital, no. 2)

The opinions and frustrations of the hospital and police are both valid and relevant to the real pressures both parties face in an operational context. However, the situation was not helped by the fact that at the end of the six-month trial the memorandum of understanding between QPS and the PAH covering police access to patient information was still in draft form. In addition, no documented information-sharing agreements between the QPS and PAH have been developed and formalised, nor has it been clarified under what circumstances it would be appropriate for police to make direct contact with hospital staff. There are also no procedures governing police access to patient information, or contact with the patients themselves, after normal business hours.

It is important that both parties work to develop specific procedures and guidelines to clarify these matters, and communicate them to hospital staff and police.

⁵⁷ During the trial, 37% of beat officers' activities consisted of performing this work, such as obtaining doctors' statements and medical records, serving summonses and subpoenas on medical staff, patients and/or visitors, and obtaining the health status of patients. (For a full list of activities, see Appendix.)

Job satisfaction among beat officers

Beat officer positions for the PAHPB trial were designated at the rank of Constable, Senior Constable and Senior Sergeant (Officer in Charge). Expressions of interest were sent out to the district, and all officers selected and seconded to beat positions held substantive positions within the Dutton Park Division. First year constables were used intermittently throughout the trial. None of the officers had previous beat experience or specialist beat training. Selected officers brought a range of previous policing experiences including general duties, single-staffed station houses, police communications, CIB, crime prevention, inquiries and interstate. According to senior police management officers were selected for their 'good communication skills, strong work ethic, and willingness to take on new and different tasks'.

At the end of the trial a series of in-depth interviews with beat officers were conducted to establish, among other things, a sense of their level of satisfaction with the PAHPB trial experience. Specific questions covered:

- » level of satisfaction with the position and their perception of morale
- » impressions of the need for training
- » perceptions of management support
- » suggestions for improvement.

Overwhelmingly, officers reported positive assessments of job satisfaction, indicating high levels of personal satisfaction with their involvement in the trial and excellent morale.

This was reflected in officers' comments during one-on-one interviews:

If I was asked if I'd rather be here than anywhere else I would say here, because it suits me. I like the work and I like the job. I know what it entails. For me personally, I like it. (Interview, beat officer no. 1)

Definitely, yeah, I enjoyed it. I've enjoyed it a lot. It sort of had the best of both worlds. You still got the opportunity to go out and turn people over, you still got the opportunity to do your presentations etc., but you're not stuck doing night work all the time. Everyone comes in, automatically checks the trays and just gets the job done ...

Everyone's sort of got that motivation to do it, and that's probably the best part of this, that there's a really good crew here and everyone's sort of chipping in and doing the work. (Interview, beat officer no. 5)

It's probably got a bit more job satisfaction than [general duties], you know, because we've got a rapport with a lot of people in the beat, which makes



Beat officers reported high levels of personal satisfaction with their involvement in the trial.

the job a bit easier and a bit more satisfying, and they're appreciative of what we do. You yeah, it just adds to the job satisfaction. (Interview, beat officer no. 3)

Everyone seems to be pretty happy. Certainly when I first came here, that was certainly the impression that I got that everyone was really keen, and happy to be here and that always helps, you know, coming to the beat here. Everyone has always been more than happy to come to work here and that's certainly shown when you work with people where everyone is keen to get in and do what they can, and you can get a good sense for that usually fairly early on. For me that's been a good thing, coming from where I'm come from. (Interview, beat officer no. 6)

It's sort of got a bit of everything, it's a good working environment. It seems to be very QPS friendly in that it's creating a great system, a practical system for doing a lot of our duties whether it be, you know, patient status, doctors' statements, medical records — seems to channel everything through and create a system that is working very effectively. It's a good environment in that the staff at the hospital are very friendly to us, and we're very accessible to the staff at the hospital, for their needs. So we're sort of providing a quicker response. Better advice because they know us all personally ... and they sort of trust in our judgment a bit better. They sort of all seem to be the key points as to why it's such a positive environment. I really can't see this failing, if ever. (Interview, beat officer no. 5)

