Policing interactions with persons with mental illness

Final Report

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Literature Review

Introduction

Mental health has been at the forefront of social and political concerns for the past several years. This is not surprising as some reports show rates of mental illness as high as one in five in the general population (Ministry of Health Services, 2010), and substantially higher rates in incarcerated populations (Steadman et al., 2008). Resources for mental illness are not meeting high demands and responsibility is being downloaded to health care officials and police, whose budgets and resources are already strained. Furthermore, much of the data on individuals living with mental illness are separated in departmental silos and unable to be shared with the appropriate partners. As such, responses to mental illness needs in British Columbia are largely reactionary and few sustainable changes are being made (Coleman, 2010). Michalski (2017) examines how mental health has become criminalized at various stages throughout the criminal justice system, estimating 1/10 incarcerated males and 3/10 incarcerated females suffer from mental health problems. The author acknowledges tension between health, social services and justice system professionals, and described the need to clarify what it is we want the police to do. This point is made particularly in regard to cost-benefit; incarceration is much costlier than even the most intensive care programs. However, promising work is being done to identify and address these institutional and structural constraints. More than ever, an interdisciplinary approach is a necessary direction for policy and practice to move to provide a meaningful solution to this problem.

While policy and practice are integral, the overarching framework that needs attention is police work done with an ethic of “fairness and social justice.” (Paterson &
Pollack, 2016). How mental health is framed and discussed have incumbent implications on the approach taken. In the ‘first generation’ of policing in regard to MH, training was a key focus. While this is still important, there also needs to be a shift to partnerships, where collaboration can improve outcomes, however, being aware of issues of overburdening and the silo effect.

Individuals living with mental illness have repeated contact with the criminal justice system (CJS) throughout the life course (Reuland et al., 2009; Atkins et al., 2014). This is often a result of the lack of mental health resources available; as a result, these populations are increasingly criminalized (Lamb & Weinberger, 2005). The police usually represent the first point of contact with the criminal justice system and, due to the lack of resources, often act as first responders (Cotton, 2004). In fact, Crocker et al., (2009) found that three percent of all police contacts with the public are related to mental illness. According to a Juristat, where the authors analyzed the Canadian Community Health Survey – Mental Health, looking at people aged 15 or older, 5 million (1/5) people came into contact with police in the 12-month period prior to the survey, 18.8% of which had a mental health or substance use disorder (Boyce, Rotenberg & Karam, 2015). Liegghio and colleagues (2017) qualitatively analyzed intake notes over a 5-year period from the Peel Region where children and youth (ages 0-24) accessed health services, finding 1,449 out of 8,920 cases involved police interventions at intake. The analysis of the memos found two main intervention points where police were involved included in the home of a distressed child, and in the community where the youth was displaying concerning behaviours. The authors suggest children and youth need to be acknowledged in their own mental health interventions, and they need help to debrief during and after what is most likely a
confusing time. Whose job that is remains unclear. Blended services would help to secure and maintain continuous care for children and youth (and adults), as the silo effect is identified as problematic.

Shore and Lavoie (2018) explain that while police contact with individuals with mental illness has increased greatly, officers still express frustration at their inability to handle such files. Their study examined official police data from a mid-sized Canadian city (n = 400), finding the mean age of clients was 37, a significant amount are from ethnic minorities, there’s a high correlation between addiction and mental illness, many calls were initiated over self-harm and by services providers, and over half of the calls resulted in an apprehension. It is pertinent to highlight the risks of police contact with individuals living with mental health issues, as contact can often become a compounding factor. This is not to say police should not be contacting such individuals, however, treating someone as though they have a mental illness, when they don’t, will have no negative impacts, whereas treating someone who has a mental illness without due care and attention, garnered through extensive training, can have deleterious effects. In using community agencies, police can reduce their future workload. Of course, many gaps exist between police and community-based agencies that provide the proper care. Diversion away from the system, but into another system, is less stigmatizing for individuals living with mental illness. This study however, found only 40% of cases were diverted in such a way.

A Vancouver-based study found over the course of two weeks that mental health related calls accounted for over 30 percent of police-attended calls (Wilson-Bates, 2008). The authors of this study also found that the high volume of calls was related to lack of information sharing and lack of resources. As a result, police officers are often expected to
provide pre-diversion support (Lamb et al., 2002) and end up arresting mentally ill individuals, or mercy-booking them, merely to ensure the protection of the arrestee and others (Watson et al., 2008).

A recent research study by Brink and colleagues (2011) has examined the relationship between the mentally ill and the police. They found that in British Columbia, persons with mental illness – when compared to the general public – have more negative attitudes towards the police, and are less satisfied with police performance. Many of these individuals have experienced numerous contacts with the police, many of which involved being picked up and taken to hospital or jail. Over 75 percent of study participants had been handcuffed or restrained by the police (Brink et al., 2011). Though many of the participants were satisfied with non-criminal interactions with police, such as mental health crises, one third perceived previous police interactions as negative (Brink et al., 2011). This research is cause for concern regarding interactions between the persons with mental health needs and the police.

