Vancouver's Mental Health Crisis: An Update Report

September 13, 2013

VANCOUVER POLICE DEPARTMENT
Beyond the Call

Executive Summary

Over the last decade, mental health related police incidents have steadily increased. In 2007, due to a concern over a spike in suicides and other crisis situations, the VPD conducted a study to determine the extent of the problem. This resulting report is known as *Lost in Transition: How a Lack of Capacity in the Mental Health System is Failing Vancouver's Mentally Ill and Draining Police Resources*. While some progress was initially made, the problem only worsened and in 2010 *Beyond Lost in Transition* was released with five additional recommendations. To date, a large number of these recommendations have been addressed, but several remain outstanding.

Since *Beyond Lost in Transition* was released, the VPD, Vancouver Coastal Health (VCH), and Providence Health Care (PHC) authorities began working in cooperation to improve the quality of life for those suffering from mental illness and to increase public safety. However, further progress cannot be made without additional resources in the health system for the mentally ill.

Recently there has been a worrisome increasing trend in persons exhibiting signs and symptoms of mental illness. Within the past three years, the emergency department at St. Paul's Hospital has seen a 43% increase in individuals with severe mental illness and/or addiction. Similarly, the VPD has experienced a significant increase in the number of section 28 *Mental Health Act* apprehensions. Between 2010 and 2012, section 28 apprehensions have increased by 16%. It is expected that this trend will worsen in 2013 as year-to-date apprehensions have increased by 23%. Furthermore, mental illness is believed to contribute to 21% of incidents handled by VPD officers and 25% of the total time spent on calls where a report is written. Accordingly, the VPD continues to assign more resources to deal with this problem. In the 1990s the VPD only had 1.5 full-time employees assigned to deal with those suffering from mental illness and addiction. However, in 2013, this has increased to more than 17 full-time employees.

In addition to these staggering figures, there have been numerous violent crimes involving mentally ill persons. Since January 2012, the VPD has identified 96 serious incidents ranging from suicides to random violent attacks inflicted upon innocent members of the public. The frequency of these incidents has increased with more than 36 violent incidents occurring in 2013. These incidents include elderly women being stomped in the head, multiple stabbings, and assaults on children as young as three years old. One incident involved an innocent man

being eviscerated in front of a movie theatre. More recently, two innocent bystanders narrowly avoided being killed in a shooting, with one victim being grazed in the head. While the media have only connected a few of the incidents in terms of involving mentally ill suspects, the trend is alarming, and currently poses the greatest risk of an unprovoked attack on citizens living low-risk lifestyles in Vancouver. Furthermore, many perpetrators of the violence are also a danger to themselves and suffer in terms of quality of life. Arrest and prosecution is not the optimal solution for their underlying psychiatric problems.

VPD data indicates that mentally ill persons are at a much greater risk of becoming victims of crime than the general public. An examination of the victimization rates of persons who have been apprehended under the *Mental Health Act* in 2012 has shown that this group is more than 15 times more likely to be the victim of crime when compared to the general public. When specifically looking at instances of violent crime, persons suffering from mental illness are 23 times more likely to be victims than the general public.

In order to reverse this trend, the VPD has five recommendations which will have a large and immediate impact on the mental health system:

1) *Add 300 long-term and secure mental health treatment beds.*

2) *More staffing at BC Housing sites to support tenants with psychiatric issues and a reduced proportion of this type of tenant.*

3) *More significant support through ACT teams for psychiatric patients living in the community, including those residing in market housing.*

4) *An enhanced form of urgent care (crisis centre) that can ensure consistent and expert care of individuals in crisis situations, located at a Vancouver hospital.*

5) *The creation of joint VPD-VCH Assertive Outreach Teams for mentally ill persons who do not yet qualify for ACT teams.*

Recommendations one through four have been endorsed by the VPD, the Vancouver Coastal Health Authority (VCH), and the City of Vancouver (COV). Without these changes and

additional resources, it can be expected that the situation in Vancouver will only continue to deteriorate, placing more people at risk and further decreasing the quality of life for those who suffer from mental illness.

The VPD is too often responding to emergency calls involving persons experiencing a mental health crisis. Often, the behaviour is criminal which results in the arrest and prosecution of mentally ill offenders. All stakeholders must shift from responding to the crisis to preventing the crisis from occurring in the first place.

Vancouver Police Background in Mental Health

During the first three quarters of 2007, VPD officers began to note an increase in the number of calls for service which involved mentally ill persons. The majority of these calls consisted of what are generally considered public disorder (such as aggressive panhandling, minor property damage, and disturbing behaviour). There were also significant incidents involving violence and a number of suicides. As a response, the VPD Executive assigned then Constable Fiona Wilson-Bates to conduct a study on the prevalence of mental illness in calls attended by the VPD, and to make recommendations as to whether anything could be done to limit the harm to both the public and to those who are mentally ill. This ground-breaking study (later described by *The Vancouver Sun* as the most powerful report to ever come out of the VPD) was titled *Lost in Transition: How a Lack of Capacity in the Mental Health System is Failing Vancouver's Mentally Ill and Draining Police Resources.*

For 16 days in September 2007, patrol officers noted if they believed mental health issues were a factor in the calls they attended. The results of the study indicated that, of the 1,154 calls attended, officers believed 31% involved someone suffering from mental illness. There was variation between Patrol Districts, with the highest percentage of calls in the Downtown East Side. It was estimated that handling these calls required the equivalent of 90 full-time patrol officers over the course of the year. This figure did not include any associated court time or follow-up work conducted by specialty units.

Lost in Transition also identified dangerous service gaps which resulted in tragic outcomes, as in the case of Corey O'Brien. Corey was a talented young man from a good home with a

promising future, but following the onset of schizophrenia he fell onto a path which would ultimately lead to his suicide after numerous contacts with both police and the medical system.
As a result of these findings, *Lost in Transition* made the following seven recommendations:

1) A mental health care facility that can accommodate moderate to long-term stays for individuals who are chronically mentally ill.

2) The creation of what has been termed an "Urgent Response Centre" where individuals can be assessed and triaged according to their needs along with additional resources to support this facility.

3) Increased services for people who are dually diagnosed.

4) A continued increase in supportive housing.

5) For St. Paul's Hospital and Vancouver General Hospital to speed up the admission process for police who have arrested an individual under the provisions of the *Mental Health Act* (by negating the need for the emergency physician to initially examine the patient, for example).

6) Enhanced ability to gather data on all calls for service that are mental health related to facilitate further research on this matter and to establish benchmarks to track changes for police in British Columbia.

7) A system, much like PRIME, that has readily accessible details of an individual's mental health history and addresses privacy concerns, for British Columbia mental health service providers.

Lost in Transition was released in early 2008 and garnered extraordinary local and national media attention and brought additional light to the issues facing the mentally ill in Vancouver. VPD Executive members met with several provincial cabinet ministers, senior VCH staff, and community stakeholders to brief them on the results of the research and seek their support. Within two weeks of the report's release, the Provincial Government announced the opening of the Burnaby Centre for Mental Health and Addiction (BCMHA), a 100-bed facility offering care to

"dual diagnosed" mentally ill and addicted persons. This facility was opened on July 1 of the same year and quickly had a waitlist of more than 300 people. In 2010, the facility was expanded to contain 40 pre-treatment and 40 post-treatment beds to aid in transitioning people into and out of treatment.

