Policing Mental Health: An Exploratory Study of Crisis Intervention Teams and Co-Response Teams in the Canadian Context

by

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Abstract

Due to an increase in interactions between the police and persons with mental illness (PMI), police services have begun deploying specialized mental health responses to more adequately address these calls. One of these responses is a Crisis Intervention Team (CIT) that is comprised of officers who are specially trained on mental health; another is a co-response where an officer is paired with a mental health specialist. Currently, little is known about these responses within Canada, therefore, this thesis employs a mixed methodology in order to explore the use of these responses nationwide. The results indicate that most of the participating services have some form of specialized response, and that these responses experience many successes and challenges – the latter of which may prevent or limit any potential successes. Recommendations and a call for future research are made which may assist Canadian police services in mitigating these challenges.

Keywords: *Policing*; *Mental health*; *Person with mental illness (PMI)*; *Co-response*; *Crisis Intervention Team (CIT)*

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Chapter One: Introduction

In Canada, the most recent estimates suggest that there are approximately 6.7 million individuals – or 19.8% of the entire population – living with mental illness, and by the year 2041, that estimate is expected to increase to approximately 8.9 million (Smetanin et al., 2011). In any given year, one in five Canadians experience a mental health or addiction problem, and by the time Canadians reach the age of 40, one in two have – or have had – a mental illness (Smetanin et al., 2011). Police interactions with people with mental illness (PMI) in Canada have been increasing (Durbin, Lin, & Zaslavska, 2010b) and may comprise a significant percentage of all calls for service (Crocker, Hartford, & Heslop, 2009). However, not all Canadian PMI will experience an interaction with police. Police contact statistics indicate that in a sample of 5 million police interactions in 2016, PMI comprised less than 1 million of these interactions – or 18.8% of the sample – (Boyce, Rotenberg, & Karam, 2015), suggesting that police predominantly come into contact with a select group of PMI.

Police contacts with this population are largely attributed to the significant lack of community-based mental health resources within the post-de-institutionalization era where certain PMI who may require psychiatric care or support are not receiving – or are unable to receive – the care or support they require, resulting in certain PMI to being more prone to police contact than others (Cotton, 2004; Cotton & Coleman, 2010; Forchuk, Jensen, Martin, Csiernik, & Atyeo, 2010; Lamb & Bachrach, 2001). An additional consequence of inadequate resources post-de-institutionalization has been the criminalization of PMI for a variety of reasons, including arrest to get treatment through the criminal justice system (Lamb, Weinberger, & DeCuir, 2002) and police culture beliefs which may encourage

citations for productivity expectations (Schulenberg, 2016), all of which contribute to PMI being more likely to be arrested than non-PMI (Boyce et al., 2015).

Historically, police contacts with this population were rare and reserved as a role for those in the mental health system pre-de-institutionalization (Ellis, 2014; Engel & Silver, 2001), thus officers have lacked the training and competence on how to appropriately address calls involving PMI (Bittner, 1967). Contemporarily, however, the police have become de-facto mental health professionals (Compton et al., 2014a) within the post-de-institutionalization era and as a result, mental health training standards and curriculums have been established to better prepare officers for PMI interactions (Cotton & Coleman, 2008; Coleman & Cotton, 2010a). Although, in Canada, mental health training for police officers varies in length and content from jurisdiction to jurisdiction where some services provide little-to-no training for their officers; whereas others may provide lengthy and comprehensive training (Coleman & Cotton, 2010a).

Moreover, in addition to mental health-specific training, police services – both domestically and internationally – have begun deploying specialized responses to mental health related calls (Butler, 2014). Research has suggested that the use of specialized responses has been able to achieve many successes, such as improved officer knowledge of mental illness (Compton et al., 2014a), stronger partnerships with community-based resources (Dupont, Cochran, & Pillsbury, 2007), less arrests (Scott, 2000), and more positive interactions for PMI (Kirst et al., 2014), among many others. As will be outlined within the following chapter, specialized responses can take many forms, the most common of which are the Crisis Intervention Team (CIT) model and the co-response team model

(Butler, 2014)[1]. The former originates out of the United States and is comprised of officers who are specially trained on mental health (Dupont et al., 2007); whereas the latter is comprised of an officer who is paired with a mental health specialist and respond as a pair to mental health related calls at the request of first responding officers (Shapiro et al., 2015). Unsurprisingly, however, due to the under researched state of Canadian policing (Huey, 2016), very little is known about Canadian officers' interactions with PMI generally, as well as the use of specialized responses specifically, such as CITs and/or co-response. Therefore, the focus and objective of this thesis is to provide a fuller understanding of the use of CITs and co-response within the Canadian context.

In the chapter that follows, existing literature will be reviewed on police interactions with PMI, de-institutionalization, mental health legislation, criminalization, mental health training for Canadian officers, the use of CITs and co-response teams, and, finally, policing strategies employed within the context of police-PMI interactions. The research questions this thesis seeks to answer will be outlined at the end of this chapter as well. Chapter Three will outline the methodology used to gather data, as well as data analysis techniques. Chapter Four will present the findings; whereas Chapter Five will be comprised of a discussion concerning the limitations of this thesis and findings presented in the previous chapter, and concludes with recommendations to police services as well as a call for future research.

Before moving on to the next chapter, however, a specific operationalization of 'PMI' must be outlined. As Coleman and Cotton (2014) argue, there are a plethora of

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[1] The terms 'CIT' or 'co-response' are used when discussing either of these responses specifically; whereas the terms 'specialized response' or 'response' are used when discussing responses generally

different terms used to describe PMI, and as suggested by the statistics above, not all PMI come into contact with the police. Therefore, to avoid grouping *all* PMI under the same umbrella, this thesis adopts an operationalization of 'PMI' from the work of Coleman & Cotton (2014). Their operationalization specifically refers to interactions where "… signs and symptoms of mental illness are readily apparent – as opposed to people who may have a history or past experience of mental illness but whose symptoms are not evident at the moment" (p. 325). However, it is important to note that operationalizations of PMI within the academic literature are not as clear cut as the one provided by Coleman & Cotton (2014). The work of these authors is only one of a few articles in this area of literature which contain a specific operationalization of PMI, as such, the context of 'PMI' in other literature is relatively unknown. Moreover, an additional note of caution is that this term and/or operationalization may be unfamiliar to police services as they may opt for different terminology or other indicators of what does or does not constitute a PMI call. Nevertheless, as Coleman & Cotton (2014) argue, this term is familiar to readers as it is the most commonly used term within the literature on this topic and has been selected to be used herein. Ultimately, with this specific operationalization, readers are aware that the focus of this thesis is interactions between specialized mental health responses and *individuals* who are specifically exhibiting mental health symptoms at the moment of their interactions.

Chapter Two: Literature Review

The purpose of this chapter is to provide an overview of literature concerning police interactions with those who are mentally ill or in mental health crisis. Specifically, factors such as the de-institutionalization of persons with mental illness (PMI) and mental health legislation will be discussed to provide an understanding of potential causes for increased police-PMI interactions. Subsequently, the criminalization of the mental health population during police interactions, through factors such as increased arrests, the police culture, and increased use of force, will be discussed. The chapter will then shift focus to the policing institution in Canada to discuss mental health training provided to Canadian officers which varies in length and content from jurisdiction to jurisdiction. Following this, efforts to improve police-PMI interactions, specifically the use of Crisis Intervention Teams (CITs) and co-response teams, will be presented and discussed and arguments will be put forth that very little is known about the use of these interventions in Canada. The literature review concludes by discussing police strategies to provide a contextual framework behind police approaches to PMI interactions, as well as identifying the research questions this thesis seeks to answer.

De-institutionalization and Police-PMI Interactions

As one of the first scholars to explore the issue of PMI interactions with police, Bittner (1967) assessed the extent of discretion that officers hold when interacting with this particular population. Specifically, Bittner (1967) argued that when officers arrive at a PMI in crisis, they undergo a process he coined as 'psychiatric first aid' which was used to determine the best course of action to address the crisis, even though most officers were improperly trained on mental health at the time. His work found that several factors may

ultimately affect how a crisis could be resolved, such as officer characteristics (e.g., personal biases), community factors (e.g., lack of mental health programs), and situational dynamics (e.g., violent subject) (Watson, Swartz, Bohrman, Kriegel, & Draine, 2014). In addition, Bittner (1967) found that transfers of PMI to hospital was a significantly time-consuming task for officers as admission into the facility took several hours, thus causing most mental health crises to be resolved informally (Watson et al., 2014).

Surprisingly, over five decades after the work of Bittner (1967), there has not been a significant amount of improvement with respect to PMI-officer interactions. Some police services provide little-to-no mental health training for their officers (Coleman & Cotton, 2010a) and there is a lack of mental health services and mental health in-take at local hospitals (Compton, Broussard, Hankerson-Dyson, Krishan, & Stewart-Hutto, 2011a). Further, officer discretion may be significantly impeded due to a lack of mental health services as well as disjuncture between department policy and police culture beliefs on how to address PMI, consequently leading to the criminalization of this population (Schulenberg, 2016). Ultimately, the cause of PMI interactions with police and the subsequent criminalization of this population has widely been attributed by several scholars to the failed process of de-institutionalization (e.g., Lamb & Bachrach, 2001; Morabito 2007).

Prior to the 1920s, police interaction with PMI was a rare occurrence as most PMI were confined within institutions for the mentally ill (Engel & Silver, 2001). However, between 1950 and 1970 a de-institutionalization process occurred where institutions were permanently closed in an attempt to reintegrate all PMI back into society (Ellis, 2014; Morabito et al., 2012). This process included three components: the release of

institutionalized PMI, diversion of PMI to alternative non-institutionalized facilities, and the development of community-based services and programs to appropriately care for PMI (Lamb & Bachrach, 2001). However, government planning post-institutionalization has been inadequate resulting in a lack of facilities, programs, and services for PMI (Cotton & Coleman, 2010, p. 304). Consequently, de-institutionalization and the subsequent lack of programs and services have caused PMI to increasingly come into contact with police (Cotton, 2004; Forchuk et al., 2010).

Police may come into contact with PMI for several different circumstances, such as social support, informal interactions, disturbances, and mental health crises (Coleman & Cotton, 2010b). However, crises encompass the greatest challenge for officers and can include various symptomatic behaviour such as repetitious questioning, emotional venting, invasion of personal space, disorientation, and scattered narratives (Iacobucci, 2014; Schulenberg, 2016). Crises can also range on a continuum from symptoms which are non-threatening in nature, such as hallucinations, to aggression and violence which may threaten the safety and wellbeing of officers, bystanders, and the PMI themselves (Bonkiewicz, Green, Moyer, & Wright, 2014). Fortunately, violent crises occur very rarely (Coleman & Cotton, 2010b), however, due to the unpredictability and a falsely perceived dangerousness of PMI, police officers are typically faced with public pressure to act quickly during a mental health crisis even though there may be no real cause for immediate arrest or intervention (Cotton, 2004; Girard et al., 2014; Morabito et al., 2012; Schulenberg, 2016; Tully & Smith, 2015; Watson et al., 2014; Lipson, Turner, & Kasper, 2010). As will be expanded upon below, such 'no win' situations, as labeled by Cotton (2004), may lead to PMI being more likely to be charged for minor nuisance offences than non-PMI in an

attempt to 'resolve' the situation (Schulenberg, 2016). Conversely, encounters with PMI may take a significant amount of time. Some studies have found that encounters with PMI may take approximately 20 minutes longer than with non-PMI (Schulenberg, 2016), while other studies have found that encounters may range anywhere from 30 minutes to two hours (Wells & Schafer, 2006). Encounters with PMI may also be extended far beyond the initial crisis location if transport to a hospital is required, which according to Compton et al. (2010), may take up to eight hours or longer in some circumstances.

It is estimated that between 5% (Brink et al., 2011) and 15% of all police calls involve an interaction with a PMI, and PMI are two to three times more likely to have interactions with police than non-PMI (Cotton & Coleman, 2008). A study by Crocker et al. (2009) found that in a sample of 767,365 police interactions, PMI represented only 0.9% of the sample, but 6.2% of all police interactions. Similarly, the 2012 Community Health Survey conducted by Statistics Canada found that in a sample of 5 million Canadians who came into contact with police, 18.8% were PMI (Boyce et al., 2015). In contrast, studies with smaller sample sizes yield similar results which indicate consistent and increasing interactions. The small town of Belleville, Ontario has approximately four officer-PMI interactions per day (Coleman & Cotton, 2010b), whereas studies by Cotton (2004) and Wells and Schafer (2006) show that approximately 70% of all officers in their samples have at least one or more PMI interaction per month. Although little research has been conducted on the recent increase of interactions, some studies have already documented a steady increase. For example, an Ontario-based study found that in 2007, Ontario police services were having 7,000 more yearly interactions than they were just four years earlier (Durbin et al., 2010b). Also, with estimates suggesting that the Canadian PMI population

is to surpass 9 million by the year 2041, police interactions with PMI are undoubtedly expected to increase simultaneously.

Since de-institutionalization and the subsequent increase in PMI contacts, police officers have been labeled as 'psychiatrists in blue' (Menzies, 1987), 'street-corner psychiatrists' (Iacobucci, 2014), and 'de-facto mental health professionals' (Compton et al., 2014a) for assuming the mental health role traditionally held by nurses and social workers (Ellis, 2014). Police have had to fulfill those labels 'by default' to the point where it has become a "regular part of an officer's job" (Iacobucci, 2014, pp. 78 & 96). Many officers have accepted their role as de-facto mental health professionals (Girard et al., 2014; Watson, Corrigan, & Ottati, 2004), and some even volunteer to receive more training (Compton et al., 2011a). However, there remains a belief within policing that interactions with PMI have 'nothing to do with police work' or are 'not real police work' (Coleman & Cotton, 2010b; Schulenberg, 2016). Much of this belief has been attributed to the failures of de-institutionalization. For example, Boyd & Kerr (2016) analyzed several reports from the Vancouver Police on mental health and argued that the reports blamed the 'failing mental health system' and reluctance to institutionalize PMI for increased interactions, which, to the Vancouver Police, were a financial burden on police resources. In addition, Boyd and Kerr (2016) further argued that these reports attempted to spread a moral panic against PMI by sharing 'worst case' officer-PMI interactions in an attempt to link mental health and violence, and claiming that 'half' of all Vancouver Police shootings since 1980 involved PMI without specifying an exact number (Boyd & Kerr, 2016). On the contrary, the amount of police shootings against PMI from 1980 to 2002 was estimated to be about

six, thus leading the authors to question the narrative of the Vancouver Police on how 'tragic' and 'violent' PMI may be (Boyd & Kerr, 2016).