Although satisfied in many respects, officers and senior police management also acknowledged that service delivery might have been improved by the opportunity to participate in beat officer training before their posting to PAHPB. One officer took part in beat officer training a month before the end of the trial and recommended it for other officers:

I think that is definitely something that the police should be doing with all their staff. Like, coming to a position like this, I think a lot of the information and what you get out of the [beat] course is really helpful, so I think if before you even start here, you've got a good grounding in what to expect and how to run a police beat ... I certainly have lots of ideas and so forth but again I think because we have only been here for six months, there has been a lot of set-up and getting organised but I certainly think there is potential because you are starting to build that rapport to start looking at doing some more problem-solving with some issues over there and with their Centre Management, getting them involved. Having regular meetings with them and so forth and identifying problems and I certainly have learnt particularly from the Police Beat course that there are so many things that you can do that don't cost money. It's just a matter of information sharing. It might be a matter of, they might be having a problem with people hanging around the front, sitting at a particular chair, using it like a bench to just hang around and drink their grog or something. It can be as simple as just having that moved ... It will be good to maybe go and start looking at those sorts of things. (Interview, beat officer no. 6).

Other beat officers commented on the importance of training to assist them with developing better communication skills for their role:

Other training that I've have had was Post Instructors and Field Training Officer ... I think both them were pretty important because we do a lot of seminars here to staff. Just being able to get up and talk and educate people on different things, to do public safety, personal safety, and I've sort of looked after

the majority of that on my own, being a post instructor ... I think I'm the only one here, so I've sort of got more of that educational background. That's helped in a huge way. It's ... a big benefit to have a least one person here that can do those roles. (Interview, beat officer no. 5)

People that do this particular job probably need to have good communication skills ... Here we're having to speak to adults who are professionals in their trade, giving them talks on aspects of the police service. So you need to be quite confident in speaking in front of professional adult people ... It's an ongoing thing over a fair period of time because there are 5500 staff here and it'll reach a point where they'll want us to do presentations at their inductions. (Interview, beat officer no. 1)

The question of senior police management support was raised, and all beat officers agreed that throughout the trial they felt a very high level of support, encouragement and appreciation. Beat officers felt they could approach their supervisor and seniors, and have their suggestions carefully considered and their decisions communicated. This was particularly important to officers during the set-up phase of the PAHPB office, when requests for further resources and equipment were being made on a regular basis.

Regarding issues that I come across, it's been very good. Very on-side. And everyone above him [the officer in charge]. We always channel everything through [the officer in charge] and through [the inspector] and then up. So I don't really have too much to do with anyone above that, but it all seems very positive and they all seem very keen to give us any advice if we need it. (Interview, beat officer no. 5)

Supplying the staff at short notice in relation to relief, helping where they can in relation to shifts where we're operating one officer out. Providing us with caged vans to transport mental patients to different areas — which is not on a regular basis, but would happen four or five times. Just the logistics for the place — if we needed something then they would point us in the right direction or help us get whatever logistics we need. (Interview, beat officer no. 1)

Finally, officers recognised the need for continued improvement of the PAHPB, consistency in staffing, and retention of the knowledge base to which they felt they had contributed:

We need a level of consistency ... so we're sort of uniform in what advice we're giving to people or how we're doing it ... And we've got staff going and some staying. The three of us that are staying are going to be in a good position to educate those that are coming in, so we've got a consistent education there of those new staff. After that I think it needs to be, I think it would have to be a set staff thereafter. You couldn't have people coming and going ... because you've just got too many different opinions and that would only be counter-productive. (Interview, beat officer no. 5)

If we were at full strength, meaning six people, then I would envisage that we should be spending a lot more time out and about. That's constrained by the fact that we're a lot of the time not operating with six people and that our workload in relation to inquiries, paperwork-wise, has impacted on that sort of thing, I guess, to identify our roles — the police service role in relation to the police beat at the hospital. To create a better working relationship with the hospital itself which will allow us to do our job better and for the hospital to help them do their job better. (Interview, beat officer no. 1)

Summary of Chapter 5

Overall, there was a high level of satisfaction with service delivery by the PAHPB among stakeholders. Hospital staff and senior management, retailers and police management were questioned about their satisfaction with the:

- » quality of the service provided by the PAHPB
- » professionalism, timeliness and courteousness of the beat officers
- » amount and quality of information provided
- » availability and accessibility of the beat officers during the trial.