Progress was also made with regard to supportive housing. The COV and the Provincial Government were able to secure funding for approximately 2,850 housing units. Additionally, the Federal Government funded a three-year program ("At Home/Chez-Soi") to provide 300 housing units for homeless persons struggling with mental health issues. The rationale was that treatment of addiction and mental health issues will be more successful if patients have access to proper housing.

Despite these initial successes, the momentum for change slowed over time and, as such, in early 2010 the VPD began working on a follow-up mental health report. This follow-up report by Inspector Scott Thompson, referred to as *Beyond Lost in Transition*, found that the resources available to properly deal with those who suffer from mental illness were still woefully inadequate. The lack of capacity and resources in the mental health system, combined with a lack of collaboration between the police and health care providers, were seen to be the key barriers to ensuring that mentally ill individuals receive adequate care. Accordingly, the need for collaboration was seen as so important that it was formalized in the VPD's *2012-2016 Strategic Plan*, with mental health agencies being specifically identified as key stakeholder agencies in the community. Ultimately, *Beyond Lost in Transition* made five new recommendations:

1) That the Ministry of Health and VCH establish an Assertive Community Treatment (ACT)[1] team model with sufficient capacity to address community based treatment needs in Vancouver and implement a model similar to the one that exists in Victoria, BC where the Victoria Police Department are part of an integrated team.

2) That Vancouver Coastal Health, St. Paul's Hospital, Vancouver General Hospital and the police establish formalized standing bodies with appropriate terms of reference with police, emergency room, and psychiatric units as well as psychiatric ward medical staff

[1] An ACT team provides care to those who suffer from significant mental illness and substance use disorder and is comprised of various resources including but not limited to medical practitioners, addiction counsellors, and now police to provide an increased level of service.

and management with a mandate to monitor, identify, de-brief and resolve critical incidents and other police/health related incidents as well as systemic issues.

3) That Vancouver Coastal Health, St. Paul's Hospital, Vancouver General Hospital establish an information sharing and feedback mechanism so attending Emergency Room and psychiatric unit and ward physicians are advised in a timely manner of suicides, suicide attempts, and other critical incidents involving their patients.

4) That the Ministry of Health make legislative changes in the Mental Health Act to facilitate a speedier health system response and reduce police wait times at the hospitals.

5) That the Coroner review and consider calling an inquest in all suicide cases where an individual received psychiatric and/or mental health treatment within a 30 day period before their death. (The VPD recognizes that this is a contentious recommendation; however, the inquest is not designed to find fault but rather to determine if improvements can be made to systems in order to prevent future tragedies).

This report, while contentious at first, eventually led the way to a healthy and productive working relationship between the VPD and both VCH and PHC, at both the staff and Board levels. As such, significant progress was made on many of the recommendations from both reports. Appendix A details the progress made on each *Lost in Transition* and *Beyond Lost in Transition* recommendation.

Current Mental Health Initiatives

Both the VPD and VCH recognize that providing care for the mentally ill requires coordination between multiple agencies. Therefore, programs such as Assertive Community Treatment (ACT) and Car 87 are utilized. Furthermore, the VPD is participating with VCH in a number of studies designed to examine common factors between mentally ill individuals who have had numerous police contacts and have been previously apprehended under s. 28 of the *Mental Health Act*. Of note, VPD resources dedicated to addressing issues related to mental illness have increased dramatically. In the 1990s the VPD only had 1.5 full-time employees assigned to deal with those suffering from mental illness and addiction. However, in 2013, this has increased to more than 17 full-time employees.

Car 87

The Car 87 program has been in existence for almost 30 years. Car 87 is a partnership between the VPD and VCH that began in 1984 and was formalized in 1987. If patrol members attend an incident which involves an individual experiencing a mental health crisis, they can call Car 87 which is deployed with one VPD officer and one registered nurse or psychiatric nurse. These resources are able to provide initial care and assessments of individuals having a mental health crisis and can begin to arrange for follow-up care. However, due to the ever increasing number of calls for service involving people experiencing psychiatric emergencies, this service on its own is generally not able to provide extended follow-up beyond initial treatment and referrals. The VPD currently has four full-time officers assigned to Car 87.

Downtown Community Court

The VPD has been a partner of the Downtown Community Court (DCC) since its creation in 2008. The goal of the DCC is to reduce crime and increase public safety by addressing the root causes of criminality, mental health, and substance abuse. Cases are dealt with in a quick and coordinated manner and the ensuing dispositions focus on treatment and rehabilitation. This is enabled by the fact that the DCC only sentences people who are willing to plead guilty and abide by the conditions set out by the court.

Unfortunately, a large number of Vancouver's chronic offenders suffer from mental illness and substance abuse issues. As such, the VPD's Chronic Offender Unit (COU) works closely with both the DCC and a large number of the severely mentally ill in Vancouver. One member of the COU is assigned to work directly with the DCC. Through their work with the DCC, the COU is able to liaise with various partners, including Provincial Crown, to ensure that once sentenced, mentally ill and addicted chronic offenders are able to obtain treatment, which reduces the likelihood of repeat offences.

Project Link

After the release of *Beyond Lost in Transition*, and as a result of discussions between the Vancouver Police Board and the Vancouver Coastal health Board, it became clear that a closer working relationship was required in order to increase public safety and increase the quality of life for those suffering from severe mental illnesses. A letter of understanding was reached between the Vancouver Police Board and the Vancouver Coastal Health Board which underscored the goals of this collaborative relationship. The goals of the partnership fall into

two categories. The first category is *health service, police service, and criminal justice system outcomes*:

- Reduction in non-urgent Emergency Department visits for previously high users with mental health and problematic substance use issues.
- Optimal length of stay in acute care beds.
- Effective and appropriate use of all emergency services such as the BC Ambulance Service, Vancouver Fire and Rescue Service, Saferide, Mental Health Emergency Services, Withdrawal Management, the Vancouver Jail, and hospital Emergency Departments.
- An increase in client access to appropriate community health care through an expansion of service hours.
- An increase in the number of clients engaged and retained in treatment.
- Reduction in the volume of police calls for [mental health] related service.
- Reduction in street and community disorder related to the target population.
- Reduction in the number of mutual clients in the court system.
- Reduction in the number of arrests and incarcerations.
- Reduction in the number of incidents where these vulnerable clients are victimized.

The second category relates to *changes in partnered service delivery*:

- Reduction in the wait times for police in Emergency Departments…to 56 minutes with outlier wait times not to exceed two hours except under exigent circumstances.
- Establishment of formalized standing bodies with appropriate terms of reference with St. Paul's Hospital and Vancouver General Hospital with a mandate to monitor, identify, de-brief and resolve critical incidents, other police/health related incidents as well as systemic issues relating to police wait times and missing hospital patients.
- Development of community based case management model(s) with capacity to address treatment needs in Vancouver while linking the practices of health and policing through the appropriate participation of police officers in access to care.

All of the aforementioned goals are meant to lead to an overall outcome of "improved quality of life for those suffering from mental illness and/or problematic substance use and addiction." This letter of understanding resulted in a formalized working group called *Project Link*. Shortly after the letter of understanding was signed, PHC was invited to join the committee. *Project Link*

meets regularly and is co-chaired by senior VPD and VCH staff and is the key method of sharing information between the VPD, VCH, and PHC. In addition to regular *Project Link* meetings, starting in 2011, the Vancouver Police Board and Vancouver Coastal Health Board began holding yearly joint board meetings.