Alternatively, other scholars attribute the police 'burden' of interacting with PMI as a symptom of police culture. According to Schulenberg (2016), "police culture consists of values and attitudes held by officers, which is made visible through interaction and the direct or indirect pressures to conform to norms of behaviour" (p. 464). In most societies, there remains a deep-seated stigma associated with mental illness (Coleman & Cotton, 2010a) consequently informing police attitudes, beliefs, and values (Iacobucci, 2014). However, Iacobucci (2014) argues that there are also many in-service influences which forge and maintain police culture beyond societal beliefs. These influences may include police leaders, such as the Chief of Police, deputy chiefs, and unit commanders who may all influence those lower on the chain of command, positive and negative reinforcements, the formal value structure (e.g., Mission and Vision Statements), and practices that may highlight the importance of certain actions over others, which in turn, may affect how officers interact with certain individuals or populations (Iacobucci, 2014).

There may be various positive attitudes and beliefs within a police culture, such as the wellness of officers, accountability (e.g., body-worn cameras), and a strong focus on honourable and professional conduct with members of the public (Iacobucci, 2014). However, there may also be negative attitudes and beliefs as well. For example, some officers may believe that police shootings of people in crisis are 'inevitable' thus leading to a lack of effort to improve crisis encounters, officer safety takes priority over the safety of the subject, the duty to de-escalate is less important than other duties, and that policing is not social work therefore interactions with PMI are less important than other tasks

(Iacobucci, 2014). Nevertheless, even though the literature suggests that the police culture may have established negative attitudes and beliefs toward interactions with PMI, and there remains an understanding that police interactions with PMI is 'not real police work', the *parens patriae* doctrine dictates that police have the duty to assist PMI.

Mental Health Legislation

Parens patriae is Latin for 'parent of his or her country' and is a legal doctrine which allows the state to act as a guardian for those unable to take care of themselves, such as children or individuals with disabilities (Cornell Law, n.d.). This, in fact, is one of the two universal duties of the police institution: the protection, safety, and welfare of the public; and, the other, as mentioned, protecting members of the public who are unable to care for themselves, most notably, PMI who are in crisis (Bonkiewicz et al., 2014; Ellis, 2014; Engel & Silver, 2001; Schulenberg, 2016; Lamb & Bachrach, 2001).

Each respective Canadian province or territory is responsible for establishing the *parens patriae* duties for officers in their jurisdiction by means of the mental health legislation of that province or territory (Coleman & Cotton, 2010b). In the province of Ontario, for example, actions of police officers during interactions with PMI are regulated under section 17 of the Ontario Mental Health Act (1990). This section states that in instances where an individual is threatening, attempting, or has threatened bodily harm to themselves or others, has or is behaving violently, or has shown or is showing a lack of care for themselves, is appropriate grounds for an officer to apprehend the PMI for transfer to a hospital for assessment (Ontario Mental Health Act, 1990). In addition to section 17, there are two other sections which outline police duties with respect to PMI. Section 28 provides officers with the authority to apprehend an individual who departed a psychiatric

facility without authorization; whereas Section 33 states that officers who transfer a PMI to the hospital for psychiatric assessment are to hold the PMI in custody until the facility has taken custody of the individual (Ontario Mental Health Act, 1990) – which as described below, may take several hours to occur.

With each province or territory enacting their own mental health legislation, the possibility of discrepancies and differences between the different forms of legislation arise. These differences are particularly evident with respect to involuntary admission to a hospital or psychiatric facility. Gray, Hastings, Love, and O'Reilly (2016) highlight these differences by comparing the involuntary admission criteria between all 13 pieces of provincial and territorial mental health legislation using the hypothetical case of Victoria – a 25-year-old law student who experiences auditory hallucinations and paranoid delusions, consequently becoming homeless, but has refused to receive voluntary medical help. Specifically, Gray et al. (2016) assess whether Victoria does or does not meet the various criteria for involuntary admission, which are: suffering from a mental disorder, harm, mental/physical deterioration, the need for treatment, and the inability to make a treatment decision. Ultimately, the results are rather inconsistent. With respect to the conditions of suffering from a mental illness and harm, Victoria successfully meets these conditions under all mental health legislations. However, for mental or physical deterioration Victoria meets the criteria in only seven jurisdictions; for need of psychiatric treatment in six jurisdictions; and the inability to make a treatment decision in four jurisdictions (Gray et al., 2016). Thus, depending on where Victoria is in the country, she may or may not be involuntarily admitted to a hospital for psychiatric care. Consequently, these 'strict set of requirements' for involuntary admission are a significant contribution to

what is known as the 'revolving door' of the mental health system (Iacobucci, 2014, p. 84)

and the subsequent criminalization of PMI.

The Criminalization of PMI

The criminalization of PMI has occurred as a consequence of de-institutionalization

due to the overuse of the criminal justice system to resolve encounters with PMI, typically

by means of arrest or citations for reasons which a non-PMI would normally not be

apprehended for (Cotton, 2004; Engel & Silver, 2001; Schulenberg, 2016). There are a

plethora of factors which have resulted in the criminalization of PMI, two of the more

prominent reasons being institutional fragmentation and the 'revolving door'.

Both the police and the mental health system have come to the understanding that

in order to address mental health crises, both institutions must collaborate in order to

properly assist PMI in crisis (Cotton & Coleman, 2010; Iacobucci, 2014). However, in

some instances, this collaboration does not have a coordinated nor comprehensive

approach, but rather consists of a fragmented network of hospitals, community

organizations, housing programs, and mental health practitioners who operate in their own

silo (Iacobucci, 2014). Particularly of concern with fragmentation is the resulting

disjuncture between the police and mental health cultures. These cultures differ in the sense

that the police focus on the safety and security of the community as a whole, thus

potentially causing a crisis to culminate in a manner which may not be adequate for PMI

(i.e., arrest), but has ensured the immediate safety of the community; whereas mental health

professionals want to ensure that the outcome of a crisis is safe and positive for the PMI

(Coleman & Cotton, 2010a; Kirst et al., 2014). To put this into perspective, a mental health

system stakeholder stated:

> 'Cause I think we just have kind of two different viewpoints where the police have multiple calls that they go through every single day so their idea is get in, get out as quickly as possible, let's resolve this situation right here so I can move onto the next call whereas we're kind of thinking more holistically with the client like there is a lot of information that might not seem relevant to the police officer, but it's relevant to us and how we might think of resources… (Kirst et al., 2014, p. 20)

This disjuncture between police and mental health cultures has led to obvious calls by scholars for a tightly knit bridge between the two collaborating cultures to ensure future success (Kirst et al., 2014), however, irrespective of the need for culture bridging, there is a significant lack of mental health assistance, programs, and services available to PMI consequently resulting in PMI not receiving appropriate treatment.

One of the most prominent issues in the contemporary mental health system is the lack of psychiatric beds. Between 1985 and 1999, the average number of days in a Canadian psychiatric facility decreased by approximately 42% due to a lack of beds (Sealey & Whitehead, 2004). Further, in 2007, select police services in Ontario reported that they conducted approximately 16,000 apprehensions under the Ontario Mental Health Act (1990), however, there were only 4,364 psychiatrist beds available in the province at that time (Durbin, Lin, & Rush, 2010a), meaning that in several thousand instances where a PMI was transported to hospital by police, they were not admitted. Conversely, in instances when a PMI is successfully admitted to hospital, it is not uncommon for them to be released shortly afterwards and having another crisis interaction with police less than 24 hours later (Canada, Angell, & Watson, 2010). The lack of psychiatric beds has put pressure on doctors to discharge patients who may be considered as 'borderline clients' (Teplin, 1983) in an attempt to free up beds for individuals who may need more serious psychiatric care. Consequently, the revolving door of the mental health system has led police officers to

operate in what scholars have labeled as the 'gray zone' with respect to officer discretion and decision making when attempting to address a PMI crisis.

When interacting with the public, police have a considerable amount of discretion thus allowing them to be perceived as the 'gatekeepers' of the criminal justice system (Lamb & Bachrach, 2001; Compton et al., 2014a). During an interaction with PMI, while heavily dependent on the context of the interaction, officers may decide to issue a warning, divert the PMI into the mental health system, proceed with charges, or take no further action (Cotton & Coleman, 2010; Bonkiewicz et al., 2014). However, due to the revolving door, several scholars have found that police may be forced to conduct a 'mercy booking'. Mercy bookings typically occur when a PMI is arrested for being a danger to themselves or others, but with a lack of psychiatric beds or community-based services, the PMI's best option to receive psychiatric treatment would be through the criminal justice system (Butler, 2014; Compton et al., 2014a; Lamb & Bachrach, 2001; Lamb et al., 2002; Schulenberg, 2016; Teplin, 1983; Teplin, 1984).

Alternatively, arresting PMI may also be the easiest conclusion for officers as opposed to transferring a PMI to hospital or other mental health service. Several studies have found that officers may spend several hours of their shift at a hospital waiting for the medical staff to take custody of the PMI (Wells & Schafer, 2006). One study found that on average, officers spend approximately 5.27 hours 'babysitting' PMI at the hospital which may take officers away from what they may consider 'real police work' (Schulenberg, 2016). Arrests to avoid lengthy hospital visits may also be further exacerbated by the police culture. Specifically, Schulenberg (2016) found that a disjuncture between department policy and police culture impacted the ability of officers to address PMI interactions

appropriately as department policy encourages police to address interactions through diversion to the mental health system, but the police culture pressures officers to resolve PMI encounters rapidly and informally with an added encouragement of charges and citations to achieve productivity expectations.

Consequently, a lack of programs and facilities, exacerbated by a lack of police discretion and pressures of the police culture, may cause PMI to be increasingly criminalized and re-institutionalized within the criminal justice system (Wood & Watson, 2017). The 2012 Canadian Community Health Survey on Mental Health found that Canadian PMI are four times more likely to be arrested (12.5%) than non-PMI (2.8%) (Boyce et al., 2015). Other empirical analyses also support these findings (Crocker et al., 2009; Fisher et al., 2006; Hartford, Heslop, Stitt, & Hock, 2005; Schulenberg, 2016). PMI are overwhelmingly arrested for nuisance or order-related crimes which tend to draw a significant amount of attention from bystanders, thus forcing police to respond even though there may not be an immediate need to (Boyd & Kerr, 2016; Reuland, Schwarzfeld, & Draper, 2009; Schulenberg, 2016; Wells & Schafer, 2006; Watson, Angell, Morabito, & Robinson, 2008a). Once arrested, PMI are upwards of twice as likely to have re-involvement with police than the general population (Crocker et al., 2009; Fisher et al., 2006; Hartford et al., 2005), 50% of whom may have an interaction occur within a two-month period after their arrest (Hartford et al., 2005). Some PMI may even have a significant amount of interactions. For example, in an analysis of 13,816 PMI-police encounters over a ten-year period, Fisher et al. (2006) found that the number of encounters for PMI in the sample ranged from two to 71 encounters. However, some scholars, such as Engel & Silver (2001), refute the criminalization of PMI by arguing that simply because

PMI are disproportionally arrested, does not mean their arrests are not justified. While it is true allegations of serious offenses limits officer discretion (Lamb & Bachrach, 2001) and PMI are more likely to display 'arrest generating behaviour' (Butler, 2014) such as being disrespectful, uncooperative, or under the influence of drugs or alcohol (Schulenberg, 2016), the aforementioned studies overwhelmingly find that arrest is a common resolution for PMI interactions.

Another prevalent issue in the criminalization of PMI is use of force. Use of force in interactions with both PMI and non-PMI is relatively rare as it occurs in less than 1% of all interactions (Morabito et al., 2012; Brink et al., 2011). Nevertheless, studies have concluded that PMI are more likely to have force used against them than non-PMI, especially PMI who may have comorbid disorders (Morabito, Socia, Wilk, & Fisher, 2017). Some scholars argue that there are four contexts which foster physical confrontations between PMI and police: (1) fear from PMI for being in an unfamiliar situation, police uniform, and/or overpowering attitude; (2) PMI reluctance to comply/cooperate; (3) lack of understanding or empathy from officers; and (4) perceptions that PMI may be unpredictable and dangerous (Ruiz & Miller, 2004). Over half of the PMI in a study conducted by Livingston et al. (2014b) reported being handcuffed or physically restrained by officers; select PMI also reported being pushed, punched, kicked, or had a weapon used against them (e.g., baton, Taser, firearm) (Livingston et al., 2014b). Consequently, studies conducted on aggressive use of force during police stops of non-PMI have found that individuals who have endured police force have developed heightened anxieties and trauma as a result (Geller, Fagan, Tyler, & Link, 2014). Such anxieties and trauma may be particularly heightened for PMI who may find future police encounters even more difficult,

especially with the increasingly militaristic appearance of contemporary policing (Coleman & Cotton, 2010b).

