TEMPO: Police Interactions

A report towards improving interactions between police and people living with mental health problems

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COMPREHENSIVE REVIEW

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PREFACE

Starting in 2007, the Mental Health Commission of Canada (MHCC), through its Mental Health and the Law Advisory Committee (MHLAC), undertook a series of projects related to police interactions with people with mental illnesses (PMI).[1] There has been a significant increase in the number of such interactions over recent years and, concomitantly, increased concerns about some of the outcomes. While most interactions between police and PMI are resolved successfully, a few have resulted in negative outcomes, including the death of the person with the mental illness. The overall goal of the MHCC projects was to identify ways to increase the likelihood of these interactions having positive outcomes–that is, better outcomes for all involved.

These projects included:

- A review of police academy/basic training education in regard to mental illness;
- A review of in-service level education;
- An extensive study of the experience of people with mental illnesses with police, including their recommendations for changes in education and practice; and
- Guidelines for police services, in regard to their interactions with the mental health system

It has now been over seven years since the initial MHCC work in this area. Where are we now? How have things progressed? The present report is focused only on police education and training, rather than on the broader systems and policies that affect interactions between police and people with mental illnesses; it addresses education and training in the broadest sense. As the preface to the 2010 report, *Police Interactions with Persons with a Mental Illness: Police Learning in the Environment of Contemporary Policing*,[2] stated:

> *no matter how well designed and complete a curriculum is, it will only result in improved outcomes if the learning engages the right people and in the right context. Thus, in this paper, attention is also paid to contextual factors—not only what should we teach, but also to whom should we teach and in conjunction with what other organizational structures and social systems (p. 5).*

The present report places an emphasis on HOW we should teach as well as what we should teach, given the many developments in the field of adult education and curriculum design. That is, how can we better prepare police personnel for interactions with PMI?

[1] There are a variety of different terms used by researchers, police, consumers and others to describe people who are living with mental illnesses or people with lived experience of mental illness. In this paper, the term "person with a mental illness" or PMI has been employed as it is familiar to the target audience, and most accurately describes the situation in which police interact with this population—that is, at times when signs and symptoms of mental illness are readily apparent—as opposed to people who might have a history or past experience of mental illness but whose symptoms are not evident at the moment.

[2] Available at http://mentalhealthcommission.ca/English/document/431/police-interactions-persons-mental-illness-police-learning-environment-contemporary-pol

EXECUTIVE SUMMARY:
A SYNOPSIS OF FACTS AND FINDINGS

It is increasingly apparent that interactions between police and people with mental illnesses constitute an ongoing challenge for police agencies. Data from a variety of sources indicate that such interactions are, if anything, reported more frequently than five to seven years ago. Lack of resources for services, treatments, and supports for people living with mental health problems and illnesses and the presence of stigmatizing attitudes and behaviours among the public continues to lead to the expectation of a police response when persons are in crisis.

Arising from fatality inquiries and coroners' inquests and within the police community itself, there continues to be a focus on providing appropriate and sufficient education for police, not only so that they might recognize and understand mental illness, but also so that they might respond appropriately and empathically, employ de-escalation techniques as needed, avoid undue use of force, and attempt to connect people with mental illnesses with community agencies and services.

Based on responses to a comprehensive survey, Canadian police organizations at the basic training/academy[3] level appear to be doing a reasonable job of providing the foundations for successful interactions between police and people with mental illnesses. Curricula increasingly tend to be multi-faceted using a variety of teaching methods (lectures, videos, online resources, role playing and scenarios, simulation, and written resources). Virtually all police academies included a firm grounding in the more academic aspects of understanding mental illness. They covered signs and symptoms of mental illness, assessment of suicide risk, basic communication strategies, essentials of mental health law, and intervention strategies. Most also include, at least to some degree, a discussion of societal attitudes and biases about mental illness and its accompanying stigma. The majority of police academies provide this education not only in a formal didactic fashion but also through scenario training and simulations.

However, there are still notable gaps. Most notable is the common failure to include people with mental illnesses in the development and delivery of curricula. The research literature about attitude change strongly supports the value of direct interactions with people with mental illnesses in order to change attitudes and, therefore, change behaviours. To a lesser extent, police academies some still do not include mental health professionals in the development or delivery of curricula. The failure to include mental health professionals has, in some cases, led to the production of curriculum which is inaccurate or outdated. However, it also denies new officers the opportunity to become familiar with their mental health counterparts and begin to develop working alliances with mental health agencies.

Given the reasonably strong preparatory training that police officers receive during basic training, the trend with in-service education has been to focus more on development of skills and behaviours as opposed to knowledge and factual information about mental illness. There is an increased tendency for verbal de-escalation techniques and other communication skills to be emphasized, including an increased emphasis during use-of-force training. However, unfortunately, it is not uniformly the case that non-physical interventions are included in use-of-force training. Interestingly, in one province (BC), there is a move to revise the way in which use-of-force training has been taught, to the extent that the criteria and selection of use-of-force trainers will be altered to ensure that a balanced perspective, including an emphasis on the less aggressive means of intervention, will be emphasised.

The amount of in-service education is variable from one organization to another. A few require mandatory requalification training in this area, whereas many others do not. The interval of mandatory re-training can vary from one to several years, and the amount of education and training can vary from a single hour up to 12 to 18 hours. Again, it was found that people with mental illnesses are typically not included during the design and delivery of in-service education.

The above mentioned changes in the Canadian situation have occurred much in parallel to those in other jurisdictions including Ireland, Australia, Sweden, and the United States. In all cases, the trend seems to be toward more inclusive training; this includes not only factual information about mental disorders but also experiential learning to address attitudes and bias, and scenario or role-based learning to emphasize skill acquisition. Nevertheless, it is not clear in the context of understanding and addressing mental illness that police organizations, overall, have well-

[3] Some police learning institutions are called an academy and some are called a college. This report uses academy to include both.

integrated and effective initiatives to create a stigma-free police environment.

Perhaps the most noticeable change, when comparing the findings of the 2014 study with the 2008 and 2010 studies, is the increased attention to the necessity to prepare police personnel to de-escalate and defuse crisis situations whenever possible. While this is apparent in several police agencies and police academies, arguably, the Crisis Intervention and De-escalation (CID) training in BC is one of the most advanced and promising programs.

After considering the findings of the literature review, review of police learning programs including those from Canada, the United States, the United Kingdom, and Australia, and directly communicating with a variety of police and mental health professionals, the following key recommendations[4] have been formulated to better prepare police personnel for contact with persons with a mental illness.

Recommendation 1: *A Framework for Learning Design and Delivery*

That notwithstanding the many important elements of police/mental health learning design and delivery, the overriding theme should be a focus on:

- anti-stigma education to challenge the attitudinal barriers that lead to discriminatory action;
- the de-escalation/defusing interactions with people with mental illness (PMI) by means of effective verbal and non-verbal communications; and,
- ethical decision making, human rights protection and social responsibility.

Recommendation 2: *The Learning Spectrum*

That, at a minimum, the objectives of the *Learning Spectrum*[5] necessary to prepare police personnel with regard to police/pmi encounters are:

TO UNDERSTAND[6]: the importance of adherence to the fundamentals of contemporary policing, such as:

  - a client focus;
  - procedural justice;
  - relationship building;
  - an outcome focus; and,
  - a multi-agency approach.
- the role of police personnel in encounters with PMI; and
- the role of mental health professionals, family and community supports in police encounters with PMI, consistent with a *systems approach*.

TO UNDERSTAND:

- the symptoms such as hallucinations, delusions, paranoia, thought disorder, mood disturbances, intellectual impairments, memory problems, dis-inhibition, behavioral disturbances and other signs and symptoms that might accompany major mental illnesses and related problems;[7]
- knowledge about mental illness sufficient to make an assessment about the influence that mental illness might be having on a person's behaviour and ability to comprehend and respond to the requests or instructions of police personnel; and,
- the interplay between culture, race, gender, and other person-specific characteristics that affect the experience of mental illness.

TO UNDERSTAND:

- the importance of fostering effective police/mental health agency relationships;
- the importance of information-sharing protocols between police and mental health agencies;
- local mental health legislation sufficient to take appropriate action when necessary;
- other relevant legislation, including that which defines privacy rights and human rights;
- the function of local mental health agencies and options and where/how to call for consultation and/or assistance and/or to make referral(s); and,
- police organizational policies and procedures relevant to police/PMI encounters.

TO UNDERSTAND:

- how to apply effective communication skills and de-escalation techniques for defusing and calming situations involving PMI;
- how to determine whether it is likely that the PMI is capable of understanding and responding to the directions given by police personnel; and
- that the standard police procedures and practices, which might typically disarm a non-mentally ill person, stabilize the situation or lead to co-operation, might have the opposite effect on a person experiencing a mental health crisis.

[4] Various issues have been raised throughout the report that deserve attention and action, this section brings together those considered to be the key recommendations of the study.

[5] The Learning Spectrum is applicable to all Police/PMI learning including basic training and in-service training.

[6] Note: the term understand is used broadly to reflect not only a factual or academic knowledge of the subject matter but also the ability to operationalize and perform the tasks associated with that understanding.

[7] As was noted earlier, there should be focus on signs and symptoms of mental health issues rather than of classification systems and diagnoses.

TO UNDERSTAND:

- the relationship between mental illness and dangerousness; and,
- be able to reasonably accurately assess suicide risk and how to contain the situation and/or when to intervene accordingly.

TO UNDERSTAND:

- how to appropriately adjust decision making regarding when to apprehend, when to arrest, when to divert/refer, and/or when to seek additional input;
- how to apply problem solving in the police/mental health environment; and,
- how to apply ethical decision making.

Recommendation 3:
Selection of Trainers/Facilitators/Instructors

TO UNDERSTAND:

a. That carefully selected trainers/facilitators/instructors have subject matter expertise and experience as well as training in how to facilitate/instruct adult learners;

b. That use-of-force trainers be carefully selected, trained, certified and monitored to ensure all use-of-force training is well balanced between verbal communications/de-escalation skills and technical use-of-force skills; and

c. That police organizations with a structured police/pmi response model include members of those response groups as trainers/facilitators/instructors of police/mental health learning.

Recommendation 4:
Competency-Based Human Resource Management

TO UNDERSTAND:

a. That police/mental health learning for police personnel in preparation for interactions with people with a mental illness is based on the appropriate competency profile required for police personnel in this role; and

b. That the development of technical and behavioral competencies with regard to verbal communication, interpersonal, conflict resolution/mediation and de-escalation techniques, ethical decision-making (all of which are required for successful police/pmi contact) be integrated and reinforced across the police personnel learning spectrum.

Recommendation 5:
A Stigma-free Police Environment

TO UNDERSTAND:

a. That police leaders ensure contemporary stigma-free policies are in place in the workplace to guide police/mental health education and training as well as operations;

b. That the provincial and national chiefs of police associations work with the Mental Health Commission of Canada as well as mental health organizations such as CMHA and the Schizophrenia Society of Canada (SSC) to develop a framework for an anti-stigma program for delivery to police personnel; and

c. That the anti-stigma program is a key component of police basic education and training and reinforced during subsequent in-service education and training.

Recommendation 6:
Attitudes of Police Personnel

TO UNDERSTAND:

a. That education for police personnel includes a focus on why and how interactions with PMI are 'real' police work.

Recommendation 7:
De-escalation and Use-of-Force Education and Training

TO UNDERSTAND:

a. That the police use-of-force training be reviewed by police academies and police agencies to ensure that ample time is dedicated to understanding, learning and practicing how to resolve situations without the use-of-force;

b. That, while recognizing the importance of technical competence with regard to use-of-force techniques, that all use-of-force training be modified to include and emphasize knowledge about mental illness and symptoms of mental illness, verbal communications, interpersonal skills and the practice of de-escalation techniques.

c. That de-escalation, defusing and calming techniques be subject of requalification training at least every three years; and

d. That learning related to de-escalation, defusing and calming be structured such that police personnel must successfully complete (pass) the requisite education and learning and, further, that the failure to pass will require successful retraining prior to operational re-deployment.

Recommendation 8:
The 'Right' Learning for the 'Right' Personnel

TO UNDERSTAND:

a. That although the extant literature does not provide strong evidence with which to confidently implement 'evidence-based' learning, police leaders, police policy analysts, and police educators stay abreast of research and evaluation developments and modify policies and learning curricula accordingly in a timely manner; and,

b. That police organizations actively partner with universities and researchers to study the outcome in the operational environment of the learning delivered with regard to police/PMI contact.

Recommendation 9:
Design and Delivery of Police Learning

a. That police learning be designed and delivered by a combination of police personnel, adult educators, mental health professionals, mental health advocacy organizations and people living with a mental illness. Further, that those who participate in the design and delivery of learning are, whenever practical, from the local jurisdiction;

b. That all learning with regard to police policies, practices and police/pmi interactions be client focused and embrace the principles of procedural justice;

c. That police agencies as well as police academies include a competency-based and problem-based learning (PBL) approach for police/pmi interactions similar to that used by the RCMP Academy;

d. That those responsible for curriculum development for basic training as well as in-service education and training should consider the TEMPO 2014 framework as a gap analysis tool against which to assess their own curriculum. By identifying the gaps and weaknesses, curriculum designers can not only work to fill those gaps but also be able to communicate the strengths and gaps to the police agencies which eventually employ their graduates;

e. That police academies which provide education and training for more than one police agency or more than one police jurisdiction maintain clear communication with the receiving agencies/detachments in order for both parties to be aware of what is, or is not, covered in training in the various locations;

f. That while police organizations might consider communication skills and verbal de-escalation techniques are best covered in curricula other than the use-of-force module, given what is known about the generalization of learning, particularly early on in the career of police personnel, it is imperative that substantial emphasis is placed on NON-physical interventions, and specific reference to assumptions about mental illness and dangerousness be included in all use-of-force training;

g. That although there is no clear answer to the question: how much training is enough?, those agencies whose specific and identifiable basic training in this area seems to be less than 10 hours should re-examine their curriculum to ensure it is consistent with general practice across Canada;

h. That police academies whose training is all, or nearly all, lecture-based should examine ways in which student learning might be enhanced by use adult learning methods such as simulations, scenarios and other experiential learning, as well as use of multi-media and online resources;

i. That because evaluation of learning remains weak at both the basic training and the in-service education and training levels, police/mental health learning programs should include a behavioral assessment of student competencies, and require successful completion in order to graduate from the respective police academy; and

j. That given the close ties between attitudes, stigma and behaviour, all police academies should ensure that these issues, as well as beliefs about the relationship between mental illness and dangerousness, are included and integrated in the basic training curriculum.

Recommendation 10:
Evidence-based Learning

a. That national and provincial police associations work with the appropriate agencies/organisations to generate and retain data suitable to assist with a better understanding of the scope and frequency of police/pmi interactions as well as aid the evaluation of police/pmi response models and police/mental health learning; and

b. That Canadian police agencies and/or Canadian policing associations work with scholars to further explore the knowledge gaps by means of research including that identified during the present study.

Recommendation 11:
Provincial Policing Standards

a. That provincial governments establish policing standards that include provision for mandatory basic and periodic police/pmi training qualification/requalification for police personnel; and

b. That subject to the successful testing of the Certified Use of Force Instructor Course (CUFIC) in BC, that a similar, if not the same, process become a police standard across Canada for use-of-force instructors.

Recommendation 12:
Strategies, Policies, and Standards

a. That police agencies develop the appropriate policies, strategies and procedures with regard to police/pmi contacts that in turn guide the design and delivery of required learning; and

b. That the design and delivery of police/pmi learning be based on an organisational strategy that emphasises the need, whenever practical, to de-escalate/defuse a crisis situation by means of effective verbal and non-verbal communications.

Recommendation 13:
Knowledge Sharing and Dissemination

a. That, at a local level, police agencies maintain an up-to-date and readily accessible resource 'library;' and

b. That, considering it appears there is substantial redundancy across police services in the development and use of learning materials, police services work cooperatively to develop an inventory of materials and programs which are widely available to other police services.

Recommendation 14:
Integrated Learning

a. That police leaders as well as directors/managers of police colleges/academies integrate the development of behavioral competencies required for interactions with vulnerable persons, such as verbal communication, de-escalation techniques, patience and relationship building, across police learning programs.

Recommendation 15:
Consumer Driven Learning

a. That as evidence continues to become available about the experiences of PMI with police interactions and the advice they might offer to police agencies, that this be integrated into learning curricula; and

b. That police agencies consult and/or formally survey their local consumers, consumer groups and advocates and integrate local issues, concerns and feedback into their local education and training.

This study found that the TEMPO framework established in 2010 was, overall, sound. Some adjustments were deemed necessary and are reflected in the TEMPO 2014 framework below. It is important to note that **TEMPO** is not a training tool per se but an umbrella approach that police organizations can use as a framework to assess their own progress in training, to identify gaps in their existing learning programs, and to use as an aspirational document to create appropriate new learning programs. It is intended to assist police agencies to make a positive difference and contribute to public safety in regard to police interactions with persons with a mental illness.

Recommendation 16:
Learning Framework–TEMPO 2014

*That Canadian police agencies be encouraged, in collaboration with their local mental health professionals, to adopt a multi-module learning delivery model–***T***raining and* **E***ducation about* **M***entalhealth for* **P***olice* **O***rganizations (***TEMPO***)–to address the learning necessary to prepare police personnel for encounters with persons with a mental illness (PMI).*

TEMPO 100:

The focus of learning at the **TEMPO 100** level is to ensure that police first responders have sufficient knowledge and skills to be able to manage and resolve the types of encounters that police personnel have on a regular basis and to know when to seek additional support or, when available, more skilled intervention.

TEMPO 101: Police Basic Training

This module for 'new police officers/police cadets' in police college/academy should cover the entire recommended ***Learning Spectrum***. (It is estimated this module would be approximately 35-40 hours in order to deliver an effective integrated program). Students will also receive reinforcement of some of the subject matter, such as verbal communication skills, during their use-of-force training (Refer to **TEMPO 500**).

TEMPO 102: Lateral-Hire Police Officers

A blended learning[8] module for lateral-hire police officers who have not previously received the comprehensive police/mental health learning such as found in **TEMPO 101**. (It is estimated this module would be approximately 15 hours in order to deliver an effective integrated program). The purpose being that these officers will then be able to operate at the same level of understanding as those who received this education during standard basic training–TEMPO 101. This module should cover the entire recommended ***Learning Spectrum***.

TEMPO 103: Police Personnel/Support Staff

A one to two-day blended learning module for personnel such as communication centre dispatchers, call-takers and supervisors, as well as 'front desk' personnel and victims services workers. The module should cover the recommended ***Learning Spectrum***.

TEMPO 104: Offender Transport/Prisoner Care Personnel

A one-day module covering the learning objectives of the recommended Learning Spectrum for personnel responsible for prisoners. A particular emphasis should be placed on symptoms of mental illnesses and suicide awareness in the context of working with both young and adult offenders.

TEMPO 200:

The **TEMPO 200** level learning assumes a pre-existing basic level of competence, and builds on it, but is still focused primarily on the police first responder. It is intended to address periodic refresher and/or the periodic requalification of previously taught information and an update on new developments.

[8] Blended learning in this report refers to a combination of on-line and classroom and/or 'hands on' scenario-based learning.

TEMPO 201: Continuing Education (In-Service Training) for Police First Responders

A minimum one-day module for:

- police officers who did not receive the police/pmi training during their basic training; and
- refresher/requalification training approximately every three years for each first responder police officer.

TEMPO 202: Field Training Officers/Officer Coaches and newly promoted Supervisors

This two-day module is intended for two target groups:

- designated FTOs/Officer Coaches to enable them to re-enforce the learning their 'new' police officers experienced in basic training; and
- newly promoted supervisors (corporals/sergeants).

TEMPO 300:

The 300 level learning is for police personnel in specialized assignments that require either a more in depth and higher level of skill and knowledge, or a more focused understanding compared to the first responder.

TEMPO 301: Specialized Assignments

A learning module for personnel such as police crisis negotiators, incident commanders, firearms/use-of-force instructors, ERT/SWAT commanders and search and rescue managers. (It is estimated this module would be approximately 40 hours in order to deliver an effective integrated program).

TEMPO 400:

The **TEMPO 400** level is learning for specialist officers who will be providing expert or consultative services with regard to Police/PMI contact.

TEMPO 401: Advanced learning for police personnel assigned to a joint police/mental health response team and/or for police specialists with regard to mental health response.

This intensive module should cover the entire recommended **Learning Spectrum**. (It is estimated this module would be approximately 40 hours in order to deliver an effective integrated program). The module should also include proficiency in reporting observations both verbally and in writing. It should also include, in addition to the formal learning, workplace learning in the form of a minimum of four job-shadow shifts with their police/mental health response team, if their police agency has one, and a minimum of four job-shadow shifts with a mental health facility.

TEMPO 500:

Learning Module to be inserted into Use-of-Force 'training'

It seems that police officers might be spending too little time and energy at the front end of the use-of-force continuum before progressing to physical contact. This one-day module to be delivered by trained and certified police personnel is intended to be integrated into what has traditionally been stand-alone use-of-force 'training.' It should complement and reinforce the learning of all other **TEMPO** modules. While it should cover the learning objectives of the recommended ***Learning Spectrum***, particular emphasis, and thus reinforcement, should be placed on:

- an understanding of symptoms such as hallucinations, delusions, paranoia, thought disorder, mood disturbances, intellectual impairments, memory problems, dis-inhibition, behavioral disturbances and other signs and symptoms that may accompany major mental illnesses and related problems;
- knowing about mental illness sufficient to make an assessment about how much control the subject is likely to have of their behavior;
- verbal and non-verbal communication skills and de-escalation techniques for defusing and calming situations involving PMI;
- whether it is likely that the PMI is capable of understanding and responding to the directions given by police;
- knowing that the standard police procedures, which might typically disarm a non-mentally ill person, stabilize the situation or lead to co-operation, might have the opposite effect on a person who experiencing a mental health crisis;
- having an understanding of the relationship between mental illness and dangerousness;
- being able to reasonably accurately assess suicide risk and know how to contain the situation and/or when to intervene accordingly;
- knowing how to apply problem-solving in the police/mental health environment; and
- knowing how to apply ethical decision-making and to exercise of police discretion.

CHAPTER 1

1. Introduction

When the Mental Health Commission of Canada (MHCC) was established in 2007, one of its first projects involved a review of situations involving interactions between police and people with mental illnesses (PMI). The MHCC Police Project was a multifaceted series of studies that included reviews of relevant police training and education, the development of guidelines for police services desirous of improving their interactions with persons with a mental illness, and an innovative study of the experiences and perceptions of PMI about their interactions with police agencies and police personnel.[9]

The literature is clear that people with mental illnesses are over-represented in the criminal justice system including, of course, policing; they are more likely to be arrested, more likely to have informal encounters with police, and are more likely to be subject to use of force (cf. Krameddine, DeMarco, Hassel & Silverstone, 2013). The reasons are complex—and many are not related to the behaviour of police personnel or police organizations but to a variety of other issues including general societal attitudes toward mental illness, the inaccessibility of more appropriate resources for PMI, as well as legislation which gives police specific powers—and, therefore, specific responsibilities—in regard to PMI. But regardless of the reasons, it is inarguable that police officers often continue to be the front line of the mental health system, and interactions between police and people with mental illnesses are common. Brink, Livingston, Desmarais, Greaves, Maxwell, Parent & Weaver (2011) indicated that:

- 2 in 5 people with mental illness have been arrested in their lifetime;
- 3 in 10 people with mental illness have had the police involved in their care pathway;
- 1 in 7 referrals to emergency psychiatric inpatient services involve the police;
- 1 in 20 police dispatches or encounters involve persons with mental health problems (p. 29).

However, while police encounters with PMI vary in nature, the incidents which (not surprisingly) capture public attention are those rare incidents in which a person with a mental illness dies during an interaction with police. There have been numerous coroners' inquests and fatality inquiries over the past several decades that have looked at circumstances surrounding the death of a PMI. Names in the past such as Edmond Yu, Jonathan Yeo, Norman Reid, Darryl Power, Donald Mayer and more recently, Michael Eligon, Sylvia Klibingaitis, and Reyal Jardine-Douglas as well as others subject of inquests and inquiries have become well known because of their tragic outcomes.

Many, if not most, of these inquests and inquiries made recommendations for more and/or improved police 'training.' Indeed, 'training' for police personnel has increased and, arguably, improved substantially over the past 10-15 years. The present study (a) explored the state of Canadian police learning in preparation for interactions with PMI and (b) conducted an international literature review of the state of police learning in this regard.

2. Background

In that context, in 2008 the MHCC conducted a review of the basic/recruit[10] training, which occurs primarily at Canadian police colleges/academies, concerning interactions with PMI.[12] To complement that study, in 2010, the MHCC conducted a review that examined the nature and extent of such police training and education at the in-service or continuing education level within Canadian police organizations[13] Based on these reviews, an aspirational model of police education and training—**TEMPO** (*Training and Education about Mental Illness for Police Organizations)*—was developed, described, and disseminated. The purpose of the present report is to review progress since that time.

For instance, is the TEMPO model still valid? Is there new

[9] *Police personnel* includes police officers but also includes other employees of a police agency.

evidence that would indicate it requires revision? Has it been implemented—or more generally, has training and education in this area progressed since the previous studies, regardless of whether police services have embraced this particular model? What are the barriers to implementation? Has there been any meaningful assessment of this or other models since 2010? Based on the aforementioned, this report will describe the current state of affairs (2013-2014) concerning police education and training in Canada.

On the surface, it is not clear there have been substantial changes in the nature and extent of interactions between police and PMI since 2010. As was noted in the 2008 and 2010 reports, it remains difficult to obtain meaningful data about the nature and extent of interactions between police and PMI.[14] At the 2013 Canadian Association of Chiefs of Police Annual Conference, President Jim Chu (Chief Constable, Vancouver Police) reported that the number of mental health-related calls to the Vancouver Police had quadrupled since 2002, and that 20% of police calls-for-service related to mental health issues. He further reported that apprehensions in Vancouver under the BC Mental Health Act increased by 23% in the previous year. Toronto Police data indicated 8500 apprehensions were made under the Ontario Mental Health Act in 2011 (Toronto Police Service, 2013). Lisa Heslop and her colleagues at the London Police in Ontario documented a 134% increase in costs related to interactions between the police and PMI for the period 2000-2011 (Heslop, Stitt and Hoch, 2011).

At the same time, however, there have been both competing as well as complementary influences at work. Ironically, it is reasonable to conclude that as police personnel become more educated and knowledgeable about mental illness more such cases will be identified correctly, thus artificially inflating the numbers. Similarly, as more cases are correctly identified, logically, more Mental Health Act apprehensions will occur—presumably instead of arrests—although data are not available to confirm this.

What is apparent and inarguable, however, is that regardless of the direction of the apparent trends, this continues to be a significant problem; moreover, police services are increasingly concerned about their role in the community management of PMI—and in the perceived failure of the mental health system.

To be clear, the problem goes far beyond the well-publicized police shootings of people with mental illnesses. A recent report by the Vancouver Police identified a number of other relatively high profile situations involving police and PMI (Vancouver Police Department, 2013); in these instances, the police were responding to violent behaviour on the part of an apparent PMI. They noted, for example, the following incidents:

- A man committed a series of three vicious assaults on elderly women, kicking and stomping each of them in the head.
- A man walking his dog in the evening was stabbed multiple times by a complete stranger. During the stabbing the victim was eviscerated with his internal organs being visible to responding officers.
- After leaving a comedy show, two innocent bystanders narrowly avoided being killed in a shooting, with one victim being grazed in the head. The suspect then fatally shot himself in the middle of the street.
- A five-year-old child and her mother were attacked while walking down a street. A mentally ill woman approached the pair, grabbed the child and proceeded to violently swing the child around the sidewalk by her hair. When the mother stepped in to protect her daughter she was thrown head-first to the ground and sustained serious facial injuries.

On the other hand, most police interactions involving a PMI are less notable; even those that are serious, seldom end in tragedy. One rarely hears of the successes, the stories such as an incident in London, Ontario, in which a woman in her 60s left hospital and went to her home where she lived alone. Police became involved when she was reported to be suicidal. They brought a psychiatrist to the scene along with the Emergency Response Team (ERT) and a crisis negotiator. The psychiatrist was able to learn that the woman was diabetic and circumstances warranted concern about her immediate physical health. He was able to assist the negotiators, spoke directly to the woman, and after an hour or so, convinced her to come in from the balcony, from which she was threatening to jump. The situation was solved successfully and she was brought back to the hospital for further treatment.

[10] The term recruit is police jargon for a new police officer. Although it is usually used while the new officer is completing basic training, it is often also used for at least the first year of the officer's service.

[11] While institutions of police learning are variously called a police college or a police academy, for the purpose of this report they are called a police academy.

[12] The report is available at: http://www.mentalhealthcommission.ca/English/document/438/study-police-academy-training-and-education-new-police-officers-related-working-people-

[13] The report is available at: http://mentalhealthcommission.ca/English/document/431/police-interactions-persons-mental-illness-police-learning-environment-contemporary-pol

[14] The reason being that the generation and collection of such data across Canada is haphazard and often incomplete.

Notwithstanding the nature and seriousness of individual interactions between police and PMI, it is widely accepted that there are too many. While most will never garner attention on the front page of a newspaper, for the people involved all incidents are serious and potentially traumatic. How do we ensure that police personnel are well prepared to deal with these potentially difficult situations? This report will provide assistance in achieving that.

The report is comprised of:

1. A summary of the 2008 report about the (then) state of academy/basic police education/training;
2. A summary of the 2010 in-service education and training report, particularly outlining the foundation and rationale for the TEMPO model;
3. An update of outcome research and data about the effectiveness of training and education in this area;
4. The findings of a 2013/2014 scan of Canadian police academy basic training and education about mental disorders including mental illness;
5. The findings of a 2013/2014 scan of Canadian police services to determine the nature and state of in-service education in this area, with particular reference to modification of the TEMPO model;
6. Conclusions and next steps, including necessary revisions to the TEMPO framework.

A note of caution when reading this report: the causes and outcomes of interactions between police and PMI are complicated and often outside the control of police alone. They reflect situational factors, social issues and resource issues as much as 'police' issues. While education and training is one essential requirement in order for the situation to change, it is far from being a sufficient component. Even the best education and training will not change the 'big picture' in terms of the numbers and frequency of interactions between police and PMI. Police personnel can only make use of options and information that are provided to them in making case-by-case decisions; they cannot compensate for bias and stigma in the community, lack of mental health resources and insufficient mental health research. The situation, overall, is larger than simply educating police personnel. A concerted systems approach is necessary that engages all the relevant parts of not only the criminal justice system but also, for example, the health system and human services systems.

3. Methodology

The aforementioned 2008 and 2010 reports led to a number of conclusions and recommendations about the nature and content of police education and training in this area based on the available research and programs at that time. The fundamental questions for the present study were:

- Compared to 2008-2010, what is the nature and extent of current police personnel learning in this area? Has education/training changed or evolved in the past five years, in its fundamental nature, amount or content?
- Has police education/training evolved to reflect the recommendations made in the 2008 and 2010 reports, in terms of content and design?
- Has Canadian police education/training been evaluated in any way in order to inform continuing development and evaluation?
- Are there data, observations or new education/training media that would inform the further development of the TEMPO framework?
- What are the current strengths and gaps in curricula? and
- What recommendations are necessary for ongoing development and implementation?

As was the case previously, the study of education and training in this area takes place at two levels—the basic training for new police officers/cadets, and at the in-service level for police personnel.

In order to address these questions, the following strategies were employed:

- The peer review published literature was reviewed, focusing in particular on the period 2010 to the present, to complement the literature reviews of 2008 and 2010 and to identify further research addressing the questions posed;
- Researchers and key contacts known to be working in this area, both within Canada and internationally, were contacted about developments;
- "Grey" literature was identified and reviewed to the extent possible;
- All Canadian police academies and institutions that provide basic police training and education were surveyed (Part I);
- All Canadian police agencies were surveyed about their current practices in regard to in-service education and training (Part II).

Part 1: Training and Education at Canadian Police Academies:

In Canada, basic police training takes place predominantly at police academies, which may be either free-standing facilities specifically dedicated to training, or in-house academies in which a specific police agency trains its own future police officers. The freestanding academies in Canada that participated in the present survey were:

- Atlantic Police Academy;
- L'École nationale de police du Québec (ENPQ);
- Ontario Police College;
- Saskatchewan Police College; and
- Justice Institute of British Columbia.

Police agencies surveyed that train/educate their own new police officers/cadets were:

- Calgary;
- Edmonton;
- Lethbridge;
- Brandon;
- Halifax;
- Winnipeg; and
- RCMP.

A few police services provide additional 'in-house' basic training to new police officers/cadets in addition to the provincial training; those surveyed were:

- Toronto Police;
- Peel Regional Police;
- Halton Regional Police;
- London Police; and
- Ontario Provincial Police.

