Policing and the Mentally Ill: A Review of Issues Related to Mental Health Apprehensions by Police in British Columbia

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Introduction

Historically, society has struggled to meet the needs of those with a mental illness. More recently, deinstitutionalization and the limited services for mental health in the community have increasingly left the criminal justice system to deal with those who have a mental disorder (or multiple disorders) in an appropriate way. Sadly, significant numbers of those dealt with by the criminal justice system are suffering from (frequently) untreated or poorly managed mental illness. Arguably, these people should not be in the criminal justice system at all but rather dealt with by the health care system. However, more and more often police are called to situations involving people with a mental illness and required to intervene in some way.

Research suggests that those with mental illness are three times more likely to interact with police than the general population (Cotton & Coleman, 2010), and that 20-40% of those with a severe mental illness will be arrested in their lifetime (McLean & Marshall, 2010). A Vancouver Police Department (VPD) report from 2008 suggests that upwards of 30% of all calls for service received by the department involved a mental health issue (Wilson-Bates, 2008). More recent data collected by the VPD suggests that the proportion of mental health calls is closer to 24% (personal communication, 2013). These individuals are not necessarily more likely to commit crime; in fact, those with mental illness are considered by police to be highly vulnerable to victimization. In many cases, the victimization is serious or violent in nature and may contribute to deteriorating mental health and to the development or maintenance of addiction problems. Thus, it is clear that there is significant overlap in the policing and mental health populations and that the criminal justice system must find an appropriate method of handling this group of individuals.

In most jurisdictions, police have several avenues to consider when intervening in a situation involving a person with a mental illness (PMI). From escorting the person home, to arrest and detention, these options for police vary significantly in terms of the impact on the PMI and the community. In British Columbia, one of the options open to police is Section 28 of the *Mental Health Act*. This Section allows police to apprehend a PMI when they are believed to be a danger to themselves or others. Once they are in police custody, the PMI is escorted to a hospital for medical evaluation and care. Depending on the evaluating physician's conclusions, the PMI may be held for 48 hours for emergency treatment to stabilize and treat their condition. However, these Section 28 apprehensions are only an option in situations where there is significant risk of injury or death to the PMI or the public, leaving police with a large proportion of interactions with PMIs who are not in fact suitable for such an apprehension. Clearly, it is important for police to be able to manage situations with those with a mental illness both under Section 28 and otherwise.

Though perhaps higher in Vancouver than in other areas, mental health issues are not uncommon elsewhere. Police in the USA and Australia also report high levels of mental health calls (Maharaj, Gillies, Andrew & O'Brien, 2011). The challenge of dealing with such high numbers of people with a mental health problem has lead to police being referred to as "social workers in blue" and "front line mental health workers". PMIs may be victims, witnesses, or offenders and police intervention obviously varies accordingly but in all cases requires police to understand and manage mental health issues. Outside of

improving police understanding and thus intervention when dealing with PMIs, the issue of police time spent on these individuals, particularly those who are dealt with repetitively, has to be an important consideration in looking at mental health apprehensions. Police typically spend significant amounts of time waiting to transfer custody of the PMI to emergency room personnel. Unfortunately, hospitals are frequently overrun and unable to see patients quickly, and further are often very limited in the number of psychiatric beds available.

Despite the valuable knowledge that both police and physicians may have regarding the PMI and efforts on both sides to enable its transmission, there are significant limitations on information sharing between third parties. This is unfortunate because there are several advantages that information sharing may bring to police, physicians and the PMI. At minimum, physicians may be able to inform an officer of valuable information and insight into how that individual should be treated to minimize negative outcomes for the individual, the officer and the public at large.[1] Without access to information on the PMI held by the police, health providers may be left without important information in their decision-making regarding the most appropriate care and intervention for an individual. In some cases, this lack of information sharing between health and law enforcement leaves health personnel and the public at risk and jeopardizes the care that could and should be provided to the individual.