The survey revealed that:

- » 75 per cent of hospital staff and 61 per cent of retailers considered the quality of service provided by beat officers to be above average
- » 85 per cent of hospital staff and 61 per cent of retailers considered the professional conduct of officers to be above average
- » the majority of hospital staff (91%) and retailers (85%) were satisfied with the level of courteousness of the beat officers
- » most hospital staff (80%) and retailers (77%) were satisfied with the amount of information provided to them by the beat officers
- » response times were considered good, with 67 per cent of retailers and 73 per cent of hospital staff satisfied with the time it took for PAHPB officers to respond
- » 71 per cent of hospital staff and 59 per cent of retailers rated the quality of information provided by the beat staff as highly satisfactory
- » the majority of hospital staff (85%) and retailers (83%) felt that PAHPB officers were often or always accessible/available.

Concerns were expressed by retailers and hospital staff about the accessibility of the beat office. It is important the beat officers engage with the beat community in order to ensure visibility, and awareness of and access to the services they provide. The issue of the conflicting roles and competing interests of the police and hospital in relation to the sharing of confidential patient information was also discussed at length. In the interests of establishing and maintaining a good working relationship, it is essential that specific procedures and guidelines are developed and formalised, and these provisions communicated to the relevant stakeholders.

The PAHPB officers were enthusiastic throughout the trial, and morale was consistently high. When interviewed, officers expressed high levels of job satisfaction, and all felt they were supported by management. They advocated training for future beat staff, and consistency in staffing.

Chapter 6: Conclusions



This final chapter summaries the key findings of the evaluation and highlights a number of issues for the QPS to consider in relation to the PAHPB or future beats that might be established in a hospital setting.

Key evaluation questions

This evaluation focused on three main questions:

- 1 Has the PAHPB improved management of calls for service to the PAH (and become the primary provider of police services to the beat community)?⁵⁸
- 2 Has the PAHPB improved perceptions of safety for hospital staff and Buranda retailers?
- 3 Are the stakeholders satisfied with the PAHPB?

Service provision

Findings

The beat was established in an effort to provide more effective and efficient delivery of policing services to the PAH and immediate surrounds. It was assumed, therefore, that for the duration of trial (6 months) the PAHPB would become the primary provider of policing services to the hospital and remaining beat areas. Its services were to include both traditional ‘reactive’ policing functions provided by general duties officers, such as responding to calls for service, and more proactive strategies such as preventive measures and community policing. A range of QPS data, including calls for service, crime reports, patrol and daily logs and rosters, were used to measure the impact of the PAHPB on the management of police services to the PAH and the designated beat area. Interviews, surveys and focus groups with key stakeholders supplemented this information with the stakeholders’ perspective on the trial’s success.

The evaluation revealed no change in the number and types of calls for service and reported crime originating from the PAHPB area during the period of the trial (see Chapter 3). This was consistent with the level of change in the South Brisbane District, of which the beat area forms a part. In an analysis of beat officers’ rosters, it was concluded that both the level of staffing and the normal operating hours for the beat were appropriate to meet demand. Operating hours and rostering were also well supported by hospital stakeholders.

⁵⁸ This key evaluation question was later broadened to incorporate a wider range of duties undertaken by beat officers during the trial within the entire beat area.