Part 2: In-Service Training and Education at Canadian Police Agencies

A list of all Canadian police agencies was compiled based on *Police Resources in Canada 2012* published by the Canadian Center for Justice Statistics. Subsequently, a contact person in each organization was determined. This person was variously the chief of police, the person in charge of in-service 'training,' or another person identified as responsible for this area of activity. In the case of the RCMP, direct contact was made with their Pacific Region Training Center (PRTC) in British Colombia.

Over 200 police agencies were identified and surveyed. In total, 32 responses were received from police agencies ranging from relatively small (under 50 officers) to very large (over 5,000 officers).

Data/Information Collection.

Each of the agencies referred to above (that is, Part 1 and Part 2) were asked to complete a questionnaire, which included requests for:

- Information about the nature and content of their education/training in this area, as assessed against the recommendations from the 2010 TEMPO model (**Appendix A**);
- Copies of course outlines or any other pertinent written materials;
- An estimate of the total amount of time dedicated to the topic;
- Any specific learning objectives, competencies or other outcome criteria;
- Any assessment/evaluation of the education/training or measurement of outcomes including evaluation criteria and processes used;
- An informal self-assessment of the strengths and weakness of the training; and
- Other relevant information.

Further input and information was obtained during the conference *Balancing Individual Safety, Community Safety and Quality of Life: A Conference to Improve Interactions with Persons with Mental Illness* hosted jointly by the Canadian Association of Chiefs of Police (CACP) and the Mental Health Commission of Canada in Toronto on 24-26 March 2014.

The authors of the present report are grateful to the speakers as and delegates who represented a unique cross section of, for example, police personnel, mental health professionals, government policy analysts and persons with lived experience. Their input and comments enhanced the content of the report.

CHAPTER 2
PROCEDURAL JUSTICE AND A CLIENT/CUSTOMER FOCUS: THE VOICE OF PEOPLE LIVING WITH MENTAL ILLNESSES

All Canadians—including those living with mental illnesses—not only expect public sector services to be delivered with a client/customer focus but they expect to be treated fairly and with respect in accordance with principles of *procedural justice* (**Table 1**).

Table 1: The fundamental principles and expectations of contemporary-policing

THE FUNDAMENTAL PRINCIPLES AND EXPECTATIONS OF CONTEMPORARY-POLICING:	
• due process, equity and fairness (procedural justice);	• teamwork;
• ethical practice;	• decentralization of authority and decision making;
• community confidence and trust;	• total involvement;
• responsive to the environment;	• participative leadership;
• a customer and client focus;	• increased communication;
• consultation and collaboration with the community;	• internal and external alignment; and
• quality and valued customer/client service;	• outcome focused.
• continuous evaluation, continuous improvement and change;	

Dantzker, 1999; Hoover, 1996; Swanson, Territo and Taylor, 1998; Carter, Klein and Day, 1992; Tyler, 2004; Tyler, 1990; Kennedy and Moore, 1997.

In their daily work, police personnel are faced with a myriad of situations, most of which do not require the enforcement of the law in the narrow sense.[16] However, many situations require a police officer to be adept at the de-escalation of conflicts, conflict resolution and mediation. All of these require the application of superior interpersonal communication skills and a service-oriented focus. Moreover, police officers often find themselves, according to Worden (1989), in situations of "ambiguity and uncertainty" (p. 671). Egon Bittner (1990), a highly regarded policing scholar cited by LaGrange (2003), concluded a police officer must have:

> *the ability to analyze situations, to determine which of several (potentially conflicting) procedures or rulings to apply, and be able to arrive at such determinations quickly – these qualities may require considerable knowledge, intelligence, and judgment, and these are the qualities that are believed to be most directly relevant to higher education (p. 92).*

Some situations, such as those in which the subject appears to have a mental illness, require superior judgment, the judicious use of discretion and a significant degree of "insight into the dynamics of human problems" (Worden, 1990, p. 589). For instance, Watson et al. (2010) pointed out that the literature suggests PMI who come into contact with the police are likely to be less distressed if they feel they are treated "fairly and in good faith" (p. 2). This is informative when designing and delivering education/training to police personnel.

[16] Studies conducted in the US and the UK found that, depending on the jurisdiction, only 15-25% of a police officer's work was crime related and it might be closer to 7-10% when calls-for-service are more closely analyzed (Bayley, 1996: 40).

While the designs and delivery of police education and training relative to police/pmi contacts vary, there is an increasing tendency, including in Canada, to use the CIT training framework[17] at least as a base for their own model. The important elements of this framework, according to Watson et al. (2010), are the building of police relationships with mental health resources and the

> *shifting [of] police roles and organizational priorities from an exclusively traditional law-enforcement model, which reluctantly dealt with persons with a mental illness to a more service-oriented model that responds to mental illness as a community safety and public health concern (p. 3).*

As explained by Coleman (2012), *a client/customer service orientation* is a fundamental principle and expectation of contemporary (community) policing (**Table 1**). Key to such an approach is the conduct of police personnel. Watson et al. (2010) stated the literature is clear about the outcome of positive and respectful behavior by police. That is, when police exercise their authority in a procedurally just manner, the result is community cooperation and respect; on the other hand, disrespectful behavior of police officers reduces the likelihood of public cooperation (pp. 3-4). For instance, Watson et al. (2010) citing McCluskey (2003), pointed out that "persons with mental illness [who perceive] their treatment at the hands of police as respectful and dignified rather than coercive may be more likely to comply with officer requests" (p. 5). Watson et al. (2010), citing Lind & Tyler (1988), Tyler (1990) and Tyler & Lind (1992), concluded that essential to satisfying procedural justice are:

- **voice/participation:** including having the opportunity to present one's own side of the dispute and be heard by the decision maker—the police officer(s);
- **dignity:** being treated with respect, politeness, and dignity and having the decision maker acknowledge the subject's rights; and
- **trust that the authority:** the police officer(s)—is concerned with the subject's welfare (p. 3).

The work of scholars such as Watson et al. (2010), Lind and Tyler (1988), Tyler (1990), Tyler and Lind (1992), Bittner (1990), McCluskey (2003) and Worden (1990) make it clear that treating people fairly and leaving them with a perception of fairness is important to the establishment of relationships and a better understanding of the situation by all parties. This decreases the probability of escalating a potentially volatile situation. Moreover, it not only improves the situation in-hand but also contributes to improved interactions in the future with the same person(s) and/or those with whom these persons have shared their experience.

While persons with mental illness are not necessarily more likely to be violent than those without mental illness, the literature is clear that a potential for at least some level of violence can be present in some of these interactions. According to Ruiz and Miller (2004), the following five situations can potentially lead to physical confrontations between police officers and persons with mental illness and, thus, awareness is required on the part of attending police personnel:

- Fear on the part of the person with mental illness because they are unfamiliar with the attending police officers;
- The reluctance of the person in mental health crisis to cooperate with or comply with police directions;
- Fear due to the police uniform or the overpowering attitude of the police officer(s);
- Lack of understanding or empathy by police officers for the plight of the persons with mental illness; and/or
- Fear that police officers harbour for persons with mental illness.

The fifth one, of course, speaks to stereotypes and the stigma of mental illness held by many including some police personnel. The appropriate response to each of these five situations must be clearly embedded in the learning of police personnel.

As Amanda Butler (2014) clearly stated,

> *Traumatic violent encounters are especially relevant for perceived procedural justice because the strength of the experience may outweigh any future or past positive experiences (p. 64).*

As is also well articulated by Butler (2014, p. 64), negative interactions with police are difficult to reverse when it comes to lasting perceptions of police. Police personnel, therefore, must be very aware of "severe and lasting consequences of negative interactions with police." Procedural justice and a customer/client focus are critical. Again, this is important to address not only during the education and training of police personnel but also in the hiring of police personnel, and the ongoing supervision, management, and leadership of personnel.

Procedural justice (due process, fairness and equity) and a *client/customer focus* fit together; they are both fundamental principles and expectations of contemporary

[17] Although the literature usually portrays CIT and CIT training as homogenous across jurisdictions, caution is necessary when interpreting results of evaluations and research concerning CIT and CIT training. While the framework appears to be relatively consistent, it is not always clear that content and the delivery are common across jurisdictions.

policing (**Table 1**). They both require the application of appropriate verbal communication skills, the building of rapport, an understanding of mental illness and the establishment of relationships. Procedural justice and a client/customer focus also mean it is necessary to have knowledge of community resources for purpose of referrals and to have a good understanding of the legislation within which police personnel must work. The desired outcome is that service 'recipients' feel they were well treated. This must influence the design and delivery of police/mental health learning in that attention is required not only to ensure understanding of available resources and processes, but also to (1) understand the skills that build rapport and equip police personnel to de-escalate sometimes-volatile situations and (2) an appreciation of the rights of the PMI.

In Canada, the voice of people with mental illnesses is not as loud as it could be in the police context. As will be noted later, it is still a minority of police services which include PMI in their education and training. The present study indicated only one police organization which had an advisory committee or panel of people with mental illnesses (such as the ones that police often have involving members of other vulnerable or disadvantaged populations, or racial or ethnic groups). It is not clear which police agencies make use of community surveys that focus on issues of concern to the mental health community, or that target members of this community for direct input and feedback.[18]

What do people with mental illnesses expect from their local police? Not surprisingly, they want police to be educated about how to handle situations they might be involved in. Over ninety percent of respondents in the landmark study by Brink et al. (2011) indicated this was an area they considered to be very or *extremely important*. For instance, in the words of one respondent:

> *I think that training in mental health is really important for the police officers. I really think it makes a difference when they know what to look for or explore. … So they know how to deal with the situation. … Without coming at it from a criminal point of view. … They can look at it more in context or if someone isn't in the common reality then at least they can understand why they're answering the way they're answering or why they're acting the way they're acting (p. 75).*

Many participants in the Brink et al. (2011) study spoke about previous police interactions in which the officer(s) did not appear to understand the basics of mental illness, including how it might affect a person's cognition and behaviour. The participants felt that increasing knowledge about mental illness, including how it is experienced and how it affects an individual, would produce improvements in police officers' attitudes and behaviours. Participants also spoke of how police officers should be trained to communicate with people who have mental illness in a more respectful and effective manner. This included using supportive language, respecting confidentiality, and using verbal de-escalation skills.

Several participants suggested that police officers should learn how to be more compassionate, empathetic, and respectful in dealing with situations involving people with mental illness. They indicated that police officers should be to be taught to adjust their response style when interacting with someone who has a mental illness, especially in the context of a mental health crisis. Several participants also discussed the need for police officers to become more adept at using non-aggressive, non-violent approaches when dealing with situations involving people with mental illness. Many indicated that a police officer's initial response is a major factor that influences whether an interaction will escalate into aggression and violence.

Participants' narratives contained several additional recommendations for improving interactions between the police and people with mental illness; these included strengthening police connections with the mental health community, rewarding positive policing, improving human resource practices, creating positive role models, increasing police accountability, and ensuring that mental health professionals are involved in police calls for service. Many participants suggested that if police had the opportunity to interact with people with mental illnesses when they were NOT in crisis, police might then see things differently when they were in crisis.

Watson and Angell (2012) also noted the relationship between a PMI's perception of procedural justice and their level of cooperation/résistance with police. Again, this speaks to the importance of addressing issues related to stigma in police education. While the relationships between these variables are complex, it appears that generally, PMI are more likely to cooperate and less likely to be resistant when they perceive that they are being treated fairly.

Although further research is necessary, of interest in the context of ensuring procedural justice there are indications in the literature that female police personnel are more effective at defusing potentially volatile situations (Balkin, 1988; Bell, 1982; Weisheit and Mahan, 1988 as cited in Breci, 1997, p. 155). This, as Butler (2014) stated, is "especially relevant to policing with persons with mental illness." The effective defusing and de-escalation, she adds, are "critical to preventing injury and increasing perceptions of procedural justice" (p. 54).

[18] All or part of the MHCC's BC study (Brink et al, 2011) might be a suitable survey model.

Are procedural justice principles and a client/customer focus receiving sufficient attention in Canadian police/mental health learning? This is an important component of police learning that, as the reader will see later in the present report, is not always well covered. Police agencies and their mental health partners, where applicable, are, thus, urged to ensure both are included as the overarching framework for police/mental health learning and police/pmi interactions.

CHAPTER 3
SUMMARY OF THE 2008 AND 2010 REPORTS ABOUT POLICE MENTAL HEALTH LEARNING

4. Summary of the 2008 Study of Basic Police Mental Health Education and Training

In 2008, 14 Canadian police academies that provided basic training to new police officers were surveyed in order to determine the nature and extent of training and education concerning mental illness that is included in their basic training. Not surprisingly, there was considerable variation among academies.

Some of the findings were encouraging—such as all police academies had included at least a minimum of curriculum specifically related to working with people with mental illnesses in their basic training programs, since at least 2000. Virtually all police basic training programs included information about signs and symptoms of mental illness, verbal strategies for interacting with people with mental illness, strategies for dealing with aggression, dealing with suicidal people, and the basics of mental health law. However, it was difficult to determine the extent to which these topics were covered in each academy, given that the number of hours varied significantly across jurisdictions. At the time of the 2008 study, the number of training hours varied from only one hour to more than 24 hours. About half of the academies reported fewer than 10 hours of training.

The results of the 2008 study also indicated that training in this area could occur in a variety of different contexts. While it is relatively easy to document the freestanding curriculum which is dedicated specifically to topics related to mental illness, most academies also reported that topics related to interactions with people with mental illness also occurred in a variety of other contexts such as during use of force training, tactical communications, law, and officer safety.

However, of note, upon closer scrutiny issues related to interactions with people with mental illness were not included in use of force training in the majority of academies or were not well included and integrated; this was of concern, given that research has documented that people with mental illnesses are disproportionately represented in use-of-force incidents. A similar observation can be made about the failure to include issues related to communication with people with mental illness during training related, for example, to tactical communications.

The 2008 study also reviewed mechanisms by which basic training was provided. Almost all courses in operation at the time of the 2008 report indicated training was conducted in the context of a large lecture format. This, of course, is not the optimal learning mechanism for adults. About a third of the respondents did not include any role-play or simulation and only about a quarter made use of online resources, training films or videos. Given the wealth of resources available at the time, it appeared unfortunate that a wider variety of teaching methods were not employed. A noteworthy exception to the above was the basic police mental health training at the RCMP Academy; this included relatively little formal lecture material but relied heavily on problem-based learning (PBL).

However, probably the most glaring gap in basic training and education was the almost universal failure of academies to involve a person with a mental illness or families of people with mental illnesses in the design and/or delivery of training. For instance, only two of the 14 academies surveyed reported they included the perspective of a person with a mental illness. Given that the research literature indicates exposure to a person with mental illness is probably the most powerful tool for changing attitudes toward mental illness, this was a significant omission.

Many police academies also did not include either mental health agencies or mental health professionals in the design or delivery of their training. Only five of the 14 respondents included presentations by mental health agencies; eight of the 14 included presentations by mental health professionals.

The 2008 report made recommendations for basic training at the academy level that included:

- police academies may want to strive for the type of comprehensive training that was offered at that time by the Royal Newfoundland Constabulary as well as the Atlantic Police Academy. These programs included

not only a significant number of hours of direct training related to working with people with mental illnesses but also included a variety of learning media and direct contact with both people with mental illnesses as well as mental health professionals;

- all training programs should include presentations by, and interactions with, people who are actually living with a mental illness and their families as well as presentations by mental health professionals;
- there is a need for the police community to work jointly to develop or encourage a common core curriculum for police academies; ideally by making use of existing materials in order to minimize duplication of efforts across academies;
- police agencies or academies which rely on external prerequisite basic training outside of their academy, such as the CEGEP situation in Québec, might want to ensure that training related to working with people with mental illness is specifically identified in that external course content; and
- programs which rely on identification of competencies and problem focused approaches, such as at the RCMP Academy, should be encouraged to develop specific goals and competencies which identify issues related to working with people with mental illnesses to ensure that all primary goals related to this client group are indeed covered in this diffused learning environment.

Notably, at the time of the 2008 report, the TEMPO model had yet to be developed; as a result, the core components of education and training in this area had not been identified or defined clearly. The 2008 study also did not specifically ask the responding academies whether they had established learning goals, objectives, or competencies related to mental illness for inclusion in the curriculum, or outcome measures. Indeed, one of the major objectives of the 2008 study and the subsequent 2010 study was, in the absence of rigorous evaluation and research, to identify and delineate those areas identified by police agencies as essential in order to ensure that these content areas were included in any proposed prototypic model.

5. Summary of the 2010 Study of Police Mental Health In-service Education and Training

This study flowed logically from the basic training study of curricula related to mental illness in Canadian police academies. Whereas the goal of the 2008 study was to learn about the context and manner in which Canadian police officers were educated and trained during 'basic-training,' the purpose of the 2010 study was two-fold. First, to determine what types of 'in-service' police/pmi education and training programs existed and second, in the context of the relevant literature, to identify and recommend a contemporary model/framework of police/mental health education and training for police personnel. The 2010 in-service study, unlike the 2008 academy study, did not constitute a complete review of all education and training, nor did it address the issue of who had received how much education and training.

The 2010 study included:

- a review of both the published literature and grey literature which spoke to the assessment of such programs, their efficacy and their outcomes;
- the identification of police learning programs and training methods both within Canada and internationally that were identified as high quality and which had in some fashion seemed to meaningfully address the broad issue of police interactions with people with mental illness;
- a review and discussion of factors other than content that contribute to the efficacy of police education and training in general and in this area in particular; and
- the integration of all of the above information, leading to the development of the proposed TEMPO model of learning, which could be held out as meeting both the necessary and sufficient conditions for police personnel learning in this area.

Since one of the purposes of the present study is to assess the degree to which the recommendations of the 2010 report were operationalized by police academies and police organizations, it is useful to refer to the 15 recommendations of the 2010 report. These can be found in Appendix A. Recommendations I and II, which follow, formed the foundation for the remaining 13 recommendations. Recommendation III was the establishment of a comprehensive multi-level framework (TEMPO) for the design and delivery of police/pmi learning.

Recommendation I:

A Framework for Learning Design and Delivery

That notwithstanding the many important elements of police/mental health learning design and delivery, the overriding theme should be:

- a focus on anti-stigma education to challenge the attitudinal barriers that lead to discriminatory action; and
- ethical decision-making, human rights protection and social responsibility.

Recommendation 2: *The Learning Spectrum*

That, at a minimum, the objectives of the *Learning Spectrum*[19] necessary to prepare police personnel with regard to police/pmi encounters are:

TO UNDERSTAND:

- the importance of adherence to the fundamentals of contemporary policing, such as:
- a client focus;
- procedural justice;
- relationship building;
- an outcome focus; and
- a multi-agency approach
- the role of police personnel in encounters with PMI; and
- the role of mental health professionals, family and community supports in police encounters with PMI, consistent with a *systems approach*.

TO UNDERSTAND:

- the symptoms such as hallucinations, delusions, paranoia, thought disorder, mood disturbances, intellectual impairments, memory problems, dis-inhibition, behavioral disturbances and other signs and symptoms that may accompany major mental illnesses and related problems;
- knowledge about mental illness sufficient to make an assessment about the influence that mental illness may be having on a person's behaviour and ability to comprehend and respond to a police officer's requests or instructions; and
- the interplay between culture, race, gender and other person-specific characteristics that affect the experience of mental illness.

TO UNDERSTAND:

- the importance of fostering of police/mental health agency relationships;
- the importance of information sharing protocols between police and mental health agencies;
- local mental health legislation sufficient to take appropriate action when necessary;
- other relevant legislation including that which defines privacy rights and human rights;
- the function of local mental health agencies and options and where/how to call for consultation and/or assistance and/or to make referral(s); and
- organisational policies and procedures relevant to Police/PMI encounters.

TO UNDERSTAND:

- how to use communication skills and de-escalation techniques for defusing and calming situations involving PMI;
- how to determine whether it is likely that the PMI is capable of understanding and responding to the directions given by police; and
- that the standard police procedures, which might typically disarm a non-mentally ill person, stabilize the situation or lead to co-operation, might have the opposite effect on a person experiencing a mental health crisis.

TO UNDERSTAND:

- the relationship between mental illness and dangerousness; and
- be able to reasonably accurately assess suicide risk and how to contain the situation and/or when to intervene accordingly.

TO UNDERSTAND:

- how to appropriately adjust decision-making regarding when to apprehend, when to arrest, when to divert/refer, when to seek additional input;
- how to apply problem-solving in the police/mental health environment; and
- how to apply ethical decision-making.

Recommendation 3: *Learning Model-TEMPO*

TEMPO is a comprehensive multilevel framework for the design and delivery of police learning relative to interactions with persons with a mental illness (**refer to Appendix A**). The utility of TEMPO is twofold. First, it provides a framework for the Canadian police/mental health environment that, by using the learning spectrum in Recommendation II, addresses what is necessary to prepare police personnel throughout their career including assignments to specialized work units. Second, it is a tool for the gap analysis of existing police/pmi learning programs. Such a tool enables assessment of existing programs and the identification of what additions or changes might be necessary.

In order to advance the concept of TEMPO for Canadian policing, from 2011-2013 the MHCC used several fora. The feedback of one forum, in particular, is helpful in considering adjustments necessary to TEMPO 2010. In March 2012, the MHCC brought together a group consisting of police representatives, mental health professionals, community advocates, persons with lived experience and stakeholders to discuss TEMPO. The roundtable produced a series of principles and suggested actions for advancing

[19] The Learning Spectrum is applicable to all police/pmi learning including basic training and in-service training.

the adoption of TEMPO. The principles that would be fundamental to the future success of TEMPO included:

- a continuous, multi-stage learning approach;
- buy-in from all levels of police agencies; and
- developing and delivering training with the meaningful inclusion of people with lived experience, mental health workers, local hospitals, and community advocates.

Some main points of agreement among participants were:

- TEMPO should aim to provide ongoing, integrated learning that improves the quality, outcomes and perception of police/pmi interactions;
- The TEMPO framework might best serve as a gap analysis tool for organizations to use to assess their own needs, strengths, and areas of weakness;
- TEMPO should not be viewed as a fixed curriculum to be adopted as standardized education and training across the Canada; instead, it should be a flexible, modular learning approach (a framework) that values the lived experience of community members and persons with mental illness, experiential learning, and co-operation across the entire spectrum of police services and stakeholders;
- TEMPO should integrate easily into existing learning modules, practices and methods to provide broad, continuous and unified messaging and education; and
- TEMPO should recognize and remove stigma, modify behaviour and practice, and ultimately improve outcomes

It was agreed that essential to the success of TEMPO would be the inclusion of mental health professionals and PMI in both the creation and delivery of content, as well as continuous reinforcement across all learning modules and buy-in from all levels of police personnel—with the TEMPO clearly supported and valued by police leadership. The discussion then shifted to next steps: actions required to advance TEMPO from concept to curriculum. Key suggestions included:

- Creating tools to assess current gaps in training;
- Establishing training scenarios and gathering learning material focused on TEMPO-aligned competencies;
- Analyzing best practices to improve PMI/police interactions through de-escalation and other means; and
- Identifying relevant stakeholders who have the ability to support adoption of the TEMPO model.

Most importantly, it was the consensus of the group that while there remained a need for overall curriculum development, TEMPO is not a training tool per se but an umbrella approach that police organizations can use as a framework to assess their own progress in training, to identify gaps, and to use as an aspirational document for police agencies to create appropriate learning programs.

CHAPTER 4
CURRENT STATE OF POLICE MENTAL HEALTH LEARNING

Before presenting the findings of the two Scans subject of the present study, it is useful to consider the following new, or relatively new, programs found not only in Canada but internationally. These programs have utility in total, or in part, in the Canadian scene.

6. Notable Programs from outside of Canada

Australia

Project PRIMeD: police responses to the interface with mental disorder:[20]

This was a collaborative research project between Monash University Centre for Forensic Behavioural Science and the Victoria Police in Australia investigating current police practices, policies and procedures for dealing with people with mental disorders as well as investigating interactions with mental health service delivery agencies. The purpose of this project was to explore the nature, purpose, and outcome of police contacts with people who are mentally disordered. The six key research questions that underpinned this program were:

2. What is the current level of knowledge of personnel of the Victoria Police concerning mental illness, what attitudes do officers hold toward those with mental illness, and what are their relevant experiences?
3. What are current initiatives that exist within the police, or between police and mental health services, to deal with people with mental disorder and how are extant initiatives perceived by consumers, justice, health and nongovernmental agencies and organizations?
4. How do police currently identify mental disorder and how accurate are these judgments?
5. How often do the police come into contact with people with mental disorder and are the processes and outcomes of these contacts different than with those they have with people without mental disorder?
6. What are the gaps in police knowledge, training, service integration and delivery that exist and how can they best be addressed?
7. What are the types of offenses and patterns of offending that bring the police into contact with the mentally ill?

While this project clearly addressed a wide range of questions beyond the scope of the present report, there were a number of findings directly relevant to the issue of the design and implementation of education and training. These included the following:

- police officers' understanding of mental illness was more likely to be based on their on-the-job training and experience of mentally ill people in their private life, rather than from information gained from more formalized courses provided by Victoria Police or other external agencies; an apprentice style approach tended to be the norm;
- most exposure to people experiencing mental illness occurring during periods of crisis;
- while most police officers were reasonably able to identify the appropriate behavioral signs of mental illness, there was a also a tendency to identify aggression and high pain tolerance as signs of mental illness;
- negative attitudes toward people with mental illness including pejorativeness and the lack of awareness (e.g. officers who "don't know what they don't know") tended to be associated with a lower likelihood of making use of mental health resources and a tendency to either walk away from a situation or resort to more restrictive outcomes such as arrest and mental health act apprehensions; this finding was interpreted as consistent with previous research that found police officer decision-making was related to inferences regarding suspects' dangerousness;

[20] Available at http://www.med.monash.edu.au/psych/research/centres/cfbs/project-primed/

- even when mental health services such as mobile response teams were available, the vast majority of officers were unaware of their availability;
- when officers were equipped with an appropriate vocabulary for describing people with mental illnesses, communication between police officers and mental health professionals improved;
- people with mental illnesses were significantly over represented in fatal encounters with police, with more than 50% of such fatalities involving a person known to have a diagnosed mental health disorder;
- people with mental illnesses were also over-represented in other use-of-force encounters, although the increased rate was primarily attributable to use of force at the lower end of the scale. Police tended to me more likely to threaten to use force against persons with a history of mental illness, but they were not more likely to use more severe forms of force.

There are clear implications for the design of learning based on the observation that police officers acquire most of their knowledge, whether correct or not, through on-the-job experience and personal experience as opposed to formal training. Obviously, the type of knowledge gleaned from these practical experiences is uncontrolled. While an apprenticeship model may be the method of choice for learning many skills, the difficulty in this instance is readily apparent. If more experienced officers do not have the appropriate skill set—for example, if they display stigmatizing attitudes—then newer officers will model this style. In general, literature (including this body of work) suggests that more experienced officers are less likely to employ restrictive measures with people with mental illnesses, as compared to relatively junior officers. However, while this is an encouraging finding, it remains the case it is likely that whatever methods have been used in the past continue will continue to be used as long as informal education is primary. The fact that education did not seem to have a significant impact on understanding mental illness may have been attributable to characteristics related to the specific training (e.g. not enough training, not the right curriculum) or it may reflect more widespread issues within a police service as related to interactions with PMI.

Once again, the Victoria Police, Australia, strategy indicates that education is only one aspect of a comprehensive approach to the improvement of police interactions with PMI. As stated above, the solution requires a structural *systems approach*. Nevertheless, in the design of education and training programs, it also remains the case that operational credibility of the trainers and practical applicability are significant concerns. As well, the findings reinforced the need to integrate education and training about mental illness into use-of-force training.

New South Wales (Australia) Police

Another comprehensive Australian project was led by Victoria Herrington and Rodney Pope (2013) at Charles Sturt University in conjunction with the New South Wales Police.[21]

In 2008, the New South Wales Police initiated a pilot project to provide enhanced mental health training to some front line officers in three geographic areas. The implementation of this project, and the accompanying reports and publications that describe its outcomes, provide an outstanding example of the complex issues and dilemmas that face police agencies in their attempts to wrestle with issues related to their interactions with people with mental illnesses. This program identified four key aims:

1. reduce the risk of injury to police and mental health consumers during mental health crisis events;
2. improve awareness by frontline police of risks associated in dealing with mental health consumers and strategies to reduce injuries to police and consumers;
3. improve collaboration with other government and nongovernment agencies in the response to a management off mental health crisis events; and
4. reduce the time taken by police in the handover of mental health consumers to the healthcare system.

The Mental Health Intervention Team (MHIT) project was modeled in large part after the Crisis Intervention Team framework from the United States. Its aim was to train first responder police officers as specialists to respond to individuals with apparent mental health concerns. The MHIT model involved a central project team which was responsible for the development and delivery of training. A superintendent/commander, who was also the corporate spokesperson for mental health within the police service, led this team. He was supported by an education development officer, an analyst and a clinical nurse consultant seconded from New South Wales Health.

The reader is referred to the original publications for details of the project overall and the research methodology that was integral to the project. Notably, there were a variety of stakeholders in this project including not only the New South Wales Police and New South Wales Health but also the ambulance service, a variety of nongovernment

[21] Refer to: Herrington, V. and R. Pope. (2013). The impact of police training in mental health: an example from Australia." Policing and Society: An International Journal of Research and Policy http://dx.doi.org/10.1080/10439463.2013.784287 as well as Herrington, Victoria, Katrina Clifford, Pota F. Lawrence, Sharon Ryle, and Rod Pope. (December, 2009). The Impact of the NSW Police Force Mental Health Intervention Team: Final Evaluation Report, Charles Sturt University Centre for Inland Health Australian Graduate School of Policing and New South Wales Police. https://www.police.nsw.gov.au/__data/assets/pdf_file/0006/174246/MHIT_Evaluation_Final_Report_241209.pdf

organizations and representatives of organizations comprised of people with mental illnesses. A wide variety of quantitative and qualitative measures were utilized to address outcomes related to the four goals identified above. In essence, the evaluation revealed: [22]

- most of the trained officers believed that the training changed their approach to mental health related events, and half thought that their behavior had changed considerably, particularly with regard to empathy;
- staff in the healthcare system supported these findings and indicated that they had observed improved understanding about mental health and a positive effect on the relations between the officers and the mental health system as a result;
- police generally felt more confident in dealing with people with mental illnesses, and this increased confidence appeared to be related to a tendency to spend more time talking to people with mental illnesses and possibly therefore to increased use of de-escalation techniques;
- there was only a marginal change in the perception of inter-agency collaboration between police and the healthcare system. Generally, there remains room for much improvement in this area; and
- it was unclear as to whether training had any significant effect on either the overall length that a mental health call required, or the amount of "dead time" involved in a mental health act apprehension.

This brief summary of the outcomes from the MHIT project does not do justice to the complexity of the issues that were addressed and the many interesting observations made in conjunction with this project.

There are numerous and complex issues related to mechanisms of data collection, simultaneous changes occurring across the police service, the indirect effects of having a small group of police officers trained and how that generalizes to other officers, and the perceptions of people outside of the police organization. As well, unfortunately, the publications deriving from this project do not include details about the nature and content of the training/education provided, and at present, the NSW research team is not at liberty to provide details. However, the training was four days in length and included substantial input from mental health consumer groups.

All of these factors make it difficult to determine what effect education and training per se might have on outcomes; identifying the essential components of necessary education and training is even more difficult. However, a police organization attempting to make significant and far-reaching changes in a manner in which they interact with the mental health system in general and with mental health consumers in particular would be well advised to pay close attention to the experiences and lessons that might be learned from this project. Of particular note are some of the authors' conclusions in regard to the role of police in their care of people with mental health problems. Herrington and Pope (2013) noted:

> *We are prompted to conclude by asking a deeper question: should police be involved in dealing with mental health issues at all?... Does police involvement in dealing with the [PMI] serve to reduce the risk of harm to all, or does it unnecessarily and inadvertently criminalize those who are in crisis, having done nothing wrong other than being unwell? If police are to incorporate mental health and other social problems as within their remit, then more needs to be done to reconceptualise the policing role as such, and to consider such activity as part of the core policing role (p. 19).*

Ireland

An Garda Siochana (Irish Police Service)

As is the case for many police services, the Garda has a variety of initiatives underway to improve relations between the mental health system and police. Their broad programs include cross-sectional meetings with a variety of government departments and agencies including the department of health, the department of justice, equity and law reform, the Irish prison services, the police, the health service executive and the national forensic mental health service. Memoranda of understanding have been established that also include the police ombudsman. There are a variety of initiatives including in-reach to prisons, court diversion programs and local agreements between mental health services and their corresponding police detachments. As is commonly the case in most jurisdictions, there is some basic training provided at the academy level as well as short courses related to human rights and mental health law and therapeutic management of violence and aggression.