Thus, PMIs are a heavy burden on both the criminal justice and health care systems. Worse, the people frequently seen by police are also frequently seen by the health care system (due at least in part to the police apprehensions). Further, most of these individuals have very little insight into their condition, meaning that they often fail to take medications or keep appointments with care providers leading to deteriorating mental health. This pattern tends to lead to a "revolving door" of care by both police and health, and additionally, to individuals being lost in the system without adequate care. Yet, at least in British Columbia, there is little ability to share information between systems and integration is minimal.

Section 28 of the Mental Health Act

The British Columbia *Mental Health Act* allows for emergency situations where police may be called upon to apprehend an individual. Section 28 states:

> **28** (1) A police officer or constable may apprehend and immediately take a person to a physician for examination if satisfied from personal observations, or information received, that the person:
>
> (a) is acting in a manner likely to endanger that person's own safety or the safety of others, and
>
> (b) is apparently a person with a mental disorder.

Once at the hospital or in a physician's care, the doctor(s) are then required to make a decision as to whether the individual meets the criteria for an involuntary admission under Section 22 of the *Act* (below). If they are deemed to not meet the criteria, they must be released. However, if the doctors believe the individual to meet the criteria under Section 22, they may be held for 48 hours. They may be held longer than the initial 48 hours, but only after further evaluation.

[1] For example, a PMI may be triggered by a police uniform and become violent. This could be avoided if the police officer is aware of this and attends the scene in "civilian" clothes.

Specifically, Section 22 identifies the reasons that a physician can order an individual to be held involuntarily:

> **22** (1) The director of a designated facility may admit a person to the designated facility and detain the person for up to 48 hours for examination and treatment on receiving one medical certificate respecting the person completed by a physician in accordance with subsections (3) and (4).
>
> (2) On receipt by the director of a second medical certificate completed by another physician in accordance with subsections (3) and (5) respecting the patient admitted under subsection (1), the detention and treatment of that patient may be continued beyond the 48 hour period referred to in subsection (1).
>
> (3) Each medical certificate under this section must be completed by a physician who has examined the person to be admitted, or the patient admitted, under subsection (1) and must set out
>
> (a) a statement by the physician that the physician
>
> (i) has examined the person or patient on the date or dates set out, and
>
> (ii) is of the opinion that the person or patient is a person with a mental disorder,
>
> (b) the reasons in summary form for the opinion, and
>
> (c) a statement, separate from that under paragraph (a), by the physician that the physician is of the opinion that the person to be admitted, or the patient admitted, under subsection (1)
>
> (i) requires treatment in or through a designated facility,
>
> (ii) requires care, supervision and control in or through a designated facility to prevent the person's or patient's substantial mental or physical deterioration or for the protection of the person or patient or the protection of others, and
>
> (iii) cannot suitably be admitted as a voluntary patient.
>
> (4) A medical certificate referred to in subsection (1) is not valid unless both it and the examination it describes are completed not more than 14 days before the date of admission.
>
> (5) A second medical certificate referred to in subsection (2) is not valid unless both it and the examination it describes are completed within the 48 hour period following the time of admission.
>
> (6) A medical certificate completed under subsection (1) in accordance with subsections (3) and (4) is authority for anyone to apprehend the person to be admitted, and for the transportation, admission and detention for treatment of that person in or through a designated facility.
>
> (7) A patient admitted under subsection (1) to an observation unit must be transferred to a Provincial mental health facility or psychiatric unit within the prescribed period after a second medical certificate is received under subsection (2) by the director of the observation unit unless the patient is

(a) discharged, or
(b) released on leave or transferred to an approved home under section 37 or 38.

As these sections of the *Mental Health Act* show, police and physicians have different criteria that they must consider in the process of an apprehension. Notably, the statutory requirements that must be met before a person who has been apprehended under Section 28(1) may be detained are more expansive than the endangerment of self or the safety of others applied by a police officer. If the statutory requirements are not met, the person must be released.