Canadian research has also demonstrated that police interactions are three times more likely for individuals living with a mental illness (Hoch et al., 2009). Forty percent of persons with mental illness will be arrested in their lifetime, and 30 percent have had the police involved in their pathway to care (Brink et al., 2011). One in 20 calls to the police are related to mental health (Brink et al., 2011). In addition, individuals living with mental illness share numerous risk factors with other populations in the criminal justice system. They often have limited access to proper housing, social services or steady education or employment. As such, there tends to be a history of drug abuse, homelessness, victimization or unemployment (Sinha, 2009).
**Policies associated with policing EDP**

In British Columbia, much of what is known about the intersection between police services and EDP is referenced back to the Vancouver Police Department (VPD). With several volumes of reports (see: Szkopek-Szkopowski, 2013; Wilson-Bates, 2008), the VPD has highlighted the high volume of calls-for-service and hours of service that are required to assist EDP. Recently, the Royal Canadian Mounted Police estimates that incidents with a mental health component increased between 2010 and 2014 by 32 percent (B.C. RCMP, 2015).

In recognizing the increasing interactions between police and persons with mental illness, frontline officers in British Columbia are now required to complete mandatory training in crisis intervention and de-escalation. The new training that recruits and in-field officers are now required to complete emerged as a result of the Braidwood Inquiry into the death of Robert Dziekanski in 2007 at Vancouver International Airport. Though the training is certainly an improvement from what was offered in the past, the training program is relatively brief and may be deemed to be inadequate in fully addressing mental health concerns that may arise in the course of a shift. For example, there are other factors, such as the increased use of illicit drugs, especially the new ‘cocktail’ drugs such as those laced with that have fentanyl which have been identified as a high risk for overdose and in some cases, death (Young, Pirie, Buxton, & Hosein, 2015). More generally, there are three pertinent policies that are associated with the direct or indirect increase in calls-for-service: deinstitutionalization, the BC Mental Health Act, and the Criminal Code of Canada.
Deinstitutionalization

Several factors have led to indirect increased pressures on the criminal justice system to respond to mental health concerns in recent years. Most notably is the decline in available psychiatric facilities for individuals living with severe mental illness (Schneider, 2010). Once the largest and only remaining provincial psychiatric hospital in Canada, British Columbia’s Riverview Hospital began to downsize in the 1990s. This downsizing was a result of policy decisions to redirect mental health response to community-focused systems (MacFarlane, 1997). Not only were half of the beds removed, but remaining beds were also being distributed to tertiary care facilities. Funding was redirected to community mental health services, and transitional costs associated with the downsizing (MacFarlane, 1997). This process continued, including cuts to staff and other funding. Riverview hospital officially closed its doors in 2012.

Similar psychiatric services were removed with the intention of de-institutionalizing the mentally ill across western countries. Much research has since demonstrated that the intent to better care for the mentally ill in the community has largely failed. Community resources have not been expanded for persons with mental illness (Sealy & Whitehead 2004; Roesch, 1997). Furthermore, there is little supervision, a lack of proper skills training and inadequate supply of medication (Fakhoury & Priebe, 2007; McEwan, 2001). Both persons with mental illness, and other social services, are now expected to overcome the consequences of deinstitutionalization, without adequate support or funding.

To be clear, with deinstitutionalization beginning some 20-30 years ago in B.C., it would be inaccurate to suggest that there is a causal link that relates to a single policy that has increased police contacts with EDP. It is important to recognize that in recent years,
changes to mental health policy in B.C. have been made to increase tertiary facilities and an attempt to redistribute mental health treatment services away from one location, Riverview, and across the Lower Mainland and Vancouver Island. Recently, the Fraser Health Authority has made it a priority to “develop and enhance a continuum of provincial and regional resource for the severely addicted and mentally ill (SAMI) population” (Fraser Health, 2014b: 52). Here, the development of team-based care such as the combination of primary and community team-based care are vital to improving efficient and effective care for patients.

Boyd and Kerr (2016) conducted discourse analysis on four policy reports on Vancouver’s mental health crisis from 2008-2013, finding the ways problems are framed directly influence how they are governed. Findings include criticisms of deinstitutionalization as directly related to the DTES, and that mental health issues are often equated to dangerousness. The authors note that VPD have been vocal claims makers about mental health in the city, and that the ways in which mental health has been framed through this policing agency could perpetuate structural discrimination. Dangerous framing around mental illness can and does occur, which leads to detrimental practices in policing and a public fear that may be overexaggerated and unnecessary. By ignoring the voices of those with mental illness and other intersections of discrimination, such policies and practices will continue to be re-produced resulting in forms of structural and systemic discrimination.
The BC Mental Health Act

The Mental Health Act has been in place since 1964. This legislation has been updated from time to time with the most recent major amendments occurring in 1999. The Act focuses primarily on individuals who require, but may be unwilling to accept, mental health care and protection (British Columbia Ministry of Health, 2005). Individuals living with mental illness are often unwilling or unable to accept psychiatric care and, thus, the Act is necessary to ensure treatment for such individuals. This can cause problems for not only themselves, but also risk the safety of others. However, the Act is also intended to set guidelines and policy for the appropriate care of these individuals, ensuring protection of their rights and safety (British Columbia Ministry of Health, 2005). Findings from Vancouver suggest that individuals who have been apprehended under the s.28 of the Act have shown higher rates of victimization than the general public, particularly violent criminal victimization (Szkopek-Szkopowski, 2013). Furthermore, the Act lays out the other relevant sections and forms which the police may use/complete when becoming involved with a patient.