Moreover, in some extremely rare instances, interactions can end in the shooting death of the PMI (Coleman & Cotton, 2010b; Morabito et al., 2017). Between 1992 and 2002, there were 11 shooting deaths of PMI in the whole of Canada (as cited in Coleman & Cotton, 2010b), six PMI in Vancouver from 1980 to 2002 (Boyd & Kerr, 2016), and five between 2002 and 2012 in Toronto (Iacobucci, 2014). PMI shootings in the United States are far more common. The United States does not collect data on police-initiated shootings, therefore, news outlets such as *The Guardian* (n.d.) and *The Washington Post* (n.d.) have established their own respective databases in an attempt to track these shootings. The data indicates that every year since the creation of the databases in 2015, individuals who have exhibited signs of mental illness have accounted for approximately one-fourth to one-third of all police shootings – 324 PMI in 2015, 241 in 2016, 236 in 2017, and as of March 1, 2018, 25 in 2018 (*The Washington Post*, n.d.).

Although PMI may disproportionally endure unnecessary arrest, force, or even death, most participants of qualitative studies by Brink et al. (2011), Desmarais et al. (2014), Livingston et al. (2014b), and Watson et al. (2008a) rated their experiences as fairly positive. One PMI stated, "sometimes cops are kind and helpful; other ones can be cocky and overly aggressive, but, I guess, overall, it's a healthy balance" (Brink et al., 2011, p. 44). Another stated "… normally they rough me up, you know, they have cuffs on too tight. They talk to me like very degrading, but this officer was very kind… Like I said, he treated me with respect, not a thief (Watson et al., 2008a, p. 453). In many instances, when a PMI had a negative contact with police, they tended to target the individual officer as the source

of the negative contact, as opposed to the entire police institution as a whole (Brink et al., 2011). However, overwhelmingly, the PMI in these studies suggested that officers need more training with respect to mental illness. A PMI spoke to this by saying,

> Police need more training of dealing with mental illness. I think many police officers do not know the signs and symptoms of mental illness and mistake them for being drunk or high or choosing to be violent. I think with most people with mental illness, fear is often the reason for symptoms. When someone is afraid, then the wrong thing to do is apply force, which happens (Brink et al., 2011, p. 76)

More specifically, PMI believe that officers should be more adequately trained in the areas of understanding mental illness and its effects, effective communication, compassion, and prioritizing non-violent responses (Livingston et al., 2014b). In addition, PMI also stressed the need for police to connect with the community, recognize and reward positive police practice, improve how police officers are selected for employment, recognize the role of peer influence in policing (i.e., police culture), increase accountability, and finally, involve mental health professionals during mental health interactions (Livingston et al., 2014b). In Canada, however, the mental health training of police officers is, at times, limited, ambiguous, and differs from jurisdiction to jurisdiction.

Police Mental Health Training in Canada

When new officers are hired in Canada, they are required to attend one of 13 police colleges for basic training and education (Cotton & Coleman, 2008). These colleges can be national (e.g., RCMP), provincial (e.g., Ontario Police College, Atlantic Police Academy, Saskatchewan Police College, Justice Institute of British Columbia), or under the control of a particular police service (e.g., Royal Newfoundland Constabulary, Halifax, Winnipeg, Brandon, Calgary, Lethbridge, Edmonton). In a survey of Canadian police academies, Cotton & Coleman (2008) found that all new police recruits receive at least

some form of mental health training, and that training at these academies is conducted in one of two ways: an entire curriculum specifically focused on mental health; or mental health training that is combined with other forms of training, such as use of force, tactical communication, firearms, and/or officer safety. In addition, the length of training varied significantly between jurisdictions, ranging from one to 20 hours. Specifically, programs which provided five hours or less included Lethbridge (1 hour), Brandon (3 hours), RCMP (4 hours), and the Justice Institute of British Columbia (5 hours); the Ontario Police College and Calgary provide seven and seven-and-a-half hours, respectively; the Royal Newfoundland Constabulary, Halifax, Winnipeg, and Saskatchewan provide between ten and 20 hours of training; and finally, Edmonton and the Atlantic Police Academy provide over 20 hours of training. The training modules may include a combination of topics such as stigma, signs/symptoms, understanding major psychiatric disorders (e.g., schizophrenia), communication strategies, dangerousness/aggression, hallucinations, suicide intervention, Mental Health Act apprehensions, alternatives to use of force, among many others. However, due to the varying length of training at these academies, the topics covered vary significantly from college to college, thus certain emphasis may be placed on particular topics causing other, potentially important, topics to be neglected (Cotton & Coleman, 2008).

     After police college, officers may receive further in-service mental health training that may be tailored towards the population they will serve within their jurisdiction (Coleman & Cotton, 2010a). Coleman and Cotton (2010a) conducted a second study in an attempt to gather more knowledge with respect to the in-service training. Approximately 500 Canadian police services, police colleges, and mental health agencies were contacted

with respect to in-service officer training – the authors only received 26 responses (Coleman & Cotton, 2010a). Nevertheless, the provided responses appear to be relatively similar to the responses of the police colleges found in Cotton and Coleman (2008) – mental health training modules differ from jurisdiction to jurisdiction due to restrained training times, which range from one to 40 hours (Coleman & Cotton, 2010a). Specifically, Coleman and Cotton (2010a) found that many remote services, particularly remote units of the RCMP, overwhelmingly rely on online training for their officers; while other remote services (e.g., Royal Newfoundland Constabulary) rely on training materials which were not specifically designed for police training, such as Mental Health First Aid from the Mental Health Commission of Canada. Larger services tend to have dedicated mental health training modules which may contain a combination of traditional classroom instruction, online learning components, and field experience with a mental health professional that is supplemented with extensive written materials (e.g., Calgary Police, Halifax Regional Police, Ontario Police College). Contrastingly, some jurisdictions do not conduct regular training for their officers, such as in the case of the Saskatchewan Police College which indicated that in-service mental health training is only available to new officers and soon-to-be supervisors. While other services, such as the Delta Police in British Columbia, may "provide employees with the education and training to perform apprehension under Sec 28 (1) of the Mental Health Act" (Coleman & Cotton, 2010a, p. 21) as opposed to other training, such as tactical communication or de-escalation, which typically emphasize that apprehension is a last resort.

The topics covered during in-service mental health training are similar to that of the police colleges, which may include a combination of stigma, suicide intervention,

diagnoses/symptoms, the Mental Health Act, crisis intervention training, among many others (Coleman & Cotton, 2010a). Ultimately, the overall goal with mental health training is to provide officers with the skills to successfully de-escalate a crisis situation without increasing the chance of police liability or injury to any parties involved (Oliva, Morgan, & Compton, 2010). Unfortunately, there are a variety of factors which may affect the design and effectiveness of in-service training.

The primary issue is that there is a lack of comprehensive and widespread research conducted on mental health training and education for police officers (Coleman & Cotton, 2010a). Watson, Angell, Vidalon, and Davies (2010) argue that this is due to all police services collecting and retaining different information – which for the most part is not adequate data for an accurate evaluation – thus leading to several methodological shortcomings when evaluations are attempted (e.g., small sample size, different operationalisations based on available data, etc.) and limited generalizability (Coleman & Cotton, 2010a). Other factors affecting training effectiveness include police discretion, behaviour and attitudes of officers, stigma, and use of force (Coleman & Cotton, 2014) – all indicative of the aforementioned topics of criminalization and the police culture. Various stakeholders interviewed by Iacobucci (2014) indicated that "culture eats training" (p. 117). Thus, in an attempt to combat the attitudes and behaviour of the police culture, Cotton and Coleman (2006) argue that "each police organization should foster a culture in which mental illness is viewed as a medical disability not a moral failure, and in which PMI are treated with the same degree of respect as other members of society" (p. 4). Coleman and Cotton (2010a) as well as Iacobucci (2014) further argue that this form of culture can be achieved by establishing a revised set of language, policies, and procedures

which emphasizes that interactions with PMI are indeed 'real police work'. Specifically, Iacobucci (2014) states that services should construct a formal statement which establishes the services' commitment to assisting people in crisis. Such a statement should be treated equal to the core values of the service and should include commitments that preserve the lives of PMI, emphasize de-escalation, eliminate stereotypes and stigma, enhance co-operation with the mental health system, and propose continuous self-improvement of the service and its officers (Iacobucci, 2014).

A positive culture can also be fostered by advanced forms of mental health training. Coleman and Cotton's (2010a) in-service training survey found that some police services had an advanced training matrix which suggest that different officers at a service may receive different forms of training based on where they are located in the matrix. For example, the Halifax Regional Police training matrix (Appendix 1) has four different levels of mental health training (Coleman & Cotton, 2010a), and resembles the later published Training and Education About Mental Illness for Police Organizations (TEMPO) model by Coleman and Cotton (2014) which emphasizes a tiered training program. Levels one and two concern basic training for new officers and in-service training for current officers, respectively. However, levels three and four include CIT and co-response (Coleman & Cotton, 2010a) – advanced forms of mental health training with an objective to improve officer communication and de-escalation skills while simultaneously improving interactions with PMI and co-operation with the mental health system.

Improving Crisis Intervention

The work of Munetz and Griffin (2006) highlights the use of the Sequential Intercept Model as an approach to decriminalize PMI. The model (Appendix 2) is viewed

as a series of 'filters' where a PMI can be diverted away from the criminal justice system and into the appropriate psychiatric care. The first filter, or the "ultimate intercept" as posited by Munetz and Griffin (2006, p. 545), is an accessible mental health system. They argue that "an accessible, comprehensive, effective mental health treatment system focused on the needs of individuals with serious and persistent mental disorders is undoubtedly the most effective means of preventing the criminalization of people with mental illness" (Munetz & Griffin, 2006, p. 545). However, as reviewed above, the current state of the mental health system, particularly in Canada, is not accessible, comprehensive, nor effective, consequently leading to a continuous increase in PMI interactions with police and subsequent criminalization. Thus, the second intercept in the model concerns the use of pre-arrest diversion programs utilized by emergency services and law enforcement (Munetz & Griffin, 2006).

Efforts to employ pre-arrest diversion programs for PMI interactions have been undertaken globally (Butler, 2014) especially as findings indicate that the use of mental health services are associated with reduced re-arrest (Constantine, Robst, Andel, & Teague, 2012). These programs may be employed in a variety of different forms and structures depending on the need of the particular jurisdiction (Butler, 2014; Deane, Steadman, Borum, Veysey, & Morrissey, 1999; Durbin et al., 2010a), however, most commonly, these programs can take one of three forms:

1. A *mental health-based* response which commonly encompasses mobile crisis teams that are a part of the local mental health system, but can also be requested to respond to a crisis at the discretion of first-responding officers;
2. A *police-based specialized mental health response*, otherwise known as the 'co-responding model', where a police officer and mental health practitioner work collaboratively and co-respond to mental health crises at the discretion of first-responding officers; and;

3. A *police-based specialized police response*, such as the 'Memphis Model' or Crisis Intervention Team (CIT), which includes specially trained mental health officers who attend and de-escalate mental health crises (Deane et al., 1999, p. 100)

Such programs have the ability to reduce the risk of police and/or PMI injury, improve officer awareness and collaboration among various mental health institutions, reduce arrests and recidivism, and can be the 'log in the fire' which has the ability to initiate positive change with respect to officer attitudes, beliefs, stigma, and the police culture (Watson, Ottati, Draine, & Morabito, 2011; Ellis, 2014; Reuland et al., 2009; Butler, 2014; Constantine et al., 2012).

Crisis Intervention Teams (CIT)

Subsequent to a Memphis police officer shooting a PMI in 1987, the Memphis police department formed a multi-party, co-operative partnership with the Alliance for the Mentally Ill, the University of Memphis, and the University of Tennessee in an attempt to develop a specialized unit within the police department which could have a greater focus on interactions with PMI (Steadman, Deane, Borum, & Morrissey, 2000). From this partnership, the Crisis Intervention Team (CIT) was formed which seeks to improve police training and emphasizes the need for co-operative and collaborative partnerships between the police, the mental health system, and various community-based mental health programs and services to improve the quality of life for PMI and to reverse the re-institutionalization of PMI in the criminal justice system (Wells & Schafer, 2006; Bonfine et al., 2014; Wood & Watson, 2017). CIT has quickly spread throughout the United States (Dupont et al., 2007) and across the world with most recent estimates suggesting that there are over 3,000 CIT programs being employed internationally (as cited in Watson & Fulambarker, 2012).

One of the founders of the CIT model, Randolph Dupont, and colleagues (2007), stress that there are several core elements that should be present within each CIT program that are "central to the success of the program's goals" (p. 3). These elements include *ongoing elements*, *operational elements*, and *sustaining elements*.

The ongoing elements of CIT emphasize the need for continuous and unobstructed co-operation, collaboration, and leadership between and within the law enforcement community (e.g., police department, corrections, judiciary, and policy development personnel), the advocacy community (e.g., PMI, family members of PMI, and advocacy groups), and the mental health community (e.g., mental health professionals, non-profit/private agencies, institutions, universities, and trainers) (Dupont et al., 2007). In addition to community co-operation, communities with CITs are encouraged to develop a sense of 'community ownership' to ensure that all concerned individuals and organizations have a stake in the initial planning stages of CIT, the implementation, its training curriculum, and ongoing feedback to ensure its success. Furthermore, the ongoing elements also concern the creation of policies and procedures which direct the actions of law enforcement and mental health officials before, during, and subsequent to a mental health intervention by CIT. These policies and procedures include the need for approximately 20-25% of a police service to be CIT trained in order to ensure adequate 24-hour coverage, and inter-agency agreements to ensure a wide range of inpatient and outpatient services are immediately available for PMI brought in by CIT (Dupont et al., 2007).

