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Canada

Contemporary Policing Guidelines for Working with the Mental Health System

Prepared by the Police/Mental Health Subcommittee
of
the Canadian Association of Chiefs of Police (CACP) Human Resources Committee

Co-Chairs

Dorothy Cotton Ph.D., C. Psych.
and
Chief of Police Terry Coleman MOM, MA, MHRM

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Contemporary Policing Guidelines
for
Working with the Mental Health System

The following guidelines are intended to provide a starting point for police programs and services related to the mental health system and people with mental illnesses They are not meant to be prescriptive but rather informative, and are intended to aid in setting up systems for police services to use when encountering suspects, offenders, victims and other members of the community who require police assistance but who also appear to experiencing a mental illness

In Canada, as in many western countries, interactions between people with mental illnesses (PMI) and the criminal justice system are increasing. For instance, the number of offenders with mental disorders entering the federal correctional system has increased significantly in recent years. While it is hard to estimate how much time and money police organisations spend on providing services to people with mental illnesses, there is no doubt, based on what has been learned to date, that it is significant. Indeed, the police are often the starting point of interactions between PMI and the criminal justice system, to the extent that the police have been described as "de facto mental health providers" and "the frontline extension of the mental health system." There remains little doubt that contacts between the police and those with mental illnesses have increased substantially in recent years as more individuals experiencing mental illnesses are residing outside the hospital and within the community

While it is generally thought that the increase in mentally ill people seen by police is simply a result of deinstitutionalization, it is actually a reflection of a variety of factors and trends which include:

- fewer psychiatric hospitals, hospital beds and the concomitant deinstitutionalization;
- improved treatment for psychiatric disorders, resulting in less need for hospitalization;
- increased emphasis on individual rights and freedoms;
- changes in mental health laws;
- increased societal concern with public safety.

While much of the focus of police services with respect to mental illness in the community has been on crisis response, in fact mental health crises are only one of several types of situations in which the police find themselves when interacting with people with mental illnesses. These situations include:

- apprehensions and other powers of police under mental health acts;
- arrests in which the accused appears to be mentally ill;
- minor disturbances in which a person appears to be mentally ill;
- situations in which a mentally ill person is the victim of crime;
- situations in which a PMI threatens others;
- circumstances in which the public or families of PMI ask for help;

- non-criminal or non-offence situations in which the police become aware that someone who has a mental illness appears to be at risk or in need of assistance;
- suicide interventions;
- situations in which a PMI provokes a reaction from police to harm or to kill them;
- circumstances in which police become instrumental social support contacts for PMI (situations in which police provide practical assistance and support to people in need).

How should police organizations provide appropriate service to this important segment of our population? Well, there is no one-size-fits-all method. Given the variety of needs, sizes of police services and geographical factors, the organization and the scope of police programs for PMI will vary from one police organization to another. But there are common denominators. Whereas some police organization might have teams or units specifically devoted to the task, some police services might only have a single designated person, and in others there might not be a formal program and all officers consequently share the responsibility. But in an ideal world each police organization will have a structure to ensure that people who have a mental illness are dealt with compassionately and humanely, and that the safety of the PMI, the officers and the public considered.

The following guidelines provide such a structure. They identify general principles, which can be implemented by any police service or police detachment, regardless of size or geographical location. The manner in which the principles are operationalized will, of course, be dependent upon the unique culture of the community served. But the principles are the same.

The term "person with a mental illness" or PMI is used to denote anyone whose behaviour at the time in question is influenced by the presence of significant mental distress or illness. It may be that the person is experiencing a persistent and severe illness such as schizophrenia, or it may be that they are experiencing a transitory period of distress and are temporarily experiencing symptoms that may be expected to abate, as in the case of an acute anxiety problem. For the purpose of these guidelines, the essential factor is that at the time of the police interaction, the person's mental state is impaired to the extent that their response to their environment is negatively affected.

Also, the term "police organization" is used in this document to refer to a police department, police service or police detachment—and should be taken to reflect the level of the organization at which local initiatives and policies/decisions are made.

The Central Tenet

Each police organization should foster a culture in which mental illness is viewed as a medical disability not a moral failure, and in which PMI are treated with the same degree of respect as other members of society.

It is incumbent on police leaders to set an appropriate tone by modelling non-derogatory language and ensuring the assignment of police personnel to mental health-related positions in the organization is considered carefully.

The principles…..

Principle 1

Each police organization should have one or more identified personnel who are responsible for issues related to people in the community with mental illnesses. The number, role and involvement of these officers will of course vary depending upon the size of the police service or detachment.

In large organizations, this responsibility might fall to an entire office or group of people. In smaller organizations, it might be a single person, or a person who holds this position along with other responsibilities. This person may simply be a "go to" person so that outside organizations have a place to start—or it may be a person with significant responsibility for program and policy development and/or program delivery. In any case, there should be an identifiable person who is recognized internally and externally as the contact person for issues related to PMI. At a minimum, this person will be the "public face" of the police organization in this context and will serve as the point of contact both internally and externally for dealing with issues related to PMI. This position in the organisation should have a clearly identifiable title that reflects its responsibility.