Beat officers' logs were indicative of the PAHPB providing a service to the PAH, with the largest proportion of officers' time attributed to managing hospital inquiries such as coronial matters and obtaining medical records for court procedures. It is a concern that, while the PAHPB officers completed an increasing amount of inquiries work during the trial, there was also a decrease in community policing activities (e.g. general liaison, lectures and talks, and meetings). Previous evaluations of the effectiveness of beat policing have all concluded that this model of policing provides the ideal environment for problem-solving. This is largely due to the close associations that beat officers establish with beat area clients (residents, retailers etc.) and the emphasis that beat policing places on relentless follow-up of reported crime and other calls for service.

It was an expectation that PAHPB officers would actively seek opportunities for problem-solving during the trial period. Two case studies are presented in Chapter 3, detailing the PAHPB officers' approach to identifying and solving community problems during the trial. Unfortunately, there were no other problem-solving examples that demonstrated the level of collaboration with the community required and expected of a beat model. This was particularly the case within the retail community. However, if the beat continues, it is likely that the officers will, over time, have more opportunities to engage in problem-solving.

Analysis of the patrol logs of Metropolitan South Region general duties officers during the trial showed that there were large reductions in the amount of time these officers spent travelling to and from, and at, the PAH. Similar time savings were made by the South Brisbane District Inquiries Office. For the duration of the trial, this office relinquished responsibility for managing inquiries within the PAH, and this allowed considerably more time to be spent on liaison with the remaining hospitals in the district.⁵⁹

Protocols established at the beginning of the trial between hospital security and the PAHPB ensured that the role of security officers remained relatively unchanged during the trial, as planned. Hospital staff have continued to use security as the first point of contact, with a subtle increase in the proportion of staff contacting police. A good relationship between the PAHPB and hospital security has been successfully established.

Unfortunately, the retailer sample was too small for any meaningful conclusions to be drawn about their relationship with security staff. In contrast to hospital staff and police contacts, they reported a reduced amount of contact with police during the trial.

Suggestions for future improvements

The community policing role of the PAHPB could be enhanced by:

- » ensuring that PAHPB officers are encouraged to increase their engagement with the beat community, including the retailers, and have the time to do so — because establishing a rapport with the beat community will be of crucial benefit to any effort made by beat officers to develop and implement problem-solving strategies

⁵⁹ At the time of publication of this report, the beat continues to retain this inquiries function.

- » minimising the time officers spend on routine inquiry tasks — one possible solution might be to consider providing beat officers with the services of an ‘administrative officer’, even if only on a part-time basis
- » providing beat officers with the appropriate training (discussed further below).

Perceptions of safety

Findings

In general, perceptions of safety among hospital staff have improved substantially since the introduction of the PAHPB. In particular, significant improvements were found both among hospital staff who worked during the day and among those who worked after dark. Changes in some other perceptions measured, such as safety walking to transport during the day, alone during the day and alone after dark, were not statistically significant, although they did show improvements.

Consistent with the literature, there were gender differences in the sample. The analysis revealed that male staff, both before and after the trial, felt safer in and around the hospital complex than did their female counterparts. Interestingly, the analysis of gender differences also revealed that female hospital staff in the sample, while feeling more fearful of victimisation than did males generally, also showed statistically significant increases in perceptions of safety since the introduction of the PAHPB. In other words, they felt safer working during the day and after dark, working alone during the day and after dark, and walking to transport after dark. Significant differences in perceptions of safety were also found among hospital staff groups, with emergency staff reporting significantly lower perceptions of safety than other staff groups.

In general, retailers also felt safer since the introduction of the PAHPB. Higher levels of perceived safety were evident for four out of the eight measures (safer during the evening; safer alone during the day, and during the evening; and safer walking to transport during the day). However, due to limited sample sizes (some as small as 14 respondents) these findings are not statistically significant; small sample size also precluded a more detailed analysis of gender, staff groups and other variables.

Due to the extensive role of hospital security at the PAH campus, hospital staff were asked about their perception of the types of services that should be provided by the PAHPB officers, PAH security staff, or both. Most staff felt that security officers should be exclusively responsible for providing staff with an escort to their transport after dark, and that the PAHPB officers should take care of recovering stolen property and taking crime reports.