Some concerns have emerged in recent years regarding the privacy rights of those detained under the Mental Health Act. The Mental Health Commission has recently commented on the stigmatizing nature of having a mental illness label attached to a police data. In Ontario, the Ontario's Association of Chiefs of Police has changed their province-wide guidelines to ensure that non-criminal contacts between the police and those living with mental illness will not appear in police record checks (Mental Health Commission, 2013).
The Criminal Code of Canada

Provisions for adjudicating mentally disordered offenders (MDOs) are found entirely within the Criminal Code of Canada, and thus, legislative options for dealing with these persons are guided by federal statute. The Code provides the parameters that courts may use to determine if the accused is mentally fit for trial through fitness assessments at designated institutions (e.g., the forensic psychiatric hospital at Colony Farm in Port Coquitlam) and/or that the accused was suffering from a mental illness that significantly interfered with their ability to possess true criminal intent. In accordance with section 16, if a court finds that an individual was suffering from a mental disorder at the time of the offence, that hindered their ability to appreciate the physical consequences of their actions, or from knowing that they were wrong, the accused is given a special verdict of Not Criminally Responsible by Reason of Mental Disorder (NCRMD). Under this verdict, NCR accused are not incarcerated in the traditional correctional stream; instead, they are assigned one of three possible dispositions based on a grouping of factors, anchored by the level of threat that the individual poses to public safety.

Under the Code, these dispositions can be levied by either the trial court or a Review Board, a quasi-judicial tribunal traditionally composed of a psychiatrist, judge or lawyer, and layperson who usually has relevant knowledge on areas of crime or mental health, and data suggest that the court defers to Review Board expertise. The British Columbia Review Board oversees all cases involving NCR accused in the province. Recently, Bill C-54 added the new disposition of high-risk NCR accused. This change places limits on the power of review boards to release an individual even on a day pass and states that only a court can lift the designation.
The structure of policing in Canada and BC

Because of the diverse nature of Canadian geography – particularly, the expansive terrain located in harsh arctic climates and the numerous large bodies of water that both surround and are contained within Canada – policing in the Canadian context is far more complex than smaller, culturally comparable countries (Griffiths, 1999). As well, the tiered policing structure in Canada differs from many comparable countries. In Canada, the majority of policing services are provided by municipal entities. However, provincial police services exist in Ontario, Newfoundland and Quebec and provide policing for provincial roads and jurisdictions without municipal forces (Hutchins, 2014). The national force, the Royal Mounted Canadian Police (RCMP) provides both contract services to municipalities and federal police services. Aboriginal police services also exist in some Aboriginal communities.

In the Lower Mainland of B.C., there is a unique police service that focuses on policing lines of public transportation. The existence of the Skytrain, an elevated commuter rail system providing service across many municipalities, has led to the development of a transit police force. This police force has jurisdiction over all rail stations and trains as many of these trains cross police jurisdictional boundaries. B.C. also has integrated units that cross boundaries as well, addressing connected issues such as gangs, road safety, and the integrated homicide investigation team (IHIT).

Boundary spanners-alternative approaches for mental health programming

Much like the collaborative units that exist within the Lower Mainland, and other areas of Canada, collaborative units have existed in various capacities often for pragmatic reasons.
However, their effectiveness may be directly linked to the influence and management style of the program directors. For example, as a result of a study of prison-based mental health programs in the late 1980s, Steadman (1992) determined the importance of a ‘boundary spanner.’ A boundary spanner is a position – similar to a coordinator – that mediates between several service providers. In the case of mental health in prisons, these providers might include psychiatric staff, correction officers and judicial staff (Steadman, 1992). Boundary spanners can operate across several different organizational structures and facilitate the sharing of information and other core needs that each institution may not be able to address individually.

Individuals in these positions would not be limitless in their powers. Unlike other organizational boundary spanners, those in the criminal justice and mental health system must respond to numerous privacy restrictions (Steadman, 1992). However, these restrictions could be re-defined for the position of a boundary spanner so they would have access to numerous institutions’ files. Recruitment for a boundary spanner position in mental health is also important. These individuals would not only need to be able to withstand the stress of coordinating several institutional demands, but also understand the formalities and informalities of each system. Thus, Steadman (1992) suggests hiring a well-respected, but lower-level employee from within one of the systems to carry out this task. Though he mentions it briefly, Steadman (1992) does not fully address how to fund this position. Funding could be obtained through a commitment of funds from all involved stakeholders as the position would not only reduce their workload initially, but also likely provide better and more sustainable care long term (Waller, 2015).
**Examples of boundary spanners**

*Provincial policy*

There are a wide variety of collaborative programs that exist in British Columbia that indirectly are tied to the intersection of police and EDP. For example, the British Columbia government has devised comprehensive approaches to address mental health and substance abuse issues that aim to improve service delivery, increase interagency collaboration, reduce costs, and most importantly, improve the well-being and quality of life of individuals affected by these conditions. One such campaign is Healthy Minds, Healthy People, a ten-year plan involving multiple government agencies and non-governmental supports that aims to not only address areas where challenges exist, but identifying potential problem areas.

