# STUDY IN BLUE AND GREY

Police Interventions with People with Mental Illness:
A Review of Challenges and Responses

CANADIAN MENTAL
HEALTH ASSOCIATION
L'ASSOCIATION CANADIENNE
POUR LA SANTÉ MENTALE
BC DIVISION

*Study in Blue and Grey, Police Interventions with People with Mental Illness: A Review of Challenges and Responses* was researched and written by Judith Adelman, PhD

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**Who are we?**

The Canadian Mental Health Association, BC Division is a provincial charity that, for the past 50 years, has worked to promote the mental health of all British Columbians and change the way we view and treat mental illness in BC.

We are part of a national association with over 80 years of experience. In BC, we have a network of 20 branches across the province that provide direct service support for people with a mental illness or a mental health problem including public education, rehabilitation services such as: supported housing, supported employment and education, clubhouses and community education.

At BC Division, our staff and volunteers focus on four major responsibilities: advocacy, public ation, community-based research, and consumer empowerment programs.

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## Background and Description of Project

Police throughout North America are responding to a significant number of 911 calls involving people who have a mental illness. In the vast majority of incidents, such calls are resolved without incident. However, sometimes the results are the death or injury of the police officer, the person who is ill, and/or another person. When this happens it has prolonged negative effects on the individuals and communities involved. When lives are lost, they cannot be reclaimed. Whether the result is injury or death, it has longstanding implications for the persons with mental illness, the family, police, and to all who survive the incident.

In October 2000, the BC Chief Coroner issued a report following an inquest. A man who was distressed and suffering from a mental illness began acting violently in the emergency department of a BC hospital. The police were called and as a result of the police action, the man was killed. The Coroner made a number of recommendations to various governments Ministries. One of the Coroner's many recommendations was that police be provided training with respect to dealing with people with a mental illness in a non-confrontational manner.

Because people are so complex and situations can vary so significantly, it may not be possible to get to the point where there are no injuries or deaths. However, the common vision requires that we look for ways to reduce injury and death by improving the responses of the police and mental health systems while recognizing already-existing, effective programs that make a difference.

Currently, there are a number of key reform initiatives in various locations in North America. This paper is intended to build on that work by providing relevant information regarding these initiatives that would enable the partners within the mental health and criminal justice systems here in BC to plan more effectively, and to improve their system of response to people with mental illness who are in crisis.

The specific objectives of the project are to:

- Find out what kind of training is offered to police in different jurisdictions to determine the common program elements, and to attempt to identify the most effective components
- Review the literature to determine what service delivery models are being used by police in various jurisdictions to intervene in crises
- Determine the impacts of the various programs: for example, whether they reduce injuries, are helpful to people with mental illness and to police etc.
- Examine recommendations from reviews of police actions
- Determine key aspects and key strategies for implementation; that is, those key factors that contribute to the establishment of effective intervention programs

This report relies on published research and reports, as well as interviews with individuals who work for or with police departments, including mental health professionals. It also includes information gained from Coroner's reports and interviews with individuals who participated in inquiries.

## Outline of the Report

*Part One* of the report looks at the nature of the problem. It begins in *Section A* by looking at why more people with a mental illness are coming into contact with the police, describing a number of factors that have contributed to this trend, including changes in the mental health delivery system, changes within the police force and the move towards 'community policing.' Then, in *Section B*, the report looks at some of the factors that create barriers to effective police response to persons with mental illness. Next, *Section C* looks at two key issues that have resulted from this state of affairs: criminalization and injury or death of persons with mental illness (as well as serious personal consequences for the police officers involved). The report then examines the factors that have caused police to change their practices.

In *Part Two*, we look at solutions. *Section A* of *Part Two* looks at different models of police programs that were developed to assist individuals who are in psychiatric crisis, and identifies the common issues that each program addresses in various ways. *Section B* looks at available outcome research, including the relative strengths and weaknesses of the models. In *Part 3* we look at conclusions and recommendations for action in British Columbia.

# Part One: The Nature of the Problem

## Section A: Why Police are Interacting More with People who have a Mental Illness

Due to a number of factors common to most of North America – such as cuts to long-term psychiatric beds, improvements in treatment, and the philosophy of integration – more people with a mental illness live in the community. Unfortunately, community supports have not expanded proportionately to make up for the loss of institutional services or for the increased need brought about by an expanding population.

In addition, existing community-based crisis response services – such as crisis lines, mobile after-hours mental health teams, and crisis residential facilities – are not well integrated and are limited in scope, particularly in rural areas. General hospital-based emergency services can also be difficult to access due to bed reductions, and a tendency to offer treatment only to those sick enough to warrant involuntary treatment under the Mental Health Act. As the *BC Early Intervention Study* found, individuals who seek help voluntarily from emergency wards in BC are often deemed 'not sick enough' to qualify for limited acute care resources. The same study found that, in large part because of these barriers, over 30% of people with serious mental illness had contact with the police while making, or attempting to make, their first contact with the mental health system.

Because of all the factors discussed above, the police are, by default, becoming the informal 'first responders' of our mental health system, and are playing this role without the necessary resources or support to carry it out properly. The results of this situation for people with mental illness can be long delays in receiving treatment, unnecessary trauma, violent incidents, and criminalization that could have been prevented if care had been received earlier from the mental health system. Estimates of the proportion of untreated mental illness in the criminal justice system range between 15 and 40%.

### Changes in Models of Policing

There has been ambivalence among police officers as to whether dealing with situations involving mental illness falls under the traditional police mandate. With changes in policing styles – including the move to 'community policing' – has come increased contact and expanded responsibilities of police officers in regards to people with mental illness. Despite the potential that these new policing models may represent, these mixed feelings remain. This is because of the perception by police that the formal mental health system has shirked its own responsibility, and because of conflicts between new and more traditional models of policing.

### Mandate

The police mandate consists generally of two duties: to ensure safety and to provide protection. This applies to interactions with members of the general public and also applies to the way police interact with people who have a mental illness. Despite this mandate, however, it is clear that police are ambivalent about dealing with people with mental illness. Researchers in the UK, for example, found that some officers may refuse to respond to a call involving a person with mental illness. They tended to interpret the call as a situation that was solely the responsibility of the mental health system, rather than one that required them to protect or provide safety for the person with the illness.

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### Changing Values and Styles of Policing

As mentioned, police departments are moving towards community policing, where there is more emphasis on problem-solving issues that arise on the day-to-day police beat. In the context of mental illness, problem-solving might entail an officer being able to recognize when mental illness is at play in a given situation, de-

escalating a situation, referring a person to services, or diverting an ill offender into treatment rather than making an arrest.

With the increased emphasis on community involvement has come greater contact with people with mental illness, and while the shift to a problem-solving focus would seem to be potentially useful in this context, the values of traditional police work – emphasizing rules and procedure, a tendency towards the use of force to maintain safety, and a devaluing of attending to non-criminal matters – may come into conflict with new ideas about the responsibilities of police officers towards people with mental illness.

For example, though some officers indicate a desire to divert people with mental illness to the mental health system, others may not feel it is their job to be able to recognize that a given person in a potentially dangerous situation, in fact, has a mental illness. They may feel that the person with mental illness who commits a crime should be treated like any other offender.

## Section B: Barriers to Effective Interactions

There are a number of barriers that prevent police from dealing more effectively with people who have a mental illness. As discussed in the previous sections, these challenges include gaps in community mental health services, and mixed feelings about the nature of their responsibility when it comes to responding to calls involving mental illness.

As will be discussed later, some police departments have developed extensive and sophisticated approaches to intervening in these situations. In the many jurisdictions that have not developed specialized programs, however, a number of systemic barriers to effective response have been identified. These include having insufficient advance warning about specific situations, having inadequate information systems, having inadequate knowledge and skills, lack of on-the-scene consultation, and lack of support from the acute care mental health system.

### Inadequate Advance Information

A common problem is that when a situation arises, police dispatchers often do not ask or pass on information about whether the person has a mental illness, about whether the situation is dangerous, or about what they might expect upon arriving. Officers in the UK reported that the situations were often ambiguous, confused and lacking context, making it difficult for them to recognize a psychiatric emergency.

### Inadequate Information Systems

Another systemic problem is that police information systems often do not indicate if a given person with mental illness has had previous contact with the police. Nor do police systems usually capture how many people with a mental illness come into contact with police. In the event of a prior police contact, valuable details that police databases often do not capture include:

- Information about successful prior interventions
- Information about specific police officers who had been involved
- Indications of whether certain officers had established a good relationship with the individuals in question

### Lack of Adequate Information and Education about Mental Illness

Research shows that police officers' knowledge of mental illness is comparable to the general population, and that training is most effective when carried out in conjunction with a specialized program for dealing with mental illness. In the absence of such a response, when police are provided with information or training, they often do not have sufficient opportunity to learn the necessary skills, to practice them, or to update them.

The research also indicates that, generally speaking, in the absence of education or training, police often have misconceptions about mental illness. For example, one study found that officers did not understand that:

- Confusion and pre-occupation with voices can affect a person's abilities to respond to directions
- There is a high risk of suicide for people who have a serious mental illness

- There is also a high rate of victimization among people who have a serious mental illness

Police require education about how to identify situations involving mental illness and about how to communicate and intervene effectively, so as to minimize the chances of violent or dangerous incidents and maximize the chances that the person with mental illness accesses the necessary care. It appears that the impact of education and training is greatest in police forces where there is a specialized group of officers who deal regularly with situations involving mental illness, and where officers have regular opportunity to practice and update their skills.