Other considerations for physicians are found in Section 18, which outlines in fairly vague terms when a person is not to be held in a mental health facility. One of these is whether the person due to the nature of their disorder can in fact be treated in the facility (i.e., if there is no treatment available for the disorder, the person should not be held). Section 18 states:

18 Despite anything in this Act, a director or person who has authority to admit persons to a Provincial mental health facility must not admit a person to a Provincial mental health facility if

(a) suitable accommodation is not available within the Provincial mental health facility for the care, treatment and maintenance of the patient, or
(b) in the opinion of the director or person who has authority to admit persons to the Provincial mental health facility, the person is not a person with a mental disorder or is a person who, because of the nature of his or her mental disorder, could not be cared for or treated appropriately in the facility.

Of course, in situations where the individual has a mental disorder and is acting in a manner that is illegal or problematic in some way (e.g., nuisance or annoying behaviour to others), the police can and do intervene without utilizing this Section of the *Mental Health Act*. Simply having a mental disorder and interacting with police does not automatically initiate the process for a Section 28 apprehension.

Mental Health Apprehensions in Other Areas

All jurisdictions in Canada have similar laws and processes in place to apprehend people who appear to have a mental illness and pose a risk to themselves or others. British Columbia, and Vancouver in particular, are not unique in requiring such legislation. The frequency of mental health apprehensions does appear to vary across jurisdictions with Vancouver reporting some of the highest numbers of interactions with PMI (Wilson-Bates, 2008). Though not without methodological limitations, research in Montreal, Quebec suggests that police interactions with PMI make up only 3% of all interactions police have (Charette & Crocker, 2011). Additionally, a London, Ontario police study indicated that only 8% of the interactions that PMI's have with police are for a Mental Health Act apprehension, though it's unclear how frequently PMIs interact with police for other reasons (cited in Cotton and Coleman, 2010). If PMIs are engaging in violent behaviour that constitutes a criminal act, police are more likely to pursue charges than to utilize the *Mental Health Act*.

There is no doubt that this trend is similar across North America. Multiple studies have reported frequent interactions between police and PMI in the USA (see for e.g., McLean & Marshall, 2010 for a brief overview). Other jurisdictions such as Europe, the United Kingdom and Australia, also report significant amounts of time spent by police with PMI (e.g., McLean & Marshall, 2010; Bowers, Clark, & Callaghan, 2003; Lee, Brunero, Fairbrother, & Cowan, 2008; Moore, 2010). The frequency of interactions with PMI varies across the jurisdictions, but tend to be around 10%, arguably a significant proportion of interactions.

Integrated Care

Both health providers and police recognize that PMIs require care and that police are often ill equipped to do so. As a result, many jurisdictions, Vancouver included, have developed integrated models of care. These models vary and multiple methods may be utilized in the jurisdiction. In Vancouver, police have a "mental health car" which is staffed by an officer and a nurse and they attend mental health calls for service. Police also frequently use mental health teams made up of mental health professionals and officers to manage such calls. Both are fairly common types of arrangement for police forces to employ.

As well, specialty courts such as drug and mental health courts have been developed. In Vancouver, a "downtown community court" was developed in order to serve those with mental health issues who committed minor crimes in a particular area of Vancouver. If they are willing to plead guilty to the offence(s), they are connected with a case manager who helps to connect the PMI with appropriate community resources and monitors their involvement with them over a period of time. Unfortunately, it requires that the PMI commit an offence to gain access such care. Though a promising option for PMI diversion from the criminal justice system proper, it is unlikely to be successful if the appropriate resources, both in terms of treatment and finances, are not available.

Challenges Related to Mental Health Apprehensions

There are several issues regarding mental health apprehensions by police: a lack of common definitions between police and health care providers, the level of violence in an apprehension, a lack of appropriate services for referral, privacy and information sharing, the use of police resources and accountability for decisions with regard to the PMI made by all professionals who interact with the PMI.

1. Lack of Common Definitions

Interpretation is always a challenge when applying legal definitions to situations. Police are required, without in-depth training, to identify people with mental disorders who are in situations that pose a danger to themselves or others. While identifying a risky situation may be second nature to most police officers, identification of a mental disorder is frequently challenging. A conflict occurs however, when police deliver a person to a physician for care for that disorder. The physician, using Section 22,[2] may assess the individual and determine that there is no form of care for this person (i.e., there is no

[2] Most legislation in other jurisdictions on mental health apprehensions has similar requirements to British Columbia's Section 18 of the *Mental Health Act* where no treatment available leads to release by the hospital.

appropriate treatment and thus nothing that the doctor can do), and/or that they are no longer currently posing a risk to themselves or the public.