*Mental health liaison officers*

A mental health liaison officer may be considered as a de facto boundary spanner (Livingston, 2008). A mental health officer is a police officer who has extensive training in the mental health field. They are able to defuse a situation like a police officer, but also can act via as direct correspondence with the mental health system (Durbin et al., 2010). They are then able to coordinate the necessary mental health services through local service providers. Finally, they ensure that all mental health officers are aware of mental health services in the community. Liaison officers are often intended to reduce calls for service, not for their qualitative effectiveness in dealing with mental health. Many larger detachments in B.C. have assigned mental health liaison officers who are responsible for building relationships with persons with mental illness who come into frequent contact.
with the police, connecting them with services to help them manage their illness in the community, and ultimately reduce police interactions by managing the symptoms of their mental illness that would cause them to come into contact with police (B.C. RCMP, 2015). Unfortunately, little research exists evaluating liaison officers at this time.

**Mental health teams**

Shapiro and colleagues (2015) conducted a systematic review on police and mental health co-responding teams, finding increased relationships with community services and reduction of the burden on the justice system. Oftentimes officers arrest people with mental health problems (a “mercy booking”) so that individuals can access services through courts and prison. While co-responding teams are often framed as humanitarian efforts, there is also evidence to suggest these approaches can save money. In addition, these programs can also reduce hospital admissions, but only if the co-responding team arrives in a sufficient amount of time such that the situation can be de-escalated without further intervention.

Car 67 and Car 87, used in Surrey and Vancouver respectively, pair psychiatric nurses with police officers. The team responds to mental health calls that have been called in by general duty officers or by existing mental health clients (Cohen, 2011). The Vancouver Police Department extended their response to mental health calls after determining that the mentally ill were more likely to suffer – rather than inflict - victimization. Assertive Community Treatment (ACT) Teams combine stakeholders from police, health, social workers and housing, to provide wrap-around services to those police contacts with the most severe of mental illness. The ACT teams have also addressed the
issue of information sharing, by establishing data sharing agreements across sectors. There are now five ACT teams, who have treated over 200 individuals since 2012 (Cohen et al., 2014).

In an even more proactive approach, the Vancouver Police Department has recently introduced their Assertive Outreach Teams (AOTs) in 2014. These teams place police officers in the Vancouver Coastal Health (VCH) office with VCH staff. Together, they monitor mentally ill individuals and determine when an individual's mental health illness is rapidly deteriorating. They then connect them with preventative services to prevent further decline. They also meet consistently to identify new issues and discuss recent mental health related incidents outside of the treatment facility to determine next steps. This proactive approach helps identify individuals who might be struggling with taking their medication early on and help redirect them before their illness worsens (Cohen et al., 2014).

**Building capacity**

In February 2005, the CMHA initiated the Building Capacity: Mental Health and Police Project (B.C.: MHAPP), aiming to develop formal protocol for emergency responses to mentally disturbed persons in six British Columbia communities: Cranbrook, Delta, Nanaimo, Richmond, Vancouver and Williams Lake (Morrow et al., 2006). The Vancouver Foundation, B.C. Mental Health and Addictions Services, and the Provincial Health Services Authority provided funding for the project, with the latter two providing funding for the evaluation. With assistance from the funding organizations, each community established a steering committee (comprised of key people such as family members, hospital staff, first
responders, and police), which met regularly over a six-month period to discuss current approaches to dealing with mental health crises, and to develop action plans that addressed problems with those current approaches.

Each community faced different challenges, but there was one consistency: Mentally ill persons referred to the emergency room by police faced lengthy wait times. Committee members noted that these waits were detrimental in that they were potentially traumatic for the referee, and consumed valuable police time. This issue highlighted the importance of involving emergency room staff in committee activities. In evaluation, participants noted that attempts to involve emergency room staff were made, but successful engagement did not always occur. Participants identified local emergency room staff as being the group most frequently excluded from meetings, possibly because of their large workloads, concerns that their participation would be ineffective, or that the committee was irrelevant to their work performance (Morrow et al., 2006).