Rationale: Police services are complex organizations, frequently puzzling to outsiders. When community members or other organizations need to deal with a police service, figuring out where to start can be an onerous task. While individual incidents will, of course, be dealt with by a variety of members in a variety of assignments, a mental health agency, for example, should be able to phone a police organization and not have to guess whether the person to speak to is in major crimes, community policing, operations, or "the desk."

While police services often maintain that the "duty officer" or "shift commander" is the most appropriate person to deal with, this can easily lead to inconsistency, lost information, and lack of leadership with regard to policy development because of the diffusion of responsibility. Conversely, it may appear to outsiders that a small organization may have no one to deal with issues such as those involving a PMI—when in fact it is the job of every officer. Whether the service is large or small, the public needs to know that someone is looking after these issues and who that person is.

Principle 2

Each police organization should identify and develop a relationship with a primary contact person within the local mental health system.

Ideally, this contact person will act as the liaison between the police and the mental health system in general and provide links to agencies within the system. In communities in which the mental health system is undeveloped or fragmented, it may be necessary to develop individual contacts with a variety of mental health services.

Rationale: Like police organizations, mental health agencies employ a wide range of people in a wide range of functions, which may have unclear names and overlapping mandates. Like police organizations, mental health personnel may not offer consistent information, be aware of precedents, or be attuned to the unique needs of outside groups such as police organizations. An identified contact person allows not only for the development of consistent practice and the identification of recurring issues, but might also decrease the amount of time spent sorting out issues related to individual cases.

Principle 3

Each police organization should have an identified contact person in the emergency services department of any and all hospitals with which they do regular business.

This may be the person, or one of the persons, identified above in Principle 2, or it may be another person.

Rationale: Interactions with emergency rooms (ER) are probably the source of more frustration and consternation among police officers than any other interactions related to PMI. The very nature of the work in an ER makes on-the-spot-resolution of disagreements between police and hospital staff almost impossible and often ill-advised. Individual disagreements may well reflect systemic issues which are better dealt with outside of the context of a situation with a specific PMI. The presence of a pre-existing contact and a relationship with a member of the ER or hospital staff increases the likelihood that systemic issues can be addressed and resolved.

Principle 4

Each police organization should ensure that their first responders/patrol staff have an appropriate basic level of knowledge and skill in order to deal with PMI.

Standard training should include

- the understanding and identification of mental illnesses;[1]
- how to communicate with PMI;
- how to use defusing and de-escalization techniques;
- how to assess suicidality;
- how to assess risk and dangerousness;
- issues related to stigma;

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[1] It is not essential that police personnel can diagnose specific metal illnesses but that they can recognize that they are dealing with a PMI.

- the role of the family with PMI;
- how to access mental health services;
- the Mental Health Act (MHA);
- issues related to the use of force with PMI.

Rationale: It is recognized that police service personnel come into this work with widely varying levels of knowledge and experience about mental illness. Thus, it is likely that a variety of learning mediums may be appropriate including, but not limited to, formal training sessions, self-directed learning, college and university courses and job sharing with mental health personnel. It might be neither appropriate nor feasible to mandate a particular course or a number of hours of training for each officer. While this may be a strategy that a police organization chooses to employ, the principle is that the organization should have a method of assessing the level of knowledge and competence of its personnel working in this area, and provide education as appropriate. One responsibility of the assigned police mental health officer described in Principle 1, for example, might be to assess the organization's learning needs and develop appropriate training initiatives. Alternatively, this might fall to the police training officer/unit.

Principle 5

Each police organization should have a clearly defined policy and procedure by which personnel can access mental health expertise on a case-by-case basis.

There are a variety of ways in which this principle can be realized. The service may have a subset of specially trained officers who serve as a resource or as consultants to other officers; a mobile response team; or a co-response team that includes mental health professionals. There might simply be a contact person or agency to phone when necessary, or they might have an agreed-upon sequential response arrangement whereby police "hand off" a PMI once issues related to dangerousness and criminal issues have been attended to. The intent is to have readily available mental health expertise on a case-by-case basis to provide assistance with the "clinical" management of the situation as well as connecting the PMI with services as necessary.

Rationale: It is unrealistic to expect that all police officers will develop the level of knowledge and skill to deal with all interactions with PMI. There will inevitably be times when they need the assistance of specially trained police officers or mental health professionals to sort out issues related to such things as suicidality, the appropriate disposition of a case and the facilitation of communication. Police officers need to know that certain agencies can be contacted, and that mental health expertise can be accessed when appropriate. In remote areas, this contact may take place by telephone rather than in person, but in any case, first responders need to know how they can access this expertise when required. Likely, this will involve the development of memoranda of agreement with an appropriate agency(s). Such arrangements and agreements are best made at a policy level because trying to obtain such advice and guidance in the face of a crisis is generally unworkable and might also have implication with respect to liability.