The operational elements emphasize that officers who wish to be on a CIT must voluntarily apply for a position. Officers will then subsequently be put through a selection process based on recommendations, the officer's disciplinary file, and an interview

(Dupont et al., 2007). Once successfully selected, CIT officers maintain their role as patrol officers, but acquire new duties and skills through CIT training. The CIT curriculum (Appendix 3) is a 40-hour comprehensive course consisting of lectures on 15 different topics associated with mental health (e.g., alcohol and drug assessment, co-occurring disorders, suicide prevention, personality disorders, community resources, etc.), visits to mental health treatment facilities, as well as scenario-based exercises (e.g., verbal skills, stages of crisis escalation, de-escalation). Police agencies with CITs are also encouraged to train their 911 dispatchers to ensure proper recognition of a crisis event, that appropriate questions are being asked of the caller, and that the CIT officers nearest to the crisis event are dispatched immediately. In addition, the operational elements also emphasize that a CIT have a designated emergency mental health receiving facility available with on demand access, no barriers to care, and minimal turnaround time for fast transfer of custody between CIT officers and the receiving facility (Dupont et al., 2007).

Finally, the sustaining elements of CIT include outreach to promote the development of the program regionally and nationally, the recognizing and honouring of CIT officers through awards, certificates of recognition, and banquets, and the continuous in-service training of CIT officers (Dupont et al., 2007). The sustaining elements also emphasize the need of continuous evaluation and research to measure the impact, outcomes, and efficacy of CIT.

Outcome research with respect to CITs, although limited, has displayed very favourable results in terms of effectiveness. Various pre-post methodologies have found that CIT officers have improved knowledge of mental illness (Compton et al., 2014a; Wells & Schafer, 2006; Ellis, 2014), improved attitudes towards PMI (Compton et al., 2014a;

Compton, Esterberg, McGee, Kotwicki, & Oliva, 2006; Demir, Broussard, Goulding, & Compton, 2009; Ellis, 2014), a higher tendency to choose a referral to a community-based mental health service or transfer to a hospital over arrest (Compton et al., 2014b; Steadman et al., 2000; Franz & Borum, 2011), improved de-escalation skills (Compton et al., 2014b), and improved comfort and confidence when interacting with PMI (Compton et al., 2014a; Wells & Schafer, 2006). Further analyses also found that CIT officers are less likely to use physical force against a PMI than non-CIT officers (Compton et al., 2011b; Morabito et al., 2012; Morabito et al., 2017) and are more likely to use verbal engagement as the highest level of force (Compton et al., 2014b). However, the amount of force used by CIT officers during a crisis depends on the context of the crisis at hand. For example, in a sample of 135 officers (48 CIT, 87 non-CIT), Compton et al. (2011b) found that in a scenario where a PMI becomes agitated, paranoid, and ignores requests, 6.4% of CIT officers indicated that they would use some level of force in that scenario compared to 11.6% of non-CIT officers; although, in a scenario where a PMI picks up a large rock and begins walking towards an officer, 43.5% of CIT officers indicated that they would use force in this scenario compared to 63.1% of non-CIT officers, thus supporting the finding that CIT officers use less force, even in situations which are escalating.

Furthermore, CIT has been widely accepted by officers. Several studies on police perceptions of CIT have concluded that officers perceive CIT as both effective and beneficial in interacting with PMI (Deane et al., 1999; Canada et al., 2010; Morabito, Watson, & Draine, 2013; Bonfine et al., 2014; Tully & Smith, 2015). Most notably, officers perceive that CIT training has the ability to reduce stigma and increase empathy (Hanafi, Bahora, Damir, & Compton, 2008). This reduction in stigma and increase in empathy may

even 'rub off' onto untrained officers, potentially changing the attitudes and stigma embedded in the police culture of that particular service (Canada et al., 2010). Ultimately, CIT officers believe that they direct more PMI to the appropriate resources as opposed to arrest, have a better ability to recognize mental illness, have the skills and patience to de-escalate a crisis, and have the confidence to effectively address a crisis (Deane et al., 1999; Canada et al., 2010; Morabito et al., 2013; Bonfine et al., 2014; Tully & Smith, 2015).

However, given that the United States has been the 'forerunner' in the development of police-based crisis response models (Butler, 2014, p. 4), and that CIT is the "most visible pre-booking diversion program" in the nation (Steadman et al., 2000, p. 646), there is a significant lack of CIT literature beyond the United States, therefore, it is unknown whether CITs beyond the United States produce similar results. In the Canadian context, to date, there have been no empirical studies on CITs even though such teams exist in Halifax, Hamilton, and in certain divisions of the Ontario Provincial Police (Coleman & Cotton, 2010a; Durbin et al., 2010b; Iacobucci, 2014; Wood, Swanson, Burris, & Gilbert, 2011). Literature which does exist on Canadian CITs is extremely limited and may include vague data on training modules and objectives which typically mirror the training and objectives found in the CIT core elements discussed above (e.g., Coleman & Cotton, 2010a; see Appendix 1), but does not include rigorous evaluations or stakeholder perceptions as seen in the American literature. This lack of Canadian literature on CITs may simply be due to the fact that although CITs have been adopted by some Canadian police agencies, they are simply less common than other forms of diversion programs (Butler, 2014; Coleman & Cotton, 2010a; Cotton & Coleman, 2010). It has been suggested that one of the predominant reasons that CIT is a less popular intervention method in Canada is because

deaths of either officers or PMI during interactions in Canada are fairly rare, whereas in the United States the numbers are far greater, especially due to the wide availability of firearms (Coleman & Cotton, 2010b). Consequently, as firearms are of far less concern to Canadian police officers than their American counterparts, there is less concern about involving civilian personnel in crisis interventions (Coleman & Cotton, 2010b). Therefore, scholars suggest that the co-response model is predominant in Canada.

Co-Response Teams

Co-response teams are a police-based diversion strategy which typically has an officer partner with a mental health professional (e.g., mental health nurse) who then co-respond to mental health crises at the request of first responding officers (Iacobucci, 2014). The overarching and universal objectives of these teams are similar to that of CIT: de-escalate crises, prevent injuries, link PMI to the appropriate community-based services, and reduce pressure on both the criminal justice system and the mental health system (Shapiro et al., 2015). The co-responding model can be a very advantageous response which cannot be easily replicated by CIT. First, the pairing of a mental health nurse and police officer can bridge the informational gap between the mental health and criminal justice systems in order to address a crisis quickly and effectively (Iacobucci, 2014). Second, mental health nurses possess a wide array of medical knowledge that cannot be easily consumed by a police officer, even with 40-hour CIT training, thus enabling a nurse to employ their knowledge to ensure a crisis is deescalated properly. Alternatively, although uncommon, a co-response could also encompass a psychiatrist, which could result in additional benefits. The findings of such a response indicate that the psychiatrist can help a PMI be properly diagnosed, and they are able to prescribe the PMI temporary

medication in the case that the PMI may have to wait a significant amount of time to be admitted for treatment (Rosenbaum, 2010). The third and final advantage to co-response is that specialized training given to officers, in addition to the direct collaborative partnership with the mental health system via a mental health specialist, can play a significant role in reducing the stigma associated with mental illness found in the police culture (Iacobucci, 2014).

Unfortunately, unlike the aforementioned CIT model, there has been even less research conducted on co-response teams. Although, studies which have been conducted to date have shown very promising results. In a literature review of three dissertations, seven reports, and 11 peer-reviewed publications on co-response, Shapiro et al. (2015) found that the co-responding model is able to forge co-operation between the police and community-based mental health services, and is able to mitigate the burden on the justice system through reduced arrest rates and time spent at a crisis. More specifically, in an American evaluation of a co-response in DeKalb, Georgia, Scott (2000) found that the team voluntarily hospitalized more PMI (64%) than non-co-response officers who predominately non-voluntarily hospitalized PMI (67%). Co-response officers were also less likely to arrest a PMI (7%) than non-co-response officers (14%) (Scott, 2000). Similarly, co-response teams in Birmingham, Alabama and Knoxville, Tennessee only arrested 13% and 5% of PMI, respectively (Steadman et al., 2000).

From the Canadian context, a survey of Ontario police services by Durbin et al. (2010b) indicated that of the 37 services surveyed, 49% employ a co-response team. Whereas other surveys and reports have found that police services in Toronto, Calgary, Halifax, Peel Region, Halton Region, Vancouver, and Hamilton have some form of co-

response (Butler, 2014; Coleman & Cotton, 2010a; Iacobucci, 2014; Wilson-Bates, 2008; Wood et al., 2011). However, detailed objectives, training modules, training length, amount of co-response officers, amount of calls for service, and relationships with the mental health system are largely unexplored within academic literature. Evaluations of Canadian co-response teams are far more limited as only three co-response teams – located in Halifax, Toronto, and Hamilton – have been evaluated to date.

The work of Kisley et al. (2010) on the Mental Health Mobile Crisis Team in Halifax found that although calls for the team increased significantly one-year and two-years following co-response implementation, the time spent at a crisis by the team (136 minutes) was significantly lower than non-co-response officers who were in a control area (165 minutes). In addition, PMI who had contact with the team showed greater engagement with outpatient services and other mental health services than PMI who encountered officers in the non-co-response control group (Kisley et al., 2010). The most detailed body of literature on Canadian co-response predominantly focuses on the Mobile Crisis Intervention Team (MCIT) employed by the Toronto Police Service (TPS).

The TPS established their MCIT in 2000 as a response to a recommendation from a 1994 Coroner's Inquest into the death of Lester Donaldson, a PMI shot by a TPS officer (Iacobucci, 2014). The aim of the TPS MCIT is to provide prompt support to PMI in crisis, avert escalation, reduce pressure on the criminal justice system, and link PMI to appropriate services (Iacobucci, 2014). It originally began with a partnership with St. Michael's Hospital and a single TPS division; currently, the TPS MCIT covers all 17 TPS divisions and has partnerships with six hospitals in the Toronto area (Iacobucci, 2014). TPS officers who have "shown a strong ability to deal effectively with persons in crisis" are selected

through an internal posting, and successful officers are sent to a week-long training course along with MCIT nurses to familiarize the officer and nurse with one another (Iacobucci, 2014, p. 222). Co-training is typically conducted as a process to de-stigmatize each other's work culture (Steadman et al., 2001). TPS MCIT officers can be part of the unit for a minimum of two-years to a maximum of five-years, and work 10-hour shifts which typically fall between 11am and 11pm depending on the division and their mental health intervention needs (Iacobucci, 2014). Toronto MCITs attend approximately 2,000 calls per year, 73% are mental health crises, 22% suicide threats, and the rest concern suicide attempts or overdoses (Kirst et al., 2014).

Studies which assess the perceptions of stakeholders associated with the TPS MCIT overwhelmingly perceive the program positively and as meeting its key goals (Kirst et al., 2014; Kirst et al., 2015). Most importantly, individuals who had an interaction with the MCIT have reported positive interactions, especially during interactions when the nurse takes the lead, as opposed to the officer. One PMI stated,

> I think specifically with the team is I've had some excellent experience with them and also not so great experiences. And I think the difference, if I can pinpoint it to what led to a good experience and what led to a not so good experience for the consumers that we work with, was if the nurse, you're right – if the nurse takes the lead, things seem to go a lot smoothly because they're giving direction to the officer. 'He's fine, this is what we should do' (Kirst et al., 2014, p. 18)

However, whether the nurse or officer take the lead is dependent on a variety of contextual factors, such as whether the team have had an experience with the PMI before, the preference of the person in crisis, and the type of call at hand (Kirst et al., 2014). Other PMI felt criminalized by the use of handcuffs and marked vehicles, preferred when there were fewer responders, preferred having a choice of which hospital to be taken to, and

emphasized the value of de-escalation and calming communication (Lamanna et al., 2015). Ultimately, evaluations of the TPS MCIT found that the MCIT voluntarily referred more PMI to hospital than non-MCIT officers (Lamanna et al., 2015).

Moreover, some police services go beyond a single form of crisis intervention. For example, Halifax employs both a CIT and co-response, whereas, most notably, the Hamilton Police Service employ a CIT and co-response, *and* work collaboratively with a mental-health based response – an approach which has been supported by scholars (Coleman & Cotton, 2010a; Ghebreslassie, 2017; Iacobucci, 2014). The mental-health based response, otherwise known as the Crisis Outreach and Support Team (COAST) was formed in 1997 and is centered out of St. Joseph's Health Centre in Hamilton (Iacobucci, 2014). COAST is comprised of psychiatric nurses, mental health workers, social workers, occupational therapists, and plain-clothed police officers who respond to crises 24 hours a day and assist front line responders at their request. However, COAST only responds to approximately 25% of Hamilton's crisis calls as the team is unable to respond to incidents which may be unsafe for mental health professionals. Consequently, Hamilton established a CIT in 2006 to ensure appropriate interventions occur even when COAST is unable to respond, and established a co-response in 2013 to address large call volumes in the center of the city (Iacobucci, 2014). While little is known about Hamilton's CIT, an initial evaluation of Hamilton's co-response team, named the Mobile Crisis Rapid Response Team (MCRRT), has displayed very promising results. In addition to diverting PMI out of the criminal justice system, the goal of the MCRRT is to avoid unnecessary hospital transfers by diverting PMI to community-based services or crisis beds (Fahim, Semovski, & Younger, 2016). In a 12-month period compared with non-co-response crisis

interventions, employment of the MCRRT resulted in a 49% reduction of people in crisis who were brought to hospital (Fahim et al., 2016). Of those taken to hospital, only 20% were discharged without psychiatric assessment in contrast to 53% taken to hospital by non-co-response crisis interventions (Fahim et al., 2016) – indicating that those who were transferred by the MCRRT genuinely needed psychiatric care.

Ultimately, the pre-arrest diversion model – or combination of models – that police services choose to employ will depend on a variety of factors that may be unique to the jurisdiction of that service. These factors predominantly concern demographics, urban or rural geographies, the programs and services available through the local mental health system, and the prevalence of PMI contacts with the police (Butler, 2014; Reuland et al., 2009). However, several factors may also hinder the potential success of either model in any jurisdiction.