Given that emergency room wait times were a clear issues across all six communities, emergency room personnel involvement in the committees was seen as critical; Consumer Engagement: Use of focus groups to enhance feedback; Stronger support from CMHA B.C. to increase ethnic diversity of committee constituents, particularly representation from Aboriginal, Indo-Canadian, and Chinese communities in B.C.; Involvement of provincial and regional health authorities to cement commitment to aiding communities implement action plans.
Additional examples

Numerous other examples of collaboration, partnerships and boundary spanners exist in the literature. In Nova Scotia, researchers conducted an evaluation of an integrated mobile health team made up of municipal police and emergency health and mental health providers that provided short term crisis intervention. Although call frequency increased, time spent at the scene and police time was significantly reduced (Kisley et al., 2010). In Niagara Falls, Ontario, the Niagara Health System partnered with the Niagara Regional Police Service to develop protocol for apprehension and transportation of mentally ill persons to emergency departments. In so doing, they reduced police emergency department wait times by almost 60 percent (Pizzingrilli et al., 2015). However, Dewa and colleagues, in their study of seven police and health collaborations in Ontario, found the development of these programs can be time consuming, involve a steep learning curve and require sustainable funding (2011). They also found that more flexible service provider systems are restrained by their partners’ constraints (Dewa et al., 2011).

A review of international literature can compare and contrast existing practices in Canada with those of similar Western nations. For example, Australia – whose mental health system has drawn comparisons to Canada’s because of its shared Commonwealth status and similar geography with under-served, remote rural communities, has seen similar challenges arise with its mental health populations and the most appropriate methods for accommodating them. For example, Thomas, Ogloff and Luebbers’ (2011) study of police officers in Victoria found that mental health calls consume a considerable amount of officer time, and that decision-making routes are not always clear. As a result, the authors recommended enhanced training that included consultation from experts in
the field. Following this line of research, Ogloff and colleagues (2011) have stressed the need for inter-agency collaboration in the same vain as the Police Responses to the Interface with Mental Disorder (PRIMeD) project, which ran from 2007-2011.

Coleman and Cotton (2016), in recognizing the ongoing interaction of police with persons with mental illness, examine past and present policing approaches, and suggests a new way forward. This new approach, termed a ‘corporate approach’, combines proactive and reactive strategies. This ‘third wave’ mental health strategy would require engrained partnerships between police and community agencies to improve outcomes for individuals with mental illness. This approach would be fully encompassing, from the service’s mandates, to training, to management, frontline works, and even clerical staff.

In the United Kingdom in 2010, a research team created a mental health screening tool for police. An action learning approach was taken by the researchers, service agencies, and police in learning about the tool and its use, finding action learning to be effective in bridging communication gaps between police and service agencies. Streamlined discussions created a collaborative working environment, and could be useful in bridging police and agency services to work together in securing the care necessary for those with mental illness.

Arguably, one of the most effective projects for improving the well-being of patients in crisis is the use of crisis response sites. These sites are physical entities that are not found within the traditional infrastructure for policing and emergency healthcare. Crisis response cites operate under a pre-booking diversion program where police officers can drop off individuals in psychiatric crisis and return to their patrol work with minimal delay (Steadman et al., 2001). It goes without saying that the upstart cost of a crisis response site
could be significant and that the costs of operation may be primarily the responsibility of the heath authority (e.g., staffing) (Cowell, Hinde, Broner, & Aldridge, 2015). However, studies have suggested that jail diversion programs for this population can lead to substantial long-term savings for taxpayers (Cowell, Broner, & Dupont, 2004).

**Geographical and temporal clustering**

Vaughan, Hewitt, Andresen, and Brantingham (2016) examine geographical locations, and clusters therein, of calls for service for emotionally disturbed persons (EDP) using a spatial point pattern test in an urban Canadian setting. Findings suggest health facilities (hospitals, pharmacies, treatment centres) are central in the hot-spots for police calls for service for EDP. The authors explore issues around police as gatekeepers to proper services for those with health complications, and officers being expected to deal with a wide range of issues beyond criminality. Officers have long protested obligations to engage in social work tasks, which they feel do not align with their job descriptions, as well as tend to lack proper training to do so. On top of that, officers are facing compiling issues that have led to training fatigue. The authors suggest the need to understand social determinants of health, and geographical clusters of activity as ways to better resource police activities. Indeed, as Boyce et al., (2015) found, mental health problems are more prevalent among: women, low-income individuals, and Indigenous folks, pointing to the need for acknowledgement of social determinants of health.

Narrowing their analysis, Vaughan, Hewitt, Andresen, and Verdun-Jones (2019) examined 4341 police files from Surrey, BC in which emotionally disturbed (ED) persons were involved, the authors investigated gender differences in police calls for service, based
on geographical location. Looking at MHA calls, criminal and non-criminal events, and
gender, the authors found spatial clusters around these variables. Most police interactions
with MHA calls are apprehensions under the health act, and then criminal and non-criminal
events. Findings indicate women with mental health complications are more likely to have
police contact in private and commercial residences while men are more likely have such
contact in commercial and public settings. This finding highlights a key difference between
male and female populations who have contact with police involving mental health issues.
The public versus private nature of these calls speaks to gendered differences in mental
health, as well as the importance of police knowledge and preparedness in addressing
these calls. The authors make many viable recommendations regarding how to address the
gendered differences in mental health that are important to reiterate. Training programs
should be developed using simulations for officers to learn best how to deal with calls
regarding mental health. The authors also speak to the SMART program in Surrey where
officers are given the opportunity to connect with the health authority as well as other
social services such as housing, social services, and income assistance. Building those
relationships can assist police with referrals and connecting individuals with the proper
resources.