In addition to *Project Link,* the VPD participates in a number of committees and working groups that relate to issues surrounding the mentally ill population in Vancouver. Below is a list of the various committees and working groups that the VPD participates in:

- Hospital Wait Time Committee
- BC Alliance on Mental Health and Addiction
- St. Paul's Hospital ED External Review Committee and two working groups which flowed from this committee
- Ministry of Transportation and Infrastructure Committee on Suicide Prevention
- Downtown Community Court Mental Health Committee
- Vancouver General Hospital ED and Psychiatry Patient Flow Committee
- St. Paul's Hospital ED and Psychiatry Patient Flow Committee
- Lower Mainland Mental Health – Police Liaison Committee

Assertive Community Treatment (ACT) Teams

In 2012, the VPD became a member of Vancouver's first ACT team, an interdisciplinary team designed specifically to treat chronic and severely mentally ill individuals who also suffer from addiction and substance abuse issues. An ACT team is comprised of various service providers including psychiatrists, nurses, addiction counsellors, and now the police. The inclusion of police officers in ACT teams was inspired locally by the Victoria Integrated Community Outreach Team (VICOT). It was realized that the police have a significant role to play in the care of the mentally ill in Vancouver due to the fact that officers tend to have daily contact with those who are chronically mentally ill. While VPD officers are by no means mental health practitioners, they are able to observe changes in an individual's baseline state and are often the first point of contact for persons in crisis.

The VPD's role on the ACT team is to assist in the flow of communication to other service providers for ACT clients, as well as to provide assistance when required during field visits to clients. Additionally, the VPD provides police and justice based collateral information and identifies and refers clients who are decompensating, becoming increasingly difficult to manage

in the community, or entering into crisis. For example, a VPD officer on an ACT team may advise a nurse that it is not safe to visit a client alone at a specific building and will accompany that nurse. Moreover, an officer may be contacted by a doctor if a patient has missed numerous appointments. In this case, the officer will be able to check police records and can share whether a patient is currently in police custody and can arrange for treatment.

Currently, there are three ACT teams, with one of two full-time ACT Liaison Officers responsible to all three teams on a daily basis. By all accounts, ACT has been a success: recent analysis of a study cohort of 32 clients revealed a 50% reduction in negative police contacts when compared to one year prior to intake. This study cohort of ACT clients has also had a 23% reduction in victimization and 70% reduction in non-urgent emergency department visits. At present, the ACT teams are almost at full capacity. Given the noted success in reducing negative police contacts and increasing quality of life for the mentally ill, both the VPD and VCH are exploring funding options to expand the program to create additional needed capacity.

Mental Health Unit

In October 2012, the VPD formalized the Mental Health Unit with the mandate to work with VCH and lead the Department's efforts on dealing with the mentally ill in Vancouver. This unit consists of four full-time employees: one sergeant, two constables, and one analyst.

The sergeant in charge of this unit takes the primary liaison role with various key partners who deal with Vancouver's mentally ill population and is involved in many of the various committees and working groups that the VPD participates in. The two constables are assigned to the ACT teams and the analyst provides support in identifying potential ACT clients and monitoring various measures and benchmarks as they relate to targets set through *Project Link* and other committees.

Mental Health Care Team

Care teams in medical settings are groups of people, medical practitioners or not, who have an important role in patient treatment. With regard to VPD inclusion, the most important part of this designation is that all persons on a care team are able to share information regarding a patient without breaching patient confidentiality.

As of 2012, the VPD officers who were embedded in ACT teams were considered part of the care team. In 2013, VCH, PHC, and the VPD agreed that the VPD and the Criminal Justice System are part of the continuum of care for mutual clients who suffer from severe and persistent mental illness and substance abuse disorder. It is agreed by all partners that the police should be considered part of the care team, even for patients who are not being treated by an ACT team. This is an important step forward in achieving the goals of *Project Link*. Much like in the ACT teams, this allows officers who have daily contact with mentally ill persons and recognize their baseline behaviour to discuss treatment with health care practitioners. An example of how this designation (for all VPD officers) aids in the care of mentally ill persons is as follows.

During a shift, an officer may come across a mentally ill individual who is well known to them; however, on this given day the individual appears much more agitated than usual and is darting through traffic in an attempt to hurt himself. When approached by the officer, it is clear that this behaviour is the result of hallucinations. Using the powers granted under s. 28 of the *Mental Health Act,* the officer will apprehend this person and take them to a local hospital. When at the hospital, it appears that this person has not had any previous mental health interventions and thus the doctor is likely not aware of what is a "normal" state for this patient. Prior to being designated a part of the care team, the officer would not have had any legal right to information regarding the patient. Once they have explained the incident to the doctor, the officer's role in this incident will have ended without the officer knowing when the patient would be released or if the instance was the result of deterioration in mental health that can be expected to continue or due to the use of illicit drugs.

As a member of the care team, doctors are able to share information regarding the patient's release and their treatment with VPD officers. For example, if a patient is released on medication, the doctors will inform officers that it can be expected that the patient's condition should improve within the next few days. The benefit to overall patient care is that the officer will likely continue to see this person on a daily basis whereas the doctor may only see the patient once every month or perhaps even less. If this information sharing does not occur, the patient may continue to attempt self-harm or harm others prior to being seen again under a s. 28 apprehension. Not only does this cause a public safety risk, it is also a very inefficient use of public resources as these apprehensions tend to be much more resource intensive than a follow-up appointment with a psychiatrist.

Furthermore, police will be able to obtain information on the person's medical history which greatly increases public and officer safety. In the event of a barricaded suspect, the police will be able to speak to the suspect's psychiatrist or obtain their medical information through resources in Car 87 to determine the best course of action to defuse the situation. This is especially important as some routine police actions (such as the use of flashlights in a certain manner and certain words or names) could act as triggers and may inadvertently agitate a barricaded person who is going through a psychotic episode.

Homeless Outreach Coordinator

With the recognition that the homeless population is inherently at a higher risk of becoming victims of crime due to their vulnerable situation, the VPD has a homeless outreach coordinator who provides assistance to the homeless population. To add to the inherent risk of being homeless, a large number of Vancouver's homeless are placed at further risk as some are also mentally ill and/or drug addicted. The homeless outreach coordinator provides assistance ranging from assistance in filling out BC Housing forms to providing necessities such as blankets and aiding in finding shelter space in times of extreme weather. In addition, this officer also refers those suffering from addiction and mental health issues to service providers to assist them in finding treatment.

Sex Trade Liaison Officer

Survival sex trade workers are arguably one of the most at risk populations in Vancouver due to challenges such as homelessness, mental illness, or addiction. The VPD's sex trade liaison officer stays in contact with Vancouver's sex trade workers and the various outreach organizations which provide support to this group. Much like the homeless outreach coordinator, the sex trade liaison officer directs sex trade workers to various outreach centres and organizations (such as the WISH drop-in centre society) and aids them in gaining access to resources to treat underlying addiction and mental health issues.

Participation on External Reviews

In February 2012, a mentally ill man stabbed an innocent bystander in the chest at a Vancouver coffee shop. This case raised numerous questions since the day prior he had been in both police custody and subsequently cared for by a local Vancouver hospital. Incidentally, the VPD raised concerns about the appropriateness of the hospital release. As a result, the VPD was

invited to participate in this review as it was recognized that the police have a large role in dealing with those who are severely mentally ill.