However, of most interest in the current context is the focus on mental illness awareness in conjunction with the education and training of crisis negotiators and on-scene commanders for critical incidents. In the way of background, it is worth noting that the research team of five consultant forensic psychiatrists were able to provide 24/7 availability to either consult with police or attend critical incidents. As part

[22] Assessments of this project were mixed-method multi-phase analyses at three time points, and included both quantitative and qualitative data.

of the standard curriculum for both crisis negotiators and on-scene commanders, there is specific training provided related to mental health knowledge.

However according to Dr. Harry Kennedy, the executive clinical director of the national forensic mental health service, the key aspects of this program viewed as most effective include (1) an awareness of mental health issues which pervades all aspects of both courses; (2) the negotiators, on scene commanders and psychiatrists all participate in the courses and the training and exercises together, and (3) there is a focus on practical exercises which create what he describes as "total immersion total participation all day" events. Part of the training focuses not only on factual knowledge related to mental illness but also on appropriate use of specialists such as psychiatrists and other intermediaries such as families or friends. There is a strong focus on victim precipitated suicide and clear identification of how negotiations with a person experiencing a mental health crisis may require a different approach as compared to other types of critical incidents.

The USA

IACP Initiative: Building Safer Communities: Improving Police Response to Persons with Mental Illness [23]

In 2009, the International Association of Chiefs of Police (IACP) convened a summit sponsored jointly by the IACP, The Bureau of Justice Assistance, SAMHSA, and JEHT Foundation and the National Federation, and the National Coalition of Mental Health Consumer/Survivor Organizations (NCMHCSO). This summit resulted in the above document which identifies a number of policies, practices and programs that support a blueprint for change in regard to interactions between police and people with mental illnesses. This comprehensive report addresses a wide variety of initiatives and juncture points in the process. Their recommendations fall broadly into the following categories:

- Improving quality and accessibility of community mental health services;
- Community wide collaboration recommendations;
- Justice system decision point recommendations;
- Re-entry from jail, prison or juvenile facilities recommendations; and
- Legislative, funding and technical assistance recommendations.

It concluded with a "law enforcement action agenda." Following are the action items and recommendations that refer specifically to training and education:

- *local advisory groups should review training protocols for law enforcement and other agencies that service persons with mental illness in crisis and make recommendations to improve training curricula and methods as needed.*
- *law enforcement agencies should carefully review their training curricula to ensure that they collectively cover all topics necessary to prepare officers to respond to and communicate effectively with person with serious mental illness who are in crisis.*

These recommendations go on to note that such training should include:

  - Behaviours associated with DSM IV categories of serious mental illness and developmental disabilities;
  - Issues unique to youth with mental illness;
  - Co-occurring disorders;
  - Psychotropic medications and their effects;
  - De-escalation techniques;
  - Communicating effectively with consumers and family members;
  - Preventing unnecessary use of force;
  - Resources available in the local community;
  - Policies, procedures and decision-making tools for responding to mental health crisis situations;
  - Cultural sensitivity guidelines; and
  - Liability issue and concerns.

- *Law enforcement executives should determine, with input from their community partners, whether all officers will be required to participate in comprehensive CIT training or whether it will be a voluntary program with some agreed upon level of basic crisis intervention training required for all other officers;*
- *Cross training opportunities for mental health professionals and other stakeholders should be incorporated into law enforcement agencies' CIT training curricula;*
- *Law enforcement leaders should ensure that emergency service dispatchers receive specialized training to familiarize them with local guidelines regarding the appropriate crisis resource to which each type of call for service involving a mental health crisis should be referred;*
- *Law enforcement agencies should involve consumers of mental health services, their family members and advocates in planning, delivering and monitoring the impact of CIT and related training for officers and other crisis responders;*

[23] Available at http://www.theiacp.org/Building-Safer-Communities-Improving-Police-Response-to-Persons-with-Mental-Illness

- *The IACP should work with CALEA[25] to establish a model curriculum that law enforcement agencies can use in implementing, expanding or maintaining CIT programs (IACP, 2009).*

Excluding the last recommendation, which is directed at the IACP organisation rather than individual police/law enforcement agencies, of the 23 items identified in the report as "the Law Enforcement Action Agenda," only six relate specifically to training.

While the content of the IACP report, in general, provides some direction to police agencies, there are interesting observations to be made. First, there is an implicit endorsement of the CIT model as the gold standard in this area. CIT is the predominant model in the US, and its 40-hour training curriculum often sets the standard by which other programs are modelled and assessed.[26] However, it remains the case that we have little knowledge of what components of the model are effective, or whether the training in isolation (without the rest of the model) actually changes outcomes. Notably, the report unfortunately does not contain specific recommendations for outcome research and evaluation. In addition, while the report acknowledges the role of stigma within the community, there is no formal mention of the necessity of addressing stigma within the core training curriculum for police (although it might well be covered within some of the areas noted above).

The Commission on Accreditation for Law Enforcement Agencies (CALEA)

Concerning the last IACP recommendation, CALEA includes a number of items related to interactions with PMI.[27] Their website states:

Periodically questions arise regarding the applicability of standards and issues that should be considered when agencies are maintaining or demonstrating compliance for the purpose of accreditation. The following standard has recently been the focus of follow-up discussions during on-site assessments and therefore it is useful to review the standard's intent.

Standards for Law Enforcement 41.2.7 states - The agency has a written directive regarding the interaction of agency personnel with persons suspected of suffering from mental illness that addresses:

a. *guidelines for the recognition of persons suffering from mental illness;*
b. *procedures for accessing available community mental health resources;*
c. *specific guidelines for police officers to follow in dealing with persons they suspect are mentally ill during contacts on the street, as well as during interviews and interrogations;*
d. *documented entry level training of agency personnel; and*
e. *documented refresher training at least every three years.*

The intent of this mandatory standard is to require agencies to provide guidance to their personnel on how to interact and respond to persons suspected of being mentally ill. Guidance in the commentary addresses what to consider when developing training in this topical area and includes such subjects as access to the court system and applicable case law. Additionally, there is a strong emphasis placed on the use of subject matter experts in the development of staff training.

The question often presented regarding the applicability of the standard focuses on who needs to be trained. Most agencies employ a myriad of staff members that perform very different tasks. They include police officers, records personnel, administrative assistants, detectives, information technologist (IT), and others. Clearly not all of these personnel need training regarding interaction with persons with mental illness. To determine who should participate in this training the key phrase in the commentary section of the standard is "who may come in contact with the public."

For example, usually the IT manager does not work with or receive calls from the public. The responsibilities for that position generally require the individual to interact only with agency personnel, so training would not be necessary. On the other hand, the receptionist in the lobby of headquarters or a telecommunicator would need training because they are likely to come in contact with the public as a part of their work duties and responsibilities.

Additionally, the respective training may vary depending on the employees' position and job descriptions. Training for the receptionist, telecommunicator, and patrol officer could be different because how each position interacts with the public. The agency should determine how training is conducted and the structure of the curriculum based on work expectations and resources available to each type of employee.

[25] The Commission on Accreditation for Law Enforcement Agencies.

[26] This report refers frequently to CIT training. While a reasonably consistent CIT and CIT training framework has developed such that the literature usually portrays CIT and CIT training as homogenous across jurisdictions, caution is necessary when interpreting results of evaluations and research concerning CIT and CIT training. While the framework appears to be relatively consistent across jurisdictions, it is not always clear that content and the delivery are common across jurisdictions.

[27] Available at http://www.calea.org/content/mental-health-training

It should be noted that despite the aforementioned recommendation of IACP, a model training curriculum has not been developed.

> **Kent State Research Briefing 1: The Effect of Crisis Intervention Team Training on Police Disposition of Mental Disturbance Calls (2005)**[28] **and**
>
> **Kent State Research Briefing 4: Police conceptions of mental illness: Labels, causes, dangerousness and social distance (2005)**[29]

These research briefings summarize studies in which the authors used longitudinal survey data of police officers from a Midwestern city prior to and at least one year after crisis intervention team training in order to characterize officers' conceptions of mental illness and its perceived causes, their perception of the dangerousness of people with mental illnesses, and their desired social distance from someone with a mental illness. The studies used a questionnaire involving a series of vignettes which described a male subject with symptoms of schizophrenia. The results indicated that not unexpectedly, the desire for social distance from the individual increased for both trained and untrained officers when the officers believed that the subject was dangerous. However, regardless of the perception of dangerous, the CIT-trained officers desired less social distance from those perceived as having a mental illness compared to the non-trained CIT officers. These studies provide some support for CIT training, or training similar to that of CIT, as a mechanism for shaping the attitudes of police officers toward people with mental illnesses.

They also provide evidence that following CIT training, there was an increase in the number and proportion of calls that involved possible mental illness. The study authors hypothesized that this increase might have been attributable to both an increased awareness on the part of the public that a specialized service was available—and, thus, a greater likelihood to call police; and also an increased ability of police and dispatchers to accurately identify and categorise calls involving PMI.

7. Notable Canadian Programs

Some of the recent work in Canada has reflected a tendency to become more specific and focused in training. Rather than simply providing didactic information about mental health diagnoses, there seems to be a trend—at least in some areas—to move toward more focused and behaviourally oriented learning, or to address a narrower range of topics in a more focused manner.[30] However, before reviewing some of the newer Canadian initiatives, it is worth highlighting one of the more comprehensive and well-developed programs in Canada for some time and which spans both basic education and in-service education—that is, the matrix model of learning used by the Halifax Regional Police.

Halifax Regional Police (HRP)

Halifax Regional Police has taken an interesting approach in that they have constructed an education and training matrix with four levels of education/training. This was developed collaboratively by HRP and the joint response Halifax Regional Mental Health Mobile Crisis Team (MHMCT). MHMCT worked with the Dalhousie University Department of Psychiatry to develop integral pieces of the training program. That component which was developed by the Department of Psychiatry—*Recognition of Emotionally Disturbed Persons*—is now also delivered online through the Canadian Police Knowledge Network (CPKN).

100 level: Basic police training

- 3.5-day training with all 'recruit' classes; and
- 1-day training for lateral hires (summary and review).

Learning Objectives are:

- to introduce new police officers to broad categories of mental illness and mental health difficulties specifically as it relates to EDPs[31];
- to provide education on appropriate strategies and guidelines for responding to EDPs;
- to increase confidence, comfort and awareness in responding and resolving EDP presentations; and
- to understand and gain familiarity with the HRP policy and procedure in relation to EDPs and the Involuntary Patient Treatment Act (IPTA)[32] to understand the role of MHMCT, the service it provides and the relationship with HRP to introduce the MHMCT HRP officer triage card for EDPs.

[28] Available at: http://www.publicsafety.ohio.gov/links/ocjs_researchbriefing1.pdf

[29] Available at: http://www.publicsafety.ohio.gov/links/ocjs_researchbriefing4.pdf

[30] The following three initiatives could just as well have been included in the later discussion of current basic education or in-service initiatives. However, given their significance and that they are essentially stand-alone programs, they are included here.

[31] Emotionally Distressed Person or Emotionally Disturbed Person. These terms are often used interchangeably with PMI.

[32] This is comparable to the Mental Health Acts of other provinces.

200 level: Continuing education for first responders

- three-hour training for police officers who have not received the basic training (Level 100);
- provided four days per year for eight separate three-hour sessions/year;
- includes the CPKN on-line course; and
- a more interactive presentation with the MHMCT is under consideration.

Learning Objectives are:

- to provide continuing education to police personnel on broad categories of signs and symptoms of mental illness;
- to provide education on guidelines for responding to and resolving EDP calls to increase familiarity with the IPTA;
- to explain the role of MHMCT, the service it provides and the relationship with HRP; and
- to introduce the MHMCT HRP officer triage card for EDPs.

300 level: CIT training

- 40 hours of education/training;
- delivered at least twice per calendar year.

Learning Objectives are:

- to increase awareness and understanding of mental health issues and particularly better understand the perspective of mental health consumers and their families;
- to develop and enhance the participants' skills in interviewing and communicating with mentally ill persons referred to as EDPs;
- to increase the participants' knowledge of the most common mental illnesses and the most appropriate ways to approach and deal with these individuals;
- to increase skills in communicating observations when providing report in response to EDP calls;
- to increase the knowledge of community resources to assist the mentally ill in the community, their family members and the police officers dealing with them;
- to develop knowledge, skills and strategies for police officers to safely de-escalate a person in a mental health crisis;
- to increase understanding and knowledge of the MHMCT role, the IPTA and the relationship with HRP; and
- to increase understanding of the systemic relationship between the Emergency Department, Psych Assessment Services and HRP.

400 level: Advanced training for MHMCT police officers

- prerequisite is successful completion of the 300 level course;
- the one week Capital Health Mental Health Orientation which is delivered to all new mental health staff; and
- a minimum of four job-shadow shifts with MHMCT.

Learning Objectives are:

- to gain a more in depth working knowledge of mental illness: signs and symptoms, strategies for maximizing individual and public safety and appropriate strategies for responding to EDP;
- to increase communication skills and strategies to respond to EDP; and
- to increase skills in reporting observations both verbally and in reports.

In addition to covering a wide range of topics, the Halifax learning program includes a variety of instructional techniques (lecture, online, scenarios, experiential learning), features participation of people with mental illnesses, is a joint effort with local mental health professionals and agencies, and also provides training to call takers, dispatch personnel and victim services personnel. In many respects, the Halifax program is the 'gold standard' and as noted, was one example that influenced the development of the TEMPO framework. If nothing else, the Halifax model, along with other police agencies that use a similar model, challenges the common belief that comprehensive education and training is not possible or is too expensive.

> ***A Novel Approach to Training Police Officers to Interact with Individuals Who May Have a Psychiatric Disorder*** (Silverstone, Krameddine, DeMarco & Hassel, 2013)

As the authors aptly noted in their introduction,

> *most police forces have some training on psychiatric conditions, but the types of training very widely in nature, design, duration and timing.... to date, there has been very little research about the best training approaches (p. 344).*

They go on to note that most seminars focus on knowledge of specific psychiatric conditions; however, they continued, it remains unclear as to whether this knowledge might have an impact on the police officers' attitudes or behaviors. The project described in their study involved a one-day training session in which police officers interacted with trained actors in a series of scenarios carefully designed to mimic typical situations that police might encounter when interacting with persons with mental illnesses. Police officers were told that they would be evaluated on their ability to develop rapport with the subject, the ability to de-escalate

situations, use of appropriate body language, and the ability to demonstrate empathy.

Upon completion of each scenario, each officer received detailed feedback from both actors and supervisory personnel about the nature and appropriateness of their behavior. There was a strong focus on empathy training, in which the actors stressed their own reactions and their own experience of the police interaction. The focus of the program was specifically to change behaviours, rather than increase knowledge or change attitudes—a focus which the authors identified as different from the focus of most such programs.

One of the outstanding features of this program was the focus on the assessment of behavioural and attitudinal outcomes (in addition to simply documenting officers' satisfaction or evaluation of the training). Outcome measures included:

- attitudes toward mental illness;
- preference for social distance from people with mental illnesses;
- ability to recognize mental illness;
- knowledge of mental illness;
- ratings by supervisory officers of the participant officers' ability to communicate and interact with PMI;
- number of calls identified as mental health calls;
- the amount of time spent on mental health calls;
- use of force with PMI;
- financial savings to the police organization in regard to time spent with PMI; and
- anecdotal community feedback.

There were a number of meaningful changes noted, as well as other areas in which no change occurred. There were no changes in attitudes toward PMI, preferred social distance, or mental health knowledge. Rating by supervisory police officers indicated an improvement of about 10% (measured six months after training), reflected in the ability to communicate well, de-escalate a situation and display empathy (Krameddine, De Marco, Hassel & Silverstone, 2013). There were also indications that officers responded more efficiently to calls for service related to PMI (and, thus, total time decreased) and that use of force decreased over the same time period. However, the authors noted there were a number of other initiatives in place during that time aimed at reducing use of force so that the reduction in this area could not be attributed solely to this training. Finally, the authors also provided some evidence for the cost effectiveness of the program; they claimed that savings in officer time spend dealing with mental health calls more than offset the cost of the training. Considering all variables involved, this claim requires further investigation and verification.

Overall, the evidence seems to suggest that this kind of intensive empathy and scenario-based scenario tends to improve officer performance—at least, in a population of officers who have already received some basic knowledge-based training about mental illness (Edmonton Police have traditionally covered this topic well in their academy level education).

The project appeared to receive favorable reviews from the participants but the value of this kind of assessment is limited, particularly given the relatively low response rate to the follow up surveys. Nevertheless, this approach might be a useful adjunct to existing programs and likely merits further investigation. It should be borne in mind that this particular study occurred in a police service which already provides a high standard of training and education about mental illness at the basic training level. Since most of the participant officers were fairly junior, it might be the case that they had already received training which covered the factual bases and basic communication strategies which are relevant in interactions with people with mental illnesses.

Using simulation to engage police in learning: the work of the Durham Police, University of Ontario Institute of Technology, Ontario Shores Centre for Mental health Sciences (formerly Whitby Mental Health Centre) and Durham College
(Goodman, Hinton, Stanyon, & Tashiro, 2009)

This project involved use of simulations to develop skills and knowledge of police officers in regard to their interactions with people with mental illnesses. Four simulations were developed, each of which included an interactive video clip with response options, learning activities, detailed feedback to the participant in regard to both their response choice and the answer is selected on the learning activities, and a library containing additional learning resources. This teaching module was self-administered, with each officer completing the scenarios and related activities on a laptop computer, at his/her own pace. The four scenarios included:

- a young man exhibiting suicidal behavior;
- a male adult demonstrating delusional thinking;
- a male adult experiencing hallucinations; and
- a young woman exhibiting self-harming behavior.

The purpose of the initial studies was not only to assess the ability of the simulations to convey information to the officers, but also to compare changes in knowledge and attitudes between officers who completed the online simulation training in comparison to those who participated in face-to-face information sessions about mental illness. Based on a combination of written pre-post measures and focus groups conclusions, the results of the initial study were promising. They indicated that simulations are an

effective tool for teaching officers about mental illness. The participants showed a high level of engagement and appreciation of the learning objectives. Researchers found that the simulations to be realistic, and easy to use, and several of the participants suggested that this type of education should be mandatory for all frontline police officers. However, in spite of these positive evaluations, the majority of officers still indicated a preference for face-to-face education sessions, citing the ability to dialogue, share ideas and experiences, and seek clarification and further explanation when appropriate. The study authors conclude by recommending a hybrid teaching model that would include both face-to-face and simulated training.

A small sample size and limited data analysis in this study make it difficult to draw firm conclusions about the efficacy or generalizability of the information learned by the officers in either the traditional didactic session or in the simulation exercises. Nevertheless, the authors ground their study in the literature related to use of technology in education and principles of adult learning. Certainly one of the take-home messages from this study is that simulations and other technology based learning strategies, such as those used in this project, can be used both to aid in standardizing training and education and also to maximize the available time of instructors and teachers. Needless to say, this particular strategy does not represent a comprehensive approach to police education and training in regard to mental illness, but it may well be a significant contributor to a more comprehensive learning regime.

Vulnerable: a web seminar developed by L'École nationale de police du Québec

This innovative web-based learning is described as a multi-layered learning strategy that includes not only a video component but is also accompanied by a number of teaching and learning tools. It can be used at either the individual level or as a classroom teaching medium. Of particular note, according to the developers of this program the title was carefully selected to reflect an attitudinal shift from seeing people with mental illnesses as a threat to seeing them as vulnerable persons. The pace of the training and the videos, in particular, is also aimed at slowing down the pace of interventions, and encouraging officers to take their time in dealing with incidents involving people with mental illnesses.

Vulnerable is composed of nine sections, each of which conveys information about a specific theme and police intervention with a person in crisis or a person experiencing a mental illness. Each of the nine sections is also both autonomous and interactive. Each section consists of a video segment lasting about 10 minutes followed by key points and information for discussion in regard to the video. The videos are carefully designed to illustrate the general principles which are further elaborated in the subsections which present specific factual information on the given theme.

The general objectives of the learning are:

- To promote a better understanding of the nature of distress and human crisis;
- To explain different mental disorders and how this may be manifest in a crisis situation;
- To provide police officers with concrete tools that will allow them to better intervene with a person in crisis and/or affected by a mental disorder by proposing intervention strategies that allow for the defusing of the situation in a safe and effective manner; and
- To respond to police questions concerning this type of intervention in a concrete fashion.

The organization of Vulnerable is as follows:

Part 1: *The Police Officer Facing Human Crisis*

- Section 1: What is a crisis—and what is the police officers' role? Section 2: Establishing Contact with the Person in Crisis: 4-Point Strategy
- Section 3: In Crisis, but Dangerous? Evaluating Risks
- Section 4: The Police Officer's Greatest Ally: Communication

Part II: *Intervening with People with a Mental Disorder Who Are in Crisis*

- Section 5: Schizophrenia, Bipolar Disorder, Borderline Personality Disorder, Delusional Disorder, Major Depression, Excited Delirium: Strategies that Work
- Section 6: Delirium and Hallucinations: Basic Guidelines for a Safe and Effective Intervention
- Section 7: How does one defuse a suicidal crisis?

Part III: Powers and Duties of the Police Officer

- Section 8: Intervening with a Person Presenting a Mental Disorder: Powers and Duties of the Police Officer

Part IV: *The Last Word: Advice from Five Experts*

- Section 9: 5 Experts, 5 Precious Suggestions

Part V: *Resource Directory*

- Section 10: Online Resource Directory

Toronto Police Response to Emotionally Disturbed Persons: 2013[33]

Training

The Toronto Police provides training to all police officers on interactions with emotionally disturbed persons that helps officers develop appropriate responses. This training emphasizes communication and de-escalation skills. The content of the training reflects the latest knowledge and practices in the field of mental health, crisis resolution, and police use-of force. The use of scenario-based training that echoes real events (often the subject of inquests) has been included in the annual use-of-force requalification program for all front-line officers and is delivered to new police officers as part of the recruit training program. The specific de-escalation techniques that are taught include developing a rapport with individuals. While communicating with someone in crisis, officers are instructed to:

- continuously assess the threat, both the person and the context;
- be professional;
- model composure;
- be aware and cognizant of body language;
- provide physical space as appropriate;
- use names and engage;
- use calm and clear language;
- validate the emotionally disturbed person's feelings/situations;
- encourage relaxation;
- provide realistic reassurances;
- be clear about limits/authority; and
- remain patient.

As part of training, officers are instructed to avoid:

- heightening panic;
- challenging delusions;
- joking, whispering, or laughing;
- judging or preaching;
- monopolizing the conversation;
- invalidating the individual/situation;
- confusing the individual with rapid fire questions;
- giving multiple choices;
- threatening or deceiving; and
- touching (if possible).

These specific de-escalation techniques are incorporated into dynamic scenario training where each officer participates in up to six scenarios during the session. The scenarios have been designed so that 80 percent require de-escalation as the anticipated and suggested response.

One particular component of the 2013 program is a lecture focusing on communication and mental disorders. This 90-minute class explores effective communication, good judgement and decision-making. Self-control techniques are taught with professional conduct being promoted at all times. This lecture also addresses the justification for the use-of-force while stressing that de-escalation and disengagement are viable options. Thirty minutes is devoted to specific strategies for de-escalation and conflict prevention. A feature of this lecture stresses that the safety of the individual, the public, and the officer is paramount. To assist in the development of training, and to incorporate the experiences of consumers/survivors into police learning to help de-stigmatize the disease and those who suffer from it, the Service has consulted extensively with advocacy groups, mental health professionals, and consumer-survivors.

In January 2012, the Police Services Board's Mental Health Sub-Committee participated in a workshop at the Toronto Police College to review and develop scenario-based training. Police Board members agreed that the following should be considered key points in all police training related to interaction with individuals experiencing mental illness:

- respectful approach;
- utilize available resources;
- create and use time and space to help de-escalate;
- do not make assumptions;
- be flexible and open to different options;
- give the person more control;
- prepare yourself for each call;
- the goal is to reduce the likelihood of using force; and
- focus on what is happening right now.

As a result, the Toronto Police translated these concepts and principles into the Service's police training. The elements, dealing with knowledge, insight, and judgment that challenge assumptions and de-stigmatize mental illness, are included in the 2013 In-Service Training Program; according to their report this is mandatory annual training for every Toronto police officer.

British Columbia Ministry of Justice-Police Services Division: Crisis Intervention and De-escalation (CID) Training

[33] Prepared by the Toronto Police. The original report is available at http://www.torontopolice.on.ca/community/tps_response_to_edp.pdf

While police have various options including the use of firearms when exercising force, one of the options—the Conducted Energy Weapon (CEW),[34] which was intended and marketed as a 'less-than-lethal' use-of-force—has been controversial. In large part, this has been because of what has been viewed as its often inappropriate and insufficiently regulated use. On several well-documented occasions in Canada, the use of the CEW has resulted in the death of subjects, including several who have been persons with a mental illness. One such incident was the 2007 death of a man at Vancouver Airport after police subdued him with a CEW.[35] This incident resulted in the Braidwood Commission on Conducted Energy Weapon Use.

In June 2009, the Commissioner released the first of two reports—*Restoring Public Confidence: Restricting the use of conducted energy weapons in British Columbia*—resulting from the work of the Inquiry (Restoring Public Confidence, 2009). Of the many recommendations made by the Commissioner, he made several of direct relevance to the present study (**Appendix B**). The BC Government subsequently established the Braidwood Implementation Committee to address recommendations of the Commissioner.

One outcome of Implementation Committee is the *Crisis Intervention and De-escalation (CID) Training*. This is mandatory for all first responder police officers and frontline police supervisors across British Columbia;[36] it spans both academy level training and in-service training. Training of all police officers in BC must be completed by January 2015. In that regard, since January 2012, all new police officer candidates at the Justice Institute of BC (JIBC) Police Academy have been required to complete the course, as have existing officers across the province. As time goes on, an increasing number of officers will have completed the training at the academy level, and will only be participating in the mandatory every-three-years requalification aspect of the program. The BC Crisis Intervention and De-escalation (CID) Training:

> *is consistent with the BC Provincial Policing Standards (BCPPS) and is designed to ensure police officers will be able to use crisis intervention communication techniques to effectively de-escalate crisis, including cases involving intervention in a mental health crisis (Course Training Standard, 2012).*

As a relatively new program, CID training has had the benefit of building on a number of existing programs but at the same time has also taken great care to use state-of-the-art methodology in both the development and delivery of the curriculum. The course itself was designed using systematic course design methodology and performance-based instructional techniques. It focuses on actual job performance and strives to ensure that the teaching methods transform content and knowledge into actual learning and, thus, change.

A preliminary training needs-analysis also ensured that the methodologies used in CID could be integrated realistically into current police learning environments. Consultation with subject matter experts ensured that the course reflected current 'best practices' in this area. Contributors to the development of the program included a variety of police personnel, people with expertise in adult learning curriculum development, mental health professionals, health services and mental health agencies, technology and e-learning experts and people living with mental illnesses.

The result is an initial blended learning course which incorporates the 3-4 hours CPKN on-line course, Recognition of Emotionally Disturbed Persons, supplemented by seven hours of in-class instruction and role plays to be conducted within individual police agencies by their own instructors. Police officers are required to complete the on-line portion every three years as refresher training.

The online component of the program includes:

1. an introduction and overview which includes discussion of the British Columbia provincial policing standard as well as the Braidwood report recommendations and a discussion of the importance of CID techniques in general;
2. an understanding of conflict and how conflict contributes to crisis, to assist officers in assessing risk and crisis situations and ultimately de-escalating these situations safely;
3. a review and discussion of the major types of mental disorders, their symptoms and behaviors and relevant medications;
4. a discussion of the British Columbia mental health act and its implications for police;
5. a four phase crisis intervention and de-escalation model incorporating a variety of specific techniques;
6. a scenario-based segment which incorporates the above principles and requires analysis and response to an evolving video scenario; and
7. a review and summary at the conclusion.

[34] Often referred to as the 'Taser.'

[35] While it is not clear whether this man had a mental illness per se, it is apparent he was behaviorally disturbed and emotionally distraught.

[36] This includes RCMP officers in BC under contract to the province and BC municipalities. Of note also, is that the RCMP via their training facility at Chilliwack, BC is working to train all RCMP officers regardless of rank or assignment.

The face-to-face aspect of training includes:

1. an introduction to the CID training and the overall requirements;
2. a review of police response to the intervention and de-escalation of crises;
3. identification of agency specific policies and procedures for working people who might be experiencing emotional crisis a panel discussion which includes local health resources and persons with lived experiences;
4. additional review of the CID model and techniques;
5. discussion of and active listening model;
6. application of the CID model and techniques through role plays and practical scenarios
7. a final written assessment; and
8. an overall review and wrap up.

The JIBC Police Academy and the RCMP's Pacific Region Training Centre (PRTC) at Chilliwack, BC in conjunction with the BC Government's Police Services Division facilitate CID orientation sessions to prepare police officers from police organizations across BC to deliver the training.[38] CID has been designed such that it can be delivered within the context of existing periodic in-service education/training programs, which vary between police organizations. Currently, RCMP dispatchers in BC only complete the 3-4 hour on-line portion of CID training. The reason, apparently, is that the priority for now is to ensure all police officers are trained.

There are a variety of materials and supportive documentation which accompanies the course. These include useful written materials provided to officers for use on the job, a written guide to mental health disorders and common medications, a facilitator guide, the discipline guide and the final written assessments. A rigorous evaluation is planned when the program has fully rolled out in 2015. In the meantime, this structured intervention and de-escalation course appears to be a successful learning program.

8. Programs—not Police Specific

Mental Health First Aid (MHFA):

MHFA, originally developed in Australia, is now widely used around the world. In Canada, it is administered and delivered by the MHCC. The program has been adopted and utilized by a number of police organizations in Canada. The MHFA Canada program[39] aims:

> *to improve mental health literacy and provide the skills and knowledge to help people better manage potential or developing mental health problems in themselves, a family member, a friend or a colleague (MHFA, 2011)*

Although MHFA does not teach how to be a therapist, it does prepare participants to:

- recognize the signs and symptoms of mental health problems;
- provide initial help; and
- guide a person towards appropriate professional help.

Specifically, MHFA was developed based on the expert advice and review from an international panel. The basic course is 12 hours; it includes techniques identified as effective for a number of mental health problems including:

- depression;
- suicidal thoughts and behaviors;
- psychosis;
- panic attacks;
- non-suicidal self-injury;
- eating disorders;
- adult trauma;
- child trauma;
- problem drinking;
- problem drug use; and
- problem cannabis use.

Niagara University First Responders Disability Awareness Training-Law Enforcement[40]

This initiative was developed at Niagara University, in New York State, further to a grant from the New York State Developmental Disabilities Planning Council First Responder Disability Awareness Training Grant. The subject matter content of this training initiative overlaps to some extent with many of the programs described elsewhere in this report. However, it also covers a number of areas not considered part of the mental health spectrum. The topics include:

- disabilities defined specific to policing;
- progressive approaches to addressing emergency situations;
- challenging behaviors and responsiveness;
- victimization and the disabled;
- service provision and supports and how to develop a collaborative relationship;
- emergency services—service provider collaboration;

[40] Available at http://www.fr-dat.com

- municipality role and responsibility; and
- proper etiquette and interaction skills.

The program is a 'train the trainer' program, which qualifies participants to deliver an eight-hour education session within their home agencies. The disabilities which are addressed in this program include:

- low vision/blind;
- hard of hearing/deaf;
- intellectual disability;
- Tourette's syndrome;
- various physical disabilities including cerebral palsy, muscular dystrophy, and spinal cord injuries;
- learning disability;
- attention deficit hyperactivity disorder;
- autism;
- epilepsy and seizure disorder; and
- dementia.

The overriding goal of this training is to enhance sensitivity to the identified disabilities and draw attention to the role of caregivers and service providers. The instructional medium includes lecture as well as video instruction; follow-up resources are provided to participants.

Clearly some of the areas identified in this particular program are outside of the realm of mental health and related disorders. However, while it does not directly address to issues related to mental health, it links them to other areas of disability. The content also generally supplements that which is traditionally covered in most mental health education training programs. Although this program is offered in New York State, the project coordinator verifies that attendance at their sessions is indeed open to Canadian police agencies. This program may well be appropriate for police services in which broader mental health training has already occurred and there is a need for supplementation in some of the areas identified above.