### Lack of Access to Consultation at the Scene

When encountering an individual with signs of mental illness, police often lack knowledge about how to proceed, for example, about their powers under relevant mental health legislation. Research in the UK showed that without access to advice from a mental health specialist, police often deferred situations to senior officers or police physicians. It could be expected that without access to consultation, situations involving mental illness would be more likely to be handled less effectively or avoided altogether.

### Lack of Responsiveness by the Hospital Emergency Departments

Both in the UK and the US, records show that police often experienced long waits in the emergency ward after bringing a person to hospital. In the UK, police reported that they were not treated professionally and that the medical staff did not always consider or make use of their knowledge of the individual and the situation. Police in both countries reported that they were often told that the persons they brought in did not meet criteria for admission. When this happened, there was often a lack of other service alternatives.

## Section C: Impacts of the Situation on People with Mental Illness

Two serious issues that have resulted from the current state of affairs are criminalization of persons with mental illness and injury or death as a result of their contact with police.

### Criminalization

As noted, police are often in the position of first responders to serious mental health emergencies. Although police intervention accounts for a significant proportion of referrals into care, estimates of the percentage of mentally disordered offenders currently in jails and prisons range from 15 to 40%.

In order to prevent criminalization and other serious incidents, it is important to understand under what circumstances persons with mental illness are arrested rather than referred into care, and under what circumstances a person with mental illness receives intervention from neither police nor mental health services.

### Likelihood of Arrest Relative to General Population Depends on Severity of Crime

The majority of arrests of people with mental illness are for non-serious crimes that were either directly or indirectly related to their illness. Common examples include disturbance of the peace, minor theft, or failure to appear in court following initial charges. When compared to the general population, however, people with mental illness who are suspected of committing a crime are more likely to be arrested. There is evidence to suggest, though, that this difference holds only for less serious crimes, and that for some serious crimes, people with mental illness may be, in fact, less likely to be arrested than would a member of the general population who committed a similar crime.

### Precipitating Factors of Arrest

A study by Rogers indicates that lack of advance knowledge of mental illness was a contributing factor to arrests. Within the area under study, most police interventions were initiated by calls from the general public, rather than by the police themselves, and that in only a quarter of

those cases did police know ahead of time that they might be dealing with a person with mental illness, raising the possibility that the individual would be arrested rather than referred for treatment. The possibility of arrest was raised if the individual in question had a history of previous arrests, or had an outstanding warrant as a result of a failure to appear in court for an earlier minor offense. Arrest was also more likely if there was a violent incident that was precipitated by the illness.

If there was advance knowledge of illness, arrests were more likely if the officer believed that the situation could not be resolved informally, if vulnerable persons such as children or elderly were involved, and if existing mental health services were difficult to access. Research has documented a number of accessibility issues that make police reluctant to go the mental health route:

- Having to wait long periods in hospital emergency wards with a patient
- Having patients that were transported and initially admitted quickly discharged
- Having admission denied because the person had committed a crime
- Believing the person would likely be deemed not to meet committal criteria

Police officers' lack of knowledge about committal and treatment also played a role in arrests. A UK study showed that police did not always know when they were authorized to transport a person to care under civil involuntary treatment legislation. A US study showed that police would arrest because of the erroneous belief that the person would eventually be referred into care. Another factor that may make arrest more likely than hospitalization is if the person possesses multiple problems in addition to the illness, for example substance use, or if the hospital staff would deem the person to be dangerous to the point of being unmanageable in the hospital.

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### Situations Where No Detention is Made

Teplin & Pruett found that individuals with mental illness who were most likely to be neither arrested nor hospitalized were individuals who were known to police, and who were:

- Seen as too difficult to manage by both the mental health and criminal justice systems
- Or at the other end of the spectrum, individuals whose behaviour was seen as eccentric, predictable, unobtrusive and non-offensive.

### Injury or Use of Lethal Force

Media reports of shootings of people who have a mental illness have become increasingly prevalent. It is important to put these stories into perspective and to understand that in BC and in Canada as a whole, police rarely use deadly force with anyone. A study by Parent, which looked at municipal police shootings over a 15-year time period between 1980 and 1994, and involving tens of thousands of police contacts, showed a total of 15 shootings. During this same period, another 38 situations involving lethal threats were resolved successfully. However, a disproportionate number of these incidents involved people with mental illness.

Of the total 15 shootings, five involved people who had histories with the mental health system. Of the 15, eight showed signs of mental illness and at the same time demonstrated suicidal behaviour prior to threatening the police officers. These individuals seemed to meet the criteria for a phenomenon known as 'suicide by cop.' That is, they seemed to be in the process of attempting suicide when the police arrived, and/or had tried to induce the officer to kill them. Mohandie and Meloy provide detailed descriptors of the indicators of this phenomenon. These include many of the usual indicators for suicide but also can include pointing a loaded or unloaded weapon at police, demanding that the police kill them, and shooting at the police.

Parent's research also looked at general factors that precipitated a shooting. Of the 15 incidents, 14 involved a weapon. Eight involved a person who was holding a gun, and in half of these situations, the person fired on the police. In another five incidents, the person was brandishing a knife at the police. In one instance,

there was a hostage, and in the last incident, the officer mistakenly perceived that the person had a weapon and was preparing to take aim. Violent crime was also a factor, and in six of the 15 incidents, the involved individuals were in the process of committing violent crimes. Drugs and alcohol played a large factor in these crimes, and in more than half the violent crimes, the individual had consumed large amounts of drugs or alcohol.

The overall impact of the situation was severe. In addition to the death, and the impact on family members and bystanders, the impact on the police officers involved was considerable. All of the police officers who had killed people showed signs of critical incident stress, and longer term physical, emotional and psychological distress, even though all of them were exonerated.

In the same time period, three police officers were also killed and a number of others were wounded. In another 38 incidents involving lethal threats, police successfully resolved the situations without deadly force. Furthermore, half of the bravery awards to police officers that were awarded in that time period went to officers who successfully prevented suicides and de-escalated situations.

Overall, the number of police shootings relative to the total number of interactions with the public is very small, and it is important to note that police in BC have successfully de-escalated twice as many incidents involving lethal threats as they failed to resolve. However, as noted, people who had a mental illness constituted a disproportionate number of individuals who were shot and killed by police. Despite the fact that in all instances, the individual police officers were exonerated, this situation constitutes a serious problem that must be addressed.

Coroner's reports have identified systemic issues relating to officer training, coordinated systems of response by police and mental health services, and police protocols around the use of lethal force. It is clear that police often do not have the attitudes, skills, information and supports that they need in order to be more effective.

## Part One: Summary

In some situations, people with mental illness are criminalized — most often as a result of relatively minor crimes — because of lack of knowledge on the part of police officers. This could be either a failure by police to recognize the presence of mental illness in a given situation, or a misunderstanding of their powers under involuntary treatment legislation. In other cases, however, police do recognize and intervene in situations where mental illness is in play. In some of these cases, the person is successfully transported to care. In other cases, criminalization occurs because of a number of factors related to inaccessibility of hospital services, especially for those who don't meet Mental Health Act criteria, or are seen as difficult or unmanageable by the mental health system. Individuals who are seen as difficult and unmanageable are more likely to be left with no intervention from both mental health and justice systems.

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A more drastic consequence of the collective failure to respond is the shooting death or injury of a person with mental illness, a family member, or a police officer. For the most part, serious incidents are resolved successfully. However, individuals with mental illness represent a disproportionate number of those who have been involved in such incidents. Shootings take a terrible toll on the individual, the family, the police, and the community. We need to look at more effective approaches in order to decrease the number of shooting incidents involving individuals who have a mental illness. Part Two of this report looks at some factors that have contributed to changes for the better, and examines the improvements that are being made in jurisdictions throughout North America.

# Part Two: Solutions

## Section A: Situations and Actions that Precede Change

As police have increasingly interacted with people who have a mental illness, a number of problems have become apparent. Despite these problems, police have not always modified their practices. Changes to police training and procedures seem to follow from several circumstances. They are:

**a) Having an incident where someone dies.** This is the most frequent antecedent to change, though this is not in and of itself sufficient for change to happen. Most often, the person with mental illness is the individual who dies following police intervention. In other cases, the ill person kills someone else. The death of Edward Yu, a former medical student with schizophrenia, was one such example, which led to much media attention, public outcry and eventual change.

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After such an event, the questions that are asked in the media, in the police and mental health communities, and as a result of inquests, often include:

- Did police attempt to defuse the situation or did their response contribute to its escalation?
- Did police receive all the information they needed to do their job effectively?
- Did they seek assistance from family members, treatment teams, or other individuals important to the person?
- Did police have sufficient training to be effective?
- Do police and mental health personnel have appropriate protocols for mental health emergencies?

Depending upon the answers to these questions further action may follow.

**b) An officer taking a personal interest in making changes.** In Canada, Inspector Jamie Graham in BC and Scott Maywood in Ontario are examples of more senior officers who have taken such an interest. Tomi Habner (New Westminster, BC) and Rick Parent (Delta, BC) are examples of patrol officers who have taken active roles in creating change. In the United States, Sam Cochran from Memphis has been very active in developing and promoting specialized police responses.