The visibility of beat officers and the level of awareness of their services among the beat community are both integral to improving perceptions of safety. During the trial, substantial increases were seen in police visibility on the hospital campus and awareness of the beat among hospital staff. These changes were largely due to proactive patrolling, inquiries, and the involvement of beat officers in new staff inductions at the hospital.

According to the retailers surveyed during the course of the evaluation, there was a slight increase in police visibility during the trial, which can also be largely attributed to the beat officers' contact with retailers while updating the Keyholders Index (see Chapter 4), responding to calls for service, and proactive patrols. However, less than half of the retailer sample reported having seen police during the trial. There are various factors that could explain low visibility and awareness of the PAHPB among retailers, including:

- » the temporary closure of a number of retail establishments during a refurbishment
- » the location of the beat at the hospital
- » the very limited amount of time PAHPB officers spent outside the hospital environment (see Chapter 3).

Suggestions for future improvements

In order to help the PAHPB community feel even safer, it is suggested that PAHPB officers consider:

- » regularly and frequently patrolling the *entire* beat area to improve visible presence and awareness of the services they provide
- » targeting these patrols at times when, and in places where, members of the PAHPB community have reported lower levels of perceived safety (e.g. working alone; walking to public transport after dark)
- » devising strategies to ensure that groups who have reported lower levels of perceived safety (e.g. female hospital staff; emergency department staff) feel safer
- » expanding the number and frequency of Protective Behaviours programs they facilitate; opening up these programs to the broader PAHPB community outside the hospital campus (e.g. retailers); and continuing to incorporate presentations outlining the purpose of the beat at inductions for new hospital staff.

Stakeholder satisfaction

Findings

Overall, levels of stakeholder satisfaction with the PAHPB service were very high. Hospital staff and retailers who came into contact with beat officers during the trial expressed satisfaction with the quality of service, professional conduct, courteousness, amount and quality of information provided, timeliness of the service and accessibility of the officers.

The survey results showed that the officers exhibited high levels of professionalism. Stakeholders commented that the officers were skilled and sensitive to the environment, and were friendly and helpful. Most hospital staff and retailers found the timeliness of the PAHPB officers appropriate, with no retailers reporting dissatisfaction and only a small number of hospital staff expressing dissatisfaction. The quality of service was reported by hospital staff and retailers to be above average, and respondents were equally satisfied with the quality and amount of information provided to them by the officers.

As expected, the accessibility of the PAHPB service was rated highly by those who had contact with a PAHPB officer during the trial period. However, in interviews and focus groups, a common theme among hospital staff and some retailers was confusion

regarding their access to the beat. Participants were often unable to recall the spread of hours, number of officers, location of the beat office, or even how to contact the beat. Confusion was also commonly expressed by hospital staff who felt they had been given sometimes conflicting and contradictory information (e.g. some staff were given beat contact details while others on the same ward were instructed not to call). Although only a very small number of retailers had contact with beat officers during the trial, those who made comments suggested that the location of the beat, 'hidden away' on the hospital campus, discouraged them from using the service.

One of the major themes that emerged during interviews and focus groups related to police access to confidential patient information. This issue has presented an operational challenge for hospital administration and staff, and for PAHPB officers, since the trial began. The main issue identified is the tension created by conflicting roles and competing interests of the police and hospital staff. The PAHPB officers require the release of specific confidential patient information to perform their investigative role and to assist other police; but hospital staff have a responsibility to only release patient information in accordance with strict provisions designed to protect the confidentiality of such information. Central to the issue is the absence of any formalised agreements between the hospital and the police regarding how, and under what circumstances, it is acceptable to share such information.

The PAHPB seems to have engendered a high level of job satisfaction among the officers involved. As might have been predicted in view of the selection of officers with good communication skills, strong work ethic and an enthusiasm for beat policing, the beat officers involved during the trial were highly motivated, positive individuals with a high level of morale. They felt well supported in their role and advocated training for future PAHPB staff.