Challenges of CITs and Co-Response

First and foremost, all CIT and co-response literature stress the need for a central and identifiable drop off location for PMI at the local hospital or psychiatric facility with a 'no-refusal' policy and rapid streamlined intakes (Deane et al., 1999; Iacobucci, 2014; Steadman et al., 2000; Steadman et al., 2001; Kisely et al., 2010; Dupont et al., 2007). Officers who had access to a specific drop off centre were more likely to perceive their CIT or co-response as effective (Deane et al., 1999). To put this into perspective, in Memphis, Tennessee, the founding city of CIT, officers wait no more than 30 minutes for the facility to take custody of a PMI; whereas in Toronto, co-response officers can wait an average of two hours at a hospital for the PMI to be transferred into the care of the facility (Iacobucci, 2014). Notably, the Hamilton Police Service has mitigated select lengthy

transfers of custody by allowing officers to assess the risk of the PMI after a 30-minute

hospital wait – if the officer determines that the PMI poses a low risk to themselves,

hospital staff, or the public, the officer and a nurse can transfer care of the PMI to the

hospital (Iacobucci, 2014). Alternatively, officers who wait hours for a PMI to be admitted

may ultimately not be admitted by the facility, *or* may be admitted and discharged only a

few hours later (Canada et al., 2010). Geller (2008) has been particularly critical of CIT

implementation without properly addressing the revolving door of the mental health

system. He states that with the revolving door, "CIT might just as well stand for

Consecutive Interventions without Treatment" (Geller, 2008, p. 58).

Consequently, long wait times for transfer of custody may result in CIT or co-

response officers not being able to respond to other PMI who may be in crisis (Iacobucci,

2014). This essentially may cause very low response rates from CITs or co-response. For

example, Durbin et al. (2010b) found that of the 49% of Ontario police services that employ

a co-response team, the teams are only utilized in less than 25% of crisis incidents. A

similar low response rate is present in Toronto with the TPS co-response team only

responding to 11% of all crises (Iacobucci, 2014). Low staffing may also affect the

response of co-response. In Knoxville, Tennessee, the co-response rate is approximately

40% due to the team consisting of only six officers, resulting in a slow response time

(Steadman et al., 2000). In-take delays and shortage of CIT/co-response officers could be

mitigated by training more officers, as in the case of Portland, Oregon where all officers

are CIT trained (Watson, Morabito, Draine, & Ottati, 2008b). However, this approach is

contrary to the voluntary element of CIT training. Delays could also be mitigated by

allowing officers to assess the risk of PMI, as in the case of Hamilton, but are only applicable for low-risk PMI.

Another limitation, particularly with respect to the co-response model, is that co-responses are a secondary response to a mental health crisis, not a primary response. Hamilton's MCRRT is an anomaly of this limitation as they are one of the first co-responses which are first responders (Fahim et al., 2016). However, former TPS Deputy Police Chief Michael Frederico argues that "If we sent the crisis team first, it would be a single officer dealing with an uncertain situation at the time and a nurse who is not either authorized or trained to deal with a public safety issue" (Ghebreslassie, 2017). Contrastingly, Iacobucci (2014) states,

> A key limitation of the MCIT model is the fact that the officer-nurse pair can only act as a specialized response. In this respect, it is unfortunate that police officers without specialized training in mental health crises are required to make a crisis situation safe before the professionals most capable of managing and de-escalating that crisis – the MCIT – are allowed to intervene. It is highly arguable that the most capable people should be engaged from the outset (p. 225)

This issue of co-responses as second responders has re-emerged following the inquest into the TPS shooting death of Andrew Loku in July 2015, along with the issue that co-response teams, particularly in Toronto, are not available from 11pm to 11am (Ghebreslassie, 2017; Iacobucci, 2014). In contrast, CITs as a first response may be favoured over co-response. For example, The Memphis Police Department prefers an 'immediate' CIT response because such responses, conducted in a humane and calm fashion, allow officers to reduce the likelihood of physical confrontations and enhance care of the PMI in crisis (Butler, 2014). Thus, in the context of CIT, it is specially trained first responding officers who attempt to de-escalate a crisis situation, as opposed to a secondary response which may

take a significant time to arrive, again, if delayed by the hospital or low co-response staffing. Certain police services, such as Halifax, have mitigated the limitations of co-response by employing both a CIT and co-response team; whereas Hamilton utilizes their co-response as a first response. However, even with implementation of specialized training, continuous training is important for information retention.

Canada et al. (2010), Compton and Chien (2008) and Tully and Smith (2015) found that once an officer receives CIT training, they do not get re-trained on mental health afterwards. In a sample of 88 CIT trained officers, 70% indicated that they did not have re-training after becoming a CIT officer (Compton & Chien, 2008). Calls for CIT continuing training have been supported by pre-post analyses which suggest that CIT knowledge retention may decrease as time elapses. Specifically, Compton and Chien (2008) found that after 88 officers completed CIT training, the mean pre-score was 16.7, however, after approximately 46.1 weeks a post-test was conducted whose mean score was 14.7. Unfortunately, the lack of re-training for CIT officers appears to have been a neglected element of the CIT core elements.

Finally, the implementation of a CIT or co-response team may be a particularly difficult challenge for some jurisdictions, especially rural jurisdictions. Qualitative interviews with CIT stakeholders in rural communities found that sending an officer for week-long training may be difficult, especially as there may only be a few officers who work full-time, and the cost to have an officer CIT trained may be far beyond the available budget available for the training of rural officers (Skubby et al., 2013; Geller, 2008). Moreover, participants highlighted that rural mental health systems are more underdeveloped and underfunded than urban systems. Some participants argued that the

federal government tends to divert most funding into urban areas where the money can have the biggest impact and ignore rural areas who have a similar lack of community-based mental health programs, but on a smaller scale (Skubby et al., 2013). Thus, Geller's (2008) comment on CIT as "Consecutive Interventions without Treatment" is more inevitable in rural areas.

There have been many recommendations for improvement of CIT and co-response teams, such as mobility of crisis teams, access to beds, broad staffing specializations (Forchuk et al., 2010), 24-hour first responses for co-response teams, employing a CIT in conjunction with a co-response, and establishing evaluation periods to ensure that CITs and co-response have the best capable officers (Iacobucci, 2014). However, as outlined within this literature review, very few studies have actually examined the use and success of CITs and co-response, particularly in Canada, therefore, recommendations for 'improvement' may not even be relevant if it is unknown whether these programs are successful and make an impact in the first place. Studies which do exist disproportionally focus on CIT employment in the United States, with little evaluations on other jurisdictions or interventions, such as co-response (Coleman & Cotton, 2010a; Wood & Watson, 2017). In addition, current CIT studies overwhelmingly assess the perceptions of various CIT stakeholders, as opposed to evaluating CIT effectiveness (Blevins, Lord, & Bjerregaard, 2014). This lack of studies on CITs and co-response have been attributed to a lack of data available on interactions between PMI and police which can make a methodologically sound evaluation extremely difficult (Blevins et al., 2014; Coleman & Cotton, 2010a; Wood & Watson, 2017). Therefore, in many cases, police services have employed CITs or co-responses based on the understanding that it is the current 'best practice' available, as

opposed to evaluative research which suggests that their specific training module is effective (Coleman & Cotton, 2010a, p. 21).

Undoubtedly, more research is required on the use of CITs and co-responses. However, prior to moving on to the present study, which seeks to address the lack of research on these responses in Canada, several policing strategies will be briefly presented, and a discussion will be put forth to summarize the aforementioned literature through the context of these strategies. In place of a traditional theoretical framework, the purpose of presenting and discussing these strategies is to provide a contextual framework which will allow for a better understanding of the dynamics and reasoning behind police approaches to PMI interactions from a policing perspective. Many innovative strategies have developed within policing over the last several decades in order to make law enforcement more effective; however, as will be exemplified within the context of specialized responses to PMI, it is not a *single* police strategy that is employed to address contacts with this population, but rather *multiple* strategies employed simultaneously.

Policing Strategies and Mental Illness

Since its inception, the policing institution operated on a 'one-size-fits-all' model known as the 'three R's' – random patrol, rapid response, and reactive investigations (Sherman, 2013). This form of policing developed into the dominant model in many English-speaking nations until the 1970s when a policing crisis occurred (Sherman, 2013; Weisburd & Braga, 2006b). This crisis developed primarily out of the realization that the 'three R's' strategy was not effective at decreasing nor preventing criminality, thus leading to a decrease in public confidence of the police (Weisburd & Braga, 2006a). What stemmed from this crisis, however, were significant innovations to the policing institution, such as

community policing, risk management, procedural justice, and evidence-based policing, which, over the past three decades, transformed policing from being *reactive* to criminality to being *proactive* (Weisburd & Braga, 2006a).

One of the first post-crisis strategies to emerge was community policing which encouraged the police and community to 'fight crime' collaboratively (Weisburd & Braga, 2006b). This form of policing heavily relies on the *decentralization of authority* which facilitates *problem-solving* efforts at all levels of the police hierarchy and, as alluded to by the name of the strategy, *community involvement* (Skogan, 2006). Some police services may also use community policing as a method to acquire information for another strategy used by law enforcement – risk management. The notion of risk was put forth by the work of Beck (1992) who argued that through the modernization of society, the world has made itself vulnerable to a plethora of new hazards, and that a systematic way of addressing the new dangers of our society is through risk management (Beck, 1992). In terms of policing, Ericson and Haggerty (1997) argue that the police are 'knowledge brokers' for a variety of institutions (e.g., insurance companies) whose duty it is to assess risk, and that community policing is not only a means of working closely with the community, but is also used to gather knowledge and to subsequently assess risk. The police have developed a variety of methods to mitigate risk and criminality (Beck, 2002; Murphy, 2007; Phythian, 2012; Ransley & Mazerolle, 2009; Schaible & Sheffield, 2012). One such method is intelligence-led policing which emphasizes the collection and analysis of information to determine police action (Ratcliffe, 2011).

Contrastingly, the President's Task Force on 21st Century Policing highlighted the need for police to transition away from a focus on effective crime control, which may be

facilitated through risk-based strategies, toward a focus on how police actions influence

public trust and confidence, such as procedural justice (Tyler, Goff, & MacCoun, 2015).

This strategy concerns the fairness and demeanour put forth by officers during interactions

with the public. Key components of this strategy include: allowing one's voice to be heard;

having your rights acknowledged and being treated with dignity, respect, and politeness;

and trusting that the officer is concerned for the welfare of the individual involved (Lind

& Tyler, 1988). When an interaction encompasses these components, the individual is more

likely to view the police as legitimate and are more likely to comply with the officer

irrespective of the outcome of the interaction (Tyler, 2004; Tyler, 2006; Tyler &

Mentovich, 2011; Sunshine & Tyler, 2003). It is, however, argued that more research is

required to establish whether procedural justice is effective in police practice (Nagin &

Telep, 2017), and evidence-based policing is one such strategy which can facilitate

evaluative research.

In contrast to the aforementioned 'three R's' of traditional policing, evidence-based

policing emphasises the 'three T' strategy – targeting, testing tracking – in order to

determine which policing strategies are effective (Sherman, 2013; Huey, Blaskovits,

Bennell, Kalyal, & Walker, 2017). *Targeting* refers to the identification of problems that

must be addressed; *testing* occurs to ensure that the strategy employed to address the

problem is achieving its desired goals; and finally, the process of *tracking* refers to the

logging of the strategy over time to ensure that it continues to work effectively, as well as

modifying the strategy, re-testing and re-tracking adjustments to achieve the desired

outcome (Sherman, 2013).

Undoubtedly, in the context of police-PMI interactions, it is evident that risk mitigation is the prevailing strategy that police use when interacting with this population. As discussed earlier, the focus of the police is the safety and security of the community as a whole, therefore, the police may apprehend PMI for being a risk to themselves or others, mercy book, or even charge PMI with minor nuisance infractions in order to mitigate risk. Contrastingly, mental health training for officers may be considered as a form of risk mitigation as well. With officers being trained on mental health, the assumption is that they will be better educated and more effective during interactions with this population, while simultaneously being more effective at mitigating risks associated with these interactions. With the introduction of CITs and co-response, however, we see risk mitigation beginning to intertwine with elements of procedural justice, community policing, and evidence-based policing in contemporary police-PMI interactions.

In comparison with the general population, PMI are four times less likely to think that the police treat people fairly (Desmarais et al., 2014). Studies on procedural justice in police-PMI interactions have found that officer behaviour can affect the experiences and behaviour of PMI within current and future interactions, therefore, procedurally just treatment from officers is vital to ensure successful and positive interactions (Livingston et al., 2014a; Watson & Angell, 2007; Watson et al., 2008a). Although CIT and co-response training does not explicitly include elements of procedural justice (Watson & Angell, 2007), the increased empathy of officers and improved treatment of PMI during CIT/co-response interactions can lead to increased feelings of procedurally just treatment in comparison to non-CIT/co-response interactions (Furness, Maguire, Brown, & McKenna, 2016).

In addition, these responses require the police to partner with community-based services and hospitals in order to ensure success. This is particularly emphasized within the core elements of the CIT program which stress *community involvement* and *problem-solving* on behalf of the police, community, hospitals, and other stakeholders to collaborate on CIT formation, implementation, and ensuring that PMI are directed to the appropriate care they may need. The community approach to crisis interventions becomes even closer with the use of a co-response model where a citizen (i.e., mental health nurse) and a police officer work together to de-escalate crises and direct PMI to the appropriate community-based service or hospital. The co-responding model in particular also facilitates the *decentralization* of police power by giving the mental health professional the authority to intervene and provide solutions in a crisis situation.

While the use of risk, procedural justice, and community policing is evident within police-PMI interactions, evidence-based policing is not as developed in this area. In the context of CIT, Watson, Compton, and Draine (2017) argue that the program has the potential to become an evidence-based practice for officer-level cognitive and attitudinal outcomes, however, far more research is needed to determine if CIT can become an evidence-based practice for other outcomes.