**c) Having the support and mandate from the police infrastructure.** In Memphis, the mayor created a task force with the authority to create a different model for responding.

**d) Implementing a problem-solving and community policing model that identifies the problem through an examination of police data.** In applying these models, administrators work cooperatively with the mental health system after:

- Identifying that a large number of people with mental illness are using the police service.
- Developing a plan to divert people with a mental illness out of the criminal justice system.

The questions that follow from this examination can include questions such as the following: Why is there an increase? What do police need to know about mental illness to address the concern?

Inherent in this approach, is a longer-term perspective that collects and examines the data with the intention of using it to inform decisions, through collaboration with community partners to look for solutions.

Solutions then focus on addressing the answers to these questions. With the help of information systems, police can identify consistent problem areas, for example, a person who had delusions about robberies might call a police station on numerous occasions to report non-existent thefts. Once the pattern has been identified, police would then develop a response jointly with that person and/or their care providers to enable the police to provide effective assistance. Later on in this report, there will be more discussion about how information systems can play a role in reform.

Being aware of the factors that lead to organizational changes in police systems can allow proponents to make use of their community resources, and to become aware of opportunities that arise to create change. So for instance, it would be important for advocates and family members to identify officers who have an interest in better serving people who have a mental illness, and who are prepared to work towards creating changes. It would also be useful for them to work with the police to collect data that identifies usage and issues, and that can point to possible solutions. If there is a serious incident, it can become an opportunity to publicize the issues and to promote change. Conversely, police can be more effective in delivering their services if they work with advocates to try to bring about systemic changes.

## Section B: Specialized Responses Involving Police and the Mental Health System

There are a number of special programs for intervening with those who have a mental illness, developed by police, often in conjunction with mental health crisis response and acute care services. In some cases, this involves having specialized police units, and in others, it involves developing a collaborative relationship with mental health programs to provide a tailored response to calls from people who are experiencing mental health symptoms.

In this section of the report, we'll outline the various response prototypes designed to intervene with people with mental illness who come into contact with the police. We then will go on to identify key components or functions that each program addresses.

The range of prototypes includes mobile teams that jointly involve police and mental health systems, either based within the mental health system such as Vancouver's Car 87 model, or based within the police force, such as the Birmingham, Alabama model. It also includes programs that are primarily police-driven, such as the police 'reception centre' model (for example, Knoxville), and the program that has been most widely replicated: the Memphis Crisis Intervention Team (CIT) model.

Other approaches exist which have evolved that are not specialized approaches, for example, developing joint police/mental health service protocols (a BC example will be reviewed later in this section) and more piecemeal approaches such as broad-based police training initiatives, and creating positions such as 'police liaison officers,' whose function is to develop partnerships and coordinated approaches between police, mental health services and other community partners (for a full description of these approaches, see Appendix 1.)

## Model Prototypes

### Joint Police/Mental Health Team - Based in Mental Health System

*Program Description*

In this model, plain-clothes police officers are located within a specialized mental health crisis intervention team and respond to calls in an unmarked police car. Incidents are resolved by a mental health professional on site, or if necessary, the individual can be transported to hospital and admitted, if necessary, under the authority given to police under the Mental Health Act.

*Considerations*

This model, which originated with Vancouver's 'Car 87,' is widely seen as a successful example of police/mental health system collaboration and has been replicated in several Canadian centres, including Surrey, Hamilton and Ottawa. Despite its gaining popularity, a notable limitation of the team is in its capacity to respond to only one call at a time and respond only during specific hours.

### Joint Police/Mental Health Team - Based in Police Force

*Program Description*

There are two variations of this model. In the Birmingham, Alabama version, mental health professionals are employed within the police force as 'civilian officers.' This means they are police officers in every respect except the fact they do not carry weapons or have the power to make arrests. They respond to police calls in-

volving mental illness that are seen as resolvable with non-violent crisis intervention techniques. Regular police officers are called in for incidents considered to have the potential for violence.

A second variation of this program was developed in New Orleans, which employs a similar strategy, using trained crisis centre volunteers.

*Considerations*

Both of these model variations can successfully resolve a majority of police calls involving mental illness, which frees regular police officers for other duties or allows them to leave an incident sooner.

This model is seen as less feasible in larger metropolitan areas, since this would entail employing or training a large number of mental health specialists at relatively high expense to the police.

## Reception Centre

*Program Description*

In Knoxville, Tennessee, all officers are trained to recognize potential signs of mental illness. Once a case has been recognized, officers then transport the individual to a reception centre where more specialized personnel (also police officers) conduct a more thorough assessment and, if necessary, refer that individual on to mental health services. In instances involving violence, a negotiation team intervenes. Los Angeles has a similar model, which involves regular police officers bringing people showing signs of mental illness to an assessment centre. A specialized outreach team intervenes with cases that involve violence.

*Considerations*

This model's strength is that it ensures that people with mental illness are transported to care and seen by officers with specialized training in mental health. It also offers greater breadth of coverage than the Car 87 model. However, it has limitations with its capacity to resolve incidents on-site, which in many cases may be a less traumatic means of intervention.

## Specialized Police Crisis Intervention Team

*Program Description*

The prototype of this approach is the Crisis Intervention Team (CIT) in Memphis, Tennessee. CIT has been widely replicated and consequently much more information is known about the details of the approach compared to other prototypes. In this model, officers with specialized training work within each catchment area of the police force, performing mental health crisis intervention along with their other duties. Officers volunteer for the teams, and then are selected on the basis of personal characteristics such as empathy and communication skills. After being selected, they undergo intensive training in areas such as non-violent crisis intervention, protocols for responding, and information about the experience of mental illness.

When an intervention is made, the incident is either resolved on-site, the individual is transported to a medical centre for treatment, or is referred to other forms of mental health care.

*Considerations*

Outcome data suggests that this model has resulted in successful resolution of a high proportion of incidents and in considerable satisfaction by mental health consumers and families. The model also is able to respond to the highest proportion of calls, compared to other models. The success of the model has been attributed to various factors, including the careful selection of officers and the nature of the training – specifically, its comprehensiveness and the opportunities it offers team members to practice and 'put into play' the skills and knowledge imparted through the training on a daily basis. The close collaboration the program has achieved with mental health services is a third factor in its success. The force has an agreement with the medical centre around a 'no-reject' policy, meaning that when officers transport an individual for treatment, they are unlikely to wait more than 15 minutes and the individual will be provided with services.

One drawback of this model is that compared to the mobile team approach, incidents are less likely to be resolved on-site, and the individual is more likely to be transported to hospital. The program's founders stress that in order for the approach to work, the mental health system it-

self must make a commitment to providing crisis and acute care services, and to other forms of community mental health services, since the CIT team relies on both for support and referral. Police and mental health services must also make a strong commitment to collaborate and develop means of resolving disputes that may arise.

### Joint Protocols

Most other programs tend to focus more on the police *and* the mental health services and tend to attempt to reform responses within these service systems. Dawson Creek, a small community in northern BC, has developed a comprehensive integrated model of responding to people with a mental illness. In that community, when there is a concern in the community about a person, community members usually call the RCMP. Because it is a small community, the RCMP sometimes know the individual, and are aware of whether the person uses the mental health system.

As a result, when the police are the first contact for a person known or suspected to have a mental health problem, they contact the mental health centre directly. If there is a concern about violence, the RCMP rather than the mental health team will take the person to hospital where they inform the attending physician of previous mental health contact, if known. If there is not a concern for violence, the mental health team will assume primary responsibility. Either way, the emergency ward physician consults with the mental health centre (a separate agency from the hospital) and determines if the person has been seen previously. The mental health centre staff then provides an assessment if the individual was not previously known, and consultation if the person is known.

The first contact may, however, be through an outreach mental health team that assesses the situation, talks to the family, and involves the RCMP if needed. In the event that a person who has been arrested and jailed is suspected of having a mental illness, if officers feel they need an assessment or consultation at the jail, a forensic nurse will provide assessments for the officers. Once a month the relevant players meet to discuss issues related to those who have a mental illness and are involved with the criminal justice system. See Appendix 2 for more information on joint protocols such as this.

## Section C: Program Components Contributing to Success

The model most widely studied and replicated is the Crisis Intervention Team (CIT), developed in Memphis, Tennessee. Based on their experience in transferring the CIT model to other jurisdictions, Dupont & Cochran identified a number of components of effective programs:

1. *Careful selection of a core group of specialized officers, who can hone their skills, and be the first responders in situations involving people who have a mental illness*. Dupont & Cochran note that not all officers are suited for work with people who are in distress and, therefore, should be screened for their suitability to work with people who are in need of crisis intervention skills.
2. *Providing specialized and ongoing crisis intervention skills training to the core group, the CIT members.* The training is aimed at developing the skills for officers to carry out a staged intervention continuum, making use of non-violent crisis intervention skills as a key element. Dupont & Cochran strongly advocate against one-time training sessions that lack experiential components and they question the likelihood that limited exposure to content and skills will significantly impact performance.
3. *Having a specialized system of dispatch* including training for dispatchers
4. *Having good information systems in place*. When police look at who they are serving, as much as 40% of police work involves people in crisis or people experiencing a mental illness. However, this is often not apparent because there are usually no systems for tracking this information.
5. *Having an accessible point of entry where coverage is available throughout the week, and throughout the geographical area in question.*
6. *Developing protocols for achieving close collaboration with mental health services*, and for addressing the barriers to mental health care, including no-reject policies that improve access to hospital and other mental health services, and access to services for co-occurring mental illness and substance use problems.