The external review team, working closely with St. Paul's Hospital, the VPD, VCH, and PHC, made 22 recommendations for improvements to the processes in treating mentally ill patients in the hopes of avoiding a similar incident in the future. Many of these recommendations pointed to the need for additional capacity in various areas of treatment. Specifically, additional acute care and observation beds were called for as well as an expansion of the ACT teams. The review also called for increased information sharing between health care partners and the police due to the frequency of incidents involving the severely mentally ill. St. Paul's Hospital and PHC accepted all 22 recommendations and four working groups were established to research, review, and implement these recommendations.

Mental Health Studies

The VPD, PHC, and VCH have considerable amounts of data regarding the apprehension and treatment of mentally ill persons; however, this data is stored on different systems, which limits general access to the other agencies' information systems. In order to more efficiently use public resources, both the VPD and VCH have begun to enlist the assistance of local universities to examine the data and look for ways to improve the processes being used by both agencies. One such study that is being considered by the UBC School of Law's International Centre for Criminal Law Reform will examine the application of s. 28 apprehensions. This study is planned to commence in the fall of 2013.

A second study is currently being planned to examine the effects of "Welfare Wednesday" on hospital admissions and will suggest potential changes to staffing and processes to minimize the effect of patient surges.

Crisis Intervention and De-Escalation Training

Beginning in 2002, the VPD started training its officers on how to handle situations involving persons undergoing a mental health crisis. The goal of this training was to give officers the tools to de-escalate a situation which has the potential to turn violent or result in a suicide. In 2010, the VPD made this training mandatory for all patrol officers. Two years later in 2012, as per recommendations from the Braidwood Inquiry, training on mental health crisis and de-escalation

became mandatory across BC. To date, more than 650 frontline VPD officers have received this new mandatory training.

Crisis Negotiation Program

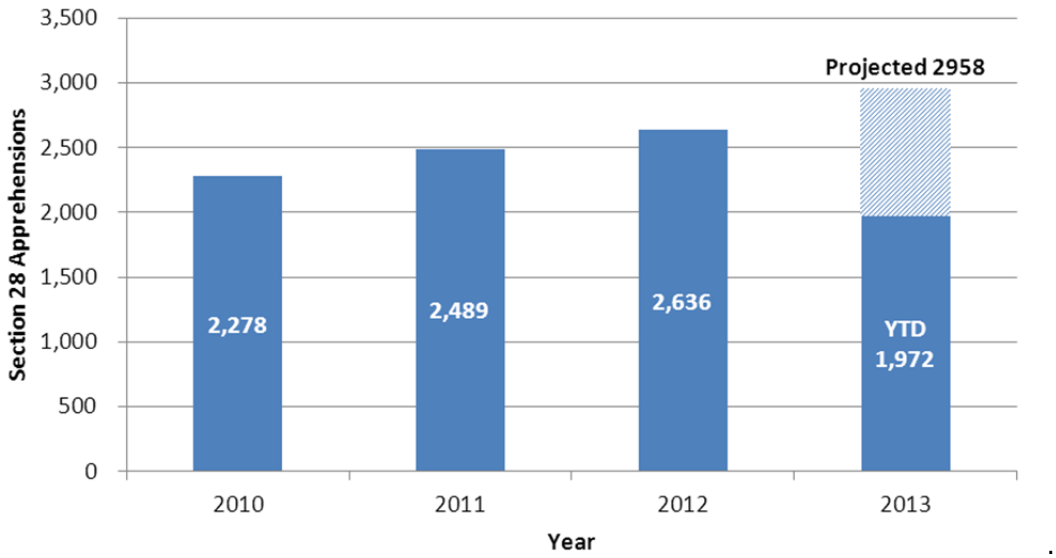
The VPD trains a number of highly skilled negotiators through the Crisis Negotiation Program. This program consists of 21 officers, one full-time negotiator/program coordinator and 20 part-time negotiators who are deployed elsewhere in the VPD but are available during their shifts or are on-call. There are six additional support staff members who handle the equipment and technical requirements for the negotiators. Training for this program consists of an intense two week course followed by a one week recertification course every three years. Additionally, there are six team training days per year.

These highly trained officers are called to situations when patrol officers require additional expertise and assistance. This includes calls such as suicidal persons, barricaded suspects, and emotionally distraught people in crisis. On average, VPD crisis negotiators attend approximately 200 calls per year.

Trends in Mental Health Related Calls and Incidents

Mental health related calls consume considerable police resources in both the volume of these calls as well as the length of time that officers must spend at an incident in the event that the mentally ill person is being apprehended under the *Mental Health Act*. When the *Mental Health Act* is being utilized, considerable health care resources are also being utilized as these patients must be examined by physicians and admitted through the emergency department at local hospitals. Disturbingly, the number of police incidents requiring *Mental Health Act* apprehensions has risen considerably over the past few years. As seen in Figure 1 on the following page, the number of *Mental Health Act* s. 28 apprehensions increased by 9.3% in 2011 and 5.9% in 2012. In 2013, the year-to-date apprehensions have increased by 23%. This is a continuing trend that has become worse over the past decade.

Figure 1 - Section 28 Apprehensions by Year



Following a s. 28 apprehension, doctors can involuntarily commit a patient to a designated facility under s. 22 of the *Mental Health Act* by issuing a Form 4 Medical Certificate when they feel that the patient "… 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…cannot suitably be admitted as a voluntary patient."

Once the patient has been certified and stabilized, they are discharged back into the community where they are monitored and further treated by community based mental health teams or their general practitioner. In the event that the patient decompensates and is at risk of deterioration, they are recalled back to the designated facility through the application of a Director's Warrant under s. 39 *Mental Health Act*, also known as a Form 21 under the *Mental Health Act*. Section 39 reads: "subject to the regulations, the director of a designated facility who recalls a patient under subsection (2), or to which a patient is recalled under subsection (2) as a result of a transfer under s. 35, may issue a warrant in the prescribed form for the patient's apprehension and transportation to the designated facility to which the patient is recalled."

In 2012, there were 3,043 apprehensions (this includes s. 28 apprehensions as well as Form 4 and Form 21 apprehensions) under the *Mental Health Act*. This accounted for more than 21,000 police hours spent on-scene to deal with the incident. These trends are generally

consistent with observations at local hospitals. From 2009 to 2012, St. Paul's Hospital has reported a 43% increase in the number of patients attending their emergency department who suffer from mental illness and/or addiction.

Incidents which result in *Mental Health Act* apprehensions comprise a small number of total police contacts which result from or have mental illness as a significant contributing factor. In November 2012, the VPD began using a PRIME template to systematically track whether mental illness was a contributing factor in incidents attended by police officers. Since then, responding officers have indicated that they believe mental health related issues directly contributed to at least 21% of all incidents attended.