Given the time delay between the time the police escort the PMI to the hospital and the physician evaluating the person, it is possible and likely that the imminent danger the PMI posed at police apprehension has passed. Alternatively, the PMI may be cogent enough to "fake" their way through the evaluation with the physician to be released. Particularly for those who frequent the systems, it is easy to learn what the "right" things to say are in order to be released. Interviews with doctors in the United Kingdom suggest that they find it difficult to determine an individual's potential for violence or how likely they are to take action on a suicide plan, particularly if they have a history of suicide attempts (Bowers, Clark & Callaghan, 2003). While this is less of an issue for those who are, for example, experiencing an active psychotic break, a large number of those with mental illness are quite capable of behaving appropriately when their freedom is threatened. Interestingly, research suggests that those apprehended by police are more aggressive, more likely to have drug and alcohol problems and require intensive psychiatric care than those who are referred to care by family or other sources (Maharaj, Gillies, Andrew, & O'Brien, 2011; Lee, Brunero, Fairweather, & Cowan, 2008). Further, they are more likely to have a psychotic disorder and less likely to have a depressive or anxiety disorder (Lee, Brunero, Fairweather, & Cowan, 2008). In fact, research suggests that those apprehended by police have a high potential for violence, though the frequency of acts of aggression vary widely and the most frequent victims of such violence are police officers not health providers (ibid). Arguably then, because of the risk they present to the public that may be more evident to police, health care providers should evaluate PMIs who are apprehended by police carefully.

There may be two situations occurring here. Police and physicians may simply be seeing different behaviours by the PMI as a result of the PMI consciously attempting to avoid being committed to hospital and/or the environment in which they are being assessed. Or, the police evaluate behaviours differently than physicians (i.e., the same behaviour is seen as dangerous by police but not by a physician or vice versa) depending on the PMI and the illness they have.

Some suggest that beyond the indicators of dangerousness, there may also be significant differences in what behaviours are considered symptoms of mental illness (Maharaj, Gillies, Andrew & O'Brien, 2011). Given that police generally have only a basic level of understanding of mental disorders and how to identify them, it is unlikely that officers are using clinical criteria for their assessment. As a result, while there may be overlap in the behaviours used to identify a problem by both physicians and police, it is far more likely that officers' will not be using the appropriate clinical criteria. This would lead to individuals being apprehended who do not in fact have a mental illness of any kind and thus the physician being required to release them since the sections of the *Act* only apply to those who have a mental disorder. There is some evidence that this is in fact the case; research suggests that those brought in by police are more likely to have behaviour problems but lower rates of serious mental disorders (cited in Maharaj, Gillies, Andrew & O'Brien, 2011).

The fact that the *Canadian Criminal Code* defines 'mental disorder' differently than a clinician using the Diagnostic and Statistical Manual (DSM) also complicates matters. Though the definition outlined in the

Criminal Code is generally referenced in terms determining criminal responsibility and not necessarily relevant to a mental health apprehension, if this is the definition that an officer is comfortable with, it may be the one he/she utilizes in a situation where apprehension is possible. A police officer may be correct in his or her assessment according to the *Criminal Code*, which defines a mental disorder as a "disease of the mind", but in a clinical setting such an assessment may fall short, particularly in light of Section 18. Because the *Mental Health* Act defines a person with a mental disorder as "a person who has a disorder of the mind that requires treatment and seriously impairs the person's ability (a) to react appropriately to the person's environment, or (b) to associate with others", the methods by which physicians and police are expected to assess whether a person in fact has a mental disorder under the *Act* remains open. This lack of clarity in definitions and assessment criteria leads to a waste of time and resources for both police and physicians, not to mention frustration on both sides and a lack of appropriate intervention for the PMI.