Suggestions for future improvements

Further steps could be taken to enhance stakeholders' satisfaction with the services of the PAHPB, such as:

- » providing clear and detailed information to stakeholders (hospital staff, retailers) to explain the roles and functions of the PAHPB and the protocols surrounding contact with PAHPB officers
- » developing and communicating specific procedures and guidelines for sharing patient information between hospital staff and PAHPB officers
- » holding regular collaborative meetings between stakeholders (beat officers, hospital, retailers)
- » providing formal beat training for officers assigned to the PAHPB.

Final comments

Police beats have been a feature of the policing landscape in Queensland since the early 1990s. Today, nearly a quarter of all policing establishments in the state are police beats; the concept of beat policing should therefore not be seen as something new or unproven. In fact, police beats have been formally evaluated by the CMC and the QPS on no less than five occasions. Each of these evaluations concluded that police beats are not only

well regarded by stakeholders, but are also crucial to the effective delivery of policing services in the state.

The overall conclusion of this evaluation is that the PAHPB has achieved a great deal in a very short time. Its record of success in terms of accomplishing its overall mission (i.e. improved management of calls for service, improved safety, and increased satisfaction among stakeholders) is praiseworthy. However, it should be noted that the current success of the beat does not necessarily guarantee future success.

There are some changes that could be made to maximise the impact of the PAHPB over time. If the QPS decides, on the basis of this evaluation, that the PAHPB should continue, the challenge will be to build on the strengths of the current approach while at the same time allowing the beat to incorporate more of the characteristics normally associated with beat policing, such as providing public access to the beat office, offering a wider range of policing services to beat area clients, and encouraging beat officers to engage in problem-solving. In addition to any efforts made by the QPS to broaden the focus of the PAHPB, it is equally important that officers assigned to the beat be provided with training for their role. The current five-day training course for beat officers may be appropriate; but additional training also needs to be provided to help officers deal with some of the complexity surrounding the exchange of confidential patient information, and with other issues that are unique to the hospital environment.



The overall conclusion of this evaluation is that the PAHPB has achieved a great deal in a very short time.

APPENDIX



Breakdown of data from beat officers' daily logs during trial period

Job categories, activities and descriptions	Nov. 2005 – Jan. 2006	Feb. 2006 – Apr. 2006
Inquiries	493	603
Summons (serve on person/s required for court)	43	61
Subpoena (serve on person/s required for court)	22	44
Statement (obtain from person/s for court)	157	198
Traffic accident version (obtain version from person/s involved in accident)	17	19
Medical records (attend at Medico-Legal and request or pick up records for court)	26	25
Authority to release (complete information for Medico-Legal)	1	0
Coronial (obtain information for investigation on behalf of investigating officer)	25	20
Warrants (execute on Medico-Legal to provide information detailed)	0	14
Police assist (ascertain information on request of external police crew)	155	184
Coronial (attending to a deceased person and instigating an investigation)	18	18
Traffic incident (accident investigation)	12	3
Blood/breath sample (attend ED to take sample from person/s involved in accident)	17	17
Proactive patrolling	240	252
Foot (PAH)	115	90
Foot (within beat division, external to PAH)	36	37
Mobile (PAH)	34	49
Mobile (within beat division, external to PAH)	55	76

(Continued)