Vaughan, Hewitt, Hodgkinson, Andresen, and Verdun-Jones (2018) used ANOVA and
negative binomial regression to examined 22,000 mental health calls in Surrey, BC, finding
a fluctuation in calls during the day, week, month, and seasonally. Highest volumes of calls
for service are mid-day and mid-week. "As such, in terms of practical implications, the
findings from this paper may allow police officers responding to MHA calls for police
service some time for mental health prevention activities, such as ‘checking in’ with known
individual who have mental health-related issues, if they are not overtaxed on a weekday and have the same number of officers on the weekend.” (Vaughan et al., 2018, p. 11). This quote provides potentially helpful direction with police resourcing or at the very least, with priorities. Instead of patrolling for unknown/observed issues, officers could take some of that time to check in, particularly with ‘high flyers’ which could reduce volume of calls and files. Incorporating these findings in a practical way could reduce the number of repeat calls for service by the same individuals. It could also help to allocate certain officers on each shift to check-ins or ‘check welfare’ rounds.

In Baltimore, White and Goldberg (2018) examine hot-spots for mental health calls for police service in Baltimore using a spatial point pattern test. The purpose is to determine if such calls are concentrated and if so, suggest ways police can address and mitigate such activity. Findings indicate 22.4% of calls for mental health occur on .5% of street segments, and those segments are spread out throughout the city. Moreover, the location of mental health calls is different from calls involving drugs or violence. Police officers face a large volume of calls relating to mental health, and are often ill-equipped to deal with these, because of a lack of training and awareness. Police have to make all sorts of judgement calls in their daily duties and when it comes to mental health issues, those calls can be either incredibly helpful or detrimental to the client. In terms of the future, training is important for police but also other workers such as dispatchers. Having consistency in reporting would help researchers be able to assist police in identifying hot spots and how to direct resources.

Using information on geographical hot-spot research in Baltimore, White and Weisburd (2017) conducted a pilot program of targeted community approaches to mental
health on four streets with concentrations of activity. The program is called the co-
responder hot spot outreach team (CHSOT). The program paired police with mental health
specialists to connect individuals with proper resources and build community trust.
Observations and interviews show program success from both the service provider and
service receiver perspective. The authors identified a need to be preventative about the
nature of these calls, which can take up considerable resources, including time and money.
The program sees police paired with mental health practitioners. As a team they first visit
the area identified as a hot spot and identify immediate needs, followed by informal
discussions with people on the streets, and then door-to-door canvassing where the team
would offer information or direct people to services as needed. Evaluation suggest these
pro-active police approaches to mental health in the community are effective, particularly
at the micro local level. In targeting specific streets which are hot-spots for mental health
and/or substance issues, officers when teamed with mental health specialists can
effectively connect people with services and build trusting relationships with communities.
This presence also helped reduce other crimes, such as drug dealing as the heightened
police presence helped deter such activity.
Original research topic and modifications based on OCR-GO consultations

As outlined in the submitted research proposal, the original research questions involved understanding the spatial temporal, and resource patterns of police interactions with PMI in order to provide the policing community with information in order to better serve this population. Though the actual nature of this research was to only use PRIME-BC data and census data, after discussions with OCR-GO representatives, discussed further below, we decided to conduct focus groups with police services first in order to better identify the specific research questions related to police interactions with the mentally ill; these focus groups would also generate key words the police use to identify calls for police service that have a mental health component and, consequently, generate a better data set to understand police interactions with this marginalized population. This latter identification of mental health related calls using the synopsis/summary section within PRIME-BC is critical because the use of Section 28 (Mental Health Act) is not sufficient: we need to use other/better ways of measuring mental health related calls given that not all police services use a mental health template for all such calls for police service.

Unfortunately, due to data access constraints, we were not able to conduct much of this research. Below, we describe what happened with regard to data access with a suggestion on how to move forward so that this research may be undertaken in the future. However, because of the modification to the research proposal to include a qualitative component (focus groups) we did identify specific research questions/interests of the police services that can be used to guide future research, potentially funded by OCR-GO.
Focus groups research to identify key research questions

As noted above, the purpose of the focus groups was to identify key words used by police officers when reporting interactions with the mentally ill to better identify those events in PRIME-BC. These key words are listed below. We also conducted these focus groups to better identify research questions that would be instructive and useful for the police. Though we were not able to conduct this research because of data access issues, discussed below, we present the research questions of interest to the police here in order to facilitate future research in this area that may or may not be funded by OCR-GO.

Extensions to research already undertaken on police interactions with the mentally ill

The following questions have been addressed in our previous research, but police services are interested in knowing the specifics of these questions with regard to their police service, in particular.