In the Canadian context in particular, very little is known about both CITs or co-response teams, especially with respect to the foundational information. Beyond the work of Coleman and Cotton (2010a) and other evaluative reports, the objectives and goals of Canadian CITs and co-responses are largely unknown. In addition, it is unknown how co-response elements can differ from the CIT elements outlined above, how many CIT/co-response officers a service trains, what their training modules contain, hours of

deployment, their overall structure and organization, and what partnerships/agreements services may have with the mental health system in order to ensure the success of these programs. Most notably, beyond the services discussed above, it is unknown *how many* or even *which* Canadian police services employ either a CIT or co-response team. This can cause future evaluative research to be difficult as there is no sample to target. Search engine results suggest that other services beyond the ones discussed above may employ either a CIT or co-response, but limited information is provided. For example, the Durham Regional Police (n.d.) has a 'Mental Health Unit' page on their website, however, the page contains no information and a 'Coming Soon' message. Therefore, this thesis seeks to contribute to the academic literature by surveying Canadian police services to answer the following research questions:

- Research Question #1: Which Canadian police services employ a CIT and/or co-response team;

- Research Question #2: For the police services who have a CIT and/or co-response, what are the elements that make up their response to PMI? Such as why these responses were established, their goals and objectives, as well as their structure and organization;

- Research Question #3: What are the successes achieved and challenges faced by Canadian CIT/co-response teams?

Chapter Three: Methodology

Due to a lack of available data on PMI interactions with police, many prior studies which have explored this area have relied on the employment of surveys (e.g., Bonfine et al., 2014; Compton et al., 2011a; Cotton, 2004; Durbin et al., 2010b; Tully & Smith, 2015), qualitative interviews (e.g., Canada et al., 2010; Girard et a., 2014; Hanafi et al., 2008; Morabito et al., 2017; Skubby et al., 2013), or a mixed methodology incorporating both surveys and qualitative interviews (e.g., Brink et al., 2011; Kirst et al., 2014; Wells & Schafer, 2006). With respect to this thesis, a mixed methodology will be utilized in order to obtain both quantitative (i.e., number of CITs/co-response) and qualitative information about CITs and co-response employed by police services in Canada.

Creswell (2011, p. 271) argues that there have been a variety of changing and expanding definitions over the last few decades as to what precisely constitutes a 'mixed' methodology. However, this approach simply "involves philosophical assumptions that guide the direction of the collection and analysis and the mixture of qualitative and quantitative approaches in many phases of the research process." Its core premise "is that the use of quantitative and qualitative approaches, in combination, provides a better understanding of research problems than either approach alone" (Creswell, 2011, p. 271), and allows for a problem to be 'seen' through multiple ways. Ultimately, the purpose of a mixed methods approach is to select and integrate certain techniques found within both methods in order to more thoroughly investigate a phenomenon (Teddlie & Tashakkori, 2011). Therefore, in order to answer the research questions posed herein, a mixed methodology will be employed using an online survey (i.e., quantitative), as well as semi-

structured interviews (i.e., qualitative) conducted via telephone to mitigate the geographical distances between the researcher and police services (Berg & Lune, 2012).

Surveys are an inexpensive and time-efficient method that allows for large amounts of data to be collected in a short period of time (Palys & Atchison, 2014). Surveys can be administered in a variety of different ways, such as pencil-and-paper, via telephone, or via the Internet (Palys & Atchison, 2014). The latter method, however, provides additional advantages over other forms of survey administration. Specifically, online surveys allow for data collection to occur 24 hours a day, they are easier to distribute, technology allows for integration of photos, audio, and video, and, finally, online surveys allow for adaptive questions where responses to certain questions may determine which subsequent questions are displayed to the participant, consequently allowing participants to avoid questions which may not pertain to them (Palys & Atchison, 2014). Questions may ultimately be structured as either open-ended questions which allow participants to respond in their own words, or closed-ended questions which may be single-response questions, categorical questions, or rating scales, among many others (Palys & Atchison, 2014).

On the other hand, semi-structured interviews are also a flexible method of inquiry that consists of a set of predetermined questions that are asked in a systematic and consistent order, but allow interviewers to probe far beyond the predetermined questions when appropriate (Berg & Lune, 2012; Palys & Atchison, 2014). This may consequently result in unanticipated information or perspectives to arise that may provide a deeper understanding of the phenomenon in question (Berg & Lune, 2012), and may be additionally beneficial in research areas that are exploratory or not sufficiently understood (Palys & Atchison, 2014) Semi-structured interviews also provide an opportunity for

interviewers to ask for clarification to ensure that the participants' perspective of a phenomenon is accurately understood (Berg & Lune, 2012).

Data Collection

A 47-question survey was constructed and inputted into the survey program *Qualtrics* (Appendix 4). Upon opening the survey, participants were provided with an informed consent form that summarized the purpose of this project, their rights and risks as a research participant, as well as what would occur with the data collected (Appendix 4). With the intention of identifying which Canadian police services employ either a CIT and/or co-response, the consent form indicated that the survey data would not be confidential, nor anonymous in order to fulfill this research question. In addition, participants were informed that for completing the survey, five dollars would be donated on their behalf to the Canadian Police Association Robert Memorial Fund to assist the families of those who lost their lives in the line of duty. At the bottom of the consent form participants were given an option to indicate whether they consented or did not consent to participating – those who did not consent were forwarded to the end of the survey, whereas those who consented were forwarded to the first question.

Of the 47 questions, the first 21 questions were concerned with the police service as well as mental health training and mental health related interactions (e.g., name of service, length of mental health training, number of mental health related interactions, etc.). Question 22 asked participants that if their service *did not* have a CIT and/or co-response, were there plans to do so in the near future – services which provided a time-frame or indicated no plans to employ one were forwarded to the end of the survey, whereas those who selected 'not applicable' because their service had a CIT and/or co-response team

proceeded to question 23 and the rest of the survey. These questions specifically inquired about the CIT and/or co-response at the participants' service (e.g., why was a CIT/co-response implemented, hours of operation, objectives, etc.).

Prior to the distribution of the survey, a list of *all* Canadian police services was compiled. Policing in Canada is conducted at three levels – municipal, provincial, and federal – as well as within First Nations communities who run self-administered police services (Greenland & Alma, 2016). As of 2016, there were 184 police services in Canada: 144 municipal, three provincial, one federal, and 36 First Nations (Greenland & Alma, 2016). Following the creation of the list, the website and email address of every service were located through the use of a search engine and added to the list for subsequent survey distribution. Efforts were predominantly focused on locating the contact information of officers who were specifically in mental health related positions, otherwise the general email address for the service was noted. However, websites and email addresses were omitted from the list for certain police services if: (1) the service did not have a website, or it was not functioning properly at the time of search; (2) there was no email address available on the website; and (3) if the service was predominantly French-speaking and did not provide an option for an English version of their website. Following these three exclusions, the survey was distributed to a total of 102 Canadian police services via email in October 2017.

The emails included a brief introduction to the researcher, the summary and purpose of the research, as well as a direct link to the *Qualtrics* survey (Appendix 5). In addition, emails which were not specifically directed towards a mental health related officer and sent to the general service email had a request to forward the email to the single most

appropriate officer to avoid several officers at the same service completing the survey. As surveys were completed, the completion was logged within the aforementioned list; similarly, services which explicitly declined to participate were logged as well. Services which did not complete the survey, but did not explicitly decline to participate were re-invited to participate via email in early December 2017 and then again in early January 2018. Surveys which were partially completed were discarded and interpreted as a withdrawal from the project. However, these services were re-invited in the December and January rounds of survey re-distribution with the prospect that the survey would be forwarded to another officer that would be more willing to participate.

At the end of the survey, participants were asked if they were willing to participate in a semi-structured interview that would allow participants to freely discuss the state of mental health policing at their service as well as in Canada, but with confidentiality ensured. For doing so, participants were informed that an additional ten dollars would be donated to the Canadian Police Association Robert Warner Memorial Fund for a total of 15 dollars by participating in both data collection portions of this project[2]. Survey participants who provided their contact information for interview participation were subsequently contacted via email that included a description of the interview process and an inquiry about dates and times that the participant would be available for a one-hour telephone interview (Appendix 6). Participants who did not respond to the initial interview invitation were followed up with at the beginning of December 2017 and the beginning of January 2018 as well. With both initial and follow up emails, participants were also

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[2] See Appendix 9 for receipt from final donation for 23 survey participants and 10 interview participants.

provided with a consent form for the interview and encouraged to contact the researcher should any questions or concerns arise. Otherwise, participants were asked to sign and return the consent form prior to the interview (Appendix 7). This consent form did not significantly differ from the one provided to participants prior to the survey, with only exception being the assurance of confidentiality.

Participants were asked 13 questions from a 17-question interview guide (Appendix 8). Four questions on the guide depended on whether the service did have a CIT and/or co-response – if they did, the CIT/co-response questions were asked; if not, then questions about mental health training for frontline officers were asked. Some questions on the interview guide were repeated from the survey (e.g., goal/objective of CIT/co-response) in anticipation of more elaborated and detailed answers; whereas others inquired about the challenges faced by CIT/co-response, as well as the challenges and successes of mental health policing in Canada. Interviews lasted between 30 and 75 minutes and were recorded on a digital audio recorder. The interviews were then transferred onto a password-protected computer file and deleted from the recorder. Subsequently, all interviews were transcribed with all potentially identifying information stripped to ensure the confidentiality of the participants and their respective police services. Following each transcription, the audio file of the interview was deleted leaving only the transcriptions for analysis.

Data Analysis

With respect to the survey data, a *Qualtrics* output was generated in *Microsoft Excel* format that displayed the responses for each participating police service. This method was predominantly used to analyze many of the closed-ended and quantitative questions within the survey (e.g., number of mental health related interactions, hours of operation for

CIT/co-response, etc.) in order to compare and contrast the similarities and differences between various Canadian services with respect to these questions. As survey response rates for police services are typically very low (Coleman & Cotton, 2010a), the use of sophisticated statistical software (e.g., SPSS) was deemed unnecessary and basic analysis through *Excel* was deemed sufficient.

Moreover, with respect to the open-ended survey responses (e.g., objectives of CIT/co-response, etc.) and the interview transcriptions, this data was analyzed with qualitative coding software, *NVivo*. As this area of research is highly exploratory in the Canadian context, a grounded, inductive coding approach was used to allow for the identification of general themes and ideas to emerge by reading the data, also known as open coding (Corbin & Strauss, 2015; Palys & Atchison, 2014). Each open-ended survey response and interview transcript was read three times – with a few days in between each reading – to ensure that all relevant themes and ideas were identified. Subsequently, axial coding occurred whereby the themes/ideas identified during open coding were sorted into more specific categories, otherwise known as a coding frame, which was ultimately used to organize data and identify the findings (Corbin & Strauss, 2015; Berg & Lune, 2012) presented below. Axial coding also occurred three times on three different days to ensure the accuracy of the codes, as well as the accuracy of the overall coding frame.

Chapter Four: Results

As of March 1, 2018, officers from 23 Canadian police services completed the online *Qualtrics* survey for a response rate of 22.5% (Table #1). Officers from ten (43.5%) services also elected to participate in a confidential semi-structured interview. In line with the assured confidentiality of the semi-structured interviews, interview participants will be identified by a participant number; whereas results from the survey will be identified by police service. The results will be presented below within three sections: (1) *Participants and Mental Health Police Interactions in Canada* where the participating police services will be presented along with data related to PMI interactions and their conclusions; (2) *Specialized Mental Health Responses in Canada* which includes results pertaining to structure and organization of specialized responses, factors leading to implementation, as well as goals and objectives; and finally, (3) *Successes and Challenges of Mental Health Policing in Canada* where the successes and challenges of Canadian police services as it pertains to the policing of PMI, as well as those of specialized mental health responses, will be presented.

Participants and Mental Health Police Interactions in Canada

Many provinces had at least one service participate: six services (26.1%) are located in British Columbia (Central Saanich, Nelson, New Westminster, Port Moody, Vancouver, Victoria), three (13%) in Saskatchewan (Regina, Saskatoon, Weyburn), one (4.3%) in Manitoba (Winnipeg), ten (43.5%) in Ontario (Brantford, Brockville, Chatham-Kent, Durham Region, LaSalle, London, Peel Region, St. Thomas, Windsor, York Region), one (4.3%) in Quebec (Mont-Tremblant), one (4.3%) in Prince Edward Island (Charlottetown), and one (4.3%) in Nova Scotia (Annapolis Royal). Most (n = 17, 74%) indicated that their

jurisdiction was within an urban area, one service (4.3%) indicated a rural jurisdiction, and five (22%) indicated a jurisdiction comprised of both urban and rural areas. Many of the participating services have 100 sworn officers or less (n = 10, 43.5%), six services (26.1%) have more than 500 sworn officers, three (13%) have between 401 and 500, one (4.3%) has between 201 and 300, and three services (13%) have between 101 and 200 sworn officers.

Table #1: Participating Police Services

Police Service	Urban / Rural	# of Officers	PMI Interactio-ns	MH Interac-tions (2016)[3]	MH Apprehen-sions (2016)[3]	Diff.
[BC] Central Saanich	Rural	0-100	Somewhat common	60	50	10 (16.7%)
[BC] Nelson	Urban	0-100	Very common	950	200	750 (78.9%)
[BC] New Westminster	Urban	101-200	Very common	5,200	447	4,753 (91.4%)
[BC] Port Moody	Urban	0-100	Very common	-	91	-
[BC] Vancouver	Urban	> 500	Very common	12,500	4,500	8,000 (64%)
[BC] Victoria	Urban	201-300	Very common	-	558	-
[MB] Winnipeg	Urban	> 500	Somewhat common	-	-	-
[NS] Annapolis Royal	Urban	0-100	Rare	8	-	-
[ON] Brantford	Urban	101-200	Very common	1,719	500	1,219 (70.9%)
[ON] Brockville	Urban	0-100	Very common	325	147	179 (54.8%)

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[3] The question used to collect this data asked for an approximate number, as such, these figures should be interpreted with caution.