IACP Alzheimer's Initiative

In addition to the broader mental health initiative described above, IACP also offers a variety of initiatives specifically geared toward interactions with people with Alzheimer's disease. These initiatives include training workshops, podcasts, videos, handouts, cue cards and structured questionnaires. The purpose of the initiative is described as facilitating the ability of police officers to:

- better understand Alzheimer's disease;
- identify the different situations first responders might encounter persons with Alzheimer's disease;
- distinguish symptoms of Alzheimer's disease from other conditions;
- learn techniques to effectively question and interview persons with Alzheimer's disease to determine the most effective response;
- communicate and collaborate with caregivers;
- engage community resources; and
- establish protocols for search-and-rescue specific to this population.

No formal evaluation of this initiative is available but it appears likely that the component parts of the initiative might be appropriately integrated into more comprehensive training related to police interactions with people with mental illness.

ASIST: Applied Suicide Intervention Skills Training Program[41]

ASIST is a 14-hour workshop by *LivingWorks Education Inc.* that teaches participants to understand and assist persons who may be at risk for suicide. It is a well-established program in Canada as well as in other countries; there is reasonable evidence to suggest that this program results in not only greater knowledge and attitudes toward suicide, but also increased intervention skills, and the application of these skills. There is somewhat limited evidence that in school situations in which personnel have completed this training there has been fewer reported suicide attempts.

ASIST is designed as a gatekeeper training workshop. Unlike many similar programs, the goal of ASIST is not necessarily to initiate formal referrals to the mental health system but rather to re-establish community connections and supports by focusing on the quality of the interaction between the gatekeeper and the person at risk. The model is essentially a three-part structure, teaching and gatekeepers to connect, understand and finally assist the person at risk.

A number of Canadian police services (Winnipeg for example) as well as some Canadian corrections agencies utilize ASIST as part of their personnel training. LivingWorks, the host organization, offers 'train the trainer' programs so that organizations can develop in-house expertise. The program is described as skill acquisition training, rather than as simply suicide awareness.

9. Results of the 2014 Basic Training Scan

The Big Picture

If one were to summarize the data about the current state of police education and training in regard to mental illness at

[41] Available at http://www.livingworks.net/programs/awareness-vs-skills-training

the basic training level, most can be described as:

- Comprehensive;
- Integrated; and
- Increased.

As was the case in the 2008 study, all police institutions that provide training and education at the basic level include a variety of training related to mental illness. Curiously, as police education and training in this regard has evolved and developed, it has become more difficult to quantify the amount of training. Whereas it used to be the case that training related to mental illness was more self-contained (and, thus, easily identifiable), there is a trend to integrate scenarios and case studies about people with mental illnesses into a variety of other areas of learning—such as communication skills, ethics, and crisis management.

To be clear, this has always been the case to some extent. As was noted in the previous report (2008), education relevant to interactions with people with mental illnesses can occur in any number of contexts. The current findings, however, suggest this has continued but with the additional trend that such inclusion seems to be more deliberate.

Who responded?

Twelve of the 14 academies that provide basic education and training for police officers responded to the study:

- Atlantic Police Academy (APA);
- Halifax Regional Police;
- L'École nationale de police du Québec (ENPQ);
- Ontario Police College (OPC);
- Winnipeg Police;
- Saskatchewan Police College;
- RCMP Academy;
- Edmonton Police ;
- Calgary Police;
- Lethbridge Police;
- Brandon Police; and
- Justice Institute of British Columbia (JIBC).

Two organizations did not respond to requests for information (although, it should be noted that in the 2008 study, one of these organizations provided outstanding basic education in this area.)

Thus, the data that follows reflects the responses of 12 police academies/colleges that provide comprehensive basic training.

Information was also obtained from several police organizations that provide additional basic training to supplement that which is delivered at their designated police academy. Furthermore, information was obtained from several organizations and institutions that provide education and training to groups closely aligned with police (e.g. Alberta Solicitor General) or pre-police academy education (e.g. Ontario's Police Foundations programs and the University of Regina undergraduate Police Studies program). These groups are not included in statistical summaries but relevant comments and additions from their programs are included where appropriate.

Do Canadian police academies generally provide basic training specific to working with people with mental illnesses?

Not surprisingly, all police academies reported that they include mandatory training related to interactions with people with mental illness in their basic training curriculum. This has been the situation for many years in most jurisdictions. For instance, in the 2008 report, this was the case. However, in the past 5-6 years there have been many competing demands and increasing stresses on the nature and content of police basic training overall. Therefore, it is somewhat reassuring to note that there has not been a decrease in mental health training and that all police academies surveyed continue to regard education in this area as a mandatory part of the standard basic training curriculum.

As was the case previously, the majority of training facilities report that there is some dedicated time in the curriculum that is specific to acquiring knowledge and skills in relation to people with mental illness, but there is also integration of case studies, scenarios and other content related to people with mental illness as well as other coursework and education. This will be described in more detail throughout the report.

What is contained in the education?

The first recommendation of the aforementioned 2010 TEMPO model (**Appendix A**) stated that:

notwithstanding the many important elements of police/mental health learning design and delivery, the overriding theme should be:

- *a focus on anti-stigma education to challenge the attitudinal barriers that lead to discriminatory action; and*
- *ethical decision-making, human rights protection and social responsibility.*

Each academy was asked to identify whether or not they addressed stigma, personal and societal feelings, attitudes and assumptions about mental disorders (Question 2-6), and whether they addressed ethical decision-making including reference to mental health law, human rights law, the decisions that an officer must make in regard to

whether to arrest, apprehend under the mental health act, or take other action when dealing with people who appear to have a mental disorder (Question 2-7).

All 12 of the basic training academies reported specific content related to attitudes toward people with mental illness and how that might affect an officer's behavior and response. The way in which this curriculum was operationalized varied across organizations:

- 8/12 organizations reported they specifically identified stigma and addressed how it might affect an officer's behavior;
- 8/12 stated they addressed social and personal attitudes toward mental illness; and
- 9/12 organizations addressed assumptions about the relationship between dangerousness, violence and mental disorders.

Notably, only the Atlantic Police Academy, the Calgary Police, the Edmonton Police and the Justice Institute of British Columbia addressed all three of these areas in their curricula. ENPQ reported all areas were covered, but some were covered in conjunction with the required community college education that precedes attendance at ENPQ. Two of the respondents indicated that they addressed none of these areas in their curriculum. While on the surface this might seem like a minority, it should be noted that the two that reported they do not address these areas are both large academies which train a significant number of Canada's police officers. Clearly there is room for further development in this area.

In regard to the question of ethical decision-making as it pertains to people with mental illness and the review of relevant legislation:

- 11/12 respondents confirmed they provide instruction specific to understanding mental health law;
- The one academy that does not specifically cover mental health law, the RCMP Academy, notes that because it is a national training facility and its graduates might be posted to any province or territory in Canada, mental health legislation is not specifically covered in the basic training curriculum as this legislation is provincial. However, they noted this topic is included in the first six months of mentorship that new officers receive at their first posting.

Thus, it appears that, overall, the subject of mental health law is widely addressed.

There is somewhat less coverage, however, in the area of human rights law, with only 9/12 academies reporting that they cover this in their basic training curriculum.

All 12 academies reported that they specifically address decision-making in regard to whether to arrest, apprehend under the mental health act or take other action when interacting with people with mental illnesses.

When these results are compared to the 2008 study, there is not substantial evidence of curriculum change. At that time it was noted that 8/11 respondents addressed the subject of dangerousness in the curriculum; in the present survey, 9/12 did so. Nevertheless, this remains an area that a minority of academies do **not** appear to be addressing. Given the short period of time that police officers might have to respond to a crisis involving a person with a mental illness and given the distinct possibility that an officer's inherent assumptions about a person with a mental illness is that they might be dangerous or that an officer might possess stigmatizing attitudes that, as the research literature suggests, predispose him/her to take more aggressive action, an examination of attitudes and a discussion of stigma including topics related to dangerousness should be provided in all basic training curricula, as was identified in the 2010 TEMPO model.

The second recommendation from the 2010 TEMPO model identified a broad learning spectrum and spoke specifically to the following content:

Signs and Symptoms of Mental Illness: The most fundamental and basic part of training in relation to people with mental illness involves acquiring a basic appreciation of the signs and symptoms of mental illness so that police personnel might accurately identify a person who is be experiencing a mental health problem and therefore, be able to respond appropriately. Not surprisingly, this area of training is covered well in most basic training curricula. With the exception of one small police service, all organizations reported that mandatory coverage of topics related to signs and symptoms of mental illness was always included in their basic training curriculum. Most academies included material related to psychotic disorders including schizophrenia and bipolar disorder, as well as related symptoms such as hallucinations, and delusions.

Most also included reference to anxiety and other mood issues, Alzheimer disease and other dementias and personality disorders. Less common, and occurring in fewer than half of the academies were topics related to autism, developmental delay, brain injury, attention deficit disorder and posttraumatic stress disorder. These findings suggest that, generally, basic level education prepares personnel to have an appropriate understanding of the types of disorders that they would most frequently encounter (e.g. the psychotic disorders); nevertheless, there are other areas in which training was not as broadly implemented.

The Atlantic Police Academy provides broad coverage which includes not only all the areas listed above but also

Fetal Alcohol Disorders and PTSD. All police academies advised that they provide basic instruction about assessing suicide risk and interacting with people who have expressed suicidal ideation.

While signs and symptoms were, as noted, well reviewed in most programs, there appeared to be significant variability in the way in which these were addressed. Some programs tended to rely more on psychiatric diagnostic terminology as opposed to observable signs and symptoms. There is some danger in the former approach given that such terminology varies over time (consider the recent release of the DSM V which will affect the way in which mental health professionals use such terms) and increases the risk of communicating inaccurate information to mental health professionals. For example, while police might not be able to make clear distinctions, a receiving physician will interpret the statement that a person "appears to be hallucinating" very differently than being told that a person "has schizophrenia." Although it is helpful for police personnel to understand what might be involved if they are told a person has a particularly diagnosis, it is fundamental that at a minimum they be able to recognize and describe symptoms and behaviours.

Communication skills and verbal de-escalation: Again, not surprisingly, there is a significant focus on assessment of people with mental disorders including their ability to comprehend direction of a police officer and the ability to communicate. Virtually all academies provided emphasis on this topic. A number of organizations have structured decision-making models which assist them with their assessment and communication skills. For example, the Atlantic Police Academy refers to the Mandt crisis cycle as well as the RADAR method of assessments. The Justice Institute of British Columbia refers to the CID model which references building rapport and de-escalating, assessing a crisis, collaboration, and resolution. RCMP officers are encouraged to use the CAPRA and IMIM models where applicable; these are models which direct not only interactions with people with mental illnesses but are used as decision-making models for many types of interactions. Several organizations referred to the *Head, Hearts, Hands* model as illustrated in the aforementioned CPKN training video—*Recognition of Emotionally Disturbed Persons*.

Although, it is difficult to quantify the actual emphasis in this area, in virtually all responses there was significant effort given to explaining how the academy approaches the issue of communication and verbal de-escalation. A few academies stated their focus is on communication skills in general, without particular heed to the unique needs of people with mental illnesses. But most responses spoke specifically to training in regard to communicating with people who might have limited cognitive ability; who may be experiencing hallucinations or delusions; who might not appear to be listening to requests or commands; who might be under the influence of substances. Also identified were issues related to altering tactical communications when necessary; using the least possible force; using 'soft' language and keeping a distance. Most also identified a variety of teaching strategies to address this area. A combination of written materials, varying from the comprehensive *Not Just another Call* from the Ontario Police College, through to tip-sheets; classroom instruction; role plays and scenarios; to videos are used for this purpose.

Interestingly, 3/12 academies reported that they do NOT address the issue of being flexible with standard police procedures when dealing with PMI. This is unfortunate in that sometimes, standard procedures have an opposite effect to what is desired when used with PMI. It is of course a fine line. It is important that officers follow procedure—especially when they are new to the job—and do not, therefore, risk harm to themselves or others. But at the same time, when these procedures themselves might be problematic, there must be room for some exercise of judgment. Consider, for example, Recommendation 10A from the *Verdict of Coroner's Jury: Inquest into the deaths of Reyal Jardone-Douglas, Sylvia Kilbingaitis and Michael Eligon* (February, 2014), which states that:

> *if the EDP[42] has failed to respond to standard initial police commands (i.e. "Stop. Police," "Police. Don't move," and/or "Drop the weapon"), train officers to stop shouting these commands and attempt different defusing communication strategies.*

Community linkages and resources

Similarly, virtually all academies provide education in regard to how to engage and work with community agencies as well as how to make use of specialized mental health personnel within the police organization should such personnel be available. Most police organizations provide information about specific local mental health agencies and contact persons. However, as noted above, this is not feasible in all training facilities as many academies train officers for a wide range of geographic locations so local resources would vary.

Summary of Curriculum Content:

Taken as a whole, it appears that all Canadian police academies, which responded to the survey, provide a meaningful introduction to interactions with people with mental illnesses. New police officers graduating from the police academy should begin their professional career with at least a rudimentary understanding of the signs

[42] Emotionally Disturbed Person.

and symptoms of mental illnesses and appropriate communication strategies. Most, but not all, have had some exposure during basic training to issues which might affect their individual decision-making such as personal attitudes, assumptions about dangerousness, and stigma. Many police academies also provide information about community agencies and resources but this can be problematic in academies which provide training to officers who may be dispersed upon graduation across either a large geographical area or a variety of different police organizations.

Manner of education and training delivery

Needless to say, while deciding upon the content of curriculum and training is essential, equally important to adult learning is how training and education is delivered. While some aspects of training lend themselves to lecture presentation (such as learning about signs and symptoms of mental illness), police candidates are unlikely to increase their behavioral repertoire or specific skill set simply by hearing about it in a classroom. Not surprisingly, most police academies make use of a variety of teaching media in relation to people with mental illnesses.

Of the academies surveyed, all except two relied to some significant extent on lectures; 3/12 conducted their training primarily in a lecture format. Of the two organizations which do not use a lecture format, one (JIBC) uses a blended learning approach in which standardized material is presented through a combination of online presentations of factual information in combination with face-to-face training that allows discussion and application. The other exception was the RCMP Academy which used a carefully scripted series of interactive modules and scenarios that attempt to ensure cadets are exposed to the variety of information they need to learn; this is completed in an interactive scenario-based format rather than a lecture format.

Nine of the 12 respondent academies included lectures by mental health professionals, and 8/12 include presentations by mental health agencies. One of the primary reasons for including participation by mental health professionals and agencies is, of course, to ensure that material presented is factually accurate. It was apparent in some of the learning materials reviewed during the study that mental health professionals had NOT been involved.[43] Some materials referred to obsolete diagnostic terminology and contained information which was not factually correct.

However, in addition to ensuring accuracy, an additional reason for including mental health professionals in curriculum delivery is to allow police trainees to meet and interact with professionals with whom they might be interacting in the future. In other words, including mental health agencies and professionals is consistent with contemporary-policing principles and expectations (**Table 1**).

Not surprisingly perhaps, three of the academies (the RCMP Academy, Ontario Police College and ENPQ) do not involve mental health professionals; they are large training centers that provide training for geographically dispersed police agencies (e.g. RCMP, OPP, Sûreté du Québec)[44] and/or training for a wide variety of different police services within their respective jurisdiction. Given the unique characteristics of these academies, it makes sense that they might not include exposure to mental health professionals in their training; however, once again, it speaks to the need for coordination with the agencies and detachments which eventually employ their graduates.

Somewhat more surprising is that in two academies, mental health professionals were not included in the development of the curriculum. It may well be that in these two instances, the academies are using curriculum developed elsewhere that might have included input from mental health professionals. However, it is a useful reminder to police academies who are developing their own curriculum that while there are many police officers with a great deal of expertise in this area, having input from qualified mental health professionals is advisable from both a practical and a risk management perspective.

Of more significant concern is the fact that only 6/12 academies involved a person with a mental illness in the development of curriculum, and only 5/12 involved a person with a mental illness in the actual curriculum delivery on a regular basis (although one other includes participation of a person with a mental illness through video materials). This represents a significant concern in regard to the nature and extent of training. If one were to draw an analogy with, for example training in regard to cultural diversity, it would be as if a police academy were providing training in regard to cultural, racial and religious sensitivity without consulting any cultural or ethnic groups in either the development of the curriculum or delivery of training.

It might be that the failure to include people with mental illnesses is a reflection of assumptions about their ability to participate meaningfully in such activities, but the fact that about half of academies are able to do this clearly confirms it can be done. As was mentioned earlier in this report, it has been well documented that one of the most effective ways in which to change attitudes and stigma in relation to mental illness is through direct contact and exposure to people with mental illnesses. It is encouraging that more police academies are including people with mental illnesses

[43] Or if they were, the professionals in question were quite out of date in their knowledge.

[44] Known as *deployed* police agencies.

in their training compared to 2008—but it is concerning that not all (and indeed not even most) academies are doing so.

There has been an increased focus on role plays and simulations with 8/12 academies indicating this is part of their training. It appears that the level of sophistication of the simulations has also improved. Many academies provided details about the nature of the simulations that they use, the feedback mechanisms, and clearer expectations of the participants.

Seven academies reported using films and videos to supplement their teaching, and 5/12 included use of online resources. Given the amount of time and energy that must be devoted to curriculum development and delivery, it would seem that this is a potential area for further development as the use of these kinds of resources could be cost effective and also provide some degree of standardization across organizations. (It might well be that a bi-lingual version of ENPQ's 'Vulnerable' series will play a significant role here) The online and video resources that are generally available (from CPKN and OPTVA) seem to be well used.

How are training activities evaluated?

Given the wide variety of training media employed, it is not surprising there are a wide variety of evaluation tools. Most academies assess the effectiveness of their training through some combination of written tests, and ongoing assessment by instructors (for practical exercises). There appears to be an increasing trend toward 'show us what you know' as opposed 'tell us what you know.' Although rigorous outcome-based evaluations appear to be uncommon, an encouraging example of student evaluation was delineated by ENPQ; this involves a certification process whereby candidates are assessed against a series of competencies (**Table 2**).

Table 2. ENPQ competencies for police interactions with PMI.

ENPQ competencies for the intervention with persons in crisis state or presenting a mental disorder are observed and evaluated in a certification evaluation. Students are placed in an intervention context and have to show the competency to intervene.	
The observed elements in the certification evaluation: • Begin an intervention • Collect the relevant information to take charge of an event • Adequate wording of the situation • Plan the arrival on site • Ask for backup if needed • Carry out the intervention on site • Carry out the action plan adapted to the situation • Adequate intervention • Adequate control of the person • Carry out the police investigation • Adequate planning of the subsequent operations • Record the evidence • Adequate writing of reports and forms	*Students have to show how they apply the competencies learned in the college part of the training which are the following:* • Adapt the principles of communication basic techniques in the context of a police intervention. • Interact with a variety of clientele. • Intervene in private situations. • Carry out the powers and duties of the police officer regarding Québec laws and municipal bylaws.

While many police academies include role plays and scenario training, it is not clear how these practical experiences are evaluated—or whether a person who does not demonstrate sufficient de-escalation skills, for example, can be 'failed' or sent for remedial training in the way in which a police officer would be 'failed' if he did not, for example, reach the benchmark for shooting accuracy. Informal reports suggest that in at least some academies, the criteria for a 'pass' in this area are stringent. The Saskatchewan Police College, for example, includes mental health professionals in the evaluation of officers' performance during scenarios.

Where else are issues related to PMI included in the curriculum?

Given the variety of training approaches used and the varying approaches to police education in general, it is not surprizing that there is significant variability in how and where topics related to mental illness are covered in the overall curriculum. In addition to focused training that is specifically identified as related to interactions with people with mental illnesses, according to respondents, the topic might also be covered in modules, courses or activities related to:

- law/provincial statutes;
- use of force;
- crisis management;
- communication skills;
- officer safety; and
- vulnerable populations/diversity training.

As previously noted, virtually all training includes coverage of mental health law, and many organizations also cover the Canadian Charter of Rights and Freedoms and Human Rights law.

Similarly, many organizations advised they include reference to PMI in sessions related to crisis management, communication skills, officer safety, and vulnerable populations/diversity training.

However, of most interest in this context is whether or not attention is paid to this topic in use-of-force training which is, of course, a core component of all police education and training. Only 6/12 academies reported this specifically includes examination of issues related to the use of force during interactions with people with mental illness during their use-of-force training. Given the over-representation of PMI in use of force encounters with police, this is a significant omission (Brink et al., 2011). Although some other academies referenced training in other modules or courses that would have emphasized verbal and other less invasive approaches to managing situations, overall, it remains a concern that this is not emphasized or specifically addressed in use-of-force training.

Consider, for example, a response from one use-of-force instructor which stated in essence that persuasion, advice, and warning can only be useful when the subject whose behavior the officer is attempting to influence is capable of "rationalizing and understanding the consequences of their actions." In other words, in situations involving people whose behaviour does not appear to make sense and who might appear psychotic or otherwise "irrational," an officer may bypass verbal techniques and proceed directly to more physical means of control.[45]

In contrast, in response to a question about the inclusion of issues related to mental illness in use-of-force training, Halifax Regional Police (HRP) reported that:

"Officers are advised that safety always comes first. However if signs and symptoms of mental illness are present, "Take a step back," speak slowly and clearly, be aware that the party may be experiencing auditory and visual hallucinations. Non-compliance may be from fear or confusion, not behaviour of choice. HRP use of force training includes mental health scenarios."

Or the Saskatchewan Police College.

We have placed a much greater focus on communication skills and the de-escalation of heightened situations. As a result we are seeing more time, effort and skill being put into de-escalation of situations, both in MH scenarios but also across the board. This is an area we continue to focus on. With additional time being allotted to our training program, communication is one specific area of focus.

A promising practice is the certification of use-of-force trainers-e.g. a 'train the trainer model' being developed at British Columbia's JIBC in order to ensure that the appropriate use-of-force instructors are equipped to provide suitable training across the full range of force options—including de-escalation and communication strategies.

How much time is devoted to topics related to people with mental illness?

On the surface, there appears to be substantial variability between police academies, which report anywhere from 1.5 to 52 hours devoted to this subject. But a more in depth review of the curriculum suggests that this is a question almost impossible to answer—especially if the academy is doing a good job in this area. Most, but not all, academies have a number of hours of formal didactic teaching that is specific to this subject. But increasingly, information related to interactions with people with mental illnesses is integrated into other courses, and into scenarios and simulations. In many training programs, issues related to PMI might come up in 5-10 different points in the basic training curriculum, including, for example, communication

[45] In order to avoid embarrassment for the police service involved, this comment is paraphrased and is not a direct quote. But information from more than one use-of-force instructor at more than one academy suggested that defacto use of physical force was almost inevitable, and even recommended, when dealing with an "irrational" person.

skills, crisis management, tactical communication, use of force, community policing and community relations.

Summary and Issues Arising

While it is easy to identify training (or the lack of training) as an issue when high profile incidents occur, the current review would suggest that overall, Canadian police officers receive fairly broad based basic training in this area. There was no single academy that described grossly inadequate training. All academies covered the basics of signs and symptoms, and communication strategies; all covered issues related to suicide and mental health law. Most addressed issues related to attitudes and stigma in regard to mental illness. Some included exposure to community agencies. There are many examples of what can be considered very good training.

As noted earlier, Halifax Regional Police has a relatively long history of providing well thought out and comprehensive training in this area, both to new police trainees and on a continuing basis through in-service training. Indeed, as was noted in the 2010 report, the TEMPO model draws from the Halifax model of education and training. Halifax was one of the leaders in the development of a multi-tiered matrix training model; their training scheme remains a leader in that in provides education at a variety of levels, to a variety of personnel, and includes a variety of teaching media, as well as significant input from people with mental illnesses. New police officers receive a full 3.5 days of training specifically dedicated to topics related to mental illness; issues related to mental illness are also incorporated into use-of-force training, as previously noted.

Edmonton Police also provides a significant amount of basic training in this area. Its curriculum, which includes dedicated mental health training, communication skills, crisis management, stress and human relations, control tactics, is estimated to take up 52 hours of the total training course at the academy. It includes thorough coverage of signs and symptoms and a number of structured scenarios which ensure broad coverage and active problem-solving.

Furthermore, the Saskatchewan Police College has invested heavily in recent years in a revised and improved curriculum which includes a variety of instructional approaches, and a clearly articulated emphasis on communication skills. The Atlantic Police Academy similarly has a broad and comprehensive approach within its academic courses. Calgary Police and the Ontario Police College have both developed useful written materials for officers. Lethbridge Regional Police has developed a comprehensive in-house program appropriate to its jurisdiction. The JIBC Police Academy's new CID program might raise the bar for others. Winnipeg uses the ASIST program in its comprehensive approach to interventions with people who might be suicidal. ENPQ's video approach has already been used by many Québec police agencies and will likely become more popular when available in English. The RCMP Academy has been able to articulate clear goals and systematically include issues related to PMI in their primarily scenario based learning.

It should also be noted that there are a number of police services that rely on provincial academies for their basic training but provide supplemental basic training after completion of training at the police academy (such as several of the larger services in Ontario as well as the Ontario Provincial Police). Peel Regional Police, for example, are working with simulators that create the experience of mental illness. This is done to help police officers develop empathy and understanding for when they encounter a person in the midst of an acute episode of delusion or hallucination. Several police agencies are involving the community by having members of organizations such as the local Schizophrenia Society speak to their new police officers about experiences of mental illness and—importantly—experiences of the family and friends of persons with mental illness.

Toronto Police also provide additional education over and above that which is part of the curriculum at the Ontario Police College. It includes use of scenarios and provides further focus on verbal de-escalation and communication skills.

Some academies, including the Toronto Police academy, test their new officers through scenarios or role-plays with actors taking on the part of a person with mental illness. These are excellent, low-stress way to introduce students to the behaviours they might encounter and to practice the strategies and tactics they will need to employ. It is also a good way to identify students who are derisive and dismissive of the subject area; it is much harder for them to *act* convincingly than it is for them to choose the multiple-choice answer they 'know' is correct.

But there are gaps as well. Most academies do not include significant input and participation from people with mental illnesses and/or their families. Many do not integrate information about PMI directly into use-of-force training. Many do not have meaningful ways of assessing learning outcomes. Some rely entirely on classroom based lectures as an instructional medium. Most stated that they needed more time to accomplish what they needed to accomplish in basic training. However, at the same time most programs had difficulty self-identifying the gaps or weaknesses in their programs (or, at least, they had difficulty admitting to them). Most were not familiar with the TEMPO model and, thus, it was not clear what if any reference point they were using to develop curriculum.

While it was not assessed directly in the questionnaire, it was also apparent there is somewhat limited exchange of teaching materials and strategies across academies. In order words, there is frequent 're-inventing of the wheel.'

Based on the totality of the information gathered, the following observations are made concerning basic training:

1. Programs which do not actively include PMI in their curriculum development and delivery should consider this a high priority in the further evolution of their training.
2. The persons responsible for curriculum development at the academy level should become familiar with the 2014 TEMPO model and consider using it as a gap analysis tool against which to assess their own curriculum. By identifying the gaps and weaknesses, curriculum designers can not only work to fill those gaps but also be able to communicate the strengths and gaps to the police agencies which eventually employ their graduates.
3. Academies which provide training for more than one police service or more than one jurisdiction are advised to maintain clear communication with the receiving agencies/detachments in order for both parties to be aware of what is, or is not, covered in training in the various locations. For example, academies may want to ensure that receiving employers/detachments are aware that subjects such as provincial mental health law and community resources are covered. Similarly, since most academies do not provide extensive coverage of problems such as developmental delay and autism, these might be identified as areas in which the receiving police agencies should focus their early in-service education and training.
4. Those responsible for curriculum development and delivery should consider developing a country-wide network in which they might exchange information, knowledge and learning materials in order to minimize duplication of effort as well as maximize usage of well-developed and researched materials which have proven effective learning tools.[46]
5. While organizations might feel that communication skills and verbal de-escalation techniques are best covered in curriculum locations other than the use-of-force module, given what we know about generalization of learning, particularly early on in a person's career, it is imperative that significant emphasis is placed on NON-physical interventions, and specific reference to assumptions about mental illness and dangerousness be included in use-of-force training at all police academies.
6. While there is no clear answer to the question: how much training is enough, those agencies whose specific and identifiable training in this area seems to be under 10 hours should re-examine their curriculum to ensure it is consistent with general practice across Canada. The training in Halifax, Edmonton and outlined in TEMPO 2014 might serve as suitable models.
7. Academies whose training is all, or nearly all, lecture-based should examine ways in which candidate learning might be enhanced by use adult learning methods such as simulations, scenarios and other experiential learning, as well as use of multi-media and online resources.
8. In regard to online resources, it might be helpful if one academy or the aforementioned national network (see #4 above), should it be developed, establish a library of materials available to all police learning facilities.
9. Evaluation strategies remain weak in many places. It is likely not sufficient for a candidate to simply pass a written test in order to successfully demonstrate his/her knowledge and skills in this area. Programs should, at a minimum, include a behavioural assessment of competencies, and require successful completion in order to graduate from the respective police academy. In the bigger scheme, police agencies might want to consider community surveys of people with mental illnesses as a way of assessing the adequacy of their education and training.[47]
10. Given the close ties between attitudes, stigma and behaviour, all academies should ensure that these issues, as well as beliefs about the relationship between mental illness and dangerousness, are included and integrated in the basic training curriculum.

10. Results of the 2014 In-service Education and Training Scan

The issue of what is or should be covered during in-service education is far more complex than the issue of what might be covered in basic training at the academy level. To some extent, in-service training will by necessity reflect the degree of education that was already provided during basic training. For example, as was noted in the section above, an academy such as the Ontario Police College which provides training to officers who will be employed by a variety of police organizations will not be in a position to provide information about local mental health resources. Therefore, in Ontario there might be an expectation that local/individual police services would provide this kind of education. It is impractical for the RCMP Academy to

[46] Is the Canadian Association of Police Educators (CAPE) a suitable vehicle for this?

[47] All or part of the MHCC's BC study (Brink et al, 2011) might be a suitable model.

educate their new officers about mental health law, since such legislation is provincial and Academy graduates might be assigned to any province or territory across Canada. Police services and the communities they serve also differ significantly in terms of community needs. One might reasonably assume that Brandon, Manitoba and Toronto might not have exactly the same training needs.

There are also differences between the police services in regard to the number of existing officers who might have had comprehensive training at the academy level. For example, if a police service employs graduates of an academy that has been providing comprehensive mental health education and training for several decades, it might be safe to assume that the majority of frontline police officers have at least foundational training in this area. While they might need refresher training, they might not as a group require extensive education in this area. Conversely, if a police academy has historically provided limited education about mental illness, or if the corresponding police service has a higher than average number of more senior officers in frontline positions, there might be a greater need for basic education. Finally, as was described earlier, there is significant variability among academies. It might be that officers subject to the extensive education and training provided by the Halifax Regional Police or Edmonton Police academies might need less additional in-service education than would an officer who received significantly less training at the academy level.

Methodologically, it is also much more difficult to survey and summarize in-service education as opposed to basic education. Whereas there are only 14 academies that provide basic training in Canada, and a small group of police services that provide basic training supplemental to the basic academy training, there remain over 200 police agencies in Canada which range in size from only a handful of officers to over 15,000 officers. Even within an individual police service, it is likely different detachments might well have both different needs and also be subject to different types and amounts of in-service education.

In order to obtain a sense of what is happening in regard to in-service education, Canada's police agencies were surveyed individually; in addition, a direct request was sent to members of the Canadian Association of Chiefs of Police (CACP). Thirty one responses were received. Not surprisingly, the responses described some programs that were extensive, whereas other police services simply said this was not an organizational priority and no in-service training has occurred in this area recently.

Needless to say, one cannot consider 32 respondents as a reasonable or representative sample of the education and training taking place across Canada. Thus, rather than report averages or percentages, the report highlights interesting observations and notes particular programs that seem to be strong. The present study identifies trends or comments that appear to represent the viewpoints of more than a few police organizations. Again, these cannot be taken as representative of practice across the country, but likely indicate issues, concerns or activities common to many police agencies.

General themes

Involvement of PMI

As is the case with academy level training, there are many police services that do not involve people with mental illnesses or their families directly in either the development or the delivery in-service education. However, this is not unilaterally the case. Seven of the organizations who responded stated people with mental illnesses participated directly in the delivery of the curriculum. Ten organizations reported that people with mental illnesses had been involved in the development of the curriculum. Several agencies reported relatively unique ways of ensuring that the voice of people with mental illness was heard. Regina, for example, includes a 90-minute panel discussion which involves a mental health professional, a person living with a mental illness and a family member of a person with a mental illness. Toronto Police have created a video of people with mental health problems discussing their previous interactions with police; the video serves as a vehicle of discussion of what did happen, what might have been better and what was done well. Other police services, including Brockville, Cobourg, Delta, and the Metro Vancouver Transit Police, also include direct participation by people with mental illnesses. Many others rely on the inclusion of people with mental illnesses through standardized teaching mediums like the CPKN course or ENPQ's 'Vulnerable.' But it remains the case that in most instances, there is no direct participation of people with mental illnesses.