- Where are the mental health and substance abuse calls for police service taking place?
- When are the peak months of the year, weeks of the year, days of the week, and time of day for mental health and substance abuse related calls for police service?
- What are the percentages of crime, disorder (calls for service), and non criminal related calls for police service?
- What is the quantity and frequency of mental health related calls for police service?
- What is the average time officers spend on mental health calls?
- What is the resource cost of responding to mental health and substance use related calls for police service?
Research questions possible to answer with existing police data and other data readily available?

General questions regarding police service and mental health

- Do we need another mental health officer?
- What is the response time to mental health calls?
- Anecdotally, we have heard that acts of aggression are up, but are they really up?
- Where are the treatment centres?
- How many apprehensions before clients actually get help?
- Is there a relationship between use of force and mental health? Is it different from other types of calls?
- What is the nature of police assaults and injury that are mental health related?
- What is the nature of actual day-to-day mental health interactions?
- Is there a relationship between the crime rate with the increase in identification of mental health related calls?
- How has the Skytrain changed things?

Nature of mental health related clients

- Once certified by a medical practitioner, how quickly after do we see that person with a mental illness again?
- What is the percentage of people from mental health calls who go to a local jail?
- What is the percentage of people brought to local hospital who are actually admitted?
- What is the percentage difference in mental health calls: homeless versus homed?
- Is there a relationship between age and mental health?
- Is there a relationship between mental health and drug abuse?
- What is the percentage of mental health calls that go to local hospital?
- Complainants, who is calling? % family members versus others?
- Is the local social housing impacting our CFS?
- Is there a relationship between mental health and gangs?
- Is this a mental health call or a missing person call?
- What is the relationship between drug use (specific), alcohol, and mental health?
  - Is crystal meth unique to our jurisdiction?
  - Is the opioid crisis impacting our interactions with the mentally ill?
- What are the socio-demographics and socio-economics of mental health and substance abuse clients?
- Where are mental health and substance abuse clients from?
- When did we see the cross over from mental health to mental health and substance abuse?

Costs of responding to mental health related calls for police service

- What is the economic cost of a suicide in society?
- If we have to shut down transit for X hours, what is the cost?
- What is the average number of officers that attend to a mental health related call?
- Are wait times at hospitals up/down? How about in other policing jurisdictions?
- Do we have enough officers?
• What is our population percentage of mental health clients, compared to other policing jurisdictions?
  
  o We have a greater percentage of calls related to mental health than other police services. Why? Are we more likely to apprehend?

• What are our percentage of mental health calls compared to others?

• Can we do something to reduce CFS regarding mental health?

• What is an accurate measure of the percentage of files that are related to mental health?

Research questions that require the development/creation of new data

General context of police interactions with the mentally ill

• What are we doing on those calls?

• As awareness goes up, are calls actually up or just recording changes?

• Persons are apprehended as MHA, but are they? Is it drug induced psychosis, for example?

• What can we do to make operations within mental health more efficient? Wait times, for example?

• We offer more services, so do we have more mental health calls as a result?

• How many are followed by an ACT team?

• Can we get funding based on % mental health? car 67, another MHO, or training for example?

• How to improve communication across services?

• Which resources and what expertise is needed?
Training

- Do we need more training?
- How do we get police trained?

Changes to legislation

- Validity and date of the Mental Health Act – rewrite?
- Could police have more discretion within MHA?

Evaluations

- Evaluation of different models: MHO, Car 67, etc.
- What is the impact of the mental health court?
- Our bike squad interacts with the homeless and our officers mention an increase in aggression. Is this occurring?
- Cost of MH versus training
- Is training working?

Key words to identify police interactions with the mentally ill in PRIME-BC

mental health, mental disorder, MHO, paranoid, carding, RCH, mentally unstable, EDP, erratic, diagnosed, disturbances, disturbed, emotionally disturbed person, mental health officer, MHA, Mental health Act, Section 28, S 28, apprehension, violent, aggressive, confrontational, acting strange, irritated, unusual, outbursts, emotional, hysterical, screaming, yelling, strange, harassing, odd, schizophrenic, abnormal, dementia, Alzheimer’s, suicidal, drug induced, crazy, nuts, suicidal, Form 4, Form 21, paranoia,
Data access and the current research

The road to data access for this research project began with a meeting between OCR-GO representatives and SFU-ICURS researchers (Martin Andresen and Tarah Hodgkinson) shortly after funding had been allocated. The purpose of this meeting was to discuss the nature of the research project/questions and the data necessary to undertake the research. We made a number of alterations to the research proposals to make the funded research more applicable to policing while maintaining academic interest, according to suggestions from both the RCMP and OCR-GO. Everyone was happy with the nature of the modifications and we moved forward with the necessary data.

In order to undertake both research projects, detailed data from PRIME-BC that included event and subject level information was necessary. Despite the level of security in the ICURS laboratory and the security clearance level of the researchers (and willingness to obtain additional clearance where necessary) care still needs to be considered given the sensitive nature of the data. We derived a list of variables we requested to undertake the research that would then be taken to the RCMP for approval of being extracted; a RCMP
representative had agreed to download data for the projects from all police services involved, who agreed to this process—more on this below. One particular aspect of data access that was a significant move forward over previous data access in ICURS was to include variables indicating the presence of particular keywords in the text portions of each criminal event: the synopsis. These keywords were to be identified in focus groups with interested police services. After this meeting, we moved forward with getting approval from the Chiefs in the various police services to be involved with these research projects, a necessary component of our being able to obtain ethics approval from SFU to undertake the research.