RECOMMENDATION: EVALUATE THE NUMBER OF THOSE APPREHENDED UNDER SECTION 28 WHO ARE SUBSEQUENTLY FOUND NOT TO BE A DANGER BY A PHYSICIAN.

RECOMMENDATION: ASSESS WHAT TYPE OF MENTAL HEALTH ISSUE APPREHENDED PMIS ARE EXPERIENCING, INCLUDING THE NUMBER WHO HAVE BEEN DIAGNOSED WITH MULTIPLE DISORDERS.

RECOMMENDATION: ASSESS WHAT BEHAVIOURS ARE SEEN AS DANGEROUS AND FITTING THE CRITERIA OF SECTION 28 AND 22 BY POLICE AND PHYSICIANS TO EVALUATE CONSISTENCY IN RATINGS.

RECOMMENDATION: EVALUATE CRITERIA BY WHICH PHYSICIANS AND POLICE DETERMINE MENTAL ILLNESS IS PRESENT FOR CONSISTENCY AND VALIDITY.

2. Violence

Given the criteria for apprehension by police under the *Mental Health Act*, it is expected that some level of violence would be present. However, it is not clear how frequently this violence is directed towards others. Anecdotally, it appears that most incidents involve self-harm or the threat of it. As noted above, if the PMI is engaging in violent behaviour towards others, police may be more likely to pursue charges rather than apprehend the individual for treatment. This may be even more likely if there is a weapon present during the incident. Yet, the frequency that police arrest a PMI for a violent crime instead of an apprehension is unknown. Further, it is unknown how often PMIs have a criminal history of violent crime that indicates a proclivity towards violence. In fact, there is much to suggest that PMIs are very likely to be a victim of violence due to their vulnerability.

RECOMMENDATION: EVALUATE THE NUMBER OF TIMES A PMI IS A VICTIM OF VIOLENCE.

RECOMMENDATION: EVALUATE THE NUMBER OF TIMES A PMI USED A WEAPON IN THE INCIDENT LEADING TO HIS/HER APPREHENSION. ALSO, DETERMINE WHAT TYPES OF WEAPONS ARE MOST COMMONLY USED.

RECOMMENDATION: ASSESS HOW OFTEN PMIS ARE DANGEROUS TO THEMSELVES OR DANGEROUS TO OTHERS IN THE INCIDENT LEADING TO THEIR APPREHENSION.

RECOMMENDATION: DETERMINE HOW OFTEN PMIS HAVE A CRIMINAL HISTORY OF VIOLENCE.

3. Lack of Appropriate Services

In some cases, a person may be appropriate for committal to the hospital but for a variety of reasons cannot be kept. This may be because the hospital is full or has limited beds for psychiatric care. The limitations of the hospital may lead the hospital staff to be more conservative in whom they admit simply because they do not have the resources to care for everyone who comes to their doors. As a result, those who are considered to be a "borderline" case are turned away. Other situations may also result in an inability for the physician to hold the patient at the hospital. Physicians may have difficulty in assessing patients who present very well during their formal assessment leaving the physician with conflicting information or the patient may have a personality disorder which does not have any treatment and thus is outside the scope of the involuntary hold criteria (Bowers, Clark & Callaghan, 2003).

It is important to note that holding an individual under Section 28 is not indefinite. Once the individual no longer meets the criteria for an involuntary hold, unless the person voluntarily seeks treatment, the hospital must release them. The voluntary treatment could be a further stay in hospital or community based care. However, in many instances, at least in Vancouver, the resources for care (hospital or community based) are not available. Long wait times, a simple lack of appropriate services, and worse, a lack of integration in the care for those with multiple issues or concurrent disorders means that many individuals who wish for care frequently do not receive it or are lost in the system. Some researchers have also suggested that the apprehension may have a negative impact on the therapeutic relationship the PMI has with their providers which may lead to PMIs avoiding care altogether due to a decrease in trust (Bowers, Clark, & Callaghan, 2003).