Use of Standardized Learning Materials

It was noted in the 2010 report that a number of police services were using the training video (Recognition of Emotionally Disturbed Persons) developed by the Canadian Police Knowledge Network (CPKN). This continues to be the case; a number of police services reported that they use this program. Since the 2010 report, an additional and more comprehensive web-based education program has been developed by the ENPQ, entitled 'Vulnerable' (as described previously). At the time of this report, this program was only available in French; this limits access. However, within Québec, there are a number of police services using this program. Several other police services reported using videos produced by the Ontario Police Video Training

Alliance (OPTVA). There is clearly a market for these types of standardized learning materials.

Mandatory versus optional education and training

Most police services do not have mandatory in-service training specific to mental illness, and most do not require periodic mandatory requalification training on this topic. Of the 32 agencies that responded to the survey, seven required a certain amount of training that must be completed once during an officer's career, and eleven stated periodic refresher training was mandatory. The frequency of required retraining varied from every year to every three years. Not surprisingly, the extent of the training varied with the retraining interval. Police services that required annual refresher training generally required only one to two hours. It was noted the police agencies that required training at three-year intervals tended to provide more extensive training; sometimes as much as 12 to 18 hours.

The question of how much and how often training needs to occur is not easy to answer. Again, it might well depend on the nature of the initial academy level training, the recency of that training, the skill level of the officer, and to what extent issues related to working with people with mental illnesses are integrated into other types of learning. For example, 16/32 respondents stated that at least some attention was devoted to issues of mental illness in use-of-force training, although in some cases it was not reliably the case or was confined to discussion of excited delirium. Ten organizations included discussion of relevant legislation (e.g. Mental Health law, Human Rights) in their reviews and updates of provincial laws and statutes. A similar number paid attention to issues related to mental illness when teaching communication skills and de-escalation, officer safety, and diversity training.

Perception of need varies

There was substantial variability in terms of the perception of the need for learning in this area. Several of the organizations that responded stated this was not a priority area within their police service and that as a result no recent in-service training had been provided. Others noted it was a high priority and training was mandated for all police officers. Many of the organizations which identified this as a high priority area were in British Columbia where training has been mandated by the provincial government. However, there were a few other police services outside of British Columbia also providing mandatory training, as noted below.

In the survey questionnaire, each police organization was asked to state what percentage of their officers had received sufficient education and training in this area. Responses were highly variable, and it was evident that 'sufficient' meant different things to different people. Several police services reported that their officers have received sufficient training at the academy level and as a result no additional training was required. Notably, this was independent of which police academy the officers had attended and how much basic education they had in fact received. Other police services, such as Delta and Toronto indicated that 100% of their officers had received not only basic academy level education but also mandated in-service education.

Others reported that the vast majority of officers had at a minimum completed the aforementioned CPKN online course. Several police services were more critical of their own performance in this area, stating that as few as 30% had received sufficient education in this area, that they relied on training at the academy level and had not provided any subsequent education, or that while more junior officers had received recent training at the academy level more senior officers have not had the benefit of this or any other specific training. Interestingly, no police service identified any specific target groups within their organization who were specifically provided additional or remedial training. A number of police services provided focused training for specialized officers (Halifax, for example) but it was unclear whether any police service focused on training, for example, for more experienced officers who would not have had the benefit of training at the academy level, or for officers who might have been observed to have weaker communication or de-escalation skills or who might have been the subject of complaints from PMI.

To be clear, the current survey did not specifically ask for this information and needless to say we cannot speak to individual remediation plans for specific officers. It is however worth making the observation that the minority of officers who have difficulty in this area are likely known within the organization and it might be prudent to identify and direct these officers to specific education and training, given that mandatory training is not the norm.

Resources available to police personnel

Regardless of how extensive an officer's academy level or in-service training is, there are bound to be times when an officer might have need of additional information or might have questions in regard to their interactions with people with mental illnesses. One question that was asked in the survey was whether police services were able to provide access to additional information for an officer if he/she had a specific question or needed more information. For many police services, about half the respondents, the answer was simply 'no.' A number of organizations reported that

officers had ongoing access to the video training materials such as the CPKN course or the Vulnerable program in Québec. The British Columbia CID training delivered by police agencies and training centres such as the JIBC's Police Academy and the Pacific Training Center of the RCMP includes substantial useful additional information by way of handbooks for police personnel who have competed CID training.

Several larger services referred to the presence of in-house 'specialists,' such as an officer in the role of a mental health coordinator or a person in charge of services for vulnerable populations. Several referred to regional or provincial libraries which were not on site but which were technically accessible by officers. A few police services referred to resources available on an internal intranet. One police service (Brockville) referred to good working relationships with the local mental health crisis team and stated that officers were always welcome to contact this team for information or advice.

It appears the majority of resources available to most officers are online and that the majority consist of programs or courses, rather than resources to which an officer might go with a specific question. If, for example, an officer is wondering if the same strategies that are useful for a person with auditory hallucinations might also be useful for persons with visual hallucinations, he is unlikely to sit down and review an entire video or other course training material. While it was not reported by many organizations in the survey sample, it seems likely that some police services have mental health counterparts with whom they consult informally about specific issues or questions. In addition, of course, one presumes that officers would have general access to the Internet at least intermittently and would be able to 'Google' questions they might have. Nevertheless, there seems to be room for significant further development in terms of providing readily available resources more appropriate on a consultation basis as opposed to a formal education and training basis.

Size of a police agency is not a predictor of the amount of education and training provided

There is often speculation as to whether smaller police services have an advantage or a disadvantage in terms of providing in-house education and training. They are often disadvantaged in that they are not able to employ full-time curriculum developers or in-service educators and, thus, might not have access to the types of materials that larger services can develop. On the other hand, smaller services can and do make use of materials developed elsewhere; the global expense involved in training within a smaller service, which might be able to be more flexible in terms of scheduling, is needless to say significantly less than that of attempting to educate an entire large police service.

Indeed, of the small police services that responded to the scan, a large degree of variability was evident. Consistent with the first observation above, it appears that a number of small police services simply provide no in-service training in this area. Several commented that they did not have the resources available; others suggested it was not a high organizational priority. Of the small police services that provide training, the mechanisms were varied.

As noted, several made use of pre-existing materials such as the CPKN program, videos from the OPVTA or Québec's "Vulnerable" program. The Brockville Police Service in Ontario, which has about 65 officers, hosts an annual or biannual conference to which both officers and community members, including community mental health partners, participate. It includes both subject matter presentations about mental illness and strategies for dealing with people with mental illness as well as updates on community resources and interagency responses.

Delta Police in British Columbia, which is a 'larger' small service (170 officers), provides extensive in-house training; this takes 12 to 16 hours and is required every three years. In their training and education, they provide coverage of a wide variety of topics and use a variety of teaching methods. Unlike most police services, they also conduct what appears to be meaningful evaluation encompassing a variety of media. They also note that people with mental disorders participate in the delivery of their curriculum on a regular basis, as do local mental health agencies.

Evaluation of education and training is an area of weakness

Evaluation, with any rigor, is an area of weakness for the majority of police services. In many cases, officers are simply required to show up; there is no subsequent evaluation of their knowledge or skills or application of the same. In other cases, officers evaluate the training they received and provide feedback; nevertheless, again there is no assessment of the officers themselves or their abilities to retain and apply the information provided. While it might be argued that deficiencies in an officer's abilities would be reflected in their performance reviews on an ongoing basis, there is generally no mechanism for linking this assessment to the presence or absence of training. Several police services specifically mentioned that evaluation in this area was reflected in annual performance appraisals but as we did not collect information specific to performance appraisals, the study is unable to comment on this mechanism or its effectiveness. One might argue that education and training in relation to mental illness might be best assessed in the same way that, for example,

an officer's ability to use a firearm is assessed regularly. In other words, if at the annual qualifications the officer does not continue to meet the minimum standard, a remediation plan or refresher training is provided until such time as the officer meets the standard.

A few police services seemed to be assessing officer performance in a meaningful fashion. Victoria Police in Canada, for example, grades officers on their ability to:

- de-escalate the situation;
- show empathy;
- demonstrate active listening skills;
- provide necessary support; and
- resolve the situation appropriately including either hospital or community referrals

Toronto Police require officers to participate in scenario training; interactions are observed and evaluated and if deficiencies are noted, remedial training is instituted.

Delta Police, as noted above, also seem to provide meaningful evaluations. They monitor officer performance through statistical analysis, using the SBOR (Subject Behaviour/Officer Response) forms; they solicit post-training feedback from participants; they also conduct face-to-face situational debriefings with participants. Similarly, Hamilton Police monitor use-of-force reports and Mental Health Act apprehensions as a method of general feedback.

Amount of in-service education and training seems unrelated to the amount of basic training and education

One hypothesis raised in the basic education portion of this report is that gaps and weaknesses in academy level training might be compensated during subsequent in-service training. The present study was not able to identify any particular trend in this direction from the in-service information available. Several responding police services whose officers are trained at provincial or centralized academies reported that they did not offer subsequent mandatory training as they felt their officers had been sufficiently trained at the academy. However, other police services whose officers came from the same academies provided extensive additional education.

Again, it would seem appropriate to ensure there is communication and collaboration between the respective academies and the police services/detachments to ensure that all areas are well covered. It was not clear what in-service education and training is available to RCMP officers at the divisional and detachment levels across Canada with the exception of that delivered by their Pacific Training Centre in BC.

Curriculum Development

There appeared to be a number of issues and problems related to curriculum development in this area. Only about half of police agencies involved mental health professionals or people with mental illnesses in the development of their curriculum, and even fewer included both mental health professionals **and** people with mental illnesses. Curiously, a number of police agencies reported their curriculum development specialists had left the agency and they were thus currently in the process of hiring for such a position. Since people with specific skills and credentials in the area of curriculum development are often not police officers and since it appears that police agencies are reluctant to solicit the opinions of people other than police officers, at least in this area of training, this might represent a systemic difficulty in the development of effective education and training of police personnel.

It was unclear during the present study as to the extent to which police services share materials in either this or other areas. Clearly, when there are online or video materials developed by organizations such as the CPKN, OPVTA or ENPQ, materials are often readily shared and used by a wide variety of organizations. It is unclear as to whether other specific learning materials, lecture materials, or scenarios are exchanged across police services. As was mentioned in the case of the basic training situation, given the relatively common needs across police agencies, it would make sense to avoid duplication of effort and share materials and curriculum design whenever possible.

Curriculum Content

Given the variability of in-service education and training across police agencies, it is difficult to comment on specific content in a comprehensive fashion. However, there were some notable trends.

Of those in-service programs that discuss signs and symptoms of mental illnesses, it appears they cover much the same diagnostic groups as do the basic training programs. What this means is that the diagnostic groups less likely to be discussed at the academy level are also not likely to be discussed at the in-service level. For example, while most in-service programs include psychotic disorders, anxiety and depression in their curriculum, few include brain injury, autism and other developmental delays.

In comparison to academy level training, however, there is a much greater focus on interactions in collaboration with community mental health agencies; the majority of programs reported that they addressed this.

During in-service learning, there appears to be a noteworthy focus on verbal and communication skills including calming and defusing techniques, and de-escalation strategies.

About two thirds of responding police agencies also addressed the need for operational flexibility in regard to standard police operating procedures when interacting with people with mental illnesses.

Education is provided to personnel other than police officers

The 2010 TEMPO report suggested that education in regard to mental illness is appropriate not only for police officers, but for other police personnel. Indeed, in the present study a number of police organizations reported they provide education and training to other personnel. It appears to be increasingly common that dispatch and communication personnel receive such education: a number of organizations provide this (Bridgewater, Brockville, Sudbury, Timmons, Regina, Delta, Hamilton and Victoria). Victoria's training is available to not only dispatchers but also victim services personnel, provincial legislature security staff and frontline mental health workers. Hamilton Police makes training available to victim services personnel, auxiliary and special constables as well as dispatchers. The program developed by the Alberta Solicitor General is specifically for non-police personnel such as sheriffs. The program at the Atlantic Police College is also open to a wide range of personnel.

Although this scan only requested information about education for police personnel, there were a number of police organizations that also reported they provided education to other groups—not only other first responders such as ambulance personnel and firefighters, but also to mental health workers. Several respondents commented on the value of educating mental health workers and police together, to ensure that they are all not only "on the same page" and also to facilitate the formation of working relationships between the various systems. Several respondents also commented on the need to provide mental health workers with education about how the police and criminal justice systems work, since typical mental health personnel are not well informed in this area.

Collaboration among Police Agencies and Police Academies

Although respondents were not asked about this specifically, it became evident in the responses that there is an increasing tendency for police services to develop training/learning materials jointly, to collaborate with other organization, and to share materials. Many police services mentioned that they had 'borrowed' materials from other organizations, that they integrated pre-existing materials into their own training, or that they worked jointly with other agencies in the development of educational materials.

This was most apparent in the case of videos and online resources but was also apparent in the number of respondents who informally mentioned being participants on regional planning committees or task forces to develop training protocols. The benefits of this kind of approach are obvious.

Given the increased number of sources and expertise of input into the product, increased collaboration among police services should result in a more improved product overall. It should 'raise the bar' by encouraging organizations whose training is less well developed to take advantage of external expertise and existing curriculum and, thus, improve their own product; it also should decrease the amount of time and expense that any one agency would be required to dedicate to development of appropriate curriculum.

As was discussed earlier, given differences in academy level basic education and in local community needs, it might well be that a uniform curriculum is not appropriate for all police services. However, there is inevitably a high degree of overlap and, thus, collaboration among police services and their partner agencies is desirable if not essential.

Summary and Issues Arising:

Again, it should be noted that given the small number of responses received to the in-service scan, conclusions are not definitive; nevertheless, they should be considered during the development of in-service education. With that caveat in mind, the following issues are raised:

1. Once again, the failure to include people with mental illnesses in either the development of in-service curriculum actual training is problematic. All police services should attempt to provide this input in some fashion, whether it is through live presentations or standardized/videotaped presentations. Again, if one uses the analogy of cultural sensitivity issues, it is unlikely that police services would hire an actor and train them to perform as if they were a member of a specific ethnic or racial group. Police services that use scenario training and, particularly, those that employ actors might consider employing people with a history of mental health disorders to play these roles. Police services might also consider working more intensively with their community partners to ensure that they are able to solicit input and participation from people with mental illnesses when they are conducting training.
2. It continues to be the case that many police services do not deliberately and reliably integrate learning about people with mental illnesses into their use-of-force training. Treating education about people with mental illnesses as separate from education about use of force propagates the misconception that the two are unrelated when in fact the data argues to the contrary. Any discussion of the use of force should, by design, include

reference to the possibility that a person might be experiencing a mental illness and that, therefore, specific and alternative strategies should be considered.

3. As noted in the review of academy level training, it is important that individual police agencies maintain open communication with their respective training facilities in order to ensure that in-service education and basic level education are complementary. It is apparent that in certain situations, basic training academies assume that receiving police agencies will complement their training as appropriate to the local situation. It is less clear as to whether police services themselves are aware of this expectation and/or assume this responsibility.
4. It is also apparent that there is a substantial market for standardized learning materials, particularly including online and video materials. The high level of success of the existing programs testifies to this. While any standardized material will inevitably need to be supplemented to meet local needs, there is a continuing need for development and evolution of such education materials. The ENPQ program is exceptional in that it includes far more than passive observation of videos, but also includes interaction, discussion, analysis, and skill acquisition. The Canadian police community should work actively toward finding a source of funding so that this valuable program can be made available in both official languages.
5. Generally, it appears there is substantial redundancy across police services in the development of materials. As was suggested in the recommendations about basic academy level education, police services should work cooperatively to develop an inventory of materials and programs which are widely available to other police services. Given the difficulty that many police services have employing and retaining personnel with the necessary expertise in curriculum development, this is particularly important.
6. Another area in which police services could work jointly would be to develop a library of resources available to officers who might have specific questions rather than a need for general education and training. Individual police services might also identify on a more formal basis mental health partners who are able to answer questions and provide advice to police personnel who request this.
7. One of the challenges that police services face when developing in-service education programs is of course a substantial variability of personnel in terms of their background, knowledge and skill in relation to interactions with people with mental illness. While mandatory training can be useful, it is also expensive and frequently not well received by the target audience. Not only in policing but in other areas of employment, staff with a high skill level might be offended and deterred by training that is perceived to be beneath them. Staff with little skill levels and negative attitudes similarly do not benefit from such training and are prone to 'going through the motions' rather than actively participating and learning from the opportunity. It might be appropriate to consider the knowledge and skills of personnel in this area as part of a periodic staff performance process, and targeting education and training for those personnel who either have insufficient formal background, request additional education and training, or who are identified by supervisory personnel as requiring improved skills in this area.
8. Evaluation at most levels of learning remains an area of substantial weakness. Police services should develop mechanisms for monitoring and measuring the effects of learning both at the level of the individual officer but more importantly at the community level. As was suggested in the Brink et al. (2011) report, it might well be that people with mental illnesses would be more likely to cooperate and essentially give police the benefit of the doubt if they are aware that police are well prepared in this area. Community surveys focused on the mental health community might be an appropriate mechanism for monitoring these kinds of attitudes and performance issues.
9. When police organizations are developing in-service curriculum in this area, they would be well advised to adopt a comprehensive frame of reference such as the 2014 TEMPO framework and use it to conduct a gap analysis of not only their own education but also that which has previously been provided at their respective academy and/or in-service training. It is unrealistic, and in fact largely unnecessary, for each individual police service to develop curriculum from scratch, including the development and conceptualization of needs in this area. This has in fact been done. There needs to be a mechanism for ensuring that police services are aware of frameworks such as TEMPO 2104 and the many outstanding existing education programs that served as a foundation for this framework.

CHAPTER 5
IMPORTANT FACTORS AFFECTING THE DESIGN AND DELIVERY OF POLICE MENTAL HEALTH EDUCATION AND TRAINING

Coleman and Cotton's 2010 MHCC report, *Police Interactions with Persons with a Mental Illness: Police Learning in the Environment of Contemporary Policing*, included a wide-ranging international literature review that established the foundation for a comprehensive learning spectrum for police learning (**TEMPO**) in preparation of police personnel for their work with multiple agencies to interact with persons with mental illness. The present study determined the 2010 literature to be current and relevant; it has, however, been revised below to reflect additional pertinent literature.

When designing and delivering curricula to prepare police personnel for interactions with persons with a mental illness, there are several important factors to take into consideration:

11. What is the appropriate content?
12. Who should be involved in the design and delivery of education and training?
13. What learning methodologies and techniques are necessary? and
14. Who should receive the education and training?

11. What is the appropriate content?

It is important to construct a learning program or a learning continuum to maximize effective knowledge exchange such that it not only imparts factual knowledge but also examines the process and outcomes of police/pmi interactions. As is discussed below, the extant evaluation and research is only moderately helpful. Nevertheless, in the absence of comprehensive and conclusive evidence, it is reasonable to use the content of some existing programs, such as CIT training, as a foundation. Indeed, Watson et al. (2008) suggested that based on research to date, CIT is "a promising approach to improving police response to persons with a mental illness" (p. 366). Complementary to what is included in CIT learning curricula, Lamb et al. (2002) found, in a US context, police officers wanted to know:

- how to recognize mental illness;
- how to deal with psychotic behavior;
- how to handle violence and potential violence;
- what to do when a person is suicidal;
- what community resources were available as well as how to gain access to them; and
- when to call a specialized mobile crisis team (p. 1269).

Lamb et al. (2002) concluded that the education/training of police officers should, at a minimum, include:

- familiarization with the classification of mental disorders;
- learning and demonstrating how to manage persons with mental illness, including crisis intervention;
- how to gain access to meaningful resources less restrictive than hospitalization; and
- the laws pertaining to persons with mental illness, in particular the criteria specified for involuntary psychiatric evaluation and treatment (pp. 1269-1270).

In addition, they added, "considerable emphasis should be placed on de-escalating situations that might otherwise lead to the use of deadly force on persons with mental illness" (p. 1269).

The Canadian Mental Health Association (CMHA)-Saskatchewan pointed out that evidence-based best practice for effective crisis response should include:

- *the development of a core of carefully selected "first call" crisis response officers available 24 hours a day 7 days a week;*
- *a specialized system of dispatch;*
- *a comprehensive 40 hour integrated training for designated officers, dispatch, psychiatric liaison nurses, and other first responders (e.g. ambulance paramedics) with ongoing annual training;*

- *good information and information sharing systems;*
- *protocols for achieving collaboration with mental health services;*
- *development and ongoing support of community crisis response collaboration teams once these professionals are trained; and*
- *a means of evaluation and measuring outcomes (Brief to the Saskatchewan Police Commission, 2009, p. 5).*

Based on their extensive experience in the police and mental health universes, Cotton and Coleman (2008) suggested that police officers should at least:

- know the signs and symptoms of mental illness sufficient to enable recognition of a person with a mental disorder;
- know about mental disorder to make an assessment about how much control the subject is likely to have of their behavior;
- know whether it is likely that the PMI is capable of understanding and responding to the directions given by police;
- know that the standard police procedures and responses that would typically disarm a non-mentally ill person, stabilize the situation or lead to co-operation might have the opposite effect on a person who is experiencing a mental health crisis;
- know how to appropriately adjust decision-making regarding when to apprehend, when to arrest, when to divert and when to seek additional input;
- be competent using techniques for defusing, de-escalating and calming situations involving persons in a mental health crisis;
- be able to reasonably accurately assess suicide risk;
- be familiar enough with mental health legislation to take appropriate action;
- be aware of mental health agencies and options, and who to call for consultation and/or assistance; and
- be aware of the stigma and bias with which most people—including both the public and the police—approach people with mental illnesses so police can adjust their own behavior accordingly (pp. 4-5).

A review of recent literature suggests that while the recommended content remains generally unchanged since the 2010 review, there are changes that might be appropriate in terms of emphasis and focus. Specifically, there is new information available which addresses the topics of stigma, of the relevance of issues related to mental illness in use-of-force training, and of the continuing emphasis on both de-escalation techniques, and discretion/ethical decision making. It should also be acknowledged that while the literature indicates the subject matter above is important, there remain significant issues around evaluation of learning.

A: Evidence-Based Design and Delivery of Learning

The design and delivery of learning will be more effective, as well as efficient, if it is based on findings of rigorous evaluation and research. However, it is apparent from the literature that rigorous evaluation of, and research relative to, police/pmi education and training has not been comprehensive or widespread. An evaluative review by Tucker, Van Hasselt and Russell (2008) revealed methodological shortcomings in the extant research which

- prevent definitive conclusions regarding efficacy of police interventions (e.g., the Memphis Crisis Model);
- have significant implications for the development of policy, standard operating procedures, and training of police personnel; and
- are potentially relevant to the safety of mentally ill persons who, as subjects or suspects, also become potential victims (p. 236).

Watson, Angell, Vidalon and Davis (2010) suggested that deficiencies are likely because the internal record keeping of police organizations is such that the empirical data required for evaluation are often not available. Of the research that does exist, the majority has been focused on Crisis Intervention Team (CIT) education and training;[48] yet, even that is, arguably, less than robust with respect to the general quality of studies. This makes its basis for designing 'evidence-based' learning programs questionable.

Although, when first established, the primary objective of CIT was to reduce police officer and citizen injuries, it has since evolved such that the diversion of PMI, when appropriate, from the criminal justice system is equally important. Watson, Morabito, Draine and Ottati (2008) opined that

> *the basic assumptions underlying CIT, are that training coupled with new policies for dispatch and patrol along with partnerships with mental health*

[46] Crisis Intervention Teams, which originated in 1988 when the Memphis Police developed CIT in collaboration with the National Alliance on Mental Illness (NAMI), are a police-based pre-booking approach. This approach uses specially trained police officers to provide police first response to calls-for-service involving a person with mental illness and then to liaise, as necessary, with the mental health system (Borum, Williams, Deans, Steadman & Morrisey, 1998). Consistent with contemporary policing principles, the evolved CIT is entrenched in a problem-solving approach that aims to address the issues underlying the reason for the call-for-service rather than "simply incapacitating the individual or removing him or her from the community" (Thompson & Borum, 2006, p. 27). The essential elements of CIT are the forging of police partnerships with mental health community resources and shifting the role of police and organizational priorities from the traditional policing model that dealt reluctantly with PMI to a service-oriented model (Watson et al., 2008). Although CIT guidelines suggest 25% of police personnel should be educated and trained, this might vary depending on local circumstances.

providers will increase linkage to mental health services for people with mental illness, reduce the use of force during encounters, and decrease arrests and injuries to both citizens and officers, remain untested against a rival hypothesis that the availability and ease of linkage to mental health treatment is the principal mechanism for effecting these outcomes (p. 362).

Critical to the successful operationalization of CIT, and important to this study, is the 40-hour education/training program that has increasingly become the defacto 'industry standard' in the US and is increasingly prevalent, although usually in a modified form, in Canada, Australia and the UK It is mental health professionals, police officers, mental health advocates and persons with lived experience from the respective communities who typically facilitate the learning, development and mastery of effective crisis intervention skills. Content usually includes education about the causes, signs, symptoms and treatment of mental illness; substance abuse; psychotropic medication; information on commitment criteria and procedures; rights of persons with lived experience; personal stories from persons with lived experience and family members; visits to mental health treatment providers and information about treatment modalities as well as training in communication and de-escalation skills.

Watson et al. (2008) pointed out that the literature has failed to be specific about "which components of CIT are most important to which outcomes, or under what conditions CIT is likely to be most effective" (p. 362). While much literature is available that explains what constitutes a CIT learning program, there has been little published research on its effectiveness (A. Watson, personal communication, January, 2010; Compton, Bahora, Watson & Oliva, 2008). Some examples are:

a. As the result of a wide literature review, Compton et al. (2008) found only twelve reports that described empirical CIT research. They concluded that "the CIT model might be an effective component in connecting individuals with mental illness who came to the attention of police officers with appropriate psychiatric resources" (p. 52). Furthermore, "early research indicates that the training component of the CIT model may have a positive effect on officer's attitudes, beliefs and knowledge relevant to interactions with [persons with a mental illness]" (p. 52). They reported that, at a systems level, "CIT in comparison to other pre and post-diversion programs may have a lower arrest rate and lower associated criminal justice costs" (p. 52). They acknowledged, though, that considerably more research is necessary.

b. Compounding the dearth of research is the issue of the quality of studies as well as the nature and value of the research to the establishment of 'evidence-based' education and training. Even though, intuitively, it might seem that police education/training is necessary for improving interactions with people with mental illness, Watson et al. (2008) were clear that "the existing research does not focus on whether training and how much is sufficient for improving outcomes" (p. 363). They cautioned that while the CIT model might seem to be attractive, there is an absence of a "solid evidence base for CIT or other interventions to improve police intervention with mental illness" (p. 366).[49]

c. With respect to the quality of studies to date, the literature includes several examples of pre-test/post-test evaluation[50] of CIT training. For instance, research by Compton, Esterberg, McGee, Kotwicki and Oliva (2006) based on a pre-test/post-test evaluation of 159 police officers,[51] indicated that

   CIT programs may effectively correct myths, enhance understanding and support, and reduce reports consistent with holding stigmatizing attitudes in the context of officers' responding to calls involving individuals with schizophrenia. This may lead to improved rapport-building skills, de-escalation abilities, and communication between officers and family members; improved patient and officer safety; better outcomes for patients in terms of referrals to mental health services; and fewer incarcerations for minor infractions related to externalizing behaviors of serious mental illnesses (p. 1201).

d. Bahora, Hanafi, Chien and Compton (2008) came to a similar conclusion by means of a pre-test/post-test evaluation of 40 hours of CIT training. Their study involved 92 police officers.[52]

e. Steadman, Deane, Borum and Morrisey (2000) concluded that the deployment of CIT in Memphis was successful in that it had reduced the "arrest rate" resulting from police/pmi contact as well as increasing referrals to appropriate mental health resources.

f. Hanafi, Bahora, Demir and Compton (2008) used thematic analysis of focus group discussions post CIT training to evaluate its effectiveness. Their findings suggested officers experienced an increased knowledge of mental illness, increased patience when dealing with PMI, an increase in referrals and a decrease in criminal

[49] As of 2013, Dr. Amy Watson and her colleagues embarked on a rigorous multi-year evaluation of CIT learning programs in the US.
[50] Pre-test/post-test evaluation is not considered rigorous evaluation. It gives no indication of how well the learning is retained and applied over time.
[51] A control group was not used.
[52] This included a control group of 34 police officers.

charges/arrests as well as improved application of learned skills. They determined that CIT training reduced the unpredictability of crisis interventions and reduced the risk of injury. However, given the methodology, they cautioned about the generalisability of their findings. Their sample size was small and represented only one perspective of the interactions between police and PMI.

g. Compton, Bakeman, Broussard, Hankerson-Dyson, Husbands, Krishan, and Watson (2014a) compared police officers from six police agencies in Georgia, US, 251 of which were CIT trained and 335 officers who were not CIT-trained.[53] The comparison focused on six constructs related to the CIT model:

    - knowledge about mental illness;
    - attitudes about serious mental illness and treatments
    - self-efficacy for de-escalating crisis situations and making referrals to mental health services;
    - stigmatizing attitudes;
    - de-escalation skill; and
    - referral decisions.

In depth, in-person assessments of officers' knowledge, attitudes and skills were made. Many measures were linked to two vignettes in written and video format that depicted typical police interactions with persons with psychosis or suicidality. The study found that CIT-trained officers had consistently better scores on the six constructs than officers who were not CIT trained. As Compton and his colleagues pointed out, the effect sizes for some measures, including de-escalation skills and referral decisions relative to psychosis were substantial.

This study tends to support the notion that learning, such as that included in the CIT training subject of the Compton et al. (2014a) study, has promise for improving police interactions with PMI. As Compton et al. (2014a) noted, future research is necessary to address potential outcomes at the system level as well as outcomes for persons with whom officers interact. Future research should also address other outcomes, in particular, safer outcomes for the public and officers such as reduced agitation and use of force. Moreover, research, they said, should determine whether CIT is an effective mental health service augmentation beyond its now proven beneficial effects for officers.

a. Compton, Bakeman, Broussard, Hankerson-Dyson, Husbands, Krishan and Watson (2014b) studied levels of force used by officers in interactions with persons who they suspected of having a serious mental illness, a drug or an alcohol problem, or a developmental disability. A sample of 180 police officers (91 were CIT-trained and 89 were not) from six police agencies reported on over 1000 interactions; reporting included the level of force used and the disposition of the interaction. That is whether there was resolution at the scene, the options of referral or transport to appropriate services were chosen or an arrest was made.

Of interest is that the researchers reported CIT training, as delivered by the six police agencies, was generally not predictive of the level of force used. Compton et al. (2014b) noted, "findings were not pronounced when physical force was necessary" (p. 1). However, CIT-trained officers were significantly more likely to report verbal engagement or negotiation as the highest level of intervention. CIT-trained officers were also more likely to refer or transport and less likely to arrest than untrained officers. Compton et al. (2014b) concluded that "CIT training appears to increase the likelihood of referral and transport to mental health services and decrease the likelihood of arrest."

Although CIT training, under the circumstances of the study, did not have a prominent effect on the use of force, Compton et al. (2014b) suggested CIT appears to be effective concerning pre-booking diversion from the criminal justice system.

h. Horace Ellis at the Jackson Memorial Hospital in Florida (Ellis, 2013) measured the effects of CIT training on police officers in the Miami-Dade area, and found improvements in attitude, knowledge and perception of people with mental illnesses. His study particularly noted there was a reduction in stigmatizing attitudes. While not part of his study, he also noted that since the introduction of the CIT model in Miami-Dade, there has been a noteworthy reduction in the number of arrests of PMI as well as in the number of deaths of PMI in interactions with police.

i. As previously mentioned, rigorous evaluations of CIT, as well as the training and education to prepare police officers for CIT assignment, have been impeded by the absence in many police agencies of the necessary "internal record keeping capabilities to determine if CIT has met its goals" (Watson et al., 2008, p. 362). Consequently, the available empirical data necessary to evaluate the effectiveness of CIT are limited. Overall, Watson et al. (2008) lamented, "the existing conceptualizations and research on CIT effectiveness have been narrow in scope and have lacked attention to broader contextual forces that may shape implementation and outcomes" (p. 362). Furthermore, they pointed out,

[53] That is, they received 40 hours of CIT training for a median of 22 months before the study. Of note is that the specific CIT curriculum tends to vary somewhat from agency to agency.