7. *Development of dispute resolution mechanisms to resolve issues as they arise*.
8. *Measuring outcomes, and disseminating the results*, in order to ensure that the broader organizational structures respond.

Each of these issues will be described in greater detail below where possible, with reference to the CIT model, and to the various other program models that have been reviewed. The last issue, measuring outcomes, will be described in Appendix 1 to the full report. This contains a detailed review of literature that is the basis of much of what has been discussed in the report. The review itself, however, goes beyond the scope of the present report.

## Selection

In the CIT program, officers volunteer for the teams, but not all officers are accepted. During the screening process, their records are reviewed to determine that they demonstrate good judgment and maturity. They take a skill test to determine their strengths and weaknesses, and they are required to participate in a structured interview. The program looks for officers who demonstrate enthusiasm and excitement for the work and they select officers who demonstrate flexibility, empathy, calmness, creativity, intuitiveness, and a willingness to try new techniques.

Car 87 in Vancouver selects officers and nurses with dispositions that would make them suitable for this work. Officers, for example, are chosen for their willingness to work in this setting, and their interest in assisting people with special needs. They volunteer for the program and often have undergraduate degrees in the behavioural sciences. Team members do not receive special training once selected.

Both of the programs described above have comprehensive screening criteria that select participants with particular skills and abilities such as independence, flexibility, creativity, empathy, and the ability to think on one's feet.

## Training

Generally, specialist programs provide additional training to officers with an emphasis on a staged crisis intervention continuum, ranging from minimal intervention, through to non-violent crisis intervention, and as a last resort to the use of non-lethal and lethal use of force. The intervention continuum is based on the ability to recognize and interact with people in distress, and on knowing how to react in a way that ensures safety for all concerned. See Appendix 3 for more information about staged intervention continuums. The most effective training programs often use mental health consumers, family members, mental health service providers, and police officers to provide the training. In the CIT, regular patrol officers are trained to provide supporting roles such as crowd control, information-gathering and back up support. Dispatchers also receive special training in recognizing and responding to a mental health call.

Most of the models reviewed involve collaboration between police and mental health service providers. Because of this, many training curricula include the opportunity for cross training, that is for members of each agency to make each other aware of the nature of their jobs, and train the other on skills they may need to employ (e.g. mental health professionals providing training about communicating with someone with a mental illness; police officers training mental health staff in crisis intervention for situations involving firearms or violence).

What seems to be common to all of the programs reviewed is a mechanism for staff to learn how to interact effectively with people who show psychiatric symptoms. Police training generally also includes topics such as the goals and outcomes of treatment, psychotropic medications, crisis intervention and de-escalation, disposition options, confidentiality, and making appropriate referrals to the mental health system. Several also include training in the use of non-lethal weapons. Training for the most effective programs always includes practice, field supervision after training and continuous opportunities for skills upgrading.

One aspect of training that appears to be quite effective but is not a component of many of the programs is experiential education that comes about through the opportunity to meet mental health consumers and their families. One component of that experience is exposure to the perspectives and experiences of those who are living with mental illness. Another component of this type of training is to learn about consumers' and families' previous experiences with the police, and to learn about what works and what does not work from that perspective. The third component is the opportunity for police to meet

people who have a mental illness who are well, and who can talk about what it is like to be ill.

Two programs that do this are the Schizophrenia Society Partnership program, which has mental health professionals, consumers, and family members jointly present to police in training. The other is the Queen Street Outreach Program in Toronto, which provides police officers the opportunity to learn the consumer perspective. The Queen Street Program touches on the following topics:

- Socio-economic factors that lead to poor functioning and mental health
- Medications and side-effects
- Traditional and alternative treatments
- Myths and truths (e.g. incidence of violence, coping and recovery)
- Stigma and discrimination
- The experience of mental illness and its impacts
- Helping strategies (e.g. client-centered interventions)
- Legal issues (restrictions and rights and their impacts)

Both police and consumer perceptions of this program are that attitude, knowledge, sensitivity, and response to people with a mental illness have improved. Since the training began in Toronto, there have been no further deaths of people who have a mental illness as a result of interactions with police, even though the number of calls has increased.

### Dispatch and Referral

As noted, the CIT model has a specialized dispatch function, involving trained dispatchers. Despite Dupont & Cochran's recommendations, most services do not appear to have special dispatch and referral mechanisms for people in distress. There were two exceptions noted in this review. For the Car 87 program in Vancouver, referral involves a 3-step process: intake, assessment and resolution. Intake involves collecting detailed information in order to determine urgency and risk. When a call is deemed to be appropriate, the team will go to the person's residence and talk to them as well as to other relevant people who are on the scene. The on-call psychiatrist may provide telephone consultation, review medications, or attend in person. Team members carry small amounts of medication that can be administered on site if needed.

The CIT program itself provides special training for their dispatchers, to enable them to better

- identify if the call involves a person who has a mental illness
- collect relevant information about the person

Providing triage would seem to be an important element of an effective program particularly in a large population centre with a high volume of calls involving people with a mental illness. This would allow for less intrusive services to be used when appropriate. At the same time, having a mechanism to collect relevant information beforehand would likely result in a more effective response at the scene. As we learned earlier, police often reported that the situation was often ambiguous. Furthermore, they often did not know before their arrival that the person who was the subject of a call had a mental illness. Having good information could potentially improve the response and prevent escalation.

### Access to Information and Feedback

Having information systems that provide information on mental illness and whether it is involved in a given situation enables police to intervene more effectively. This provides them with opportunities to consult with knowledgeable mental health professionals, and to assess or rule out any risks, thereby helping to reduce the uncertainty that frequently accompanies their calls. It also helps police to take preventative action by identifying high use locations and individuals, and taking appropriate action. However, appropriate precautions need to be taken in order to address privacy concerns, and to ensure that mental health records are not misused.

The following are examples of strategies taken by various programs to address their informational needs, while at the same time respecting ethical and legal issues having to do with confidentiality and privacy of information.

The Albuquerque, New Mexico, CIT team assigns detectives who do intensive follow-up after any intervention is made, providing information that can be used to make a more effective response in the future. The detectives visit people who are likely to pose a threat, identify resource-intensive individuals and take measures to reduce the number of police contacts. They also provide bulletins to police about potentially dangerous individuals.

In Los Angeles, the police members of the mobile outreach units have access to mental health records of referrals; in turn, the mental health professionals have access to police records on arrests, warrants, prior contacts and weapon ownership. Unit members may not share information from the other's records with colleagues of their respective organizations who are not members of the unit.

In Madison, Wisconsin, the police receive feedback in writing on all referrals that they make to the mental health system, and when an individual with mental illness is identified by the police as having many encounters with police officers, police are able to request a review of the person's treatment plan by the mental health system.

In Lexington, Kentucky, police collect information about mental-health-related calls, allowing them to identify trends or hotspots in need of response. For instance, they have identified individuals and locations in 3 boarding homes that were generating a substantial number of calls. As a result, they were able to do some problem-solving to better develop responses to people who had a mental illness and who were in frequent contact with police, and were able to work jointly with families, service providers, and individuals in the source locations to develop a more effective response at those sites. They did this by creating unique police interventions and protocols that were tailored to better meet the needs of the individuals, to address the specific requirements of the locations, and to take into consideration the circumstances that lead to the problems.

### Accessible Coverage

Specialized programs varied in how much coverage they provided – that is, when coverage was available, and how wide an area they could serve. Ideally, a specialized crisis response should be available 24 hours a day, seven days a week to all areas in a given town or city. Some programs reviewed had such coverage, but most did not. The CIT provided full coverage to people who were experiencing psychiatric crises. In the CIT, the officers are based in teams within police divisions that serve specific geographic areas within the city. Officers engage in regular patrol duties in addition to their CIT functions, and are called upon to respond to all mental health incidents in their area.

As mentioned, most other teams did not provide full coverage, but they did develop ways of providing expanded coverage. In Knoxville, Tennessee, one evaluation unit serves the entire city. The team provides full coverage during the day, evening and night, and team leaders provide weekend coverage. In Birmingham, Alabama, the unit members are on duty 7 days a week for 15 hours per day and on-call the rest of the time. In Vancouver, daytime coverage is not available and regular police officers or the mental health emergency team responds to calls. A single team covers each of these cities at any one time. The drawback of this is that if they are already answering a call, they are not available for other calls that come in. In Vancouver, if the unit cannot respond immediately to other patrol officers, they will provide advice to assist officers to manage and/or intervene in the meantime.

### Access to Mental Health Services

As discussed earlier in this report, one stumbling block to police intervention is that mental health services have not been accessible to people with mental illness who are encountered by police officers in the course of duty. Ideally, police and mental health systems would develop a no-reject policy, meaning that if a police officer needed support from the mental health system – for instance, if he or she felt there was a need for a hospital bed – then there would be some guarantee that the services would be available. Particularly when people have concurrent disorders and other serious and complex needs, the no-reject or no-refusal feature is identified in the literature as a characteristic of an effective plan. Having access to a specific program for dealing with concurrent disorders, notably mental illness and addictions, is also seen as a characteristic of an effective program.