This is clearly frustrating for both care providers and police. However, care providers may be more aware of the treatment situation and what options are available to an individual than the police are. The decisions of the care providers may then be confusing or aggravating for police who bring individuals to hospital because of a known issue that threatens the public or the individual. To have doctors effectively dismiss this concern (in the officer's eyes) by releasing the person after an evaluation, if there is one, leaves the individual as a risk to the public and to themselves and often leads to repeat interactions with police. However, it is unknown just what kind of risk this type of situation really presents. Anecdotally, it is not uncommon for a suicidal person, for example, to be released from hospital and complete their suicide plan. Yet, it is unknown how often this occurs, and what factors may be in common across those individuals who continue to move forward with their plans.

RECOMMENDATION: FOR THOSE BROUGHT TO HOSPITAL BY POLICE UNDER SECTION 28, EXAMINE NUMBER AND TYPE OF INTERACTIONS WITH POLICE AFTER RELEASE BY HOSPITAL.

4. Privacy/Lack of Communication

Though a mental health apprehension by police requires both health care providers and police to work together to care for the PMI, there is little overlap and thus little communication between parties. This is unfortunate since it means that the PMI has disjointed care and worse, the care given potentially lacks

the relevant information required. Both physicians and police end up in a position of making a decision regarding appropriate intervention and physicians in particular may benefit from the information given by police about the situation that precipitated the apprehension. Police of course could also benefit from knowing more about the individual they are dealing with; for example it may help police to keep the PMI calm by ensuring they do not exacerbate the situation inadvertently and reduce the necessity for force during the apprehension. It may also reduce the number of apprehensions when no mental illness is in fact present (or the number of situations in which the PMI has a disorder that has no treatment and thus the PMI will not be held by the hospital).

However, though there are clear benefits to police, health care providers, and most importantly to the PMI for their care, information is not shared between police and health except on a case-by-case basis with the PMI's consent. Even health care systems are not always conversant with each other meaning that doctors do not always have access to important information. Records in one location may not be available in other locations; a particular problem if the PMI is transient across many jurisdictions. Though police in British Columbia generally have access to each other's records through the use of PRIME (Police Record Information Management Environment), all databases suffer from data collection issues such as incomplete or missing information, incorrect information or access problems.

Privacy legislation makes information sharing exceptionally difficult between police and health given the privacy regulations for public bodies. In British Columbia, the *Freedom of Information and Protection of Privacy Act* limits the types of information that can be disclosed to third parties without the consent of the individual. An exception exists under Section 35 that allows the disclosure of personal information for research or statistical purposes. This allows organizations (such as health and police) to share information between them when it is in the context of a research project or study. Some research attempts have been made under this Section but it does little to facilitate long-term information sharing between these groups. Arguably, even in a research context, informed consent is required for any information sharing and thus, police and health care providers are in a difficult situation regardless when it comes to balancing the PMI's privacy and the need for relevant information.

Privacy considerations are irrelevant however if there is little relevant information held by police for health care providers about a PMI (and vice versa). It is unclear how much information would be held in a record that would be beneficial to police and health providers or even how much overlap there is in the clientele that are served by both. As a result, it is unknown just how much increased information sharing would improve care for PMIs. Integrated teams such as those used currently by police suggest that there would be a significant benefit to those with mental illness if there were to be an increased level of coordination in services provision and information sharing.

RECOMMENDATION: IDENTIFY THE NUMBER OF PERSONS WHO ARE REFERENCED IN BOTH POLICE AND HEALTH RECORDS. FURTHER, EXAMINE HOW MANY ARE REPEAT USERS OF EITHER OR BOTH SYSTEMS.

RECOMMENDATION: EXAMINE THE TYPE OF INFORMATION HELD BY POLICE THAT WOULD BE USEFUL TO HEALTH CARE PROVIDERS AND VICE VERSA TO DETERMINE WHETHER AND WHAT INFORMATION THERE IS THAT COULD AND SHOULD BE SHARED BETWEEN THESE PARTIES THAT CURRENTLY IS NOT.