[ON] Chatham-Kent	Both	101-200	Very common	836	100	736 (88%)
[ON] Durham Region	Urban	> 500	Very common	-	-	-
[ON] LaSalle	Both	0-100	Somewhat common	156	-	-
[ON] London	Urban	> 500	Very common	10,000	-	-
[ON] Peel Region	Urban	> 500	Very common	7,500	7,000	500 (6.7%)
[ON] St. Thomas	Urban	0-100	Very common	2,500	100	2,400 (96%)
[ON] Windsor	Both	401-500	Very common	1,600	175	1,425 (89.1%)
[ON] York Region	Both	> 500	Very common	3,500	2,000	1,500 (43%)
[PEI] Charlottetown	Urban	0-100	Very common	515	-	-
[QC] Mont-Tremblant	Both	0-100	Somewhat common	350	100	250 (71.4%)
[SK] Regina	Urban	401-500	Very common	6,750	351	6,399 (94.8%)
[SK] Saskatoon	Urban	401-500	Very common	2,000	300	1,700 (85%)
[SK] Weyburn	Urban	0-100	Very common	250	29	221 (84.4%)

With respect to PMI interactions, almost all services indicated that interactions with this population are *very common* (n = 18, 78%), four (17.4%) indicated *somewhat common*, and one service (4.3%) indicated that interactions with this population are *rare* within their jurisdiction. In 2016, PMI interactions for these police services ranged from eight in Annapolis Royal, NS, to 12,500 in Vancouver, BC, with a mean amount of interactions at 2,985; whereas apprehensions of this population in the same year under provincial mental

health legislation ranged from 29 in Weyburn, SK, to 7,000 in Peel Region, ON, with a mean amount of 1,000 apprehensions.

The difference between interactions and apprehensions, however, differs significantly from jurisdiction to jurisdiction. For instance, in 2016, officers in St. Thomas, ON had approximately 2,500 interactions, but only 100 apprehensions under mental health legislation – a difference of 2,400 (96%) interactions; whereas in the same year, officers in Peel Region had approximately 7,500 interactions, but 7,000 apprehensions – a difference of 500 interactions (6.7%). Survey participants were not specifically asked to elaborate on the difference between interactions and apprehensions at their service, or the decision-making factors which may lead an officer to apprehend a PMI as opposed to referring them to community-based mental health resources. Nevertheless, interview participants emphasized that, at times, determining what should occur after an interaction may be significantly complicated because several factors may affect how an interaction ultimately concludes.

Officers indicated that de-escalation is most commonly the first objective of first responders, except when there is a high degree of danger or risk from the beginning:

> I think all police at this point in stage of training, and just best practice, are always obligated to attempt some kind of crisis de-escalation. The only time where we're not expected to do that is in serious crisis states, so we're talking about when somebody pulls a firearm or knife at you and there's no time to negotiate with these people. But other than that, that's an expectation (Participant 5)

Interactions with PMI were also described as being on a continuum where de-escalation is attempted on the lower end when someone is in an agitated state, to a full-scale emergency response on the other side of the spectrum, depending on what is being dealt with:

> The very initial meeting with somebody, there's always got to be that de-escalation piece. Not that somebody's always escalated, but if they are, de-escalation's always the primary responsibility of the first responders to get the situation a little bit in hand so they can sit down and have a conversation with somebody. Sometimes [it's] just that the person's agitated, right? Or it could be up to the very point where they're holding mom or dad or their neighbour hostage, right? You're going to get various responses in relation to what we first see. So, it might be simply a to officer response right up to full-scale, Emergency Response Unit, helicopter, K-9 and all those kinds of things depending on what we're dealing with (Participant 10)

Although, if de-escalation is appropriate and occurs successfully, or if officers interact with someone who may not necessary be 'escalated', then conclusions other than apprehension under mental health legislation may be enacted, such as simply sending them home:

> I would say the vast majority we deal with on a 1-to-1 basis on the street, assess, and in most cases, we'll send people on their way. We'll have a chat with them. If they're talking to themselves, or their yelling, or something like that, we can deal with them, usually, on a 1-to-1, send them home, walk them up to mental health. But yeah, it doesn't require an arrest or an apprehension (Participant 3)

Or connecting them to community-based resources:

> Most common resolution, probably 70% are resolved through crisis de-escalation, and either an update, reconnection, new referral/new connection to a community partner or mental health. So, 'resolved at scene' or they're potentially just driven over to our community mental health to see somebody there (Participant #4)

> Contrastingly, if de-escalation is necessary but fails, and the attending officer(s) have deemed the individual to be a danger to themselves or others, officers will use their powers under their province's mental health legislation in order to apprehend the individual and transport them to a designated facility for a psychiatric evaluation:

> … at some point [if the officers] made the determination that they fit the criteria of the Mental Health Act, they're coming [….] I won't say it's straight forward, but, if it's going to be a mental health call, then we're going to use our powers under the Mental Health Act in our province which allows us to apprehend if they're a danger to themselves or a danger to others […] Typically, in those occasions it's going to be what would be an 'involuntary admission' – we're actually going to take them in the back of a police car to the [hospital] and then have a doctor examine them (Participant 2)

Furthermore, if the interaction has a criminal element, the officer's options for how to proceed become tangled between two pieces of legislation: the provincial mental health act and the Criminal Code of Canada. For instance, one officer stated, that "… when things become too violent and it has to proceed along a criminal route – and that's something that we will do – the criminal code is always – as a federal legislation – more committing than the provincial act, which is the Mental Health Act as a provincial criteria" (Participant 8). Another officer indicated that, even though an officer makes a determination that someone committing a crime has some form of mental illness, they may not meet the requirements of an apprehension and may have to be processed criminally:

> … if we find somebody suffering – depending on what they did too, we do have to deal with the criminal part of it, and if we don't feel that their mental health is where they're at risk... They could be committing a crime and be suffering from a mental illness, but we can't bring them to the hospital for that, right? Because they're two parts of apprehension, one is them suffering from a mental illness, but the other part is that they're at risk to harm themselves or others. Stealing a roast from the local shop to trade it for drugs – and that's what they do, just so you know – you can't apprehend somebody for that, so you would arrest them in that case… (Participant 3)

Despite the complexities highlighted above, when ranking case conclusions from most common to least common, many services indicated that most of their interactions concluded informally – that is, interactions with no apprehensions or referrals to a community-based mental health service (i.e., 'walk away' interactions) (Table 2). The second most common conclusion was identified as referrals to community-based mental health services, followed by involuntary transport to a designated facility (i.e., apprehension), and arrest as the least common conclusion. However, even when situations arise where officers may be conflicted or unsure of how to proceed, the use of specialized

responses can help responding officers make the appropriate decision that may

significantly benefit the individual involved in the interaction:

> Sometimes, objectively, not everybody would agree on the same thing, but it's what the officer is dealing with in front of them. My team helps make a proper assessment with that. So, I've got a mental health police officer, who's a sworn officer, as well as a crisis worker who are, for the most part, that's all they do. The crisis workers come with the experience in relation to better recognition of the signs and symptoms, or what the diagnosis may be, and the issues that the medications may cause in relation to somebody, and the ability to refer people to resources as opposed to say, 'You know? We have no option other than apprehend this person because this person needs some connections to resources', where a crisis worker can say, 'I can make those connections, we can leave this person at home. You don't have to apprehend them and take them to a hospital' (Participant #10)

In the sections that follow, results pertaining to such specialized responses in Canada will

be presented and discussed.

Table #2: Most Common Conclusion of PMI Contacts[3]

Conclusion	#1	#2	#3	#4	#5	#6
Informal	13 (65%)	2 (10%)	0 (0%)	2 (10%)	2 (10%)	1 (5%)
Arrest	0 (0%)	3 (15%)	1 (5%)	4 (20%)	12 (60%)	0 (0%)
Referral to Community-Based Mental Health Service	1 (5%)	8 (40%)	4 (20%)	7 (35%)	0 (0%)	0 (0%)
Voluntary Transport	4 (20%)	3 (15%)	4 (20%)	6 (30%)	3 (15%)	0 (0%)
Involuntary Transport (i.e., apprehension)	2 (10%)	4 (20%)	11 (55%)	1 (5%)	2 (10%)	0 (0%)
Other	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (5%)	19 (95%)

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[3] This question had a response rate of 86.9% (n = 20).

Specialized Mental Health Responses in Canada

As discussed in Chapter Two, specialized responses to mental health calls or mental health crises can take many forms depending on a variety of factors. At the general level, these responses can take the form of a mental health-based response, a police-based specialized mental health response (e.g., co-response), or a police-based specialized police response (e.g., CIT). Of the 23 services that participated in this study, all but six – Winnipeg, MB; Annapolis Royal, NS; LaSalle, ON; Charlottetown, PEI; Mont-Tremblant, QC; and Weyburn, SK – have at least one of the three aforementioned responses in some form or another (Table 3).

Table #3: Composition of Specialized Mental Health Responses

Police Service	Composition of Response
[BC] Central Saanich[4]	The Greater Victoria Region has a variety of integrated units comprised of officers from this region[5]. The Integrated Mobile Crisis Response Team (IMCRT) is comprised of nurses, counsellors, child and youth mental health clinicians, and two police officers – one from Saanich and the other from Victoria. Officers from Oak Bay and Central Saanich occasionally fill in. **Hours of Operation:** 1200-2400, 7 days/week **Assign/Volunteer:** Either | **Rotation:** Yes (3 years) **Response:** Requested by frontline
[BC] Nelson	Work informally with a mental health team from the health authority who can co-respond if available. **Hours of Operation:** 0800-1600, Monday-Friday **Assigned/Volunteer:** N/A | **Rotation:** N/A **Response:** Requested by frontline
[BC] New Westminster	Two mental health-specific officers who work in conjunction with those from the mental health system. The two positions are a hybrid liaison/co-responder position, but are not a dedicated co-response (i.e., do not have a dedicated mental health specialist partner). The positions also provide support/consultation to the

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[4] The composition of this response is reported as identical to that of Victoria, BC.
[5] See: http://cspolice.ca/wp-content/uploads/2017/11/Annual-Report.pdf

	frontline, and they co-respond on an 'as available/as appropriate' basis with an available mental health worker or the mental health worker of the individual in crisis. **Hours of Operation:** 0700-1700, Monday-Friday **Assign/Volunteer:** Volunteer | **Rotation:** Yes (5 years) **Response:** Requested by frontline
[BC] Port Moody	One mental health-specific officer who works on a casual basis with mental health partners. Provides support/consultation to the frontline and liaises/co-responds with community mental health teams as needed. **Hours of Operation:** 0700-1700, Tuesday-Friday **Assigned/Volunteer:** Assigned | **Rotation:** No **Response:** Requested by frontline
[BC] Vancouver	Mental Health Unit – named 'Car 87' – is a co-response with a nurse and an officer. There is a morning and afternoon car (i.e., two teams/day). Four officers are in this unit. Beyond the crisis response, Vancouver also has five Assertive Community Treatment Teams (ACT), with two officers embedded within, that provide service for clients who have been unsuccessful in traditional care models. ACT can assist in finding long-term care, housing, and more. Finally, an Assertive Outreach Team (AOT) is made up of four officers, nurses, and psychiatrists who are a short-term bridging service from hospital or corrections to a primary care provider. Both ACT and AOT attempt to locate and help clients who may be at risk and prevent issues before they happen. **Hours of Operation:** 0700-1815 & 1600-0345, 7 days/week (Car 87); 0700-1615, 7 days/week (ACT); 0700-2300, 7 days/week (AOT) **Assigned/Volunteer:** Assigned | **Rotation:** Yes (5 years) (Car 87) **Response:** Requested by frontline (Car 87)
[BC] Victoria	The Greater Victoria Region has a variety of integrated units comprised of officers from this region[5]. The Integrated Mobile Crisis Response Team (IMCRT) is comprised of nurses, counsellors, child and youth mental health clinicians, and two police officers – one from Saanich and the other from Victoria. Officers from Oak Bay and Central Saanich occasionally fill in. In addition to the crisis response, Victoria also has four Assertive Community Treatment Teams (ACT), with three officers embedded within, that can assist in finding long-term care, housing, and more.

	Hours of Operation: 1200-2400, 7 days/week (IMCRT); 0630-2000, 5 days/week (ACT)
	Assigned/Volunteer: Either | **Rotation:** Yes (3 years) (IMCRT)
	Response: Requested by frontline (IMCRT)
[MB] Winnipeg	N/A
[NS] Annapolis Royal	N/A
[ON] Brantford	Two Mobile Crisis Rapid Response Teams (MCRRT) comprised of an officer/mental health care specialist co-response, and one Mobile Crisis Team (MCT) comprised of mental health care specialists who respond at the request of frontline.
	Hours of Operation: 0900-1700 & 1500-2300, Monday-Friday (MCRRT), Unknown for MCT
	Assigned/Volunteer: Assigned | **Rotation:** No (MCRRT)
	Response: First response if available (MCRRT); requested by frontline (MCT)
[ON] Brockville	One officer is partnered with a mental health worker who conduct proactive outreach work, but can be requested by frontline at any time.
	Hours of Operation: Fluid hours/days
	Assigned/Volunteer: Either | **Rotation:** No
	Response: Requested by frontline
[ON] Chatham-Kent	The HELP Team is comprised of officers who are specially trained on mental health[6]. One HELP officer is paired with a psychiatric crisis nurse to form the Mobile Crisis Team (MCT) for co-response.
	Hours of Operation: 0800-1600, Monday-Friday (MCT)
	Assigned/Volunteer: Assigned | **Rotation:** Yes (4 years) (MCT)
	Response: First response (HELP); requested by frontline (MCT)
[ON] Durham Region	Two co-response teams where an officer is paired with a nurse.
	Hours of Operation: 0800-2100, Days unknown
	Assigned/Volunteer: Either | **Rotation:** -
	Response: Requested by frontline
[ON] LaSalle	N/A – In process of implementing a co-response with social worker at time of data collection.