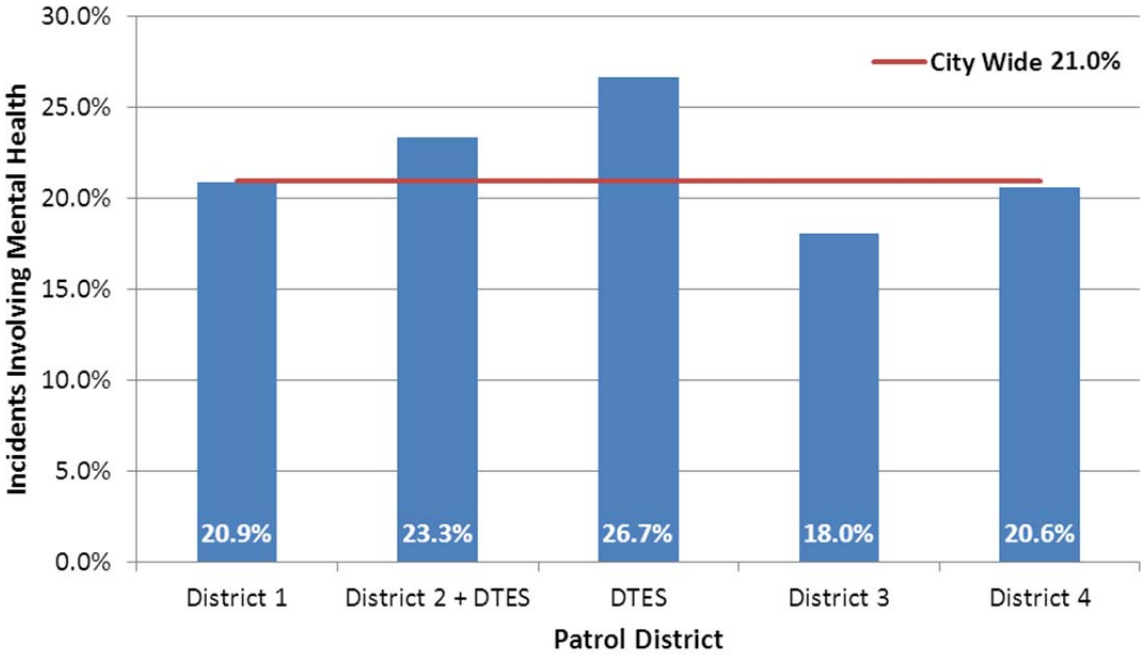
It should be noted that the proportion of incidents where officers believe mental illness to be a factor is lower than noted in the initial *Lost in Transition* study in 2008. However, this is the result of significantly different methodology, not a decrease in incidents involving the mentally ill, especially in the face of the dramatic increases noted in *Mental Health Act* apprehensions and self-reporting from local Vancouver hospitals. The *Lost in Transition* study only collected data over a 16-day period and the overall compliance rate was unknown. The lack of a systematic and reliable method to collect such data was identified in *Lost in Transition* and was reflected in the recommendations, resulting in the current process. The figures being collected since November 2012 have a policy compliance rate of over 99% and provide a more accurate depiction of the extent of police incidents involving mental illness in Vancouver.

The following graph (Figure 2) shows the proportion of mental health related incidents in each Patrol District as well as the city-wide average as indicated by the red line. Vancouver is divided into four Patrol Districts, each responsible for a specified geographical area:

- District 1 – North-West (Downtown Core and West End)
- District 2 – North-East (East Vancouver, north of Broadway – includes the Downtown East Side)
- District 3 – South-East (East Vancouver, south of Broadway)
- District 4 – South-West (West Side of Vancouver up to UBC Endowment Lands)

As can be seen below, mental illness is a contributing factor in 26.7% of incidents in the Downtown East Side. This is well above the city average of 21.0%

Figure 2 - Incidents Involving Mental Illness by District



Impact on Public Safety and Quality of Life

Currently, there are insufficient mental health resources to adequately treat the number of mentally ill persons in Vancouver. The impacts of an overburdened mental health system affect all residents of BC, both those suffering from severe mental illness and those who do not. In recent history there have also been an alarming number of significant – often violent – events involving persons suffering from mental illness. This should come as no surprise given the dramatic increase in s. 28 apprehensions in the last decade; this increase is a leading edge indicator of the number of people in Vancouver with serious mental illnesses. With such a dramatic increase, the percentage of serious, violent incidents can also be expected to have increased, consistent with the current pattern observed.

A number of studies have noted that there is an increased likelihood of violence associated to certain types of severe mental illnesses, such as schizophrenia and bipolar disorder. In 1990, Swanson et al. noted a higher rate of violence for persons suffering from mental illness

compared to those who were not suffering from any mental illness.[2] Furthermore, it was discovered that multiple diagnoses compound the likelihood of violence. Those who were not diagnosed saw a 2.05% likelihood of committing a violent act within one year, while those with one to three diagnosed mental illnesses saw a likelihood ranging from 6.81% to 22.36%.

An Australian study conducted between 2007 and 2011 also examined the impact of mental disorders and offending rates in a group of patients suffering from psychotic mental illnesses over a ten year period.[3] It was found that those who suffered from mental disorders, and were classified as psychotic, had offending rates 3.5 times higher than a general community sample. When looking specifically at violent offences, this rate increased to 4.5 times higher than the general sample. It was also found that people with psychosis were more likely to have contact with the police, and there was a greater instance of police attendance for family violence. Furthermore, when patients who also suffered from substance abuse issues were examined, it was found that almost 50% committed an offence and roughly 20% committed a violent offence.

Since January 2012, the VPD has identified 96 serious incidents ranging from suicides to random violent attacks inflicted upon innocent members of the public. The frequency of these incidents has increased with more than 36 violent incidents occurring in 2013. In one 15-month period, 26 innocent victims were attacked and injured – some very seriously – in 11 separate incidents. The following are synopses of some of the most serious of these incidents.

Recent Critical Incidents

December, 2012

One late December 2012 morning, a mentally ill man ran up to an elderly woman and without provocation kicked her once in the head. After she fell, he proceeded to repeatedly stomp and kick her in the head and face. He ran away from the scene where he encountered another elderly woman and assaulted her. Again, this unprovoked assault resulted in the woman being stomped and kicked in the head and face once she was knocked to the ground. A third assault occurred in a similar manner, where another elderly woman was punched in the head and while

[2] Swanson J.W., Holzer C.E., Ganju V.K., Jono R.T. (1990). Violence and psychiatric disorder in the community: evidence from the epidemiologic catchment area surveys. *Hospital and Community Psychiatry*. 41(7), 761-770.
[3] Short T., Thomas S.D.M., Luebbers S., Mullen P.E., and Ogloff J.R.P.. Brief research report 5a: Criminal offending and victimisation in severe mental illness. Retrieved from: http://www.med.monash.edu.au/psych/research/centres/cfbs/download/5a.pdf

on the ground was kicked and stomped in the head. After the third assault, the suspect kicked in the window of a car after threatening the occupants (stating that he had a gun). The glass from the window got into the eye of one of the occupants. Shortly after, the suspect was arrested by the VPD.

The suspect had one documented PRIME entry in BC prior to this incident. Two days prior to this incident, he called for an ambulance due to a schizophrenic episode and was transported to hospital voluntarily but was released shortly afterwards.

January, 2013

One afternoon in early 2013, Vancouver Fire and Rescue Services responded to a fire alarm at a Vancouver high rise. Upon arrival they noticed that several standpipes used by firefighters were opened and that a large amount of water was flowing through the building. When they reached the floor where the fire alarm was pulled, they found the suspect standing with a fire extinguisher. He stated that he put out a fire and was ensuring that the building was safe. The VPD was then called to investigate the scene as a mischief; however, the suspect had already fled. He was later found in the laundry room of a different building in a disturbed mental state and was aggressive with police.