Having these options makes it more likely that police will divert people out of the criminal justice system and into the mental health system when they perceive that a person is at risk.

A range of strategies has been developed to deal with this issue. In some cities, police programs have preferred status in hospital emergencies. One defining characteristic of the CIT program is that if a person requires hospitalization, officers can leave consumers at the hospital within 15 minutes of arriving, as set out in Memoranda of Agreement that exist between the

Memphis police and the University of Tennessee Medical Center. There is a no-refusal policy in place at the medical centre, so that if officers have assessed and diffused a situation and decide that the individual is in need of treatment, the Center accepts responsibility for ensuring that the person's needs are met. The medical centre also has an agreement with the state hospital not to refuse any patient that meets minimum commitment criteria.

In Pennsylvania, police use a free-standing psychiatric hospital that provides crisis intervention, telephone hotline assistance, crisis mobile outreach, and referral to treatment. In addition, it operates a detoxification and dual diagnosis treatment program. When police identify someone who may have a mental illness, they either transport the person to the centre or the centre sends an ambulance to meet police. The ambulance personnel have medical and psychiatric training and provide specialized treatment. When an ambulance is sent, police do not need to go to hospital, but rather provide a statement to the ambulance personnel that is used to inform decisions for commitment.

### Mechanisms for Collaboration and Dispute Resolution Between Police and Mental Health Services

Inherent in all collaborations between agencies are inevitable challenges. Sometimes, policies of either agency can interfere with effective interventions. Sometimes, there are differences in the interpretation of protocols that have been developed to guide collaboration. Sometimes, attitudes prevent effective collaboration. Different programs have developed ways to address these.

In Los Angeles, both the unit that assesses people for symptoms of mental illness and the outreach team that intervenes when there is potential for violence have 24-hour access to high-level administrators to resolve any disagreements that arise. In Madison, Wisconsin, a police liaison officer position was created within the police force who was responsible for

- developing policy about mental health issues
- assisting officers on the scene
- resolving police/social service issues
- reviewing all police contacts with people who have a mental illness to ensure that police understand and respond appropriately

As noted earlier in the report, collaboration between police, mental health professionals, and the mental health advocacy community is necessary for service change to take place in the first place. As suggested above, mechanisms are necessary to ensure that such collaboration is maintained over time, to ensure that an effective system of response continues to take place.

Various other means for promoting collaboration have been developed, either in specialized programs, or in areas where collaboration has been achieved on a more informal basis. A description of these is provided in Appendix 2.

The issue of collaboration brings this report full circle, for collaboration between all key stakeholders – police, mental health services, mental health advocacy groups, and local politicians – is a necessary ingredient for any meaningful change to occur towards the implementation of a coherent, concerted approach to improving outcomes for all concerned, when people with mental illness come into contact with the police. Once these initial partnerships are in place, then leadership from individuals in any or all of these sectors is crucial to getting the change to happen.

### Measuring Outcomes

As mentioned at the outset of this section, the final attribute of a successful program, once it has been established, is to be able to measure and communicate the results that have been achieved and to make any changes that are necessary. In Appendix 1, we present a review of the research that has been carried out to date, and which has identified many of the attributes of success that have been identified.

While progress has been made to date in achieving success and in measuring and disseminating these results, more work has to be done, particularly in confirming that these interventions achieve the outcomes that matter most: improving the lives of people with mental illness in a way that is safe for all parties concerned.

# Part Three: Conclusions and Recommendations

The experience of first treatment for many people with a mental illness starts with being arrested or brought into care by police, an experience that is usually traumatizing for those individuals. Consumers need the benefit of programs that help them to understand their treatment needs and to recognize escalating symptoms so they can avoid the need for police contact. If they cannot avoid police contact, then police and emergency personnel need to learn how to interact effectively with them and to make the experience less traumatizing.

One of the greatest challenges in conducting this review is that very little has been written from the Canadian perspective, based on Canadian experiences. Most of the research and experience is American. Yet, even in the United States, there are few researchers. Most police forces do not even keep statistics on contacts with people who have a mental illness and information about outcomes is more sparse, even when there is a special program.

Still, it is possible to draw some conclusions from the information that exists. Police deal with people who are very ill and who are often experiencing psychiatric emergencies. Police do not often have sufficient information to know ahead of time that a person who is ill is at the scene, and the context is often very ambiguous. Some incidents involve individuals with multiple problems, and a small number of these are potentially violent. It is clear that police officers want to be of assistance to people who are experiencing psychiatric symptoms. However, they need to have the skills and supports from the police and mental health systems to help them to recognize people who have a mental illness, and to interact effectively with them. The consequences of not doing so can be extremely serious, including injury and death.

It is clear from this review that providing police with experience and training does not necessarily address the needs of people with mental illness. It appears to be very difficult to change attitudes and behaviour if officers do not already have some pre-requisite skills and characteristics. It is difficult for training to have an impact if officers do not have the opportunity to implement and upgrade those skills on an ongoing basis.

There are a number of policing models that divert people with mental illness from the criminal justice system. The most effective programs involve the police and the mental health systems as well as consumers and family members. In the most successful programs, police officers are selected on the basis of attitudes and skills that demonstrate suitability for the work. The police and mental health professionals provide training to each other, share relevant information, and provide mechanisms for resolving disputes and breaking down systemic barriers. Training is ongoing. Furthermore, police officers maintain consistent relationships with the people they serve, and police information systems provide mechanisms for officers to gain access to information about previous contacts and successful interventions. Disseminating information and assessing quality services are also important components. Having access to a no-refusal site enables this kind of service to gain acceptance by police in assisting consumers to access the services that they need.

Cities clearly require formal protocols and procedures to deal with the larger, more complex service delivery systems. In smaller communities, it is often easier to achieve this level of cooperation informally, if the community is large enough to sustain basic services such as an after-hours service and a hospital with psychiatric coverage.

When the community is too small to support basic services, it either has to rely on larger centres for back up or it has to partner with other neighbouring villages in order to be effective. In smaller centres, particularly in remote areas, people with psychiatric disorders often wait in police cells until they can be transported to hospital. Clearly, this is unsatisfactory, and these smaller communities may have to look at the other alternatives. These can include providing secure space in hospitals or clinics, designating special police cells for people who have a mental illness and changing their design, accessing remote training, providing police and medical personnel with a broader range of assessment and treatment skills, and accessing psychiatric consultation at a distance.

Unfortunately, despite the fact that there are numerous special police programs, it is unclear whether they contribute to better clinical outcomes for consumers. They clearly assist police in diverting those with a mental illness out of the criminal justice system, but we do not know whether they lead to improved quality of life for consumers. It is even more critical that we avoid situations where people are injured or killed because they were unable to access mental health services and the first responders did not how to de-escalate the situation. Whatever services or solutions are developed must also avoid creating a system where police, families, and mental health professionals collaborate to get people into the criminal justice system in order to get them into treatment.

## Recommendations

BC should develop a comprehensive strategy for addressing the needs of people with a mental illness who come in contact with the police. This strategy needs to include special police units that incorporate the critical components of effective programs. At a minimum they should

- collaborate with the consumers, families, and the mental health, addictions, and social service systems in the design and implementation phase
- screen and provide ongoing training and support to specially-trained officers
- ensure that dispatchers and regular officers are trained to support these units
- within appropriate legal and ethical frameworks, collect information and provide officers with access to key records about police contacts with people who have mental illness
- develop protocols for police and mental health system collaboration, and mechanisms for resolving disputes as they arise
- evaluate their impact on the people they are serving

This strategy needs to be based on a collaborative approach between police, mental health services, and the mental health advocacy community. It must also be flexible enough to meet the unique needs of remote and rural communities, as well as urban centres, recognizing the diverse ethnocultural and geographic needs of each.

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# Appendix 1: Outcomes

### Program Satisfaction and Outcome Data

This last section will look only at outcomes for specialized programs involving the police. Police do not generally collect information about people who have a mental illness unless they have special programs. These programs have identified that people with a serious mental illness frequently call the police and use a substantial proportion of police resources. Researchers found that 47% to 80% of police officers rated their programs as effective in meeting the needs of people in crisis when they had a special program. This was considerably better than the experiences of police departments without specialized programs.

It is interesting to note, however, that while most officers felt confident about their own ability to manage calls from people experiencing psychiatric crises, they were less confident about their colleagues' abilities. Since it is common for most people to rate themselves as better than their peers, one way to try to confirm that programs are working – beyond self-reports – is to look at outcomes.

Unfortunately, most specialized police programs have not been evaluated and their performance has not been compared to regular police forces. The CIT program has collected information and examined impacts in the most detail. Besides the CIT reports, only one other published study looked at outcomes for the recipients. One other study examined whether more diversions happen when there is a special program and the last study looked at whether no-refusal sites were effective in assisting police.

### Impact on Quality of Life

Los Angeles, California, conducted the only published research study that looked at outcomes of its program for consumers. They did a six-month follow-up of those who had received their service. The people who received services were those who had a high incidence of psychiatric symptoms, committed serious violence against others, showed poor compliance with medication, and demonstrated serious substance use problems. At follow-up, only 11% were homeless compared to 31% at initial referral; 39% were in outpatient mental health treatment, 12% were in locked mental health facilities, and 15% had been assigned to guardians.