By the end of August 2018, we had received approval from all police services, less Vancouver to be involved with the research projects and to have the RCMP representative download their data for the research projects. This led to our getting ethics approval from SFU to continue, a necessary component for our being able move forward with the research projects. At this point we were ready for data extraction to be performed by the RCMP and have the data delivered to our secure computing facility that has been approved by the RCMP at the national level privacy impact assessment and threat risk assessment.

Although all parties involved wanted to have all police services in British Columbia a part of these research projects, there was no specific requirement for the Vancouver Police Department (VPD) and we decided to move forward with the research. OCR-GO representatives were hopeful that one of their members would be able to move things forward with the VPD and have this police service involved in the research projects (which would mean all police services were involved). We were hopeful as well given the significant hole in the data that would be present if VPD was not present. We continued to
work on the literature reviews and focus groups (both part of the revised research proposals).

In early October, VPD expressed interest in the project and we placed everything on hold so we could (hopefully) have province-wide research studies in these two areas. As part of this process, MOUs that stipulated protocols for data delivery, use, and publications were developed and sent to all police services for comments. The MOUs (one for each project) were based on MOUs previously signed by the RCMP and the independent police services that operated in the Fraser Health Authority.

Martin Andresen and Tarah Hodgkinson met with VPD to discuss this MOU and their concerns regarding data security/privacy/confidentiality/breaches, responded to a number of email questions from the legal team at VPD, and acted as liaisons between the legal teams at VPD and SFU. These communications continued for months, answering further questions regarding cyber-attacks and data breaches. However, because of our physical, personnel, and server security at SFU, these risks are non-existent or extremely minimal. This was clearly explained on numerous occasions.

Based on our discussions with legal counsel at VPD and with police leaders in BC, we were aware that there were a number of meetings when these MOUs were discussed. Given that we were not invited to these meetings, the other police services (and VPD executives for that matter) did not hear the benefits of research that was not conducted “in house” and present our levels of security that may have eased any concerns. In particular, that despite some in-house statistical expertise, the opportunity for widespread comparison and academic objectivity around these two research areas.
At the end of the research project timeline (February 2019, with a project end date of March 2019), we were informed via email from Chief Dubord that none of the police services would be involved. As such, VPD had decided to not be involved in the research and also convinced the other police service to revoke their initial agreement to be involved in the OCR-GO research projects. Once this decision had been made, our ethics approval was effectively revoked.

**Suggestions for moving forward with OCR-GO research involving police data**

As stated above, there are benefits to having research undertaken by those not working within police services. First and foremost, there is the independence of the research; this is rooted in academic objectivity. Second, if provided with data from other police services, comparisons across police services can be undertaken very easily. And third, unburdened by operational demands, we can conduct this research without being pulled in other directions that are deemed more important at the time for day-to-day police service provision.

In order to conduct this type of research sensitive police data are necessary. Most often, in order to protect the providers of the data and those receiving the data for research purposes, some form of a research agreement is necessary. We have found that obtaining such an agreement after the research funding has begun delays, and in the current case prevents, research from being conducted. As such, it is our recommendation that OCR-GO engages into a data sharing agreement with the various police services who wish to be involved with this type of research. This agreement would dictate the conditions upon
which must be met in order to release data to researchers. Under such an agreement, OCR-GO would know whom and to which institution they would be able to allocate research funding and have that research begin immediately rather than having research obtain an agreement to conduct the research after the funding has started. This would not only facilitate the research process, but prevent one (or more) police services from bringing ongoing and funded research to a halt.
References


Health Apprehensions by Police in British Columbia. Retrieved from

McEwan, K. 2001. Accountability and Performance Indicators for Mental Health Services
and Supports. Prepared for the Federal/Provincial/Territorial Advisory Network on Mental
Works and Government Services Canada.


Mental Health Commission of Canada (2013). Mental health commission of Canada annual
report 2011-2012: Together we spark change. Retrieved April 25, 2016 from
http://www.mentalhealthcommission.ca/English/document/4909/mental-health-
commission-canada-annual-report-2011-2012-together-we-spark-change

grc.gc.ca/ViewPage.action?siteNodeId=229&languageId=1&contentId=-1

Ministry of Health Services. (2010). Healthy minds, healthy people: a 10-year plan to
address mental health and substance use in British Columbia. Ministry of Health Services.


the Epidemiologic Catchment Area (ECA) Study. *Journal of the American Medical Association*, 264(19), 2511-2518.


Schneider, B. (2010). *Hearing (our) voices: Participatory research in mental health*. Toronto, ON: University of Toronto Press.


system is failing Vancouver's mentally ill and draining police resources. Vancouver Police 
Department.


Retrieved from http://www.whiterockcity.ca/assets/City~Services/2015Year%20End.pdf