> *given the various methodological and resource constraints inherent in evaluating applied interventions, studies to date have not included control groups or modeled important organizational and contextual factors likely to influence CIT implementation and the outcomes of interest (p. 362).*

Nevertheless, CIT is presumed to have wide-ranging effects and thus outcomes. From the perspective of Watson et al. (2008), CIT training

> *should enhance the skills of officers in encounters with those who have mental illness and their families, reduce the need for force by officers, reduce the incidence of violence in these encounters by persons with mental illness, reduce the incidence of arrest, reduce the incidence of injury to all parties involved, and increase access to crisis and other psychiatric treatment. These concepts can be readily measured. A more challenging question is how to study change in these concepts in a way that can assess the effectiveness of police interventions such as CIT. This challenge is apparent in outcomes such as reduced shootings. In a police agency, what does a change of one or two shootings over a year mean in terms of effectiveness of CIT? By more thoroughly conceptualizing these outcomes, we may find opportunities to develop evidence for components of the logic of CIT effectiveness, refine the model, and move toward testable outcome models (p. 362).*

Despite some reservations about evaluations to date, Watson et al. (2008) agreed that "the current research supports CIT as a promising approach to improving police response to persons with mental illness" (p. 366). They suggested, that although research about the effectiveness of the CIT model is imperfect, there is growing evidence that it might reduce officer injuries, minimize the use-of-force, improve officer knowledge, improve the identification of mental illness, improve attitudes of police personnel and their confidence in responding to persons with mental illness, at least in the short term, as well as increase transports to emergency treatment facilities and referrals to mental health services. However, there was not, they cautioned, any "evidence to suggest that the other [desired] outcomes of CIT have been realized." In particular, it is not clear that the "implementation of CIT has decreased arrests of persons with mental illness" (p. 362).

While the above review tends to focus on the shortcomings of research in regard to CIT, this is by no means intended to reflect negatively on the program or the education and training itself. There is no question that the CIT model has been responsible for influencing the landscape in regard to interactions between police and PMI in the US. It is indeed because of the use of this model across multiple US jurisdictions that there are opportunities to systematically evaluate what works and what does not, what the essential components of a constructive response are, and what optimal education might include. While research related to CIT might not be perfect, it is more advanced than other research in this area. The authors of the present study readily acknowledge the inherent ethical and logistical difficulties in conducting research in this area.

Although CIT and the respective education and training are widespread in the US, this is not the only learning model used by police to prepare them for their work with PMI. Examples of research related to police/mental health learning other than CIT training are:

a. McAfee and Musso (1995) found that police/pmi education and training across 50 US states had four common themes:
   - crisis intervention;
   - interpersonal communication/human relations;
   - mental illness/mental retardation;[54] and
   - mental health referral agencies (p. 57).

   They added,

   > *new police officers must be sensitized to a recognition that many citizens have special needs, may not easily understand police commands, cannot understand the concepts of a police caution and may have difficulties communicating information about a crime (p. 62).*

b. A study by Vermette, Pinals and Applebaum (2005) of 150 U.S. police officers found that police officers identified dangerousness, suicide by cop, decreasing suicide risks, mental health law and the "potential liability for bad outcomes" (p. 42) as being the most important to police officers. Vermette et al. (2005) acknowledged that given the limitations of their study, such as a small sample and potentially a bias of the study population, the findings should be treated with caution.

d. Research in the US by Godschalx (1984) concluded that whereas a brief education seminar was effective in increasing knowledge of police officers, it was ineffective in changing attitudes. Their research was based on a small sample, however, and thus caution is necessary when applying these findings.

e. Based on a UK evaluation using pre and post questionnaires, Pinfold, Huxley, Thornicroft, Farmer, Toulmin and Graham (2003) concluded "short educational interventions can produce changes in participant's

[54] This is the terminology used in their paper.

reported attitudes, and can leave police officers feeling more informed and more confident to support people in mental distress" (p. 337). This study also had limitations due to the absence of a control group and only a four-hour learning intervention. Thus, they concluded, the effect of the intervention was not strong.

It is apparent that even though some literature is available with regard to education and training for police/pmi interactions, in general, and for CIT in particular,[55] scholars, overall, have concerns about the methodology of the extant research (e.g. study quality), including the frequent use of pre-test/post-test methodology[56] and the often-small sample sizes.

Canada, Angell and Watson (2010), working in conjunction with the Chicago Police, investigated the relative performance of CIT and non-CIT trained police officers by using a grounded dimensional approach. They found that CIT trained officers tended to utilize a wider range of response options in their daily interactions compared to officers who had not received CIT training. This qualitative study provided a number of compelling quotations and anecdotes which seem to indicate a direct link between training and the actions of police officers. Notably, officers in the study often referred to the more experiential aspects of training as most effective, as opposed to the more factual information and 'lectures.'

B: Stigma Related to Mental Illness and Mental Health Problems

Even though all factors discussed in Section V are relevant and important, arguably, *one of the most important factors is that of stigma* and associated stereotypes relative to mental illness. The manifestation of such stigma and stereotypes often negatively affects the behaviours of persons who do not fully understand mental illness. This tends to influence the behaviour of service providers ranging, for example, from transit drivers to health care personnel to educators to police personnel. Whereas additional targeted research is necessary, it appears that stereotypes about persons with a mental illness remain with some police personnel; that is, many still subscribe to the notion that mental illness equates to violence and, thus, personal risk to the police officer. Although this is but one of several manifestations of stigma attached to mental illness, this can affect how a police officer approaches and responds to someone experiencing a mental health crisis.

Because the understanding of stigma related to mental illness is critical to the design and delivery of learning subject of this study, Dr. Jamie Livingston, a respected scholar in this regard, prepared the following:

How Stigma Affects the Interaction between Police Personnel and People with Mental Illnesses

Mental illness-related stigma is a social process that aims to exclude, reject, shame, and devalue people who live with, or have experienced, a mental illness. It includes prevailing societal beliefs that people with mental illnesses are dangerous, incompetent, untreatable, and worthless (i.e., social stigma). Individuals who endorse such stereotypes are predisposed to behaving in a harmful manner, through either action or inaction, towards those who live with mental illnesses. Stigma also encompasses the rules, policies, and practices of social institutions that arbitrarily restrict the rights of, and opportunities for, people with mental illnesses (i.e., structural stigma). Within this social and structural context, people with mental illnesses are socialized into believing that they are devalued members of society, which can transform their feelings about themselves, their relationships with others, and their perceptions of the world (i.e., self-stigma) (Livingston & Boyd, 2010).

Stigma is expressed behaviourally through interpersonal interactions, such as when people with mental illnesses interact with family, friends, or healthcare providers. Those who live with mental illnesses are susceptible to unfair treatment by others who harbour negative attitudes and beliefs about mental illness. The adverse consequence of these behavioural expressions of stigma is especially acute when it occurs during interactions characterized by extreme power imbalances, such as encounters with the police. Such situations can provoke strong feelings of disempowerment, unfairness, inequity, and injustice among people with mental illnesses.

There are numerous ways in which stigma can exert a negative influence on interactions between the police and people with mental illnesses. Research in Canada (Cotton, 2004), Australia (Godfredson, Ogloff, Thomas, & Luebbers, 2010; Godfredson, Thomas, Ogloff, & Luebbers, 2011), the United States (Compton et al., 2014a; Compton, Esterberg, McGee, Kotwicki, & Oliva, 2006; Watson, Corrigan, & Ottati, 2004a), and several other countries (Chen et al., 2013; Pinfold et al., 2003; Psarra et al., 2008) has examined the attitudes that police officers have towards people with mental illnesses. Although police officers are not immune to mental illness-related stigma (Chen et al., 2013; Psarra et al., 2008), there is great diversity regarding their perceptions both towards mental illnesses and their role in handling situations involving people with mental illnesses (Cotton, 2004; Ruiz & Miller, 2004). In many respects, the attitudes of police officers towards people with mental illnesses appear comparable to that of the public as well as professionals in other sectors (e.g., mental health).

[54] On both counts, most of this is US based.

[55] Pre and post-test evaluations identified in the literature review were conducted immediately before the learning event and soon after completion of the event. Thus, they are unable to account for the necessary mid to long-term behaviour change of police personnel.

Clearly, because of their powerful role in society, any action taken by a police officer that directly flows from stigmatizing beliefs and attitudes can have harmful and enduring consequences for people with mental illnesses—including their willingness to engage and cooperate with the police. Some scholars speculate that the stigmatizing beliefs of police officers contribute towards the over-representation of people with mental illnesses in police shootings, conducted energy weapon (CEW) incidences, and fatalities. The theory is that police officers who endorse stereotypes regarding mental illness are quicker to use physical force as a means of resolving conflict that involves people with mental illnesses. This assertion is currently without solid empirical evidence. However, two studies have examined the relationship between the attitudes and behaviours of police officers in the context of mental illness. The findings provide preliminary evidence that police officers' attitudes and beliefs towards mental illness can affect their behaviour during interactions with people who have mental illnesses. For instance, officers who harbour negative attitudes about mental illness may be more likely to resort to coercive methods, such as arrest or detention, as the principal means for resolving situations involving people with mental illnesses (Godfredson et al., 2010). Similarly, officers who endorse negative stereotypes about people with mental illnesses (e.g., that they lack credibility) may be less likely to investigate claims of people with mental illnesses who have witnessed or have been victimized by a crime (Watson, Corrigan, & Ottati, 2004b). Together, these studies suggest that police officers who harbour stigmatizing attitudes and beliefs about mental illness are unlikely to employ strategies that promote the safe, effective, and fair resolution of interactions involving people with mental illnesses.

Research in Canada (Brink et al., 2011; Livingston et al., 2013; Livingston et al., In press) and the United States (Watson & Angell, 2012; Watson, Angell, Morabito, & Robinson, 2008; Watson, Angell, Vidalon, & Davis, 2010) has revealed that people with mental illnesses report numerous experiences in which they believed that their mental illness contributed to their unfair or unjust treatment by the police. Overall, however, people with mental illnesses tend to evaluate the quality of their interactions with police as being mixed (i.e., positive and negative). For instance, a study of 60 people with mental illnesses in Vancouver, Canada found that, despite prevalent experiences of police use of force, the majority of participants held positive attitudes regarding their interactions with the police (Brink et al., 2011). Importantly, positive perceptions were associated with interactions in which officers employed procedural justice-related skills, such as active listening, perspective taking, empathy and respect, and fairness, rather than coercion and force. Within this study, almost all of the participants indicated the need for police officers to be better prepared to handle situations involving people with mental illness.

Most police personnel and scholars agree that providing mental health education and training to police officers is important and necessary for reducing negative outcomes for people with mental illnesses. Studies indicate that delivering mental health training to police officers can produce attitudinal and behavioural improvements (Compton et al., 2014a, 2014b; Pinfold et al., 2003). For example, Crisis Intervention Team (CIT) training has been found to be associated with small to moderate improvements in police officers' knowledge about mental illnesses, attitudes towards people with mental illness (e.g., social distance), and behavioural intentions (e.g., referral and arrest decisions) (Compton et al., 2014a, 2014b). A point that seems to get lost in discussions about police training is that preparing officers to respond appropriately to people with mental illnesses (e.g., those in psychiatric crises) is primarily about building professional competence, not reducing stigma.

It is an expectation that police officers have adequate knowledge about the community members whom they serve, including the mental health community. Officers are also obligated to treat everyone with whom they interact in an ethical and respectful manner. Moreover, police officers should be required to have the appropriate skills to de-escalate situations involving all types of citizens, including those who live with mental illnesses. These skills and competencies are vitally important, but they should not be conflated with mental illness-related stigma.

Police education and training focused on addressing stigma would help officers understand how endorsing certain stereotypes about mental illness can predispose them to behave in a harmful manner towards people who live with such conditions. Stigma-related education and training should provide officers with the opportunity to reflect on and question their own stereotypes about mental illnesses, and to understand the influence that these biases and misperceptions can have on their decision-making and practices. It would also be beneficial for officers to learn about the police practices that people with mental illnesses perceive to be stigmatizing, and the way in which these experiences contribute to self-stigma. The goal of providing such information is to encourage police officers to be mindful of how their demeanour and conduct can perpetuate stigma. Facilitating direct social contact between the police and people who are recovering from mental illnesses is one of the most effective methods for reducing stigma (Dalky, In press; Thornicroft, Brohan, Kassam, & Lewis-Holmes, 2008).

Factors beyond the attitudes and behaviours of individual police officers are relevant for understanding how stigma affects the interactions between the police and people with mental illnesses (Cotton & Coleman, 2010). Police officers do not perform their day-to-day duties in a vacuum, but rather, they represent a single cell within a large social organism. As Daniel (2004) astutely observes, the decision-making and behaviour of front-line police officers are affected by attitudinal, situational, and contextual factors. People with mental illnesses are—to varying degrees—rejected, excluded, and devalued in the policies and practices of most institutional systems, such as employment, social welfare, and housing. For instance, mental illnesses have been systematically deprioritized in the allocation of healthcare funding (Stuart, Arboleda-Florez, & Satorius, 2012). As a result, many people with mental illnesses have poor access to substandard care that does not meet their needs (Angermeyer, Schulze, & Dietrich, 2003; Muhlbauer, 2002).

The ineffectiveness of the mental healthcare system places people with mental illnesses at a disadvantage by reducing their choices, hindering their recovery, and placing them at risk for a host of negative outcomes (e.g., victimization, medical problems, treatment and non-adherence). These factors, combined with the mental health system's emphasis on psychiatric crises and coercive interventions (Kaiser, 2009), place people with mental illnesses at risk for frequent and recurring contact with the police. Deficiencies in the health and social service systems also severely constrain the options that are available to police officers as they try to resolve situations involving people with mental illnesses. As such, structural stigma that materializes in other life domains (e.g., insufficient funding of mental health services, lack of affordable housing, barriers obtaining employment) exerts a significant influence on the frequency and nature of interactions between people with mental illnesses and the police.

Police have a central role in handling situations involving people with mental illness. Attending to mental health crises, responding to people with mental illness who are witnesses and victims of crime, and diverting people with mental illness to social and mental health services are routine duties for police officers. These interactions are affected by mental illness-related stigma in its various forms. Improving the way in which police officers think, feel, and act in relation to mental illness is certainly a worthwhile activity that has been endorsed by people who live with mental illnesses. However, anti-stigma interventions seeking to improve the lives of people with mental illnesses must also target the structural factors that have created the undesirable social context in which people find themselves in terrible situations (e.g., victimized, in psychiatric crises, homeless, as perpetrators of crime) requiring routine intervention by the police.

Based on research by scholars such as Trovato (2000),[57] Cotton (2004) and Vermette et al. (2005) as well as personal experience of the authors of the present study, it is apparent that some police personnel do not consider responding to calls-for-service for PMI to be 'real' police work: or as some might say: it is not 'core' policing. Why does this perception exist? Is it possible that stigma associated with person with a mental illness is a factor–a manifestation of prejudice? The literature indicates that it might well be.

The literature also recommends police education should include anti-stigma initiatives to challenge the attitudinal barriers of police personnel that lead to discriminatory actions. For instance, curricula designed to prepare police personnel for interactions with persons with a mental illness should include more than fleeting attention to an explanation of why it is that police interactions are important and, indeed, are an integral element of contemporary-policing. Learning models, thus, should include clear linkages between working with persons with a mental illness and the fundamental principles and expectations of contemporary-policing (Coleman, 2012).

While anti-stigma learning should be part of police learning focused on police/pmi interactions, learning limited to that context will not alone result in the desired organisational culture. For a sustainable change of organisational and occupational culture to take place mental health learning must be integrated into all parts of human resource leadership and management including the hiring process, the basic and in-service training and education of police personnel as well as the way the police organisation conducts its internal workplace and also its external public interactions. This begs the question: Can stigma related to mental illness concerning interactions with persons external to the police workplace be reduced by improving the knowledge about mental health internally in their respective workplaces? It seems likely that it should.

Even though intuitively this makes sense, despite an extensive search there does not appear to be any literature available to support the hypothesis that a healthy police workplace which values and actively addresses the mental wellness of employees creates an environment for enhanced understanding and sensitivity that improves police interactions with community members with a mental illness. Nevertheless, if we are to address the mental health needs of personnel who arguably work in a stressful environment, anti-stigma initiatives would, and should, be part of such a wellness program. This type of program is, arguably, the responsible way to lead and manage a workplace.

While research is necessary to support the hypothesis that a robust workplace mental health wellness program would make a positive difference externally as well as internally, it

[57] Inspector Frank Trovato (ret'd). Previously of the Toronto Police.

is reasonable to consider that well-integrated mental health workplace wellness programs such as mentioned above are likely to improve the understanding of mental illness, reduce stigma and debunk many stereotypes such that it would improve police interactions with PMI.

The implementation of the Mental Health Commission of Canada's *National Standard of Canada for Psychological Health and Safety in the Workplace*[58] and/or a comprehensive workplace mental wellness program such as the Calgary Police Service's *The Working Mind: Workplace Mental Health and Wellness* program[59] and a similar program of the RCMP, both established in collaboration with the MHCC, would meet this need. These two programs have been established in collaboration with the Mental Health Commission of Canada based on the Road to Mental Readiness (R2MR), a program developed for the Canadian Department of National Defense (DND). Apparently, an evaluation of the RCMP program is planned for the future.

C: Procedural Justice and a Client/Customer Focus

The importance of perspectives of procedural justice has been discussed above at some length in Section II. However, it is worth restating that in addition to considering procedural justice as a core philosophical element and guiding factor to be taken into account when developing curriculum, it is also a process and attitude that needs to be formally taught and learned in police education programs. As has been noted previously, there are some newer programs such as the Silverstone et al. (2013) scenario-based sessions that focus on the development of empathy, and other initiatives that include a focus on the consumer viewpoint of their interactions with police, and, thus, their perceptions of fairness. However, in education programs which are more factually/technically based, this component is easily lost. Again, as has been noted earlier, many programs still do not include the voice of people with mental illnesses, and, thus, their perceptions of justice and fairness might not be evident. There remains a need to teach and allow police personnel to experience not only what to do and how to do it, but to do so with an appreciation of how it looks and feels to those receiving the service.

D: Police Discretion and Ethical Decision-Making

Police are accorded substantial discretion in how they resolve calls-for-service to which they are dispatched as well as encounters they make directly during their course of business. However, the literature explains, the application of discretion is enhanced when a police officer has the appropriate knowledge, understanding and experience with which to make the best decisions from all available options. For instance, discretion is required when decisions such as whether to apprehend involuntarily or whether or not to make referrals to mental health agencies rather than arrest/charge for an offence. It also applies to situations that present an ethical dilemma.

The nature of incidents involving PMI often requires police officers to assess the situation quickly in order to apply the necessary considerable informed judgment. Menzies (1987, p. 430), cited by LaGrange (2003), concluded a police officer must

> *assess situationally the mental condition of their subjects and ... develop sufficient linguistic skills for communicating such 'diagnoses' to superiors and other officials"–including mental health professionals, for whom they must provide a capsule summary of the incident and behavior that will support and justify the police response (p. 94).*

In police encounters with PMI, discretion must be based on sound reasoning and unbiased good judgment in order to determine which of several options, ranging from patient verbal communications to the use of force, is most appropriate to resolve the situation. Police also must use discretion in making decisions and taking action that sometimes arise from ethical dilemmas. This has implications for police education and training, and even police personnel hiring criteria, with regard to being prepared for such encounters. When police exercise discretion in interactions with PMI, arguably they have historically done so in order to:

- protect members of the public, and
- act in a paternalistic role to safeguard disabled individuals (Bloom & Schneider, 2006).

However, herein lies potential for an ethical dilemma;[60] one that arises most obviously when police interact and work with mental health professionals, but that might also be apparent in the individual daily work of police personnel. If one reviews ethical guidelines and value statements of police agencies on the one hand, and those of mental health professionals on the other, some clear differences become evident. In a broad sense, the responsibility of police is to the collective community–society. For instance, many police agency mission statements from across

[58] Available at: http://www.mentalhealthcommission.ca/English/node/5346

[59] For additional information: http://www.mentalhealthcommission.ca/English/mhcc-newsletter-december-2013-working-mind#sthash.wCpvXSeF.dpuf

[60] For the purpose of the present study, an ethical dilemma is a situation wherein moral precepts or ethical obligations conflict in such a way as to make any possible resolution to the dilemma morally intolerable. In other words, an ethical dilemma is a situation in which guiding moral principles cannot determine which course of action is right or wrong.

Canada include common phrases such as: [61]

- "...ensuring that police are accountable to the public;"
- "the fundamental duties of a police officer include serving the community;"
- "law enforcement official shall at all times ... serve the community and protect all persons;" and
- "in partnership with the community ... to secure a safe and secure environment."

Conversely, the duty of mental health professionals is to the 'individual.' Ethical priorities for mental health professionals[62] include such statements as (taken from various Codes of Ethics for physicians):

- "a physician shall act only in the patient's interest...;"
- "a physician owes his patients complete loyalty...;"
- "the health of my patient will be my first consideration...;" and
- "a physician shall regard responsibility to the patient as paramount."

These distinctions, which speak to the occupational cultures as well as the legal obligations of each group, not only have ramifications at the operational level but also for the design and delivery of learning to police/mental health groups. Each group must understand the culture as well as the occupational and legal constraints of the other.

One situation that sometimes challenges decision-makers and can raise an ethical dilemma is the exercise of authority further to provincial mental health legislation. Canadian provinces and territories, pursuant to their respective mental health legislation, empower police by virtue of an order authorized by a judge or physician to apprehend a person who appears to be mentally disordered and has displayed indication of actual or potential harm to themselves or to others.

In this situation, discretion is usually limited to transporting the person involuntarily to a facility for psychiatric assessment or persuading the person to accompany them voluntarily. In the absence of a pre-authorized order when police have reasonable grounds that a person is a threat to others or to themselves due to a mental disorder, one of their options is to apprehend without an order when it is not practical to obtain one from a physician or a judge (Gray, Shone & Liddle, 2008). If that is their decision, they can then take the subject involuntarily to a "facility" for psychiatric examination or refer the person to a mental health professional.

The situation is similar when an offense has been committed by a PMI. Police have discretion about whether or not to arrest for the offence(s) in question. This is particularly so when the offence is minor. A police officer might decide to arrest and charge, to take no further action, to conclude the contact with a warning, or divert/refer that person to the mental health system. Lamb et al. (2002), albeit in a U.S. context, concluded that when police officers are not aware of appropriate referral alternatives, or such alternatives are not available, they will likely arrest or charge the PMI. This is compounded in communities that have few psychiatric inpatient beds or have limited community mental health services. In such cases, it will seem to a police officer that psychiatric attention might be better accessed through the criminal justice system.

The above issues have the sometimes problematic and unintentional effect of influencing police discretion whereby some PMI who commit minor crimes are inappropriately charged and, thus, enter the criminal justice system. Citing Patch and Arrigo (1999), Lamb et al. (2002) pointed out "some police officers are [found to be] more prone to arrest persons with mental illness, some make a more vigorous attempt to have these persons hospitalized, and a few tend simply to release them with no further disposition" (p. 1267).

Important to note is that, while police officers have substantial discretion when resolving a police/pmi contact, Lamb et al. (2002) found that "there is considerable potential for the disposition to be influenced by police officers' personal attitudes or beliefs" (p. 1267). Furthermore, "in these instances," they shared, "the officers act freely and solve the problem in whichever way they deem appropriate on the basis of their particular attitudes toward, perceptions of, and assumptions about persons with a mental illness" (p. 1267).

Another ethical dilemma often encountered by both police and mental health professionals in the context of police/pmi encounters relates to decisions about what information to share between agencies. For example, at what point does the broader issue of public safety override consideration of individual privacy rights? When do exigent circumstances override the rights of a PMI with regard to self-determination? Yet another dilemma presents when a police officer encounters a person with an apparent mental illness who, in the police officer's assessment, is in serious need of treatment/hospitalization. However, that person does not want to attend voluntarily and the circumstance does not meet involuntary apprehension criteria. The ethical dilemma is: what is the right thing to do?

The appropriate exercise of police discretion is a complex but critical issue. There is not always a clear disposition, in particular, resulting from a police/pmi interaction. However, and of relevance to this study, even though not all ethical dilemmas require police discretion in the traditional sense,

[61] Although these have been paraphrased, they reflect the messages found in many mission statements.
[61] In this instance, this refers to physicians and psychiatrists.

they do, as with police discretion in general, require the necessary appropriate knowledge in order to make well-informed decisions. It is reasonable to conclude, and supported, for example, by Borum (2000), that the exercise of discretion will be improved with the necessary knowledge and competency level. This knowledge will include not only factual information about the nature of mental illness, but also systems knowledge about their mental health partners and local resources. Hence, the necessity to deliver well-structured and evidence-based learning for police personnel.

The resolution of police/pmi situations will be enhanced if the police personnel involved have been educated about mental illness and what is or is not a myth, the options for resolution, their availability and consequences of the various options. With regard to the discretion required to resolve ethical dilemmas, significant time is required during formal learning to discuss the situations likely to be encountered, including both the practical options available and the rights of the PMI, and then work through them with experienced police, mental health personnel and persons with a mental illness. The point is that the issue of discretion (decision-making) as well as the resolution of ethical dilemmas must be included in formal learning and be reinforced at the operational level. In 2014, it appeared that most, but not all, education programs provided sufficient focus in this area and do specifically attend to the question of which alternative action is most appropriate (e.g. arrest, apprehend, other). However it is apparent that not all programs provide sufficient information to ensure that police can interact constructively with their mental health partners. In some cases, as has been noted, this is attributable to the nature of the police academy, which might require that this kind of knowledge is best imparted post-academy once the officer has reached his/her initial place of employment.

E: Behaviour and Attitudes of Police Personnel

Even though effective knowledge transfer is the key to learning, the primary goal of police/mental health learning should also be to ensure appropriate police officer behavior and attitudes regarding persons with mental illness (Price, 2005). As we have already seen, Reuland and Schwarzfeld (2008)[63] pointed out learning in preparation for police/pmi interactions "must do more than *inform* its participants—it must also *transform* them" (p. 2). Transformation as a goal of learning is vital, especially in work environments a) where some police personnel still view police/pmi interactions to be less than 'real' police work and b) where stigma and bias is still evident to at least some degree.

Although somewhat obvious, Lamb et al. (2002) concluded police officers "have assumed the role of 'street-corner psychiatrist' by default" (p. 1266). They added, while speaking from a US perspective, that many officers have accepted this role. Nevertheless, according to Husted, Charter and Perrou (1995) as well as Borum (2000), albeit also in US contexts, they have apparently done so reluctantly and sometimes even with resentment. The ambivalence of Canadian police officers was noted in a study conducted by Trovato (2000). He noted, "on the one hand, officers feel a profound obligation toward EDPs [emotionally disturbed persons] .... while, on the other hand, they feel the public needs protection from them" (p. 81).

Also in a Canadian context, a study of police officer attitudes by Cotton (2004) indicated ambivalence. It showed approximately 50% of officers were concerned that PMI take up more than their fair share of police resources. A considerable minority (38%) of police officers felt they would not be in the position of having to deal with mental illness-related issues if it were not for inadequate mental health services (Cotton, 2004). This would appear to suggest that some police officers did not consider dealing with PMI to be 'real' police work. On the other hand, Cotton's 2004 study also indicated that many, if not most, police officers respond to PMI situations appropriately and with sensitivity. Her study showed most police officers (80%) agreed that dealing with PMI is part of their role and supported the notion that they should be appropriately trained (Cotton, 2004). This is similar to findings reported in a U.S. context by Vermette et al. (2005). They found that police officers were interested in learning more about interacting with persons with a mental illness and that they considered it to be an integral aspect of community-policing. These findings are encouraging and consistent with the philosophical shift of many police agencies from a traditional reactive enforcement model to the collaborative and problem solving community-policing model (Price, 2005).

Borum (2000) cited research from the 1960s and 1970s that suggested negative attitudes and bias of police personnel towards people with a mental illness "was largely due to a lack of information" (p. 333). It has also been suggested that the inadequate preparation of police officers for this role has unnecessarily resulted "in the criminalization of persons with mental illness" (Lamb et al., 2002, p. 1267). The literature suggests education can be, at least, a partial solution to negative attitudes.

Watson and colleagues (2004b) studied whether a police officer's knowledge that a person has a mental illness influenced their perceptions, attitudes, and responses. They

[63] Notwithstanding Improving Responses to People with a Mental Illness: Strategies for Effective Law Enforcement Training (Reuland & Schwarzfeld, 2008) is prepared for the US environment, it also provides a good base for structuring Canadian learning for police/pmi interactions.

found that police officers with such information viewed PMI as being less responsible for their personal situation, more deserving of pity and more worthy of help, but at the same time, more dangerous than persons for whom no mental illness information was available. Of specific note, and important to the design of education and training, they found that a police officer's perception of a person to be violent was significantly increased when a police officer 'knew' that a person had schizophrenia—a manifestation of stigma and stereotypes.

This is of concern since "if this heightened sense of risk causes officers to approach persons with mental illness more aggressively, [police officers] can escalate the situation and may evoke unnecessary violence" (Watson, Corrigan & Ottati, 2004b, p. 52). Borum (2000) was clear that education and training in verbal skills is critical to de-escalate real or perceived conflicts. Such training can not only improve the confidence of officers but also can reduce fear and decrease the risk of harm to officers and persons with mental illness (Price, 2005).

Evidence that 'attitude matters' can also be apparent when the attitude is not as constructive as one might like or expect. For example, the following is a quote from a document reviewing use-of-force training from one police service in a major Canadian city:

> *the concept of utilizing persuasion, advice, and warning as a deterrence can only be attained when the subject whose behavior the officer is attempting to influence is capable of rationalizing and understanding the consequences of their actions. These subjects who often display unpredictable and violent behavior are typically only restrained or controlled by means of physical force.*

Similarly, consider the following quote from a Canadian police candidate at the basic training level, when considering the appropriateness of using CEWs:

> *Of course some people say that Tasers[64] are overused. Obviously it is important that we have really good training and that we try to use communication and try to talk people down when we can. But sometimes, you can't. I mean, if you have an elderly person with Alzheimer's or something who is not making any sense and is agitated, you can't really talk to them, if they get aggressive, a Taser is probably the best option.*

This would seem to indicate that in cases in which the thought process of the person is not logical and coherent, one might reasonably escalate to the use of physical force almost automatically. This, of course, is NOT the case and in most instances people with psychotic disorders and disturbed thought processes can still be 'talked down' in the majority of cases. Indeed, not only police officers but unarmed mental health professionals and family members also do this frequently. These observations would lead one to conclude that a crucial part of education and training therefore would be to not only provide officers with the specific skills to use in interactions with PMI, but also to convince them that one CAN successfully use these skills even when a person might not appear to be completely rational. The learning must be designed and delivered to change attitudes and behaviour of such police personnel

Following in this vein, while as noted there remains scant evidence about the efficacy of education and training in general, there are some outcome assessments that support the belief that experiential learning is a worthwhile and essential addition to tradition classroom-type education. In BC, the provincial government has mandated education and training for police personnel about people with mental illnesses (the Crisis Intervention and De-escalation (CID) Training) but local police agencies are able to adapt and add to the required curriculum as they see fit. In Victoria, BC, such additions include having people with lived experience of mental illness participate in a panel where they speak about their experiences and exchange ideas and experiences with the police officers. The intent is to raise awareness of mental illness, some of the services available, and strategies for communication with individuals in crisis. The BC Schizophrenia Society has been a partner in this learning program.

In the self-evaluations following the training, over 90% of the officers who participated reported they felt that the information from persons with lived experience provided valuable additional information over and above the formal training; 89% felt that they learned new strategies for interacting with people in crisis from these sessions, and 92% felt all police services should include sessions such as this in their training. As one anonymous officer reported,

> *When you get sent to these mandatory training sessions, you often have the feeling that people are just going through the motions to meet some requirement or rule. But having the chance to actually sit and talk to some of the people we interact with on the job, to see them when they are not in crisis, and to hear about their experiences....it really made me stop and think.*

As was noted in the 2010 report, the attitudes of police officers toward PMI are not, on the one hand, particularly negative compared with the attitudes of the general public. On the other hand, it has been well documented that the public, in general, possesses significant misconceptions and stigmatizing attitudes about PMI, particularly when it

[64] Taser is one brand of CEW.

comes to the issue of dangerousness. Given the inherent concern in policing about officer safety, it makes sense that officers will escalate their level of force in any interaction with a person whom they perceive to be dangerous. If officers—or anyone else—possess pre-existing attitudes which link mental illness with dangerousness, then the likelihood of officers moving up the use of force continuum also increases.

F: Defusing and De-escalating Situations

While many police personnel are effective at defusing and de-escalating dangerous, or potentially dangerous situations, they are skills that should be 'second nature' to all police officers as well many other categories of police personnel. Although not directly related to police interactions with PMI, a study by Eby (2011) in rural British Columbia found that in many of the communities studied, respondents noted the apparent deficiency of police de-escalation skills. This, according to the study, was particularly evident among younger police officers. Indeed, they advised, in some instances attending police officers escalated the situation to the point of making it dangerous for themselves and others.