The total damage to the building was in the hundreds of thousands of dollars. Prior to this event, the suspect had one documented PRIME entry for a fare evasion.

January, 2013

One evening in early 2013, the suspect smoked marijuana in his suite in a West End apartment while on prescription medication. He assaulted his first victim in his suite. During this attack she sustained life altering injuries. The suspect went on to assault two neighbors by stabbing and slashing them with a knife. One of these victims received a slash to the throat. He then attacked three more victims with a hammer in the lobby of the building. The suspect used the hammer once more to attack the seventh and final victim in the victim's suite. While being arrested, the suspect assaulted a VPD member.

The suspect is a foreign national with no PRIME history other than three traffic citations issued towards the end of 2011; however, he had been admitted to and discharged from hospital for suicidal ideation within days of this incident.

February, 2013

One late evening in February 2013, the suspect was walking in Downtown Vancouver and encountered his first victim. Without any provocation the suspect stabbed the man in the neck with a folding knife. He walked away from the scene of the stabbing and encountered his second victim who was walking his dog. The suspect approached the victim from behind and without warning stabbed him in the back and then a second time in the stomach. The injury to the victim's stomach was so significant it resulted in internal organs being visible to responding officers and the victim immediately went into surgery upon arrival at the hospital. Once again, the suspect proceeded to walk away from the scene. Further down the road, the suspect encountered yet another victim and, again without provocation, attacked her by attempting to stab her in the face. The final victim was able to defend herself; however, she received a large cut to her hand. At this point the suspect dropped the knife and proceeded to walk along the street where he arrested by the VPD shortly after.

At the time of the attacks, the suspect had 47 PRIME entries including ten *Mental Health Act* related calls.

March, 2013

The victim, a 30-year-old woman, was paying for cigarettes at the counter of a convenience store. The suspect suddenly attacked the victim from behind with a knife, stabbing her in the neck causing a near-fatal injury. The attack was so violent that the blade of the knife broke off inside the victim. He was tackled by another patron and held until police arrived at the scene. The victim required emergency surgery but survived the attack. The entire incident was captured on the store's CCTV system and shows the sudden unprovoked savagery of the attack.

The suspect is a diagnosed schizophrenic who was collecting disability payments due to his mental illness. In December 2012, the suspect completed a sentence for a 2008 aggravated assault. However, upon the end of his sentence, treatment for his mental illness ended and he ceased taking his medication. Prior to his 2008 conviction, he had one previous PRIME entry.

March, 2013

The victim was a three-year-old child at a Vancouver library amongst a group of children being read stories. The suspect approached the child, who was seated in the children's area, and

struck the child in the face with a book, knocking her off her chair. He then proceeded to threaten the young woman who was reading to the children, stating, "I'm going to kill you...I can just strangle you right now." After making these threats, he finally left upon being confronted by numerous others within the library. When arrested he admitted to the assault and it was evident he suffered from significant mental health issues.

The suspect has 24 documented incidents in PRIME and it was noted that his aggression level increased as threats began turning into assaults.

May, 2013

The victim was standing on the sidewalk when the suspect approached him and began speaking incoherently. At this point the suspect, without warning or provocation, assaulted the victim by repeatedly punching and kicking him in the head. The victim was not able to defend himself. Witnesses were able to pull the suspect off the victim.

The suspect was noted to have more than 260 documented police contacts at the time of the incident. In 21 instances, he was noted to have suffered from a severe mental illness with no offence committed.

May, 2013

As a mother and her five-year-old daughter were walking down the street one early evening in May 2013, the suspect approached them. Without provocation the suspect began yelling and swearing at the five-year-old then suddenly grabbed the child by the hair. The suspect proceeded to drag and swing the child around the sidewalk by her hair. The mother was able to free her daughter and used her own body to protect her from a further attack. At this point the suspect pushed both victims to the ground and kicked the mother multiple times. The mother was left with serious swelling, bruising, and abrasions to her face.

Upon arrest, the suspect told officers that more children would be hurt as a result of her actions. In the year and a half prior to this assault, the suspect had 25 documented police incidents with seven resulting in s. 28 apprehensions.

July, 2013

The suspect exited his car and approached two males leaving a comedy show. He pulled out a handgun and aimed at their heads, firing twice. One victim narrowly escaped death as he was grazed in the head by the bullet; the second victim was missed entirely. The suspect then shot himself in the head and shortly after passed away in hospital.

According to preliminary information, the suspect has a family history of schizophrenia. The family claims to have asked for his committal to a treatment facility only to have been refused three times in the previous month. Earlier that day it appears that the suspect visited his psychiatrist who concluded that his condition and outlook was improving. The suspect had 28 PRIME entries with one documented *Mental Health Act* apprehension

July, 2013

Members of the VPD were approached by a member of the public who informed them that a woman had just given birth to a child in a park. As members approached the woman, they observed her holding a newborn while giving birth to a second child. She was gripping both babies by their heads and necks and told police to leave and to not touch her or her babies when they attempted to get her medical attention. The woman attempted to walk away from the police and other emergency personnel. The members feared for the well-being of the children and apprehended her under s. 28 of the *Mental Health Act*. It was a chaotic scene in which the woman was clearly in a psychotic state and police officers had to struggle with her to save the children. In the course of doing so they became covered with her various bodily fluids. When the children were taken to the hospital it was noted that they sustained injuries by being gripped so tightly on their heads.

The woman had ten previous negative PRIME entries with two resulting in *Mental Health Act* apprehensions.

Increased Victimization

Those suffering from mental illnesses are not simply perpetrators of violence upon unsuspecting victims. Due to their mental illness, and in many cases substance abuse or addiction issues, they themselves are often placed into an increased state of vulnerability.

VPD data indicates that mentally ill persons are at a much greater risk of becoming victims of crime than the general public. An examination of the victimization rates of persons who have been apprehended under the *Mental Health Act* in 2012 has shown that this group is 15.2 times as likely to be the victim of crime in that same year. These same individuals are 13.5 times as likely to be victims of property crime and are 23.2 times more likely to be victims of violent crime. This represents a significant quality of life issue that cannot be ignored.

This finding is consistent with academic literature which notes that people who suffer from mental illness are more likely to be victims of crime due to their vulnerable nature and the associated problems such as drug addiction and living in more crime prone areas.

In the United Kingdom, Walsh et al. (2003)[4] found that 16% of outpatients with psychosis reported being violently victimized within the previous year. By comparison, the British Crime Survey revealed that inner cities at that time had an annual contact crime victimization rate of 7.1%.

In North Carolina, Hiday et al. (2002)[5] found that 9.9% of involuntarily admitted patients with severe mental illness reported suffering violent victimization within one year after being released from hospital. By comparison, the national violent victimization rate reported by the U.S. Bureau of Justice Statistics at that time was 3.1%.

A third study in Chicago, Teplin et al. (2005)[6] found that 25.3% of patients with several mental illnesses living in the community were victims of a violent crime within a one-year period. By comparison, the violent victimization rate measured by the U.S. National Crime Victimization Survey was 2.8%.

Teplin et al. also noted that, “symptoms associated with severe mental illness, such as impaired reality testing, disorganized thought process, impulsivity, and poor planning and problem solving, can compromise one’s ability to perceive risks and protect oneself.”