Job categories, activities and descriptions	Nov. 2005 – Jan. 2006	Feb. 2006 – Apr. 2006
Administration	235	238
Portfolio (attend to management, station accountability requirements)	115	110
Extraneous duties (specialist services as per individual officers knowledge or skills, e.g. negotiator)	6	4
Intelligence correspondence (management of information gathered or received including data entry, e.g. ARIs)	20	27
Dutton Park (attend at Dutton Park Station for exchange of files etc.)	94	97
CRISP investigation	113	133
CRISP (attend to crime report work list for follow-up investigation)	113	133
Property/person	125	121
Stealing complaint (reported to police)	15	17
UEMV (unlawful entry of a motor vehicle reported to police)	0	2
UUMV (unlawful use of a motor vehicle reported to police)	3	1
UTAG (unlawful take away shop goods – shop stealing – reported to police)	2	2
Wilful damage (complaint reported to police)	3	8
Domestic violence (complaint reported to police)	0	2
Assault (complaint reported to police)	17	13
Mental health related (job allocated a code of '504' which related to person/s displaying mental health problems)	6	9
Transport (person/s to court, home etc.)	41	32
Suspect activity (general report to police)	22	21
Disturbance (non-arrest – report without charges, e.g. restraint of mentally ill person)	16	14
Community policing	129	63
General liaison (attend informal meeting with stakeholders)	34	11
Formal liaison (attend formal meetings with stakeholders)	72	40
Lectures/talks (provide informative lecture or presentation)	6	7
Community based policing (attended to community-based policing projects)	2	2
Welfare check (check on the welfare of a member of the public or police officer)	12	3
Counter inquiry (inquiry received at the beat for police assistance)	3	0
Training	7	18
Training (attend to training requirements as identified by Metropolitan South Region)	7	18

(Continued)

Job categories, activities and descriptions	Nov. 2005 – Jan. 2006	Feb. 2006 – Apr. 2006
Drug/alcohol	17	6
Drug/alcohol activity (suspected activity reported to the police)	17	6
Liquor offence (suspected activity reported to the police)	0	0
Other	62	105
Other police job (request from police communications to attend a job not specified by activities defined above)	36	72
Police assist (attend to an incident to assist another police crew)	26	33

Source: Beat officers' daily logs

References



- Bond, CEW & Gow, DJ 1997, 'Policing the beat: the experience in Toowoomba, Queensland', in R Homel (ed.), *Policing for prevention: reducing crime, public intoxication and injury*, Criminal Justice Press, New York.
- Cohen, J 1988, *Statistical power analysis for the behavioural sciences*, 2nd edn, Lawrence Erlbaum, Hillsdale, New Jersey.
- CJC, *see* Criminal Justice Commission.
- Criminal Justice Commission 1995, *Toowoomba beat policing pilot project: main evaluation report*, CJC, Brisbane.
- Criminal Justice Commission 1996, *The West End Police Beat: an evaluation*, CJC, Brisbane.
- CMC, *see* Crime and Misconduct Commission.
- Crime and Misconduct Commission 2003, *On the beat: an evaluation of beat policing in Queensland*, CMC, Brisbane.
- Dindia, K & Allen, M 1992, 'Sex differences in self-disclosure: a meta-analysis', *Psychological Bulletin*, vol. 112, p. 106.
- Edwards, C 2005, *Changing policing theories for 21st century societies*, 2nd edn, Federation Press, Sydney.
- Grabosky, PN 1995, *Fear of crime and fear reduction strategies*, Trends and Issues in Crime and Criminal Justice, no. 44, Australian Institute of Criminology, Canberra.
- Guidi, S, Townsley, M & Homel, R 1997, 'Repeat break and enter crimes: an analysis of police calls-for-service data', paper presented at Second National Outlook Symposium: 'Violent Crime, Property Crime and Public Policy', Canberra, March 1997.
- PAH, *see* Princess Alexandra Hospital.
- Princess Alexandra Hospital 2005, 'PA Police Beat', *WhisPAH*, 16 November 2005.
- QPS, *see* Queensland Police Service.
- Queensland Police Service 2004a, QPS bulletin board operational performance review briefs, viewed 22 May 2006, <<http://www.qldpol/home/home4.htm>> [secure site with no public access].

Queensland Police Service 2004b, *Metropolitan South Region Princess Alexandra Hospital Police Beat environmental scan*, QPS, Brisbane [available from the QPS on request].

Queensland Police Service 2005a, *Metropolitan South Region Princess Alexandra Hospital Police Beat project plan*, QPS, Brisbane [available from the QPS on request].

Queensland Police Service 2005b, *QPS 2004–05 annual statistical review*, QPS, Brisbane.

Segrave, M & Ratcliffe, J 2004, *Community policing: a descriptive overview*, Australian Institute of Criminology, Canberra.