Much of what a police officer is called upon to do is not enforcing the law, but consists of activities focused on service activities, maintaining peace and order and problem solving (Walker and Keitz, 2008). This includes responding to situations that require police to interact with a person with mental illness. Canadian police personnel engage in hundreds of thousands of such interactions each year.[65] Fortunately, the vast majority of these are successfully concluded without resort to the use of any force. These situations require patience and a careful response to avoid harm not only to the police officer(s) but to the person in crisis.

While a police officer(s) should by no means disregard the personal safety of others or themselves, it is apparent that some situations could be better resolved if attending police personnel first used, for example, measured verbal communication skills to defuse or de-escalate, or at least try to avoid escalating, a crisis situation. Although the nature of some situations might make the defusing/de-escalation of the situation challenging, it is incumbent on police personnel to at least consider the option and wherever possible try to defuse/de-escalate the situation. At a minimum, active attempts should be made to not escalate the situation. A good understanding of the dynamics related to persons in a mental health crisis is, thus, an important element of police learning and practice.

Oliva, Morgan and Compton (2010) are clear that "de-escalation techniques can be an effective intervention tool that not only helps individuals who are in crisis but also reduces police liability and injury [to all parties]" (p. 15). Oliva et al. (2010) posit that "when officers are properly trained to recognise these events, they can use effective crisis intervention techniques in addition to skills they already possess to fully intervene during the crisis event" (p. 18). They also pointed that when attending police officers de-escalate a crisis, their intervention "will assist the individual in crisis in regaining control emotionally and resolve or reduce the crisis to a manageable state" (p .18).

The effective communication required to successfully defuse/de-escalate a situation requires not only talking to the individual but also careful attentive listening. The purpose of police interactions, such as with PMI, is to help individuals in crisis achieve, with the assistance of the crisis intervener [the police officer], equilibrium within themselves so they can resume their normal activities (Romano, 1990).

CMHA-Sask emphasized that the most appropriate and effective response when dealing with persons with apparent mental illness is the use of de-escalation techniques. These techniques, they added,

> *must be clearly understood and practiced as they are very different from the communication techniques generally used in police interventions. There must be a recognition and acceptance that these techniques take time and patience, and require listening skills and ways of interacting that may be out of sync with police practices of "command and contain" [which are] applicable in other police interventions. These are, however, the methods most likely to effectively resolve an incident involving a person with mental illness safely and with the best outcome for all involved* (Brief to the Saskatchewan Police Commission, 2009, p. 6).

Overall, they recommended that "best practices in crisis intervention training be incorporated in police recruit and ongoing training for all officers" (Brief to the Saskatchewan Police Commission, 2009, p. 9).

Research in Australia by Kesic, Thomas, and Ogloff (2013) concerning use of non-fatal force during interactions with persons with a mental illness found that incidents of use of force between the police and people who appeared mentally disordered represented a small but significant proportion of their workload. Persons whom police perceived as mentally disordered were more likely to present as irrational and unstable and to threaten or use weapons on the police.

[65] There are no firm reliable data available about the actual annual number of interactions, but based on extrapolations from analysis conducted in places including Toronto (Toronto Police Service, 2013), Belleville (Belleville Police Service 2007) and London (Heslop et al., 2011), it is safe to say that the numbers are high.

On the other hand, the police were also more likely to threaten or use weapons on those who appeared mentally disordered. However, neither the police nor these persons were more likely to injure each other. One of the main implications of their findings was the need to train police officers in more effective communication and verbal de-escalation of incidents that involve people whom they perceive to be mentally disordered in order to minimize the likelihood that they resort to, perhaps unnecessarily, increased severities of force when responding to such incidents.

Equally important, they concluded, is the continued development and evaluation of proactive joint interventions between the police and the mental health system in improving the outcomes of people who find themselves in these situations and who might be experiencing symptoms of mental disorder. Such targeted interventions, they maintained, have the potential to not only reduce the likelihood of these incidents occurring and reducing the use of more severe force by police when they occur, but they also have the potential to contribute to improved longer term health and justice-related outcomes for vulnerable people.

The 2014 Scans indicated that recently this has been an area of significant development in many Canadian police education programs. Whereas previously, there was a tendency for education about mental illness to be more localized in the curriculum, it now seems to be the case that links between use-of-force training, communication skills and other more general topics of education are increasingly including specific reference to issues related to mental illness. Nevertheless, this is not uniformly the case and there continues in many jurisdictions to be a disconnect between use-of-force training, verbal de-escalation skills and issues specific to mental illness in police learning regimes.

G: Mental Illness, Violence and the Use-of-Force

The inclination by police officers to use force during interactions with PMI can be found in the literature. For instance, Watson et al. (2008) found this was so during interviews of PMI who had contact with the police. Although many in our communities, including many police personnel, associate mental illness with violence, the link between mental illness and violence is not well supported by evidence. For that reason, it is important to share accurate knowledge about the relationship between mental illness and violence in order to correct the stereotypical relationship perceived by many. Factual knowledge about the real relationship between mental illness and dangerousness is, therefore, critical when weighing the presenting situation and then applying discretion to avoid escalation of often-delicate situations. While the majority of police/pmi interactions do not include violence or the need to use force, those that inevitably do require the use of force become very public and/or often end tragically. The likelihood of violence increases when a person with a mental illness "has a co-occurring substance abuse disorder and/or is not taking his or her medication" (Reuland, Schwarzfeld & Draper, 2009, p. 6). Again, this is important information for police personnel.

Dupont and Cochran (2000), Nicoletti (1990) and Fyfe (1989) expressed concerns about the use of force by police officers. They identified the necessity to modify use-of-force training to include a greater emphasis on the lower end of the use-of-force continuum (**Appendix C**). That is, an emphasis on initial approach and contact—'officer presence'—and verbal as well as non-verbal communication by the officer. In the specific context of police/pmi contacts, Dupont and Cochran (2000) suggested this can be achieved by a better understanding of the symptoms and behaviors of a person with a mental illness and by learning and applying verbal communication and de-escalation techniques. The literature suggests this will reduce the incidence of the use of physical force.

In part, the literature tells us, this will be because stigma and a police officer's fear is reduced and, in part, because the officer has increased confidence based on the knowledge gained through education and training. Use-of-force training must be more than technical skills such as those necessary to use a weapon and to ensure containment. It must also include a client focus and an emphasis on procedural justice.

The work of Compton, Demir, Broussard, McGriff, Morgan and Oliva (2011) also supported this. They examined the use of force by US police officers during interactions with persons with schizophrenia. Their methodology required 48 CIT-trained officers and 87 non-trained officers to complete a survey containing three scenario-based vignettes depicting an escalating situation involving a person with psychosis. Typical CIT training, as mentioned previously, includes an emphasis on understanding mental illness and the symptoms of mental illness as well as an emphasis on de-escalation techniques. They found that the CIT trained officers tended to rely more on 'non-physical action' to resolve an escalating situation of psychosis than did non-trained officers. CIT trained officers chose less escalation than the non-trained officers.

Moreover, the CIT trained officers consistently endorsed lower perceived effectiveness of physical force. As a result, Compton, Demir et al. (2011) determined that the model of CIT training used by the police agencies involved might be an effective means of reducing the use-of-force in police/pmi encounters. Moreover, they concluded, their findings demonstrated a role for clinicians, advocates, and schizophrenia researchers in promoting social justice through partnerships with diverse social sectors such as the criminal justice systems. Compton, Demir et al. (2011)

concluded "efforts are needed to reduce use of force towards individuals with psychotic disorders" (p. 737). In addition to clinical and programmatic implications, such findings "demonstrate a role for clinicians, advocates and schizophrenia researchers in promoting social justice through partnerships with diverse social sectors" (p. 737).

Morabito, Kerr, Watson, Draine, Ottati and Angell (2012) found that CIT-trained police officers tended to interpret resistant behaviour of PMI differently than did non-CIT trained officers, and that use of force, overall, was lower in police services in which CIT was widely utilized and entrenched, as opposed to services where CIT was not in place.

The authority for police officers to use force, pursuant to the Criminal Code of Canada, is one that is intended to be used 'when all else fails.' When police officers are trained in the use-of-force, most Canadian police agencies employ a use-of-force continuum model (Appendix C). This is usually demonstrated graphically by means of concentric circles that represent a recommended continuum of action for a police officer from initial contact up to, and including, the use of lethal force. While discussing the utility of the graphic is outside the scope of this study, what is relevant is that the continuum starts at 'officer presence.' That is, the initial attitude and actions of a police officer upon arrival can affect whether or not the situation will escalate and, thus, whether a more direct intervention such as voice or physical restraint is necessary.

Anecdotally, it has been apparent that at least some police officers spend insufficient time at the 'lower' end of the continuum—'presence' and verbal communication—before escalating to a 'higher' level–the use of physical force. While each situation faced by a police officer is potentially different, there are often common denominators across situations that require attention. For instance, one common denominator is the difficulty a police officer might have when trying to communicate with a person behaving in a 'bizarre' manner. In these situations, improved comprehension of the total circumstance and a good understanding of the appropriate communication skills could avoid escalation of the situation. This is supported by the work of Compton, Demir, Broussard et al. (2009) and Compton, Demir, Oliva et al. (2009).

Dupont and Cochran[66] (2000), who instituted the first CIT program, have been critical of how police officers are taught the use-of-force, at least, in the US context. Cited by Tucker et al. (2008), they pointed out

> *that the survival model of training regarding self-defense and firearms not only exceeds the real-life frequency of such an occurrence (particularly when compared to the rate of incidents involving mentally ill individuals in crisis) but also seems to inappropriately mold an officers' perception of dangerousness (p. 245).*

Over time, a 'rule' has emerged in policing that a police officer should not permit an armed offender with a knife or other edged weapon to get closer than 21 feet without the officer drawing their handgun ready to shoot if the subject came closer.[67] It is not clear whether this 'rule' is formally taught by Canadian use of force instructors. In any case, many Canadian police officers have attended events such as the private sector *Street Survival Seminar* on their own time or watched the instructional video *Surviving Edged Weapons*. While data are not available about if and when responding officers have applied the 'rule' in Canada,[68] careful observations of some Canadian situations in which the subject has had an edged weapon during a confrontation with police suggests that this 'rule' has likely been applied on at least some occasions.[69] Of note is that Dupont and Cochran (2000), cited by Tucker et al. (2008), not only questioned the '21-foot rule,' but in particular, they questioned the validity of this rule when dealing with a person who might have a mental illness.[70]

A study by John Nicoletti (1990) with respect to the use-of-force by police in Colorado, US and cited by Borum (2000), found that

> *elevated stress levels, lack of training, lack of control over the situation and lack of self confidence were the most frequently cited causes for over reaction, while behaviors mentioned most frequently as being desirable for de-escalation of force were communication and mediation skills, attitude, self defense, physical condition and anger control* (p. 335).

This is informative and applicable for not only the design and delivery of use-of-force training but also for police/

[66] Major Cochran was a long time Memphis police officer.

[67] For more than 20 years, a concept called the '21-foot rule' has been a core component in training officers to defend themselves against edged weapons such as knives and axes. Apparently, originating from some work by Salt Lake City trainer Dennis Tueller and popularized by the Street Survival Seminar as well as the instructional video Surviving Edged Weapons, the 'rule' states that in the time it takes the average officer to recognize a threat, draw their sidearm and fire two rounds at center mass of a person, an average person charging at the officer with a knife or other cutting or stabbing weapon can cover a distance of 21 feet. (http://www.policeone.com/edged-weapons/articles/102828-Edged-Weapon-Defense-Is-or-was-the-21-foot-rule-valid-Part-1/)

[68] In depth data are required about this issue from the various Canadian organisations that investigate use of force of this nature.

[69] Independent research is necessary not only with regard to the validity of this rule but also to determine to what extent it is a) formally or informally taught in Canadian police organisations and b) what if any relationship this rule has played in past Canadian police shootings including Conducted Energy Weapon (CEW) discharges.

[70] Rigorous independent research is required in regard to the '21 foot rule.'

pmi education and training in general. James Fyfe (1989), a leading scholar with regard to the use-of-force, maintained that the notion deadly force encounters result from 'split-second' decisions is not supportable (Borum, 2000). He suggested that excessive force could be reduced by focusing police learning on what a police officer should do and say when *approaching* a situation rather than focusing training primarily on what the officer does during the encounter. Similarly, Watson et al. (2008) posited that the "lack of knowledge and skills on behalf of police officers can cause them to respond with undue force" (p. 360).

12. Who should be involved in the design and delivery of education and training

A: Selection of the 'Training' Personnel

The careful selection of those who instruct and/or facilitate learning can greatly contribute to success in shifting the behaviour of police personnel as well as the organisational culture. Reuland and Schwarzfeld (2008) pointed out the necessity to identify and utilize police and mental health 'trainers' who have the required competencies, experience and credibility to 'teach' their colleagues. Trainers, they said, should have an understanding and appreciation of the goals of the respective police/mental health response model and have experience with PMI in the criminal justice system.

Although it is important to include mental health professionals as well as persons with a mental illness and their families as 'trainers,' those who are selected should have a positive attitude toward the police. That is, they should "have moved beyond any negative outcomes of [past] encounters [with police]" (Reuland & Schwarzfeld, 2008, p. 12).

Overall, Reuland and Schwarzfeld (2008) maintained, the trainers, including police personnel, should "be prepared to contribute in a constructive, positive manner" (p. 12). They must be selected to reinforce the organisational culture desired by police leaders. That is, when a change of practice and culture is necessary, it is imperative to use trainers committed to the desired culture. By using trainers still committed and practicing in accordance with the old culture will not lead to the, sometimes, urgently required change.

The need for qualified and credible trainers/instructors is critical to the effectiveness of not only 'training' but also the success of the service delivery model and, thus, the practices used to interact with PMI. For instance, as Reuland and Schwarzfeld (2008) clearly pointed out, it is important for police personnel to understand the occupational culture of the mental health profession and for mental health professionals to understand the occupational culture of police organizations. It is, thus, essential that messaging during learning also speaks to the necessary commitment of police and mental health professionals to work together for the achievement of better outcomes for all parties, notwithstanding their different occupational cultures and, on occasion, different legislative and regulatory regimes.

Historically, police organisations with a traditional policing culture, as opposed to a contemporary-policing culture, have relied on police officers to lead, manage, design as well as instruct the various training programs delivered to police officers. With rare exception, these police officers, although well intentioned, often have minimal expertise in adult education methods. The result has been a reliance on the traditional classroom lecture format which has been deemed not ideal for adult learners and, thus, is less than effective. The practice still predominant in many Canadian police agencies is that all 'training' should be managed, designed and/or delivered by a police officer insufficiently versed in adult education methods; this is no longer supportable.

Fortunately, in recent time some of Canada's larger police agencies and academies have hired adult education specialists as curriculum designers and to assist delivery of learning suitable for adult learners. A qualified curriculum designer brings to the table the necessary shift in thinking from the traditional approach of 'content/information delivery' to about how to make a difference in how people think and act—how do we help police personnel develop and practice new skills? That is essential for the change of culture and practice.

Notwithstanding the aforementioned, if police personnel are selected to educate and train their colleagues, they must have the necessary experience and the required attitude. Police educators and trainers should also have credibility. This is important in the police occupational culture, but is also important generally since it is human nature to more readily accept and act upon information if the person delivering the message is considered credible. For instance, police personnel who do not consider police/pmi interactions to be 'real' police work might not have been sufficiently educated and trained to understand their police role as well as understand mental illness and the tactics for resolving interactions with PMI (Borum, 2000). Police officers such as this would not likely be appropriate trainers/instructors for the education and training subject of this study. What is required are credible instructors with messaging that empowers positive thinking around mental health. Regardless of the instructor or duration of the course, if the education and training does not address the issue of stigma and prejudice then the desired cultural shift will not be achieved.

While all subject matter included in police/mental health learning requires competent instruction using the appropriate

learning methods, the education and training relative to police use of force is particularly important. That is, it is important to have a trainer/instructor who is technically knowledgeable as a subject matter expert but also understands the value of police practices necessary to avoid escalations and preferably to de-escalate/defuse tense situations.

The BC government and the JIBC have developed an encouraging process that has not only established selection criteria for use-of-force instructors but has also established a *Certified Use of Force Instructor Course* (CUFIC); the goals, of which, are to ensure all participants have the knowledge, skills and attitudes to instruct, assess and certify that officers have the knowledge, skills and attitudes to legally, ethically, safely and tactically:

- select the level of force necessary to protect the public, the officer and the subject and to articulate the rationale that influenced the force response decision(s); and
- judiciously apply the level of force necessary to gain compliance while recognizing human dignity through professional skill, integrity and mutual respect.

While, at the time of the present study, the selection of appropriate instructors and their subsequent certification are subject of field testing by way of a pilot project, the CUFIC program, which integrates de-escalation/defusing with traditional use-of-force training, bodes well for ensuring the 'right instructors' will be training and educating personnel about crisis resolution and the critical use-of force continuum. That is, they will be well positioned to instruct not only the traditional hard skills of use-of-force training but also the essential 'soft skills' necessary to mitigate the need for the use of force. When CUFIC has been successfully piloted, it is destined to become a BC Policing Standard.

Of note, although not directly related to police mental health learning, the Calgary Police prepares their school resource police officers for 'teaching' students by means of PREVNet's Healthy Relationships Training Module "Train the Trainer."[71] The aforementioned examples from JIBC and the Calgary Police indicate a positive trend by police agencies to better prepare police officers to be instructors.

Of significant note is that the literature suggested the design of learning, with respect to content and delivery, for police personnel should be in conjunction with mental health personnel. For instance, Reuland and Schwarzfeld (2008) recommended a "multidisciplinary planning committee to discuss all issues related to program planning, including training" (p. 4) as well as for determining the composition of the training cadre. Lamb et al. (2002) posited that the most effective learning process to prepare police officers for police/pmi contact is led by, and includes, both police and mental health professionals.

Furthermore, with regard to delivery, the literature is clear that it is important to also include a person with a mental illness and/or a family member. For instance, Pinfold et al. (2003), citing the work of Penn, Guynan, Daily, Spaulding, Garbin and Sullivan (1994); Angermeyer and Matschinger (1996) and Corrigan, Green, Lundin, Kubiak and Penn (2001), determined that "a consistently effective strategy for improving public understanding is ... personal contact with someone with a mental health problem, providing a believable and positive experience to dispel myths and stereotypes through direct experiences" (p. 337). The result, they concluded, was that police officers felt better informed and had increased confidence for their future contacts with PMI.

13. What learning methodology and techniques are necessary?

A: Design and Delivery of Learning

Reuland and Schwarzfeld (2008)[72] pointed out that although learning is an essential element of police interactions with PMI, it "must do more than *inform* its participants—it must also *transform* them" (p. 2). Moreover, it must be designed to be congruent with the desired organisational culture and practices of the police agency. Reuland and Schwarzfeld (2008) cautioned that mental health trainers/facilitators should be careful not to over-focus on specific diagnoses and thus lose the attention of police personnel. The intent of the learning should be such that police personnel understand and recognize symptoms so that they can better problem-solve and, when appropriate, make suitable referrals to community resources.

Lamb et al. (2002) further warned that education and training alone are insufficient for the instruction of the use of force, including lethal force, as well as, at an operational level, the establishment of mobile crisis teams without changes to police academy curricula. That is, the resolution to improve police/pmi interactions goes beyond just education; a *systems approach* is necessary to achieve desired sustainable shifts of attitudes and, thus, shifts of occupational and organizational culture as well as practices.

Role-playing as a means for learning is not suitable for all learners or for all situations. Nevertheless, role playing developed by Dr. Silverstone, a psychiatrist, in conjunction with the Edmonton Police appears to be successful in improving the learning experience for police personnel (Silverstone et al., 2013). Furthermore, notwithstanding

[71] Information at http://www.prevnet.ca/sites/prevnet.ca/files/2012-002-Workshop1-1-Healthy-Relationships-Training.pdf

[72] Notwithstanding Improving Responses to People with a Mental Illness: Strategies for Effective Law Enforcement Training (Reuland & Schwarzfeld, 2008) is prepared for the U.S. environment, it also provides a good base for structuring Canadian learning for police/pmi interactions.

scholars such as Vermette et al. (2005) found police officers did not value role-playing, Reuland (2004) found that CIT training often includes role-play exercises. Moreover, although not always popular with police personnel, Reuland and Schwarzfeld (2008) suggested that experiential learning techniques[73] such as:

- role-plays;
- site visits;
- consumer and family member testimonials; and
- simulation exercises (p. 18)

should be included in learning.

14. Who should receive the education and training?

A: The Target Group(s) for Police/Mental Health Learning

The design and delivery methods of police/pmi learning will be dependent on the composition of the target group. Determining the composition of the target audience–the participants–of the learning is of course a critical consideration. Traditionally, police/mental health training has only included police officers. However, it is clear from the literature that education and training relative to police/pmi interactions should not be limited to police officers. At a minimum, it should include all of those police personnel who have, or are likely to have, contact with PMI. Schwarzfeld, Reuland and Plotkin (2008),[74] were emphatic that:

> *all law enforcement personnel who respond to incidents in which an individual's mental illness appears to be a factor receive training to prepare for these encounters; those in specialized assignments receive more comprehensive training. Dispatchers, call takers, and other individuals in a support role receive training tailored to their needs (p. 3).*

Moreover, Reuland and Schwarzfeld (2008) were specific that supervisory and support personnel, such as midlevel managers and field-training officers[75] should also be trained so that they can assist police first responders and facilitate successful resolutions. To this can be added 'front desk' personnel as well as victim services workers and volunteers. The literature is also clear that the target group should include local mental health personnel who are, or will be, working in conjunction with police personnel.

Although some Canadian police organizations' in-service learning, subject of the present study, included police personnel other than police officers as learners, it appeared that many organizations still did not do so. Nevertheless, a few Canadian models have emerged that target a wider group of police personnel than only police first responders. As was described in the summary of in-service education, a number of police organizations in Canada provide training to personnel other than officers. Police in England and Wales include police crisis negotiators, incident commanders and designated police firearms officers such as those assigned to Emergency Response Team (ERT) or Special Weapons and Tactics (SWAT).[76] These examples represent wise decisions and should be encouraged (Coleman & Cotton, 2010b).

B: Post-Secondary Education

While to some extent peripheral to the discussion of in-service learning, it is useful to look briefly at the literature with regard to post-secondary education of police personnel. Even though pre-hire post-secondary education is not, usually, a pre-requisite for hiring police officers in Canada, according to research a candidate with a higher level of education is likely, in many respects, to be better prepared police officer. This includes how they will interact with persons with a mental illness.

LaGrange (2003) posited that contemporary policing in urban communities is "a demanding balancing act in a highly diverse and complex world, one in which officers must have a grasp of social forces, ethics" (p. 91) and the intricacies of applicable legislation. Many scholars[77] cited by LaGrange (2003), found that university education results in an improved appreciation of the ethical issues inherent in policing and an improved understanding of the social and legal complexities. For example, studies have indicated that when police officers are less authoritarian due to greater sensitivity based upon increased knowledge and understanding, the result is that police agencies receive fewer citizen complaints about police conduct. Overall, she determined, the evidence shows that higher education results in "a more professional, less dogmatic approach to police-work" (p. 88). This is supported by a meta-analysis that concluded higher education "is a valid predictor" of superior police officer performance "except for commendations and injuries" (Aamondt, 2004, p. 51).

[73] Experiential learning refers to structured activities designed to enable students to learn through experience (Reuland & Schwarzfeld, 2008).

[74] This is a useful and recommended source relative to the necessary learning for police/pmi response and interactions.

[75] Field Training Officers (FTOs) are experienced police officers assigned to coach new police officers and familiarize them with the variety of situations that police encounter. The coaching period varies between police agencies from a few days or weeks up to approximately six months.

[76] Police emergency response teams with the responsibility of resolving 'high risk' incidents involving potential violence have various names. Two of the more common are Emergency Response Team (ERT) or Special Weapons and Tactics (SWAT).

[77] Such as Lynch, 1976; Tyre & Braunstein, 1992; Cascio & Real, 1976; Finckenauer, 1975; Gross, 1973; Reed, 1988; Roberg, 1978; Smith, Locke, & Fenster, 1970; Feldman & Newcomb, 1994; Carter & Sapp, 1989; Kappeler, Sapp, & Carter, 1992.

Notwithstanding some identified and important benefits, Rydberg and Terrill (2010) pointed out that "college education[78] will [not] provide amelioration of all intricacies of police discretion" (p. 114). However, of relevance to this study is a finding by Rydberg and Terrill (2010) that "college education ... significantly reduced the likelihood of [the use-of-] force occurring" (p. 92). This is supported by findings of Aamondt (2004), McElvain and Kposowa (2008) as well as Terrill and Mastrofski (2002).

With regard to police/pmi interactions, LaGrange (2003) found in a US police agency[79] that even though the encounters she studied were overall comparable in nature, the reported outcomes differed depending on the officers' level of education. More specifically, even when other factors were taken into consideration, university-educated officers were statistically more likely to make 'psychiatric referrals' than their less educated colleagues (LaGrange, 2003). Compared to the university-educated officers, those with lower levels of education were more likely to make an arrest as well as more likely to handle incidents informally.

While debate continues about the advantages of a university education to the work of a police officer, evidence overall seems to be positive. Police agencies or police academies that rely on mandatory education prior to hiring or admission to a police academy might want to ensure that the necessary behavioral and technical competencies related to working with PMI are included in the curricula of the mandatory or desired pre-hire post-secondary education. Considering the findings of research, pre-hire 'higher-level' education coupled with an appropriate behavioral competency profile would provide a good foundation on which to build the post-hire learning and development necessary for police/pmi encounters.

C: Section of the "right" personnel

While to some extent outside the mandate of this study, it is worth noting that training and education are likely to be more effective if the "correct" people are hired as police personnel initially. There is a substantial literature about the recruitment, selection and hiring of police officers. Many organizations including the Canadian Police Sector Council[80] have developed competency profiles for a variety of positions and levels within policing. While none of the identified competencies specifically identify the ability to work with people with mental illnesses, many of those identified competencies are nevertheless relevant- adaptability, ethical accountability and responsibility, interactive communication, problem solving, fostering relationships, for example. Police organizations might want to consider including the assessment of pre-existing attitudes and interactions with PMI as part of their initial selection process.

It was also suggested by at least one police organization surveyed that one way to ensure candidates are aware of the importance of this area of police work, as well as a way to reduce training demands on police academies and organizations, would be to require that police candidates complete the equivalent of the Mental Health First Aid (MHFA) course prior to application for employment, much the same way as many police organizations require First Aid and CPR certifications prior to application.

15. Conclusion

The necessity to improve interactions with persons with a mental illness is a priority for the criminal justice system, in particular police officers in their capacity as first responders. Chief Constable Jim Chu, President of the Canadian Association of Chiefs of Police (CACP), was clear when he said "improving the quality of interfaces and outcomes among persons with mental illness and the police, the criminal justice, mental health and broader human services systems is a primary focus for us" (Chu, 2013). He further stated that a goal of CACP is to advance multi-disciplinary, collaborative learning in support of such practices.

Notwithstanding that education and the training of police personnel alone is insufficient to archive improvement in this regard and that a *systems approach* is vital, compared to ten to twelve years ago, there are now many police academies and police services in Canada that deliver police/mental health education and training in one form or another. During this study, it was not possible—or particularly useful—to review each of these courses in detail. Some use modified CIT-training, and others have developed in-house programs based on local perceptions of need. Based on the literature and the program reviews, there does not appear to be a great deal of new information about the content of education and training curricula that would inform the further development of the TEMPO framework. However, it is apparent that some adjustments are necessary. To that extent, despite the TEMPO framework remaining relatively unknown amongst respondents to the 2014 survey, overall, the TEMPO framework remains a useful and comprehensive framework.

Regardless of what one might call an education/training program, content similar to that included in CIT training appears, based on extant research, to have potential to change police officer behaviour and improve outcomes

[78] Colleges in the US are degree granting institutions.
[79] An agency with 156 patrol officers.
[80] http://www.policecouncil.ca/wp-content/uploads/2013/04/Competency-Based-Management.jpg

of interactions with PMI. Having said that, there are no clear data-based studies, including in Canada, that provide direction as to what parts of education and training or what learning modalities are most effective. There does, however, seem to be increasing evidence that education and training in general has beneficial effects in terms of increasing patience, decreasing use of force and improving attitudes.

The absence of rigorous evaluation in Canada might be due to the lack of adequate appropriate resources to conduct such studies or it might be due to the absence of an appreciation by police leaders about the importance of thorough evaluations. Regardless, research is necessary to determine the efficacy of the various training and education used to prepare police personnel for interactions with PMI.

The literature is also clear that education and training alone, while important to operationalise a strategy(s) of the organisation, are insufficient to change organisational direction and organisational culture when the strategy(s) is inappropriate. Structural and systemic changes are necessary to ensure the strategies for which the education and training is designed and delivered are the right strategies to achieve the desired outcomes.

In most societies, including Canada, there remains a deep-seated stigma associated with mental illness, and often an unwillingness to recognize or deal with the resulting discrimination. The experience of the authors of the present study as well as various colleagues in policing, the community and mental health agencies as well as persons with lived experience and families of PMI is that stigma with regard to mental illness, and, thus, with regard to persons with a mental illness, is still present in police agencies. While this likely does not apply to all police personnel, its presence is such that it is a concern and, thus, must be a focus of education integrated throughout police learning curricula.

For instance, during the present study, it was disconcerting to hear the negative opinions and attitudes of some *use-of-force instructors*. The extent of such attitudes across Canadian police organisations was difficult to determine. Nevertheless, close attention is required by police leaders to how the use of force is taught, the curriculum design and content as well as who is selected to instruct 'use of force.' More specifically, the question arises: notwithstanding examples such as BC's CID training, are techniques to defuse or de-escalate situations taught sufficiently and/or by using appropriate learning methods?

For example, it appears that in some instances, police personnel when facing a crisis involving real or perceived danger fail to apply the appropriate communication and de-escalation techniques they have apparently been taught. Is it a matter of retaining what they learned and/or applying what they learned? Is this due to the effect of the crisis they face or is it because the communication and de-escalation techniques were not taught appropriate to the target group and circumstances? For example, were adult education and learning methods part of the design, delivery and follow up to the learning event(s)? Further study is necessary to clarify these issues.

In summary, in contrast to the 2008 and 2010 reports, the 2014 Scan clearly illustrated concern by some academies and agencies about the criticality of adequately teaching and practicing the de-escalation and defusing of crisis situations in order to potentially reduce the need for the use of force. In this regard, during the present study it was apparent that the necessity to requalify periodically in the 'soft skills' of crisis management as well as the 'hard skills' of use-of-force tactics was recognised and, in some instances, implemented. Furthermore, what has seemed to emerge in the last few years is a greater focus on specific skills and attitudes rather than on only factual knowledge, as well as increased attention to disorders other than psychotic disorders that have traditionally been the major focus. Overall, the study indicated:

- it continues to be a challenge to evaluate training and education programs in any meaningful way. As Watson et al. (2008) noted there are a variety of reasons why straightforward evaluation remains problematic. There are, however, some indications of change in some behavioral responses; this is encouraging. What is somewhat surprising, however, is that given the general reliance that police organizations place on community surveys and perceptions of the public, there appears to have been no such work conducted in terms of the public's perception of the ability of their local police to interact appropriately with people with mental illnesses.

  Given the correspondence between the level of trust that people with mental illnesses have in the police and their resultant tendency to either resist or cooperate noted earlier in this report, a change in attitudes on the part of the public as well as the police might well be predictive of improved outcomes. As far as can be discerned, outside of the comprehensive MHCC research project in BC in 2011,[81] no one has yet undertaken this.
- there also appears to be a tendency for education programs to be embedded in broader and more comprehensive police strategies to improve interactions with the mental health system and individuals with mental health problems.
- there is a continuing trend to focus on attitudes, behaviors and issues related to stigma in addition to simply relating factual knowledge about mental health diagnoses, signs

[81] MHCC's BC study (Brink et al, 2011).

and symptoms. There is some preliminary evidence that focusing on attitudes and assumptions might maximize the likelihood that police will use their pre-existing factual knowledge appropriately.

- there is also indication that some police organizations are incorporating training about mental illness into other aspects of police learning including that which is provided for crisis commanders and negotiators, as well as incorporating police/mental health into use-of-force-training.
- there are several specific training modules in addition to the well-established CPKN course which can be adopted by police services in ready-made form as part of a comprehensive blended learning approach to mental health education and training.
- there is some preliminary evidence that the use of non-traditional police learning techniques, such as simulations, might prove to be a useful adjunct to face-to-face training in this area.