[4] Walsh, E. et al. (2003). Prevalence of Violent Victimisation in Severe Mental Illness. *British Journal of Psychiatry*. 183, 233-238.
[5] Hiday, V.A. et al. (2002). Impact of Outpatient Commitment on Victimization of People with Severe Mental Illness. *American Journal of Psychiatry*, 159, 1403-1411.
[6] Teplin, L.A. et al. (2005). Crime Victimization in Adults With Severe Mental Illness. *Archives of General Psychiatry*, 62(8), 911-921.

Current Critical Issues

Despite the fact some progress has been made in improving mental health care since the initial *Lost in Transition* report was released, there are still considerable service gaps. This is evident in the ever increasing number of apprehensions under the *Mental Health Act* and serious incidents involving grievous bodily harm, both to mentally ill persons as a result of their own actions, and to innocent parties who have been victimized by unprovoked attacks. The following are the main issues which require immediate attention and are expected to have the largest impact on public safety and the quality of life for those who are severely mentally ill.

System Capacity

Within Vancouver, there are insufficient resources to treat those with significant mental health issues. This extends from a lack of acute care beds in hospital emergency departments to tertiary care beds for those who are chronically mentally ill and are not able to function without supervised medical care.

Intake and Acute care Beds

When patients suffer a psychiatric emergency, they are usually brought to a hospital's emergency department and placed in a secure area of the hospital for observation. These beds are usually separated from the emergency department in order to aid in calming those in an agitated state. However, at St. Paul's Hospital, which due to the proximity to the Downtown Eastside sees the majority (60%) of the psychiatric emergencies in Vancouver, there are only four observation beds. When these beds are at capacity, patients experiencing a psychiatric emergency are left in the emergency department. St. Paul's Hospital has an additional 13 beds in its Psychiatric Assessment Unit which are generally reserved for acute care with patient stays averaging three to four days; however, these beds are often used for overflow when the observation beds are all in use.

A dedicated crisis centre facility would aid in the treatment of those suffering from psychiatric emergencies. A psychiatric specialist would be the initial contact point, rather than an emergency physician who may not have the expertise to diagnose mental illnesses. It should be noted that it would be best if this facility was attached to an existing medical facility as the resources available in a major hospital would assist in the assessment and care of mental

patients. Furthermore, it is not uncommon that patients undergoing a psychiatric emergency are also suffering from medical emergencies.

This facility would also aid in reducing the number of critical incidents within hospitals as patients would be seen more quickly and would not be placed in a busy emergency department. This would avoid situations where patients with medical emergencies inadvertently agitate someone who has already demonstrated behaviour which poses a risk to themself or others.

Tertiary and Long-Term Care

Tertiary care beds are generally used for patients who cannot be treated or cannot function in the community in their current state. Patients requiring tertiary care will usually be those suffering from multiple mental illnesses, drug addiction, or substance abuse issues. For example, tertiary beds are used when standard prescription medications are not functioning as expected and the patient requires observation to determine the most appropriate prescription and dosage. Ultimately, patients that require tertiary care are also likely to require long-term care.

When still open, the facility at Riverview was home to a large number of tertiary care beds. Currently, the BCMHA and Willow Pavilion at Vancouver General Hospital are the only local facilities with a significant number of tertiary care beds. Smaller facilities such as Venture, Trout Lake Tertiary, and UBC have a small number of tertiary care beds on-site. The BCMHA has 100 treatment beds with 40 pre-treatment and 40 post-treatment beds. Much like the BCMHA, the Willow Pavilion is also at capacity. It is estimated that there is demand for approximately 300 tertiary care beds in Vancouver. This is far fewer than the maximum number of beds at Riverview at its peak capacity, but is estimated to be sufficient for the most seriously mentally ill. While many individuals suffering from serious mental health issues were never in Riverview (i.e. they weren't deinstitutionalized), they were indirectly affected by this trend in that they likely would have been institutionalized in earlier decades. The increase in serious, violent offences committed by the mentally ill can be partially attributed to the reduction of secure care beds, as these are the same dangerous individuals who would have been institutionalized and would not have posed a risk to the public or themselves.

The objective moving forward must be to ensure that there are sufficient secure beds, but not to "over-institutionalize" those who do not require secure care. It is believed that 300 additional beds would meet this goal.

Resources in Supportive Housing

Beginning in 2010, the federally funded *At Home/Chez-Soi* project began housing persons who were homeless and mentally ill, and in many cases also suffering from addiction and substance abuse issues. This was one of five study groups to determine the best manner to treat the homeless and severely mentally ill. The study that was run out of the Bosman Hotel, at 1060 Howe Street, is known as the congregate treatment model. Congregate treatment consists of housing and treating a large number of mentally ill individuals at the same location. As this was a treatment program, the premises contained on site medical care in the form of a nurse, a psychiatrist, and a pharmacy.

In March 2013, three years of federal funding for housing at the Bosman ceased, and the results of the congregate housing model have been mixed. Some mental health professionals have criticized the concentration of persons suffering from the same type of mental illness at the residences. For example, when multiple patients suffering from paranoid delusions are housed in the same building it creates a situation where a calm environment is difficult to achieve, thereby making treatment difficult and exacerbating the illness.

The other study groups consisted of Coast ICM (an intensive case management model); Raincity ACT (known as a scatter site model as clients are housed together in relatively small numbers in a market housing environment); a control group which received no additional support other than what was present in the current health care system; and a fifth group that refused to receive any treatment at all.

Currently, the COV and the Province of BC are increasing the amount of subsidized housing units for those suffering from mental illness. However, these buildings do not have on-site medical staff and as of late there has been a marked increase in crime and disturbances in the area surrounding two of these buildings. Learning from the experience at the Bosman, these facilities should be staffed with mental health practitioners who are able to provide psychiatric treatment.

ACT Team Capacity

The ACT teams have seen great success in reducing the number of negative police contacts thereby increasing public safety and improving the quality of life for those suffering from a mental illness. Moreover, the teams have received support and praise from various stakeholders and mental health professionals. Currently, two of the three Vancouver teams are at capacity and one is at half capacity. It is estimated that there is demand for up to seven more teams within Vancouver alone, which would bring the total to ten teams.

The greatest challenge facing all partner agencies participating in ACT is a lack of resources to provide the staff required for more teams, as the cost for each team is approximately $2 million per year. However, these teams are a very efficient use of public funds as these teams reduce the amount of additional resources (such as police, health care, and the criminal justice system) which are required to deal with mental health emergencies and public safety issues, including criminal actions.

Pre-ACT Team Intervention

When mentally ill persons come into contact with the VPD, the initial contact point to proactively assist them in obtaining mental health treatment will come in the form of Car 87 resources. These resources are able to set up initial meetings with local community mental health teams. However, due to the high workload, this partnership of a nurse and police officer is unable to provide follow-up assistance.

Aside from contact with patrol members in the event of *Mental Health Act* apprehensions, the second contact point for treatment will generally be when a person has deteriorated to the point where they will qualify to be an ACT team client. By this time, the client will have usually demonstrated that they suffer from a severe mental illness and will have developed significant addiction or substance abuse issues. At this point, ACT is a reactive strategy for those who are at the last stage before they require long-term care in a secure facility.

Between these two contact points mentally ill persons have mental health services available. While the current services work for a large number of those suffering from mental illnesses, there is still a sizeable population which will continue to deteriorate and become ACT clients or require long-term care in a secure facility. This group will likely be contacted by community

health teams but will prove difficult to deal with. These individuals will likely stop taking medication and their condition will worsen. When community health teams come to their homes, they will likely not answer their door or phone, or they will be verbally abusive. After three failed attempts at communication, community health teams will close these files as their ability to treat these patients is limited by their resources and training. For example, if a patient is verbally or physically abusive, these teams do not have the training and equipment to ensure their own safety.