Principle 6
Not only should police officers have an understanding of how best to work with people with a mental illness but police organizations should also ensure that all personnel who may be involved with PMI , including those working in victim services and those answering calls and dispatching officers, have sufficient knowledge and understanding of mental illness to carry out their jobs. For dispatch personnel and those taking calls, it means that they need to be able ask the necessary questions and recognise signs that mental illness may be a factor.

Ideally, responding officers should know in advance when a call might involve a PMI. This would facilitate their use of appropriate internal and external resources. In many cases, dispatch staff who have received the necessary training can garner this essential information. Police leaders also need to be assured that those conducting follow ups are sensitive to these issues and are able to provide appropriate support and information about available resources.

Rationale: While there will be many cases in which there is no advance information that would lead to the conclusion that a person is mentally ill, in many cases that information WILL be apparent, or there may be behaviours or other indications that this might be the case. Thus, those employees who take calls need to have a basic awareness of the indicators and symptoms of mental illness as well as other information that might be useful when alerting first responders about the nature of a call. Those who are expected to provide support and services after an event need to be aware of the special needs of PMI.

Principle 7
Each police service should have available a directory or other print material that provides descriptive and contact information for mental health agencies in the area for both employees as well as PMI and their families.

While some situations involving PMI will result in arrest and others in an apprehension under the MHA, many will involve more informal resolutions such as directing PMI and/or their family to local mental health, housing and/or social assistance agencies. First responders should, therefore, have a written list or pamphlet both for their own usage and to be given to PMI and their families.

Rationale: Because social service agencies are often not well coordinated and the needs of PMI may be diverse and complicated, it is unrealistic to expect first responders to either know about all social services agencies, or to be able to locate and evaluate this information on a case-by-case basis. A general guide to the local resources and contact persons is expedient and will save time. Such a list might be developed or provided by the people in Principle 2. It might also be within the purview of Victim Services to develop and provide this information.

Principle 8
Each police organization should participate in a regional liaison committee which is comprised of members of the mental health system and members of the criminal justice system.

While specific links with members of the mental health system are of course essential, they are not sufficient. Police services should be part of the larger continuum of human service and criminal justice system agencies addressing the issues of PMI who become involved with the criminal justice system. That requires coordination and planning at the community level. Coordinating committees typically involve not only police organizations and mental health agencies, but also representatives from the crown, the courts, defence bar, social services, other health care agencies and ambulance services. Coordinating committees might provide contacts to help deal with specific situations but more importantly they can develop policy and identify local service needs. In rural areas, such a group could meet—by necessity—through teleconferencing or videoconferencing.

Rationale: Issues related to the criminalization of PMI are not unique to police services and are attributable to a complex series of interactions between many community partners, as well as social trends and legislation. The police have a critical role to play in the development and implementation of approaches to this broad issue, as well as participating in a local needs analysis and the establishment of service agreements. Liaison committees can also provide a forum for follow-ups and debriefings after difficult interactions and can also develop crisis plans for PMI who come in repeat or frequent contact with police.

Principle 9
Each police organization should establish a data collection system that reflects the nature, quantity and outcome of interactions with PMI.

Estimates of how much time police spend with PMI and in what capacity are indeed just that - estimates. We have few data that describe the nature and extent of such interactions. A comprehensive data collection system will identify and track such interactions.

Rationale: The majority of record management systems do not provide a sufficient base for monitoring this type of information. Consequently, there is need for leadership in the development of appropriate standards and processes. Data provide a way of tracking what the problem is, how many resources are currently used, what future resources are necessary, whether changes in policy or procedure are necessary and/or have the desired effect and the identification of unmet service needs. Only by recording systematically, over time, can these questions be addressed and solutions developed. In addition, such tracking and data collection sends a clear message about what is important and whether an organization is seeking change or improvement. It is an essential planning and evaluation tool.

Principle 10
Each police organization should have a central location where general information about mental illness, local resources and legislation can be stored and easily accessed when needed.

This might be a binder, a box or a library under the auspices of the designated mental health person. Regardless, first responders should have ready access to information and data that can be accessed when necessary.

Rationale: Information about services and trends changes quickly and it is unrealistic to think that all first responders will have access to timely in-service education on these issues. However, officers will usually take advantage of information that is readily available when a problem situation arises. A small "library" or reference area provides such information on an "as needed" basis. It also creates an atmosphere that encourages continuous learning. (This principle does not of course refer to information about specific people known to the police but rather to general information and resources)

The role of leadership...

As indicated in the "Central Tenet" at the start of this document, there is a key role to be played by police leaders so that people with mental illnesses are treated respectfully and pro-actively. According the Consensus Project (see www.consensusproject.org)

"The single most significant common denominator shared among communities that have successfully improved the criminal justice and mental health system's response to people with mental illness is that each started with some degree of cooperation between at least two key stakeholders—one from the criminal justice system and the other from the mental health system." (Consensus Project report p. 14)

That's the challenge.