This data suggests some success for the program in connecting people to mental health services. Earlier studies showed that many people who have a mental illness and who come in contact with police are not involved in any services. Still, the authors of this study found that 24% were arrested at a later date, and 12% of the total were arrested for violent crimes. A further 42% were re-hospitalized. While this data suggests that the program was able to divert most of the referrals away from the criminal justice system, it is clear that these were individuals with many challenges. Clearly, their problems were not resolved simply by being diverted into the mental health system and away from the criminal justice system.

The CIT program has reported the following improved client outcomes as a result of intervention:

- Police used restraints and deadly force less often
- Fewer consumers were sent to jail
- Ongoing and more positive relationships developed between police and those who have a mental illness
- Reduced stigma and perception of danger attached to mental illness
- Involuntary commitments have decreased from 40 to 25%
- Consumers have demonstrated 15% fewer criminal offences a year after intervention
- Access to care was provided for those who have been least served by the mental health system, that is, 45% of the people who were brought in by police have never had mental health treatment
- quick response times for 92 to 97% of cases; response occurred within 10 minutes

In a personal communication, S. Cochran indicated that following CIT implementation:

- When police bring people to hospital, the consumers are much less agitated and are much more receptive to treatment than previously
- Family members and consumers call the police to ask for assistance whereas in the past family members were critical of the department and fearful for their ill relatives

- Consumers did not call the department at all previously, and they now call for assistance in addition to reporting when they are victims of crime

Looking at the results from these together, two clear benefits to people who have a mental illness are reduced homelessness and improved access to treatment and other mental health services. The CIT also appears to provide less coercive and less intrusive treatment to the people it serves, compared to what was provided in the past. The Los Angeles program also provides increased access but it appears to provide a more coercive service. This may be because that department is dealing with a group of people who have more serious and complex problems than the Memphis group, or this may be a function of a specialized program that is not as individualized as the Memphis program. Further research would have to be conducted to determine whether the group of people served by the CIT has comparable levels of illness and needs as the people in Los Angeles study.

### Benefits for Police

Research on the CIT has also found the following benefits for the police:

- A decreased need for more intensive and costly police responses (e.g. high intensity specialized police units such as SWAT)
- Police, those with mental illness, and others experienced fewer injuries
- Improved police morale
- Police spent less time in ER
- Officer downtime is significantly reduced for crisis events
- Officer recognition by the community has increased
- Implementation of CIT involves minimal costs

### Benefits for the Mental Health System

The CIT program found the following benefits for the mental health system

- Police report better informed health care professionals in hospital emergency rooms
- Less violence occurred in the medical centre

### Do Specialized Police Programs Divert People out of the Criminal Justice System?

The research project described below compared three specialized programs to determine if they were effective at diverting people from the criminal justice system prior to arrest. It compares diversion for three models that were described earlier in this paper. The three programs were in Memphis (specialized police teams: CIT), Birmingham (mobile police-based civilian team), and Knoxville (evaluation unit).

To review, the specialized police teams consist of teams of police officers in each division of a police service who have received special training to enable them to assist with and, if necessary, defuse situations involving people who are showing psychiatric symptoms. The police-based mental health team consists of a single mobile team of trained mental health professionals who are based in a police force and respond to calls from patrol officers. The evaluation unit consists of a single specially-trained unit that provides assessments and assistance for people with psychiatric symptoms who are brought in by patrol officers.

As indicated in Table 1 below, depending on the program, between 5 and 13% of people were arrested, and the programs responded to a relatively high number of the total calls to the mental health system (ranging from 28% in Birmingham, 40% in Knoxville, to 95% in Memphis.) While there was a difference in the proportion

**Table 1:**
**Comparison of three police forces on their ability to divert people into the mental health system**

| MODEL | Specialized Police Team (CIT) | Mobile Police Based Civilian Unit | Evaluation Unit |
|---|---|---|---|
| Proportion of mental health calls directed to the team | 95% | 28% | 40% |
| Resolution on site | 23% | 64% | 17% |
| Taken to treatment | 75% | 20% | 42% |
| Response Time | Shortest | Longest | Middle |
| Arrests | 6% | 13% | 5% |

of calls to which each of these teams responded, when they did respond, most individuals were diverted out of the criminal justice system.

In terms of responsiveness, both of the programs that provided lower response rates had a single team. The civilian-based team is only fully operational for 14 hours per day and limited hours on the weekend, while the evaluation team is available 24 hours. The CIT model, featuring multiple teams available 24 hours a day has a clear advantage in that it allows more individuals to receive a specialized response.

Knoxville's evaluation unit provides a mid-range response, providing coverage for as many hours as the Memphis team, but with proportionately fewer specially-trained officers at any given time. Therefore, it is limited in its capacity to provide service to as many people as multiple teams, and it is unable to respond to more than one situation at a time.

The Birmingham model of having a single mobile team during limited hours appears to provide the lowest rate of response because of the challenges inherent in travelling over large geographic areas, and the capacity limitations inherent in a single team. When the police-based civilian unit was compared to the other teams on response times, they were found to be significantly longer than for the other two models as well. As a result, police in the city often made decisions and took action without using the team. In other words, having a single unit in an urban area means that it was not available for all calls in all locations.

The strength of the mobile, police-based civilian mental health team appears to be its ability to resolve calls on-site. Compared to the other programs, it was able to resolve the highest number (64%) on-site, a significantly higher proportion than both the other models, which were each able to resolve approximately 20% of calls. As might be expected, having the highest proportion of resolved cases is associated with having the lowest rate of taking people to treatment (20%), compared to the other models: Knoxville evaluation unit (42%), and Memphis CIT team (75%). This may be an indication of the effectiveness of having trained mental health professionals (as in Birmingham) who are:

- better able to diffuse situations
- more able to assists clients to develop a plan of action

To some extent, this is confirmed when examining the same statistics for the specialized police team. They were most likely to transport people to mental health treatment and least likely to resolve the situation on the spot.

It is also interesting to note that the mobile, police-based mental health unit had the highest rate of arrests, although it was still much lower (13%) than rates in forces without special programs. The specially-trained police teams had even lower rates of arrest at 6% and 5%. Consistent with the earlier research, this may reflect reluctance by the police to arrest individuals with mental illness when they have reliable alternatives for referral (the Memphis model had the medical centre as a reliable backup; the Knoxville model had the assessment centre as a backup).

Regardless of which of the three models was used, diversion from the criminal justice system was much higher than was reported in earlier studies that examined non-specialized teams: 92% diverted vs. 79% diverted. The authors concluded that all three programs were effective in diverting people with a mental illness from the criminal justice system, and that the no-refusal site for police referrals was a significant factor in achieving success.

In a second study, several of the same researchers looked specifically at the issue of the no-refusal site, comparing the CIT site in Memphis, and two additional sites that had no-refusal policies. One of these other two was also a CIT program, but outside of Memphis.

The authors concluded that a no-refusal site was an effective mechanism for assisting those with a mental illness and returning police officers quickly to their beats. The factors that they deemed to be important included the following:

- All three programs were available 24 hours per day, and had co-located mental health/ substance abuse programs
- All three offered cross-training that enhanced cooperation and mutual understanding between police and mental health, and were closely linked to community services
- They offered police a streamlined intake process
- Their procedures recognized the dual roles of public safety and individual heath care, and provide a legal foundation to support their models

They concluded that collaboration between police, mental health services, and advocates was a major factor in the effectiveness of these programs.

## Summary

It is clear that specialized police programs reduce the use of the criminal justice system by people with a mental illness, and that they are more effective at doing so than programs without special teams. At the same time, the authors identified some important considerations. These would need to be addressed in the development and implementation of new programs. For example, where there is a single mobile team in an urban area, availability becomes a concern. The team members may be able to address access issues by providing consultation by phone when they are not available to respond, as in Vancouver. Another consideration in the choice of model would be the size of the catchment area. The single mobile team tends to work well in smaller cities, multiple teams work better in larger centres.

Unfortunately, information about quality of life or outcomes for participants is limited. Currently, the GAINS Center, a research institute in Florida, is looking at outcomes for a number of different programs. However, the data is not yet available. Clearly, this kind of information is critical in making decisions about the effectiveness of the different models. Diversion is important, but only if it contributes to more effective treatment or a better quality of life. Further research needs to examine the clinical and psychosocial outcomes for individuals in the different diversion programs. The CIT program has examined this in the most detail, and has demonstrated some positive findings such as fewer repeat offences one year after intervention and better relationships with police. The Los Angeles study also found some positive results.

Still, we know that contact with police is often traumatic for people with a mental illness and none of the studies looked directly at level of trauma and fear of police. Only two programs looked at whether consumers were better off following contact, and this needs to be explored further. In conducting interviews with respondents, most felt that their work benefits those with a mental illness. However, one would expect that people would be involved in programs that they supported, and that their impressions might be biased. Having data to confirm these perceptions would be helpful. As Nancy Pangabko, a crisis consultant suggested, one of the primary goals should be to serve consumers' needs when they are in crisis. It is tempting, however, to design a system that serves the needs of the criminal justice system without improving life for those with a mental illness. It is important to promote a person-oriented approach.