What is clear from the literature and embraced to a greater or lesser extent by some of the learning programs reviewed during the present study is that education and training to prepare police personnel must at a minimum adequately address:

- procedural justice;
- the stigma and attitudes of police personnel;
- the de-escalation/defusing of crisis situations;
- the desired outcomes of interactions with PMI;
- the meaningful involvement of persons with lived experience and their families in the design and delivery of police education and training; and
- the criticality of rigorous evaluation of both basic and in-service education and training to determine the efficacy of same.

While considerable change and improvement has occurred, the findings of the present study are such that some facets of police learning related to interactions with persons with a mental illness can be improved.

CHAPTER 6
KEY RECOMMENDATIONS

After considering the findings of the literature review and the review of police learning programs including those from Canada, the United States, the United Kingdom and Australia, as well as directly communicating with a variety of police and mental health professionals, the following key recommendations[82] have been formulated to better prepare police personnel for contact with persons with a mental illness.

Recommendation 1:
A Framework for Learning Design and Delivery

That notwithstanding the many important elements of police/mental health learning design and delivery, the overriding theme should be a focus on:

- anti-stigma education to challenge the attitudinal barriers that lead to discriminatory action;
- the de-escalation/defusing interactions with PMI by means of effective verbal and non-verbal communications; and
- ethical decision-making, human rights protection and social responsibility.

Recommendation 2: *The Learning Spectrum*

That, at a minimum, the objectives of the ***Learning Spectrum***[83] necessary to prepare police personnel with regard to police/pmi encounters are:

TO UNDERSTAND: [84]

- the importance of adherence to the fundamentals of contemporary policing, such as:
    - a client focus;
    - procedural justice;
    - relationship building;
    - an outcome focus; and
    - a multi-agency approach.
- the role of police personnel in encounters with PMI; and
- the role of mental health professionals, family and community supports in police encounters with PMI, consistent with a *systems approach*.

TO UNDERSTAND:

- the symptoms such as hallucinations, delusions, paranoia, thought disorder, mood disturbances, intellectual impairments, memory problems, dis-inhibition, behavioral disturbances and other signs and symptoms that may accompany major mental illnesses and related problems;[85]
- knowledge about mental illness sufficient to make an assessment about the influence that mental illness might be having on a person's behaviour and ability to comprehend and respond to the requests or instructions of police personnel; and
- the interplay between culture, race, gender and other person-specific characteristics that affect the experience of mental illness.

TO UNDERSTAND:

- the importance of fostering effective police/mental health agency relationships;
- the importance of information sharing protocols between police and mental health agencies;
- local mental health legislation sufficient to take appropriate action when necessary;
- other relevant legislation including that which defines privacy rights and human rights;
- the function of local mental health agencies and options and where/how to call for consultation and/or assistance and/or to make referral(s); and
- police organizational policies and procedures relevant to police/pmi encounters.

[82] Various issues have been raised throughout the report that deserve attention and action, this section brings together those considered to be the key recommendations of the study.

[83] The Learning Spectrum is applicable to all police/pmi learning including basic training and in-service training.

[84] Note: the term understand is used broadly to reflect not only a factual or academic knowledge of the subject matter but also the ability to operationalize and perform the tasks associated with that understanding.

[85] As was noted earlier, there should be focus on signs and symptoms of mental health issues rather than of classification systems and diagnoses.

TO UNDERSTAND:

- how to apply effective communication skills and de-escalation techniques for defusing and calming situations involving PMI;
- how to determine whether it is likely that the PMI is capable of understanding and responding to the directions given by police personnel; and
- that the standard police procedures and practices, which might typically disarm a non-mentally ill person, stabilize the situation or lead to co-operation, might have the opposite effect on a person experiencing a mental health crisis.

TO UNDERSTAND:

- the relationship between mental illness and dangerousness; and
- be able to reasonably accurately assess suicide risk and how to contain the situation and/or when to intervene accordingly.

TO UNDERSTAND:

- how to appropriately adjust decision-making regarding when to apprehend, when to arrest, when to divert/refer and/or when to seek additional input;
- how to apply problem-solving in the police/mental health environment; and
- how to apply ethical decision-making.

Recommendation 3:

Selection of Trainers/Facilitators/Instructors

d. That carefully selected trainers/facilitators/instructors have subject matter expertise and experience as well as training in how to facilitate/instruct adult learners;

e. That use-of-force trainers be carefully selected, trained, certified and monitored to ensure all use-of-force training is well balanced between verbal communications/de-escalation skills and technical use-of-force skills; and

f. That police organizations with a structured police/pmi response model include members of those response groups as trainers/facilitators/instructors of police/mental health learning.

Recommendation 4:

Competency-Based Human Resource Management

b. That police/mental health learning for police personnel in preparation for interactions with people with a mental illness is based on the appropriate competency profile required for police personnel in this role; and

c. That the development of technical and behavioral competencies with regard to verbal communication, interpersonal, conflict resolution/mediation and de-escalation techniques, ethical decision-making (all of which are required for successful Police/PMI contact) be integrated and reinforced across the police personnel learning spectrum.

Recommendation 5:

A Stigma-free Police Environment

d. That police leaders ensure contemporary stigma-free policies are in place in the workplace to guide police/mental health education and training as well as operations;

e. That the provincial and national chiefs of police associations work with the Mental Health Commission of Canada as well as mental health organizations such as CMHA and the Schizophrenia Society of Canada (SSC) to develop a framework for an anti-stigma program for delivery to police personnel; and

f. That the anti-stigma program is a key component of police basic education and training and reinforced during subsequent in-service education and training.

Recommendation 6:

Attitudes of Police Personnel

a. That education for police personnel includes a focus on why and how interactions with people with a mental illness are 'real' police work.

Recommendation 7: *De-escalation and Use-of-Force Education and Training*

e. That the police use-of-force training be reviewed by police academies and police agencies to ensure that ample time is dedicated to understanding, learning and practicing how to resolve situations without the use-of-force;

f. That, while recognizing the importance of technical competence with regard to use-of-force techniques, that all use-of-force training be modified to include and emphasize knowledge about mental illness and symptoms of mental illness, verbal communications, interpersonal skills and the practice of de-escalation techniques.

g. That de-escalation, defusing and calming techniques be subject of requalification training at least every three years; and

h. That learning related to de-escalation, defusing and calming be structured such that police personnel must successfully complete (pass) the requisite education and learning and, further, that the failure to pass will require successful retraining prior to operational re-deployment.

Recommendation 8:
The 'Right' Learning for the 'Right' Personnel

c. That although the extant literature does not provide strong evidence with which to confidently implement 'evidence-based' learning, police leaders, police policy analysts and police educators stay abreast of research and evaluation developments and modify policies and learning curricula accordingly in a timely manner; and

d. That police organizations actively partner with universities and researchers to study the outcome in the operational environment of the learning delivered with regard to police/pmi contact.

Recommendation 9:
Design and Delivery of Police Learning

k. That police learning be designed and delivered by a combination of police personnel, adult educators, mental health professionals, mental health advocacy organizations and people living with a mental illness. Further, that those who participate in the design and delivery of learning are, whenever practical, from the local jurisdiction;

l. That all learning with regard to police policies, practices and police/pmi interactions be client focused and embrace the principles of procedural justice;

m. That police agencies as well as police academies include a competency-based and problem-based learning (PBL) approach for police/pmi interactions similar to that used by the RCMP Academy;

n. That those responsible for curriculum development for basic training as well as in-service education and training should consider the TEMPO 2014 framework as a *gap analysis* tool against which to assess their own curriculum. By identifying the gaps and weaknesses, curriculum designers can not only work to fill those gaps but also be able to communicate the strengths and gaps to the police agencies which eventually employ their graduates;

o. That police academies which provide education and training for more than one police agency or more than one police jurisdiction maintain clear communication with the receiving agencies/detachments in order for both parties to be aware of what is, or is not, covered in training in the various locations;

p. That while police organizations might consider communication skills and verbal de-escalation techniques are best covered in curricula other than the use-of-force module, given what is known about the generalization of learning, particularly early on in the career of police personnel, it is imperative that substantial emphasis is placed on NON-physical interventions, and specific reference to assumptions about mental illness and dangerousness be included in all use-of-force training;

q. That although there is no clear answer to the question: how much training is enough?, those agencies whose specific and identifiable basic training in this area seems to be less than 10 hours should re-examine their curriculum to ensure it is consistent with general practice across Canada;

r. That police academies whose training is all, or nearly all, lecture-based should examine ways in which student learning might be enhanced by use adult learning methods such as simulations, scenarios and other experiential learning, as well as use of multi-media and online resources;

s. That because evaluation of learning remains weak at both the basic training and the in-service education and training levels, police/mental health learning programs should include a behavioral assessment of student competencies, and require successful completion in order to graduate from the respective police academy; and

t. That given the close ties between attitudes, stigma and behaviour, all police academies should ensure that these issues, as well as beliefs about the relationship between mental illness and dangerousness, are included and integrated in the basic training curriculum.

Recommendation 10: *Evidence-based Learning*

a. That national and provincial police associations work with the appropriate agencies/organisations to generate and retain data suitable to assist with a better understanding of the scope and frequency of police/pmi interactions as well as aid the evaluation of police/pmi response models and police/mental health learning; and

b. That Canadian police agencies and/or Canadian policing associations work with scholars to further explore the knowledge gaps by means of research including that identified during the present study.

Recommendation 11:
Provincial Policing Standards

c. That provincial governments establish policing standards that include provision for mandatory basic and periodic police/pmi training qualification/requalification for police personnel; and

d. That subject to the successful testing of the Certified Use of Force Instructor Course (CUFIC) in BC, that a similar, if not the same, process become a police standard across Canada for use-of-force instructors.

Recommendation 12:
Strategies, Policies and Standards

c. That police agencies develop the appropriate policies, strategies and procedures with regard to police/pmi contacts that in turn guide the design and delivery of required learning; and

d. That the design and delivery of police/pmi learning be based on an organisational strategy that emphasises the need, whenever practical, to de-escalate/defuse a crisis situation by means of effective verbal and non-verbal communications.

Recommendation 13:
Knowledge Sharing and Dissemination

c. That, at a local level, police agencies maintain an up-to-date and readily accessible resource 'library;' and

d. That, considering it appears there is substantial redundancy across police services in the development and use of learning materials, police services work cooperatively to develop an inventory of materials and programs which are widely available to other police services.

Recommendation 14: *Integrated Learning*

a. That police leaders as well as directors/managers of police colleges/academies integrate the development of behavioral competencies required for interactions with vulnerable persons, such as verbal communication, de-escalation techniques, patience and relationship building, across police learning programs.

Recommendation 15:
Consumer Driven Learning

c. That as evidence continues to become available about the experiences of PMI with police interactions and the advice they might offer to police agencies, that this be integrated into learning curricula; and

d. That police agencies consult and/or formally survey their local consumers, consumer groups and advocates and integrate local issues, concerns and feedback into their local education and training.

This study found that the TEMPO framework established in 2010 was, overall, sound. Some adjustments were deemed necessary and are reflected in the TEMPO 2014 framework below. It is important to note that TEMPO is not a training tool per se but an umbrella approach that police organizations can use as a framework to assess their own progress in training, to identify gaps in their existing learning programs, and to use as an aspirational document to create appropriate new learning programs. It is intended to assist police agencies to make a positive difference and contribute to public safety in regard to police interactions with persons with a mental illness.

Recommendation 16:
Learning Framework–TEMPO 2014

*That Canadian police agencies be encouraged, in collaboration with their local mental health professionals, to adopt a multi-module learning delivery model–***T***raining and* **E***ducation about* **M***entalhealth for* **P***olice* **O***rganizations (***TEMPO***)–to address the learning necessary to prepare police personnel for encounters with persons with a mental illness (PMI).*

TEMPO 100:

The focus of learning at the TEMPO 100 level is to ensure that police first responders have sufficient knowledge and skills to be able to manage and resolve the types of encounters that police personnel have on a regular basis and to know when to seek additional support or, when available, more skilled intervention.

TEMPO 101: Police Basic Training

This module for 'new police officers/police cadets' in police college/academy should cover the entire recommended ***Learning Spectrum***. (It is estimated this module would be approximately 35-40 hours in order to deliver an effective integrated program). Students will also receive reinforcement of some of the subject matter, such as verbal communication skills, during their use-of-force training (Refer to **TEMPO 500**).

TEMPO 102: Lateral-Hire Police Officers

A blended learning[86] module for lateral-hire police officers who have not previously received the comprehensive police/mental health learning such as found in **TEMPO 101**. (It is estimated this module would be approximately 15 hours in order to deliver an effective integrated program). The purpose being that these officers will then be able to operate at the same level of understanding as those who received this education during standard basic training–**TEMPO 101**. This module should cover the entire recommended ***Learning Spectrum.***

TEMPO 103: Police Personnel/Support Staff

A one to two-day blended learning module for personnel such as communication centre dispatchers, call-takers and supervisors, as well as 'front desk' personnel and victims services workers. The module should cover the recommended ***Learning Spectrum***.

[86] Blended learning in this report refers to a combination of on-line and classroom and/or 'hands on' scenario-based learning.

TEMPO 104: Offender Transport/Prisoner Care Personnel

A one-day module covering the learning objectives of the recommended ***Learning Spectrum*** for personnel responsible for prisoners. A particular emphasis should be placed on symptoms of mental illnesses and suicide awareness in the context of working with both young and adult offenders.

TEMPO 200:

The **TEMPO 200** level learning assumes a pre-existing basic level of competence, and builds on it, but is still focused primarily on the police first responder. It is intended to address periodic refresher and/or the periodic requalification of previously taught information and an update on new developments.

TEMPO 201: Continuing Education (In-Service Training) for Police First Responders

A minimum one-day module for:

- police officers who did not receive the police/pmi training during their basic training; and
- refresher/requalification training approximately every 3 years for each first responder police officer.

TEMPO 202: Field Training Officers/Officer Coaches & newly promoted Supervisors

This two-day module is intended for two target groups:

- designated FTOs/Officer Coaches to enable them to re-enforce the learning their 'new' police officers experienced in basic training; and
- newly promoted supervisors (corporals/sergeants).

TEMPO 300:

The 300 level learning is for police personnel in specialized assignments that require either a more in depth and higher level of skill and knowledge, or a more focused understanding compared to the first responder.

TEMPO 301: Specialized Assignments

A learning module for personnel such as police crisis negotiators, incident commanders, firearms/use-of-force instructors, ERT/SWAT commanders and search and rescue managers. (It is estimated this module would be approximately 40 hours in order to deliver an effective integrated program).

TEMPO 400:

The **TEMPO 400** level is learning for specialist officers who will be providing expert or consultative services with regard to Police/PMI contact.

TEMPO 401: Advanced learning for police personnel assigned to a joint police/mental health response team and/or for police specialists with regard to mental health response.

This intensive module should cover the entire recommended Learning Spectrum. (It is estimated this module would be approximately 40 hours in order to deliver an effective integrated program). The module should also include proficiency in reporting observations both verbally and in writing. It should also include, in addition to the formal learning, workplace learning in the form of a minimum of four job-shadow shifts with their police/mental health response team, if their police agency has one, and a minimum of four job-shadow shifts with a mental health facility.

TEMPO 500:

Learning Module to be inserted into Use-of-Force 'training'

It seems that police officers might be spending too little time and energy at the front end of the use-of-force continuum before progressing to physical contact. This one-day module to be delivered by trained and certified police personnel is intended to be integrated into what has traditionally been stand-alone use-of-force 'training.' It should complement and reinforce the learning of all other **TEMPO** modules. While it should cover the learning objectives of the recommended ***Learning Spectrum***, particular emphasis, and thus reinforcement, should be placed on:

- an understanding of symptoms such as hallucinations, delusions, paranoia, thought disorder, mood disturbances, intellectual impairments, memory problems, dis-inhibition, behavioral disturbances and other signs and symptoms that may accompany major mental illnesses and related problems;
- knowing about mental illness sufficient to make an assessment about how much control the subject is likely to have of their behavior;
- verbal and non-verbal communication skills and de-escalation techniques for defusing and calming situations involving PMI;
- whether it is likely that the PMI is capable of understanding and responding to the directions given by police;
- knowing that the standard police procedures, which might typically disarm a non-mentally ill person, stabilize the situation or lead to co-operation, might have the opposite effect on a person who experiencing a mental health crisis;

- having an understanding of the relationship between mental illness and dangerousness;
- being able to reasonably accurately assess suicide risk and know how to contain the situation and/or when to intervene accordingly;
- knowing how to apply problem-solving in the police/ mental health environment; and
- knowing how to apply ethical decision-making and to exercise of police discretion.

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APPENDIX A
RECOMMENDATIONS OF THE 2010 REPORT

Recommendation 1:
A Framework for Learning Design and Delivery

That notwithstanding the many important elements of police/mental health learning design and delivery, the overriding theme should be:

- a focus on anti-stigma education to challenge the attitudinal barriers that lead to discriminatory action; and
- ethical decision-making, human rights protection and social responsibility.

Recommendation 2: *The Learning Spectrum*

That, at a minimum, the objectives of the ***Learning Spectrum***[87] necessary to prepare police personnel with regard to Police/PMI encounters are::

TO UNDERSTAND:

- the importance of adherence to the fundamentals of contemporary policing, such as:
    - a client focus;
    - procedural justice;
    - relationship building;
    - an outcome focus; and
    - a multi-agency approach.
- the role of police personnel in encounters with PMI; and
- the role of mental health professionals, family and community supports in police encounters with PMI, consistent with a *systems approach*.

TO UNDERSTAND:

- the symptoms such as hallucinations, delusions, paranoia, thought disorder, mood disturbances, intellectual impairments, memory problems, dis-inhibition, behavioral disturbances and other signs and symptoms that may accompany major mental illnesses and related problems;
- knowledge about mental illness sufficient to make an assessment about the influence that mental illness may be having on a person's behaviour and ability to comprehend and respond to a police officer's requests or instructions; and
- the interplay between culture, race, gender and other person-specific characteristics that affect the experience of mental illness.

TO UNDERSTAND:

- the importance of fostering of police/mental health agency relationships;
- the importance of information sharing protocols between police and mental health agencies;
- local mental health legislation sufficient to take appropriate action when necessary;
- other relevant legislation including that which defines privacy rights and human rights;
- the function of local mental health agencies and options and where/how to call for consultation and/or assistance and/or to make referral(s); and
- organizational policies and procedures relevant to Police/PMI encounters.

TO UNDERSTAND:

- how to use communication skills and de-escalation techniques for defusing and calming situations involving PMI;
- how to determine whether it is likely that the PMI is capable of understanding and responding to the directions given by police; and
- that the standard police procedures, which might typically disarm a non-mentally ill person, stabilize the situation or lead to co-operation, might have the opposite effect on a person experiencing a mental health crisis.

TO UNDERSTAND:

- the relationship between mental illness and dangerousness; and
- be able to reasonably accurately assess suicide risk and how to contain the situation and/or when to intervene accordingly.

TO UNDERSTAND:

- how to appropriately adjust decision-making regarding when to apprehend, when to arrest, when to divert/refer, when to seek additional input;

[87] The Learning Spectrum is applicable to all Police/PMI learning including basic training and in-service training..

- how to apply problem-solving in the police/mental health environment; and
- how to apply ethical decision-making.

Recommendation 3: *Learning Model - TEMPO*

That Canadian police agencies be encouraged, in collaboration with their local mental health professionals, to adopt a multi-module learning delivery model - **T**raining and **E**ducation about **M**entalhealth for **P**olice **O**rganizations (**TEMPO**) - *to address the learning necessary to prepare police personnel for encounters with persons with a mental illness (PMI).*

TEMPO 100:

The focus of learning at the **TEMPO 100** level is to ensure that police first responders have sufficient knowledge and skills to be able to manage the types of encounters that police personnel have on a regular basis and to know when to seek additional support or, when available, more skilled intervention.

TEMPO 101: Police Basic Training

This four-day module for 'new police officers/police cadets' in police college/academy should cover the entire recommended ***Learning Spectrum***. Students will receive reinforcement of some of the subject matter during their recommended modified use-of-force training (Refer to **TEMPO 500**).

TEMPO 102: Lateral-Hire Police Officers

A two-day module for lateral-hire police officers that might not have previously received the comprehensive police/mental health learning such as found in **TEMPO 101**. The purpose being that these officers will then be able to operate at the same level of understanding as those who received this education during standard basic training – **TEMPO 101**. This module should cover the entire recommended ***Learning Spectrum***.

TEMPO 103: Police Personnel/Support Staff

A one-day to two-day learning module for personnel such as Communication Centre operators/supervisors, 'front desk' personnel and victims services workers.

The module should cover the recommended ***Learning Spectrum***. The CPKN course *Recognition of Emotionally Disturbed Persons* or the Alberta Government course *Policing and Persons with Mental Illness* could also be useful as a learning tool within this module.

TEMPO 104: Offender Transport/Prisoner Care Personnel

A one-day module covering the learning objectives of the recommended ***Learning Spectrum*** for personnel responsible for prisoners. A particular emphasis should be placed on symptoms of mental illnesses and suicide awareness in the context of working with both young offenders and adult offenders.

TEMPO 200:

The **TEMPO 200** level learning assumes a pre-existing basic level of competence, and builds on it, but is still focused primarily on the first police responder. It includes both a refresher/review of previously taught information and an update on new developments.

TEMPO 201: Continuing Education (In-Service Training) for Police First Responders

A minimum one-day module for:

- police officers who did not receive the 'training' during their basic training; and
- approximately every 3 years, each first responder police officer.

TEMPO 202: Field Training Officers/Officer Coaches & newly promoted Supervisors

This two-day module is intended for two target groups:

- designated FTOs/Officer Coaches to enable them to re-enforce the learning their 'new' police officers experienced in basic training; and
- newly promoted supervisors (corporals/sergeants).

TEMPO 300:

The 300 level learning is for police personnel in specialized assignments that require either a more in depth and higher level of skill and knowledge, or a more focused understanding compared to the first responder.

TEMPO 301: Specialized Assignments

A one-week (40 hour) learning module for personnel such as police crisis negotiators, incident commanders, firearms/use-of-force instructors, ERT/SWAT commanders and search and rescue managers.

TEMPO 400:

The TEMPO 400 level is learning for specialist officers who will be providing expert or consultative services with regard to Police/PMI contact.

TEMPO 401: Advanced learning for police personnel assigned to a joint police/mental health response team and/or for police specialists with regard to mental health response.

This one-week (40 hour) intensive module should cover the entire recommended ***Learning Spectrum***. The module should also include proficiency in reporting observations both verbally and in writing. It should also include, in addition to the 40-hour formal learning, workplace learning in the form of a minimum of four job-shadow shifts with

their police/mental health response team, if their police agency has one, and a minimum of four job-shadow shifts with a mental health facility.

TEMPO 500:

Learning Module to be inserted into Use-of-Force 'training'

It seems that police officers might be spending too little time and energy at the lower end of the use-of-force continuum before progressing to physical contact. This one-day module is intended to be integrated into what has traditionally been stand-alone use-of-force 'training.' It should complement and reinforce the learning of all other **TEMPO** modules. While it should cover the learning objectives of the recommended ***Learning Spectrum***, particular emphasis, and thus reinforcement, should be placed on:

- an understanding of symptoms such as hallucinations, delusions, paranoia, thought disorder, mood disturbances, intellectual impairments, memory problems, dis-inhibition, behavioral disturbances and other signs and symptoms that may accompany major mental illnesses and related problems;
- knowing about mental illness sufficient to make an assessment about how much control the subject is likely to have of their behavior;
- communication skills and de-escalation techniques for defusing and calming situations involving PMI;
- whether it is likely that the PMI is capable of understanding and responding to the directions given by police;
- knowing that the standard police procedures, which might typically disarm a non-mentally ill person, stabilize the situation or lead to co-operation, might have the opposite effect on a person who experiencing a mental health crisis;
- having an understanding of the relationship between mental illness and dangerousness;
- being able to reasonably accurately assess suicide risk and know how to contain the situation and/or when to intervene accordingly;
- knowing how to apply problem-solving in the police/mental health environment; and
- knowing how to apply ethical decision-making and to exercise of police discretion.

Recommendation 4:

Selection of Trainers/Facilitators

a. That trainers/facilitators have subject matter expertise and experience. Furthermore, for police personnel at least, they should have operational credibility with their peers.

b. That police organizations with a structured police/pmi response model such as a joint response model or a model similar to CIT include members of those programs as trainers/facilitators of police/mental health learning.

Recommendation 5: *Competency Based Human Resource Management*

a. That police/mental health learning for police personnel in preparation for interactions with people with a mental illness is based on a competency profile congruent with bona fide occupational requirements (BFOR).

b. That the development of technical and behavioral competencies with regard to verbal communication, interpersonal, conflict resolution/mediation and de-escalation techniques, ethical decision-making (all of which are required for successful Police/PMI contact) be integrated and reinforced across the police learning spectrum.

Recommendation 6:

A Stigma-free Police Environment

a. That police leaders ensure they have contemporary and stigma-free policies in place to guide police/mental health education, training and operations.

b. That the provincial and national chiefs of police associations work with the Mental Health Commission of Canada as well as mental health organizations such as CMHA and SSC to develop a framework for an anti-stigma program for police personnel.

c. Further that the anti-stigma program must be a key component of police basic training and reinforced during subsequent in-service education and training.

Recommendation 7:

Attitudes of Police Personnel

a. That education for police personnel includes a focus on why and how interactions with people with a mental illness are 'real' police work.

Recommendation 8:

Use-Of-Force Training

A. That the police use-of-force training be reviewed by police academies and police agencies to ensure that ample time is dedicated to understanding and learning how to resolve situations without the use-of-force; and further,

B. That, while recognizing the importance of technical competence with regard to use-of-force techniques, that all use-of-force training be modified to include and emphasize knowledge about mental illness and symptoms of mental illness, verbal communications, interpersonal skills and de-escalation techniques.

Recommendation 9:
The 'Right' Learning for the 'Right' Personnel

a. Notwithstanding the extant literature does not provide strong evidence with which to confidently implement 'evidence-based' learning, that police leaders, police policy analysts and police educators stay abreast of research and evaluation developments and modify policies and curricula accordingly.

b. That police organizations partner with universities and researchers to study the effect in the operational environment of the learning delivered with regard to police/pmi contact.

Recommendation 10:
Design and Delivery of Police Learning

a. That police learning be designed and delivered by a combination of police and mental health professionals, mental health advocacy organizations and people living with a mental illness. Further, that those who participate in the design and delivery of learning are, whenever practical, from the local jurisdiction.

b. That all learning with regard to police policies, practices and police/pmi interactions be client focused and embrace the principles of procedural justice.

c. That police agencies as well as police academies use a competency-based and problem-based learning (PBL) approach for police/pmi interactions similar to that used by the RCMP Academy.

Recommendation 11:
Provincial Policing Standards

a. That provincial police acts/regulations include provision for mandatory police/pmi 'training' for police personnel.

Recommendation 12:
Policy and Standards

a. That police agencies develop the appropriate policies and procedures with regard to police/pmi contacts that in turn guide the required learning.

Recommendation 13:
Resource data-base/library

a. That, at a local level, police agencies maintain an up-to-date and readily accessible resource 'library.'

Recommendation 14:
Integrated Learning

a. That police leaders as well as directors/managers of police colleges/academies integrate the development of behavioral competencies required for interactions with vulnerable persons, such as verbal communication, de-escalation techniques, patience and relationship building, across police learning programs.

Recommendation 15:
Consumer Driven Education

a. That as evidence becomes available about the experiences of PMI with police interactions and the advice that they might offer to police agencies, that this be integrated into learning curricula.

b. That police agencies consult locally with consumer groups and advocates and integrate local issues, concerns and advice into the **TEMPO** model.

APPENDIX B
RECOMMENDATIONS OF THE BRAIDWOOD COMMISSION

Emotionally disturbed people:

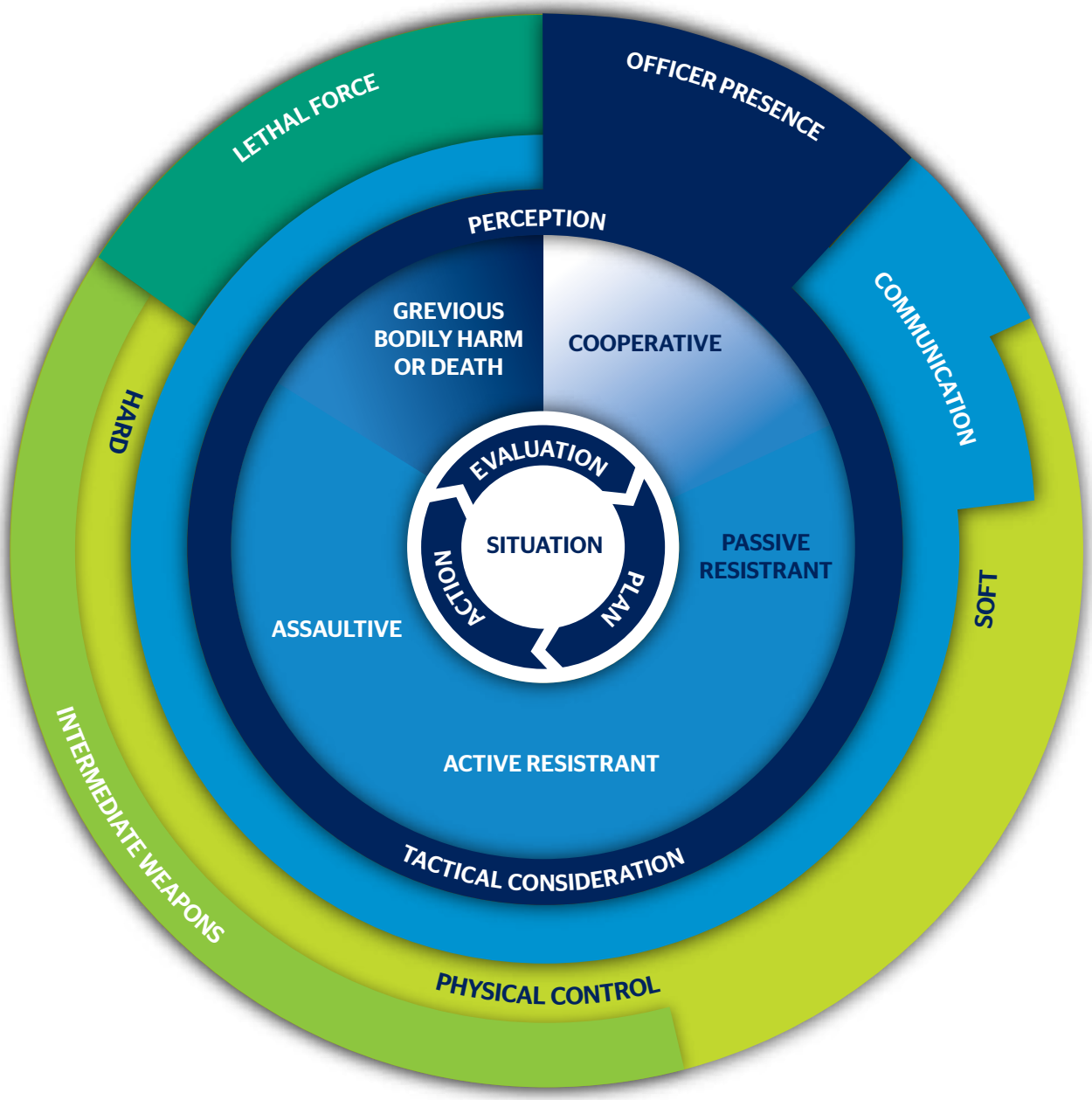
4. I recommend that the Ministry of Public Safety and Solicitor General approve a curriculum for crisis intervention training comparable to that recommended by presenters at our public forums, and require:
    - That it be incorporated without delay in recruit training for officers of provincially regulated law enforcement agencies; and
    - That all currently serving officers of provincially regulated law enforcement agencies satisfactorily complete the training within a time frame established by the Ministry.
5. I recommend that officers of provincially regulated law enforcement agencies, when dealing with emotionally disturbed people, be required to use de-escalation and/or crisis intervention techniques before deploying a conducted energy weapon, unless they are satisfied, on reasonable grounds, that such techniques will not be effective in eliminating the risk of bodily harm.

Subject self-harm

6. I recommend that officers of provincially regulated law enforcement agencies be prohibited from deploying a conducted energy weapon in the case of subject self-harm unless:
    - the subject is causing bodily harm to himself or herself;
    - or the officer is satisfied, on reasonable grounds, that the subject's behaviour will imminently cause bodily harm to himself or herself (Restoring Public Confidence, 2009, pp. 19-20).

APPENDIX C
NATIONAL USE-OF-FORCE FRAMEWORK

National Use-of-Force Framework



The officer continuously assesses the situation and acts in a reasonable manner to ensure officer and public safety.

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