A partnership of a nurse and police officer would allow medical staff to treat patients who may react aggressively if they cease taking their medication and do not have routine monitoring. As this partnership would include a medical professional, it would also be possible to administer medication in the event the patient has lost or thrown away their current dosage.

This gap in services presents an opportunity to be proactive in responding to public safety and quality of life issues as opposed to being reactive, which is in line with Sir Robert Peel's first principle of policing, which is the main goal of police is to prevent crime and disorder.

Recommendations

Upon consultation with stakeholders, the VPD has five recommendations, which, if implemented, will aid in increasing public safety and improving the quality of life for those suffering from mental illness.

1) *Add 300 long-term and secure mental health treatment beds.*

It is currently estimated that there are approximately 300 mentally ill persons who pose a serious threat to themselves or others and require long-term care in a secure facility.

2) *More staffing at BC Housing sites to support tenants with psychiatric issues and a reduced proportion of this type of tenant.*

While progress is being made in reducing the level of street homelessness in Vancouver, the sites in which a large number of mentally ill are housed do not have adequate on-site psychiatric support. This lack of support is further compounded by housing patients with similar mental

health issues in the same building. As a result, these tenants' mental health issues are not improving and in some circumstances are actually deteriorating further. Initial estimates put the yearly cost at $400,000 per site.

3) *More significant support through ACT teams for psychiatric patients living in the community, including those residing in market housing.*

The success of the ACT teams has been noted by the VPD, VCH, and the external review team which conducted the 2012 review into mental health issues at the emergency department at St. Paul's Hospital. Internal VPD data shows that an ACT study cohort of 32 clients have had a 50% reduction in negative police contacts when compared to their police history prior to joining the team. Moreover, VCH has noted a 70% reduction in non-urgent emergency department visits. The cost per team is approximately $2 million per year.

4) *An enhanced form of urgent care (crisis centre) that can ensure consistent and expert care of individuals in crisis situations, located at a Vancouver hospital.*

This facility would serve as the primary intake for persons suffering psychiatric emergencies and would be built to primarily serve this function. Hospital emergency departments are primarily designed to deal with medical emergencies and do not function well when providing emergency psychiatric treatment. It should be noted that this facility would need to be attached to a medical facility as all patients still require medical clearance and it is not uncommon for patients to also experience concurrent medical issues.

5) *The creation of joint VPD-VCH Assertive Outreach Teams for mentally ill persons who do not yet qualify for ACT teams.*

The creation of a treatment model which partners one police officer with one nurse will allow for a large number of patients to be seen within a day and will limit the number of mentally ill persons whose condition continues to worsen to the point they become an ACT client. In addition to improving the quality of life for these mentally ill persons, public safety will also be improved as it is not uncommon for ACT clients to be involved in violent incidents prior to referral to an ACT team.

Conclusion

In the late 1990s, Vancouver's Downtown Eastside faced a public health crisis due to a spike in HIV/AIDS infections and drug overdoses. Effective collaboration between different levels of government and health authorities resulted in steady progress and has saved hundreds of lives.

The current situation regarding untreated, severely mentally ill people is on par with, if not more serious than, what Vancouver faced over a decade ago. The "public health crisis" is now a "mental health crisis". Many seriously mentally ill people are receiving inadequate care, sometimes with tragic consequences, and have a low quality of life. Furthermore, the number of unprovoked, violent attacks by mentally ill persons on innocent members of the public is alarming.

The VPD is responding to too many emergency calls involving persons experiencing a mental health crisis. Often, the behaviour is criminal which results in the arrest and prosecution of mentally ill offenders. While the VPD and health service providers are doing as much as they can with the resources available, these current resources are not enough to reverse the troubling trend that has been continuing for more than a decade. Stakeholders and service providers must shift from responding to the crisis to preventing the crisis from occurring in the first place.

Lead Author
Tim Szkopek-Szkopowski, Planning and Policy Advisor

Contributors
Deputy Chief Constable Adam Palmer
Deputy Chief Constable Doug LePard
Superintendent Dean Robinson
Inspector Ralph Pauw
Sergeant Howard Tran

Appendix A

Lost in Transition Recommendations	
Recommendation	Status
A mental health care facility that can accommodate moderate to long term stays for individuals who are chronically mentally ill.	Little progress has been made. Demand for services still greatly outnumbers the capacity.
The creation of what has been termed an "Urgent Response Centre" where individuals can be assessed and triaged according to their needs along with additional resources to support this facility.	This facility has not yet been created.
Increased services for people who are dually diagnosed.	Progress has been made in the form of the Burnaby Centre for Mental Health and Addiction; however, there is still much greater demand than capacity.
A continued increase in supportive housing.	While supportive housing is being created, these buildings require on-site medical staff.
For St. Paul's Hospital and Vancouver General Hospital to speed up the admission process for police who have arrested an individual under the provisions of the *Mental Health Act* (by negating the need for the emergency physician to initially examine the patient, for example).	Continual progress is being made through the continued efforts of local health authorities and hospital administrators.
Enhanced ability to gather data on all calls for service that are mental health related to facilitate further research on this matter and to establish benchmarks to track changes for police in British Columbia.	Data is gathered and analysed on a regular basis. This information is reported at *Project Link* meetings.
A system, much like PRIME, that has readily accessible details of an individual's mental health history and addresses privacy concerns, for British Columbia mental health service providers.	Progress is being made on this recommendation.

Beyond Lost in Transition Recommendations	
Recommendation	Status
That the ministry of Health and Vancouver Coastal Health establish an Assertive Community Treatment (ACT) team model with sufficient capacity to address community based treatment needs in Vancouver and implement a model similar to the one that exists in Victoria, BC where the Victoria Police Department are part of an integrated team.	ACT teams have been implemented with police participation and they have been very successful. However, there is a need for additional ACT teams as demand greatly outnumbers the current capacity.

That Vancouver Coastal Health, St. Paul's Hospital, Vancouver General Hospital and the police establish formalized standing bodies with appropriate terms of reference with police, emergency room, and psychiatric units as well as psychiatric ward medical staff and management with a mandate to monitor, identify, de-brief and resolve critical incidents and other police/health related incidents as well as systemic issues.	This has been completed and regular meetings occur.
That Vancouver Coastal Health, St. Paul's Hospital, Vancouver General Hospital establish an information sharing and feedback mechanism so attending Emergency Room and psychiatric unit and ward physicians are advised in a timely manner of suicides, suicide attempts, and other critical incidents involving their patients.	Progress has been made with continual improvements occurring.
That the Ministry of Health make legislative changes in the Mental Health Act to facilitate a speedier health system response and reduce police wait times at the hospitals.	Discussions have occurred; however, in order to implement this recommendation, legislative changes are required.
That the Coroner review and consider calling an inquest in all suicide cases where an individual received psychiatric and/or mental health treatment within a 30 day period before their death. (The VPD recognizes that this is a contentious recommendation; however, the inquest is not designed to find fault but rather to find if improvements can be made to systems in order to prevent future tragedies).	Little progress has been made towards completing this recommendation; however, an external review has occurred in one case where a patient attempted to murder a bystander.