# Appendix 2: Other Non-Specialized Approaches to Achieving Collaboration between Police and Mental Health Systems

### Liaison Officers

The City of London in the UK and the City of Toronto have liaison officers. In Toronto, the role of this person is to

- liaise with community agencies on task forces that look at issues such as legislation and homelessness
- develop inter-agency responses, tools, and programs to assist people with mental illness
- educate other agencies about police/mental health issues
- review information about contacts between police and people with a mental illness

### Protocol Development

At a minimum, a number of police forces in the United States and in Canada have worked with mental health departments to develop protocols for responding. These protocols vary considerably in the amount of detail that is provided. However, they appear to be the least effective mechanism for developing sound programs. Most do not appear to require officers to have any special training, seemingly assuming that officers have the skill and knowledge to implement. The protocols that were examined for this study did not provide any mechanisms for resolving disputes or for addressing concerns and there was no information available to evaluate whether these protocols were being followed or whether they were effective.

# Appendix 3: Staged Intervention Continuum

As described below, many of the programs reviewed provided officers with a continuum of responding or alternative disposition options.

One feature of the CIT program is that officers regularly visit with mental health consumers and establish ongoing relationships. As a consequence, consumers will call their designated officer to ask for assistance. However, there are times when another person makes the call. If dispatchers classify a call as a mental disturbance, it is assigned to a CIT officer. In Memphis, the CIT lapel pin identifies the CIT officer and signifies that he or she becomes the officer in charge when they arrive at the scene. Once at the site, the CIT officer will assess the situation. Because the team has established excellent relationships with other mental health services, they will release clients into the care of their case managers, if appropriate. They will also transport individuals to hospital if required.

When they arrive, they use a multi-stage continuum of intervention. Their first levels of intervention involve effective communication and negotiation. If negotiation and de-escalation fail, they bring out a non-lethal weapon (a long-range rifle that fires rubber batons). The organization's experience is that this weapon is preventative in that it is quite intimidating in appearance. Often, the act of bringing it out is often sufficient to convince someone to change his or her behaviour. If not, they will use it, and if this is unsuccessful, their continuum includes lethal force as the final alternative.

In Knoxville, all officers are trained to identify people who have a mental illness. If the officer who responds identifies the situation as being non-violent, they will take the person to the reception centre for evaluation. If the person is armed or threatening, the crisis negotiation teams respond.

The Los Angeles police have a two-component program. If officers in the field encounter someone who appears to have a mental illness and has been involved in a low-grade misdemeanor, they bring the person to a mental health evaluation unit for assessment and referral. The mental health evaluation unit is staffed by police officers that are trained in assessment and referral. This unit also:

- provides consultation to officers in the field
- creates a database of resources and persons with a mental illness who use police services
- provides training to different departments
- assists relatives

This unit does not address situations where the person is violent or threatening; for those situations, Los Angeles uses a specially-trained outreach team.

In Birmingham, a civilian team of officers responds to repeated calls for service or to mental health calls where police service is unnecessary. In general, this team is in charge at the site and allows the police officers to return to their other duties. They work closely with the person's family and the mental heath and hospital services. The police remain on-site only if violence is a concern, or as long as it takes to accompany the individual to hospital. The civilian officer remains at hospital while the police officer returns to duty. Following intervention, they inform the police officers of the disposition and regularly review referrals.

The Car 87 police/mental health team in Vancouver takes action that depends on the result of an in-depth assessment. The team may take the individual to hospital, they may admit on an emergency basis to a care facility, or they may provide medication and reassurance to those involved. Regardless, they will make a referral to the appropriate resource and the team will notify the person who made the emergency referral of the outcome.

In Madison, Wisconsin, a mental-health-based crisis intervention team is available by phone, on the scene, or to provide follow-up. Officers are provided with 5 possible disposition options and guidelines for choosing each. For example, the police are required to consult with mental health staff before detaining or transporting someone to hospital, and officers have the authority to place violent people into the state psychiatric facility. They also can overrule the evaluating psychiatrist if the psychiatrist does not recommend temporary custody.

The After-Hours Team in Kamloops, BC, provides support to police in several ways. If the RCMP requires assistance, the team will provide assessments and advice in jail; if the person is too intoxicated to be assessed, the team will return when they are sober. Team members will also provide a bridge between the mental health system and the police so that people do get connected to services by arranging to do follow-up visits and by offering appointments to those people who are detained and released without charges.

The team will also meet the officers on the street and provide advice about known clients, and provide consultation for people who are experiencing psychiatric crises but who are not clients. If the individual requires hospitalization, the mental health team will provide assistance and advice to assist the officer to have them admitted. RCMP also provides assistance when the crisis team requires it.

It is clear from these descriptions that police can potentially have a wide range of options and discretionary powers when dealing with a person experiencing a psychiatric crisis. The form of these responses varies considerably. Some employ mental health professionals, others employ specially-trained police officers, and others use teams that combine police and mental health professionals. Some programs have a two-stage process while others have one stage. It appears that they all include a method of assessing the person's functioning, and match that to a range of dispositions. Generally, responses differ if there is a perceived risk of violence. In some programs, a more highly trained ream intervenes in that event. In other programs, there is one team that has available a continuum of escalating options.

# Appendix 4

**Web Sites Providing Useful Information about Policing and Mental Illness**

www.mhnet.org
Mental Health net

www.nami.org
National Alliance of the Mentally Ill

www.nmha.org
National Mental Health Association

www.prainc.com/gains or GAINSCTR.com
GAINS Center for People
with Co-occurring Disorders

www.nih.gov
National Institutes of Health

www.samhsa.gov
Substance Abuse and Mental Health
Administration

www.ncjrs.org
National Criminal Justice Reference Service

www.rcmp-grc.org
RCMP

www.policeforum.org
Police Executive Research Forum

www.usdoj.gov
US Department of Justice

www.ojp.usdoj.gov
Office of Justice Programs,
Department of US Justice

www.fbi.gov
FBI

# Appendix 5

**People Interviewed or Who Provided Information for This Project**

Karen Abrahamson, Consultant

Gary Bell, RCMP Cadet Training Institute

Kim Bell, Peel Branch, CMHA Ontario Division

Marilyn Blackett, Kamloops Mental Health Centre

Keith Bromwell, RCMP, Dartmouth

Brian Case, National GAINS Center, Policy Research Associates

John Chisholm, Kamloops RCMP

Sam Cochran, Memphis Police Force

Peter Collins, Ontario Provincial Police

Dorothy Cotton, Forensic Services, Providence Continuing Care Center, Kingston, Ontario

Lucy Costa, Queen Street Outreach Services

Richard Dolman, BC Schizophrenia Society

Simon Davis, Inter-ministerial Program, Vancouver, BC

Eric Fabris, Queen Street Outreach Services, Toronto

Marianne Farmer, Justice Institute of BC

Cynthia Gass, Knoxville Police Force

Bill Gaudette, Canadian Mental Health Association, President

Gary Glacken, BC Schizophrenia Society

Gord Glasgow, RCMP Training Institute

Art Gondziola,
Saskatchewan Schizophrenia Society

Jamie Graham, Chief of Police, Vancouver Police Department

Dave Jones, Vancouver Police

Nancy Hall, former Mental Health Advocate, Province of BC

Margaret Hansen, Riverview Hospital

Tomi Hamner, New Westminster Police

Darryl Kean, Police Consultant, Surrey, BC

Laurie Koziak, Mental Patients Association

Ron Lajeunesse, Alberta Division, Canadian Mental Health Association

Scott Maywood, Toronto Police

Lori McPherson, CMHA Winnipeg

Joan Montgomery, Canadian Schizophrenia Society

Barry Niles, Mental Patients Association

Richard Offer, Police Complaints Authority, UK

Jim Ogloff, Monash University, Melbourne, Australia

Janet Peters, Mental Health Consultant, New Zealand

Nancy Panagabko, Crisis Intervention Consultant

Richard Parent, Delta Police

Irene Ralph, Grand Forks After Hours Service

Melissa Reuland, Police Executive Research Forum

Lorri Ross, Emergency Health Services, Vancouver

Heidi Schoenberger, Vancouver Police

Fred Smith, Dawson Creek Mental Health Centre

Julian Somers, Mental Health Evaluation and Consultation Unit, UBC

Linda Teplin and Judith Wray, Northwestern University

Mike Webster, Centurion Consultants, Denman Island BC

Jennifer White, formerly of the Mental Health Evaluation and Consultation Unit, UBC

# Executive Summary

## Introduction

In October 2000, the BC Chief Coroner issued a report following an inquest. After a series of aggravating incidents, a man who was distressed and suffering from a mental illness began acting violently in the emergency department of a BC hospital. The police were called, the situation escalated, and in the ensuing confrontation the individual died.

The Coroner made a number of recommendations to various government Ministries relevant to the situation. One of the Coroner's many recommendations is the focus of this report. It was:

- That police be provided training with respect to dealing with people with a mental illness in a non-confrontational manner.

CMHA BC was an intervenor in that Coroner's Inquest, and in carrying out this project, seeks to help the various relevant parties move forward on the key recommendation above. The specific objectives of this project are to:

- find out what kind of training is offered to police in different jurisdictions, to determine the common program elements, and to attempt to identify the most effective components;
- review the literature to determine what service delivery models are being used by police in various jurisdictions to intervene in crises;
- determine key aspects and key strategies for implementation, i.e. those key factors that contribute to the establishment of effective intervention programs.

This report relied on published research and reports, as well as interviews with individuals who work for or with police departments, including mental health professionals. It also included information gained from Coroner's reports and interviews with individuals who participated in inquiries.