5. Police Resources

Several studies have demonstrated that PMIs take up significant police resources (see for example: Wilson-Bates, 2008; Thompson, 2010; Lee, Brunero, Fairbrother & Cowan, 2008; Cotton & Coleman, 2010; McLean & Marshall, 2010). A survey of police officers reported that 50% of officers felt that PMIs use a disproportionate amount of police resources (Cotton & Coleman, 2010). In Vancouver, estimates suggest that attending mental health calls costs upwards of $9M (not including non-police and indirect police costs) annually for the police department (Wilson-Bates, 2008). This is a significant cost and is indicative of the large number of resources put forward to manage mental health issues at the police level.

When resources are in use for an apprehension (or any other call that does not involve a criminal act), they are unavailable to deal with other calls for service. Frequently, the officers spend the majority of their "on scene" time for the apprehension at the hospital waiting to transfer custody of the PMI to the physician. Worse, if the physician subsequently releases the PMI, the time the officer(s) spent waiting has been for naught. This impacts the response time for other calls, which may be life threatening. In some smaller jurisdictions officer safety may also be jeopardized when officers are not available for back up. Presumably, this issue affects the morale of officers who feel that their efforts are not appreciated or taken seriously. Officers may be less likely to intervene with a Section 28 if they consistently have a PMI turned away at the hospital or if they have complaints filed against them as a result of their intervention. While Vancouver may be somewhat unique in the large proportion of mental health calls for service, given the high frequency of interactions with PMI in other jurisdictions, the relative cost and resource intensive nature of mental health calls are unlikely to differ significantly in other areas.

RECOMMENDATION: EXAMINE THE TIME ASSOCIATED WITH A MENTAL HEALTH APPREHENSION FOR POLICE, HEALTH AND OTHER AGENCIES (E.G., AMBULANCE) THAT MAY BE INVOLVED. ALSO EXAMINE THIS FOR PMIS WHO INTERACT WITH POLICE AND HEALTH REPETITIVELY.

RECOMMENDATION: EXAMINE THE IMPACT TO POLICE RESPONSE TIMES WHEN UNITS ARE TAKEN UP WITH A MENTAL HEALTH APPREHENSION.

6. Accountability

One of the complaints by police around Section 28 apprehensions is that when someone is erroneously released by physicians (i.e., they are in fact a danger to themselves or others and has an illness that should be treated), and subsequently injures himself or herself or someone else, it is unclear who, if anyone, bears responsibility for this. Police argue that the hospital should be accountable for the release when the individual met the criteria for committal (Thompson, 2010). If in fact the hospital or physician is accountable, then a process for assessing this is required. While anecdotally this occurs with relatively high frequency and the VPD have some preliminary data to support this view (Thompson, 2010), it is unclear how often a PMI is released and then continues with his or her dangerous behaviour.

RECOMMENDATION: ASSESS THE FREQUENCY WITH WHICH A PMI IS RELEASED AND SUBSEQUENTLY COMMITS SUICIDE, INJURES HIM OR HERSELF, OR INJURES OR KILLS A MEMBER OF THE PUBLIC OR

COMMITS SIGNIFICANT PROPERTY DAMAGE. FURTHER, DETERMINE A PROCESS OF ACCOUNTABLITY FOR BOTH POLICE AND HEALTH CARE PROVIDERS IN SUCH AN EVENT.

The second issue regarding accountability is related to police officers. Given their generally minimal training in mental health issues, it is questionable whether it is appropriate to require them to essentially diagnose/identify mental disorders in individuals in crisis. In one study, 80% of officers felt that they required special training on PMI to do their job (Cotton & Coleman, 2010). As a result, some have argued that "police are 'burdened inappropriately with responsibility for the mentally ill' yet are 'unfairly criticized' by mental health professionals" (cited in McLean & Marshall, 2010, p63), because of their lack of expertise in the area. When officers make an error with regard to actions they take during a call for service including their treatment of the mentally ill, the British Columbia *Police Act* outlines the process by which officers should be investigated and disciplined (if necessary). As well, individuals can file a complaint with either the police department, the Office of the Police Complaint Commissioner or the newly formed Independent Investigation Office (in situations of injury or death) if they believe they were treated unfairly or unjustly. Between the internal investigations, the complaint process and the likely public attention, police generally are required to be accountable for their actions.