## Outline of the Report

The first part of this report looks at the nature of the problem, by first looking at why more people with a mental illness are coming into contact with the police, and identifying a number of factors that have contributed to this trend. The report then looks at some of the factors that create barriers to effective police response to persons with mental illness, and next, looks at two key issues that have resulted from this state of affairs: criminalization and injury or death of persons with mental illness (as well as serious personal consequences for the police officers involved).

The second part of the study looks at solutions, describing different intervention "prototypes" designed to assist individuals who are in psychiatric crisis who come into contact with the police, and identifying key attributes of each model, and key attributes of successful programs in general.

## Key Findings

### Background

A number of factors that have lead people with mental illness to come into increased contact with the police, including:

- deinstitutionalization, especially problems with crisis response and other community support that would avert crises from happening in first place
- the move to "community policing" that increases day to day contact between police and individuals in the community.

This combination of factors, and others, have placed police in the position of being a frequent "first responder" in situations involving mental illness, usually without the necessary training or backup to deal effectively with such situations.

### Barriers to effective response

Police face a number of barriers in their attempt to successfully resolve situations involving mental illness. These include:

- lack of knowledge, including general knowledge about mental illness, including signs and symptoms
- misconceptions about people with mental illness (shared with the general public)
- lack of specialized training re mental illness and non violent crisis response
- lack of situational knowledge or consultation (i.e. background information re whether a given situation involves mental illness)
- lack of responsiveness of crisis and acute

care mental health system, resulting in:

- officers spending long periods of time in emergency departments
- officers making an arrest instead of a referral in hopes of initiating treatment (especially in situations where a minor crime has been committed)
- officers avoiding mental illness-related situations in some cases, especially in "nuisance" situations or in cases where the individual is seen as quite difficult to deal with by either the mental health or criminal justice systems)

The result of this state of affairs is that too many people certain people ignored or remain untreated, (especially in situations where dual diagnosis is involved).

Another result is an unnecessary criminalization, trauma, injury or death of people with mental illness. It must not be forgotten that police officers, too, are left in situations that may be dangerous for themselves, with little access to specialized consultation or backup.

## Specialized Responses

The next part of the report looks at specialized responses that have arisen to improve the current state of affairs. The research reviewed reform efforts from across North America, with particular attention to the Crisis Intervention Team (CIT) model, which arose out of Memphis Tenessee, and has been replicated with various modifications in other American jurisdictions. In addition to the CIT model, the research identified three other response prototypes. The table on the next page outlines each of these models, together with a consideration of their respective strengths and weaknesses.

*Key Attributes of Successful Programs*

When the programs are looked at as a whole, a number of key features emerge as key attributes that contribute to success. These include: leadership; extensive specialized training; access to information and consultation; a staged response continuum; close collaboration with the mental health system; and comprehensive coverage. It appears that the Memphis Crisis Intervention Team (CIT) model possesses more of these characteristics than the others, but each model has its own set of strengths and weaknesses that need to be considered. The following section outlines each of these attributes in greater detail.

### 1 Leadership/Clear Mandate

- need for high level leadership from both police and mental health systems
- leadership from advocacy community is also key
- police buy-in regarding need for change often relies on internal champions as well as municipal leadership (e.g. from Mayor)
- reform efforts often triggered by tragedy or by specific incident

### 2 Extensive Specialized Training of a Core Group of Carefully Selected Officers

- non violent crisis intervention a key feature (communication, negotiation, de-escalation, specific to mental illness)
- cross-training between police and mental health system (Madison model)
- experiential training (consumers/families cross train police; Queen St. Toronto model)
- practical/hands on training (selecting and training specialized officers – Memphis model – means that officers can "put skills into play" on regular basis)
- dispatcher training also a key feature of CIT model
- training should be based on staged intervention continuum (see below)

### 3 Information/Consultation

- specialized information systems provide opportunity to provide relevant on-site information from dispatcher to officers on scene (e.g. if person has a mental health history or history of violence, etc.)
- information systems can track trends over time (e.g. where calls are coming from; what types of calls are most problematic, etc.) and can offer valuable system baseline information (Memphis found that over 40% of police work involved mental health situations) or outcome information (re both successes and ongoing troublespots)

## Specialized Responses: Summary Table of Responses

| Prototypes | Mobile team – Police-based | Mobile team – MH Based | Assessment Centre | Crisis Intervention Team (CIT) model |
|---|---|---|---|---|
| **Example** | Birmingham, AL | Car 87<br>Vancouver, BC | Knoxville, TN<br>Los Angeles, CA | Memphis, TN |
| **Definition/Key Attributes** | • single team<br>• staffed by mental health professionals who are "civilian officers"<br>• takes referrals from patrol officers in cases where resolvable with non-violent crisis intervention<br>• swat-like team intervenes if violence | • single team<br>• staffed by police & mental health professional<br>• team members can consult over phone, resolve situation on site, refer to crisis residential facility or hospital | • all officers receive basic training in regards to mental illness<br>• bring suspected cases of mental illness to "assessment centre"<br>• assessment centre staffed by mental health professionals who are police employees<br>• specialized team intervenes if violence | • specialized police crisis intervention teams<br>• specially trained officer within each "catchment area" of city responds to all 911 mental health calls from public or from patrol officers within each city "catchment area"<br>• specially trained dispatchers provide backup information to officers or make referral to mental health system<br>• CIT officer resolves on site with crisis intervention, refers to mental health system or brings to medical centre<br>• medical centre has "no reject" policy<br>• has co-located mental health / substance use service |
| **Considerations** | • single team has limited capacity to respond to calls<br>• considerable training / personnel costs for police<br>• strength is on-site crisis resolution | • single team and limited response capacity<br>• a model that has been widely replicated in Canada | • limited response since one assessment centre covers entire area<br>• relatively limited on-site resolution capacity | • strong geographic and after-hours coverage<br>• only model to have substantial positive research backing (satisfaction of consumers/families and police; time efficient for police; less involuntary commitment; less trauma for police<br>• relies on close, formalized collaboration with mental health system |

- mental health professionals and police need to establish, within legal and ethical frameworks, effective ways of sharing information

### 4 Staged Response Continuum

- developing ongoing positive relationships with mental health community and with mental health consumers is first stage (proactive/preventive) part of continuum
- non-violent crisis intervention is basis of intervention
- back-up for more potentially violent cases is necessary (e.g. from specially trained swat team or negotiation team that is trained in appropriate use of "non-lethal" weapons, e.g. stun guns or TASER)
- close collabaration with mental health system a must (referral to regular crisis or

acute care services where possible)
- special attention to concurrent substance use seen as a key issue in many programs

### 5 Close collaboration with mental health system

- response protocols specifying mutual responsibility, and enabling efficient referrals and information sharing
- access to dispute resolution
- high level mandate within each department
- "no-reject" service by mental health system seen as key; i.e., need to establish agreement that individuals referred by police to acute or community mental health services *will* receive appropriate service
- special attention to concurrent substance use seen as a key issue in many programs

### 6 Comprehensive Coverage

- model should ensure after-hours response
- chosen model should ensure geographic coverage and ability to respond to more than one call at a time

## Conclusions/ Recommendations

BC should develop a comprehensive strategy for addressing the needs of people with a mental illness who come in contact with the police. This strategy needs to include special police units that incorporate the critical components of effective programs. At a minimum they should:

- collaborate with the consumers, families, and the mental health, addictions, and social service systems in the design and implementation phase
- screen and provide ongoing training and support to specially trained officers,
- ensure that dispatchers and regular officers are trained to support these units
- within appropriate legal and ethical frameworks, collect information and provide officers with access to key records about police contacts with people who have mental illness
- develop protocols for police and mental health system collaboration, and mechanisms for resolving disputes as they arise
- evaluate their impact on the people they are serving

This strategy needs to be based on a collaborative approach between police, mental health services, and the mental health advocacy community. It must also be flexible enough to meet the unique needs of remote and rural communities, as well as urban centres, recognizing the diverse ethnocultural and geographic needs of each.

Notes

# Yes!

## Sign me up as a member

CANADIAN MENTAL HEALTH ASSOCIATION
L'ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE
**BC Division**

# YES, I'd like to be a member of CMHA BC Division!

**Members are vital to the success of the organization. The more members we have, the greater the opportunity to inform and educate the province at large. You can make a difference in the lives of people and their families and friends who have had a mental illness or are at risk – just by becoming a member of CMHA. As a member I am entitled to:**

- receive 4 issues of *Visions: BC's Mental Health and Addictions Journal,* a national award-winning publication produced by the *BC Partners for Mental Health and Addictions Information*, of which CMHA is a partner.
- vote to elect a regional delegate to the provincial board
- volunteer for committees and other projects
- access agency educational resources including our library

Please note that membership is available to any citizen, society or company in Canada and will not be denied due to economic or financial hardship. As a member you will receive periodic information from CMHA including requests for support and information on upcoming events.

1200-1111 Melville St., Vancouver BC, V6E 3V6
Tel: (604) 688-3234 or toll-free 1-800-555-8222
Fax: (604) 688-3236 E-mail: office@cmha-bc.org

Yearly membership fee
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❑ In addition to my membership, I am donating: _____

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❑ Credit Card

❑ Visa ❑ MasterCard

Amount _____

Card No. _____

Expiry date: _____ / _____

Signature _____

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Notes

Notes

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