Despite this relatively high level of accountability, when officers are incorrect and an individual is apprehended under Section 28, the individual is left with a police record that may colour all future interactions they have with police. Depending on whether police know the outcome of the apprehension at the hospital, the police record may be incomplete and the erroneous nature of the apprehension may be unknown[3]. As well, a London (Ontario) Police study showed that 20% of PMI who had interacted with police had a violent caution flag on their record despite having never been violent as a perpetrator or having been involved in a violent offence (Cotton & Coleman, 2010). It is unclear whether this flag is based on behaviour during the apprehension rather than criminal history. This type of information, particularly when validating information is not present, can obviously be destructive to an individual who is recovering from a mental illness in future police interactions. However, it is unknown how frequently people are impacted by erroneous information in a police record, as police are rarely privy to such information about a PMI.

RECOMMENDATION: DETERMINE HOW OFTEN AN INDIVIDUAL IS APPREHENDED UNDER SECTION 28 BUT DEEMED TO NOT HAVE A MENTAL ILLNESS OR ARE NOT HELD BY THE HOSPITAL FOR TREATMENT.

RECOMMENDATION: EVALUATE USE OF "VIOLENT" CAUTION FLAG (AND ANY OTHERS DEEMED RELEVANT) IN THE POLICE AND HEALTH SYSTEMS WITH MENTALLY ILL INDIVIDUALS.

Conclusion

Mental health apprehensions are one of several tools for police to call upon when dealing with a mentally ill person. However, these apprehensions highlight the issues facing the health care system and law enforcement in dealing with mental illness. Despite the apparent overlap in the population dealt

[3] It is not uncommon for people to file a complaint with police when this type of situation becomes known or is anticipated.

with by health and criminal justice systems, there is little information sharing, if any at all. This has created discrepancies in the criteria utilized by police and physicians for apprehension. Section 28 apprehensions are resource intensive for police in particular and likely has a significant impact on the morale of officers and the ability of the police to respond to all calls for service. Issues with accountability for the decisions made regarding the care for a PMI as well as the difficulty in accessing services overall, contribute to frustration for the public, police, physicians and the PMI.

More research into the areas highlighted by the recommendations outlined here will assist policy makers and front line workers in health and law enforcement to better serve those with a mental illness and in so doing, increase public safety.

Recommendations

1. Evaluate the number of those apprehended under section 28 who are subsequently found not to be a danger by a physician.
2. Assess what type of mental health issue apprehended PMIs are experiencing, including the number who have been diagnosed with multiple disorders.
3. Assess what behaviours are seen as dangerous and fitting the criteria of section 28 and 22 by police and physicians to evaluate consistency in ratings.
4. Evaluate criteria by which physicians and police determine mental illness is present for consistency and validity.
5. Evaluate the number of times a PMI is a victim of violence.
6. Evaluate the number of times a PMI used a weapon in the incident leading to his/her apprehension. Also, determine what types of weapon are most commonly used.
7. Assess how often PMIs are dangerous to themselves or dangerous to others in the incident leading to their apprehension.
8. Determine how often PMIs have a criminal history of violence.
9. For those brought to hospital by police under section 28, examine number and type of interactions with police after release by hospital.
10. Identify the number of persons who are referenced in both police and health records. Further, examine how many are repeat users of either or both systems.
11. Examine the type of information held by police that would be useful to health care providers and vice versa to determine whether and what information there is that could and should be shared between these parties that currently is not.
12. Examine the time associated with a mental health apprehension for police, health and other agencies (e.g., ambulance) that may be involved. Also examine this for PMIs who interact with police and health repetitively.
13. Examine the impact to police response times when units are taken up with a mental health apprehension.
14. Assess the frequency with which a PMI is released and subsequently commits suicide, injures him or herself, or injures or kills a member of the public. Further, determine a process of accountability for both police and health care providers in such an event.
15. Determine how often an individual is apprehended under section 28 but deemed to not have a mental illness or are not held by the hospital for treatment.
16. Evaluate use of “violent” caution flag (and any others deemed relevant) in the police and health systems with mentally ill individuals.

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