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[6] See: http://ckpolice.com/help-team-mobile-crisis-team/

[ON] London	Work with a mental health-based crisis team through a formal agreement. Not a dedicated pairing, but are on call and respond as needed. **Hours of Operation:** 24 hours/day **Assigned/Volunteer:** N/A | **Rotation:** N/A **Response:** Requested by frontline
[ON] Peel Region	Crisis Outreach and Support Team (COAST) is a co-response team comprised of a mental health specialist and a police officer. Four officers are on COAST, with two officers on duty. COAST also connects individuals with community programs. **Hours of Operation:** 1100-2300, 7 days/week (Mental health specialist works 1200-2130) **Assigned/Volunteer:** Assigned | **Rotation:** No **Response:** Requested by frontline
[ON] St. Thomas	Canadian Mental Health Association (CMHA) worker co-responds with an officer. **Hours of Operation:** 0700-1500, Days unknown **Assigned/Volunteer:** - | **Rotation:** - **Response:** Requested by frontline
[ON] Windsor	Two Community Outreach and Support Teams (COAST) comprised of two officers and two crisis workers who facilitate access to community services and supports. COAST is a support team, not a response team, and will only attend crisis calls if the individual is a COAST client. **Hours of Operation:** 0800-1600 & 1400-2000, Monday-Friday **Assigned/Volunteer:** Assigned | **Rotation:** Yes (3 years) **Response:** Requested by frontline if individual is a COAST client
[ON] York Region	One co-response with an officer and a crisis worker, and two on call crisis workers who can respond to calls when requested by frontline) **Hours of Operation:** 1000-2200, 7 days/week (Co-response); 0900-2400, 7 days/week (Crisis workers) **Assigned/Volunteer:** Either | **Rotation:** No (Co-response) **Response:** Strives to be first response (Co-response); requested by frontline (Crisis workers)
[PEI] Charlottetown	N/A

[QC] Mont-Tremblant	N/A
[SK] Regina	Two Police and Crisis Teams (PACT) where an officer is paired with a social worker. Four officers are on PACT, and on each shift there are two PACT-trained frontline officers to fill in or to attend calls when PACT is not working. **Hours of Operation:** 0900-2100, Monday-Friday (Social worker works 0900-2000) **Assigned/Volunteer:** Volunteer | **Rotation:** Yes (5 years) **Response:** Requested by frontline
[SK] Saskatoon	Two Police and Crisis Teams (PACT) where an officer is paired with a mental health trained social worker. **Hours of Operation:** 0700-1900 & 1300-0100, Days unknown (Officers work 12-hour shifts; social workers work 10-hour shifts) **Assigned/Volunteer:** Either | **Rotation:** (3-5 years) **Response:** First response
[SK] Weyburn	N/A

Structure and Organization

As suggested by the findings provided in Table 3, while there appear to be similarities between services with respect to the structure of their specialized response, such as in New Westminster, BC and Port Moody, BC where officers liaise and co-responded as needed, there are also a large variety of differences from service to service. The predominant difference that arises within the structures of the participating services are that some deploy a mental health-based response only (e.g., Nelson, BC; London, ON); whereas others deploy a dedicated[7] co-response (e.g., Vancouver, BC; Saskatoon, SK), a combination of a mental health-based and a dedicated co-response (e.g., Brantford, ON; York Region, ON), two dedicated co-responses (e.g., Durham Region, ON; Regina, SK),

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[7] The term 'dedicated' refers to the officer/mental health specialist pair who co-respond together. However, 'co-response' itself is a term that may be used for both mental health responses and police-based specialized mental health responses.

or have officers who are not dedicated, but work in a hybrid co-response/liaison role (e.g., New Westminster, BC; Port Moody, BC). Additional differences arise in Central Saanich, BC and Windsor, ON. The former does not have its own specialized response as the Greater Victoria Region has an Integrated Mobile Crisis Response Team (IMCRT) comprised of officers from Victoria, BC and Saanich, BC, where officers from Central Saanich, BC occasionally fill in if needed; whereas the latter has a two Community Outreach and Support Teams (COAST) which are described as support teams, not co-response teams, meaning that COAST in Windsor, ON will only "… attend a call on the road if they are already a COAST client."

Further differences are also found in term of the hours of operation, whether the co-response is requested by frontline officers, whether officers are assigned or volunteer for the position, and whether there is a rotation period in place for the position. With respect to the hours of operation, there is wide variety between the responses at different services as hours are typically set based on the needs of the jurisdiction – almost all of the participating services lack of 24-hour availability. However, even if the co-response is available to attend while within working hours, most appear to be a secondary response after frontline officers attend the scene. Of the participating services, only three indicated that their co-response is the first response to a mental health call, or strives to be the first response. Moreover, there is quite the variety with respect to whether officers are assigned or volunteer to co-response positions. The latter, as discussed in Chapter Two within the context of CIT literature, is most preferable as it ensures that the most appropriate officers are within these positions. Finally, while many services indicated no rotation period, some indicated that officers are only able to stay in these positions for a limited period of time.

One service elaborated by indicating this was due to "… career pathing, stress, burnout, flow of staff, etc."

However, findings concerning CIT employment – or police-based specialized police responses – are not as clear. Within the survey, participants were asked to select the response types employed at their service (Appendix 4). In total, eight of the participating services indicated that they had a CIT, but later in the survey described a mental health-based response and/or a police-based specialized mental health response, as displayed in Table 3. Upon re-confirming with the websites of all participating services, it was found that Chatham-Kent, ON what the only service which explicitly indicated that they employ a CIT-like response – known as the HELP Team – in addition to their police-based specialized mental health response.

Factors Leading to Implementation of Specialized Response

With respect to *why* services implemented their specialized mental health response, many factors were identified and typically surrounded two themes: (1) high volume and chronic calls related to mental illness; and (2) the services' realization and acknowledgement that there needed to be an improvement with how they responded to these high volume and chronic calls for service. For instance, one officer's time on patrol, and then on their service's Emergency Response Tactical Team, made them realize that another approach was needed for chronic mental health calls:

> … from working years as a patrol responder, and then having spent some time on our Emergency Response Tactical Team, just recognizing that a lot of the calls we were going to seemed to involve some significant mental illness and mental health challenges, and recognizing that as a police agency we could do things differently and do things better (Participant 4)

In another jurisdiction, chronic interactions in their downtown core led this officer's service

to establish a specialized response:

> … some of our core neighborhoods, that are around the downtown, is kind of a whole melting pot of types of calls that we respond to. Many of those calls involve vulnerable persons with a […] comorbidity of mental health and addictions issues. What we would continually do is we would deal with them day in and day out and we were looking – always looking – for a better way (Participant 7)

Officers from New Westminster, BC; Port Moody, BC; Victoria, BC; Brantford, ON; Peel

Region, ON; and Windsor, ON also mirrored comments on increased calls for service as

to why their service established a specialized response. Officers from Victoria, BC and

Windsor, ON also added that high volume and chronic mental health calls can lead to long

hospital wait times which was another reason for their respective services.

In terms of response improvement, officers from Vancouver, BC; Brantford, ON;

Brockville, ON; York Region, ON; and Saskatoon, SK all noted improvement,

effectiveness, and/or efficiency as to why a specialized response was established. For

instance, the officer from Chatham-Kent, ON indicated that "patrol officers are very busy

and don't have the time to adequately deal and get the help required"; whereas another

officer explained that his service's reason for establishing a specialized response

surrounded the realization that frontline officers were not necessarily the most appropriate

response:

> So, at the time, there was a committee, and everybody sort of sat down and decided there needs to be a response, other than just [a] frontline policing response where officers – depending on who they are – may or may not have any idea about what a mental health issue might be, or mental illness, what medications, or what resources are available out in the community. So, their only response was to apprehend in the vast majority of times. The team was formed as a result of that… (Participant 10)

Ultimately, by establishing a specialized response, services believed that it would not only improve interactions with this population and address the high volume and chronic mental health calls, but that the response would also lower call times, assist frontline officers, assist those with mental illness in acquiring psychiatric assistance/support, and foster collaboration with their local mental health system.

Goals and Objectives

Many of the reasons for implementing specialized responses are also mirrored within each services' goals and objectives for their specialized response (Table 4). Most services do not have a single goal or objective, but rather many that intertwine. Overall, the identified goals and objectives fell into three interrelated themes: (1) assisting those with mental illness, (2) supporting individuals with mental illness in the community, and (3) reducing the need for police intervention and transfers to hospital. Most services indicated one – or a combination – of these themes within their objectives.

Table #4: Goals and Objectives of Specialized Mental Health Responses

Police Service	Goal/Objective of Response
[BC] Central Saanich	-
[BC] Nelson	-
[BC] New Westminster	"Safely support individuals in the community experiencing a mental health crisis through collaboration with community mental health partners thereby reducing the selected person's risk to self or others. An additional objective is to reduce the likelihood of the individual's likelihood of experiencing repeat crises through the appropriate connection to mental health services in the community."
[BC] Port Moody	"Ultimately, to decrease the need for police intervention in persons experiencing a mental health crisis, while at the same time, ensuring that mental health clients are able to access the mental health and social resources they require."
[BC] Vancouver	"Car 87/88, ACT and AOT divert mental health incidents from patrol and provide more appropriate mental health services for

	clients whose primary concern is health-related and is not a criminal concern."
[BC] Victoria	Reduce calls for service involving mental health crisis, reduce hospital presentations of individuals experiencing mental health crisis, intervention before stage 4 crisis, support to front line staff, better level of care to those who are experiencing mental health challenges."
[MB] Winnipeg	N/A
[NS] Annapolis Royal	N/A
[ON] Brantford	"To assist those in our community that suffer from mental health issues. Not every person in crisis needs to be taken to the hospital. The MCRRT team helps divert individual from the hospital and find more appropriated supporting agency in the community. This in turn assists the hospital with the volume in their emergency room. The MCRRT teams assist with creating a safer and healthier community."
[ON] Brockville	"To improve timely referral and engagement with individuals in the community suffering from mental health issues. One goal being to reduce unwanted, or negative police interactions that are traditionally a heavy drain on police recourses."
[ON] Chatham-Kent	"The MCT is a secondary response unit that provides support to front line members, builds and maintains relationships with community partners while maintaining a trust between police and persons afflicted with mental health issues."
[ON] Durham Region	-
[ON] LaSalle	-
[ON] London	"To deliver the best, and most appropriate, mental health care to members of the public in need."
[ON] Peel Region	"The overall objective is to decrease the number of mental health calls received by front line officers by providing the essential support needed by the caller (EDP) emotionally disturbed person during the early visits. In addition, by attending and assisting or being available to the front-line officer for a consult with regards to the interaction with the EDP will assist in the final direction that is taken, i.e.,: apprehension or not. Bottom line, officers are spending too much time in the hospitals waiting for a doctor to see the EDP before they can return back to road."
[ON] St. Thomas	-
[ON] Windsor	"Our team is there to lower the amount of mental health calls for front line officers and lower the amount of visits to the emergency department. This is a system/community issue not just a police issue therefore this partnership has expanded to

	educating our officers and other services providers with respect to the resources available other than the ED, expanding their knowledge with respect to mental health and de-escalation techniques. With the increase in the use of opioids and homelessness, our calls for service are on the rise, COAST has become the hub for all community agencies to contact in attempt to assist those in crisis."
[ON] York Region	"To deliver the highest quality service to those suffering from mental health crises in the community. To provide coordinated care for frequent users of mental health crisis services."
[PEI] Charlottetown	N/A
[QC] Mont-Tremblant	N/A
[SK] Regina	"Create an environment and a network between, Regina Police Service, Saskatchewan Health Authority and the community that would maintain an environment of trust and support to produce an efficient access for people struggling with a mental health illness. In addition to stabilizing vulnerable people in the community, PACT will participate in the development of training and education to continuously improve upon interactions between police and people with mental illness (and persons with complex needs such as, addictions)."
[SK] Saskatoon	"Reduction in mental health calls for service requiring police response, reduction in repeat calls for service involving the same person, calls resolved/de-escalated and triaged to appropriate service, proper use of Emergency department, arrest diversions, reduction in police wait times at hospital."
[SK] Weyburn	N/A

Assisting Those with Mental Illness. The contents of this theme particularly concern objectives that indicate generally assisting those with mental illness. For instance, the goal and objective of the response in London, ON is, "To deliver the best, and most appropriate, mental health care to members of the public in need." Similarly, part of the goal and objective of the response in Brantford, ON is, "To assist those in our community that suffer from mental health issues"; whereas in Brockville, ON it is, "To improve timely referral and engagement with individuals in the community suffering from mental health issues." Moreover, another part of this theme also concerns assisting those with mental

illness by providing better service from a law enforcement perspective. For example, part of Vancouver, BC's objective is to "… provide more appropriate mental health services for clients whose primary concern is health-related and is not a criminal concern"; whereas, part of the goal and objective in York Region, ON is, "To deliver the highest quality service to those suffering from mental health crises in the community."

Supporting in the Community. A second identified objective is to support those with mental illness in the community, which can encompass a variety of approaches, such as connecting PMI to community-based resources, collaborating with community-based organizations, and conducting proactive outreach to ensure that those who are being treated in the community are looked after and do not reach crisis.

For instance, the objective in New Westminster, BC is to, "Safely support individuals in the community experiencing a mental health crisis through collaboration with community mental health partners thereby reducing the selected person's risk to self or others" and to "reduce the individual's likelihood of experiencing repeat crises through the appropriate connection to mental health services in the community"; whereas in Port Moody, BC part of their objective is to ensure "… that mental health clients are able to access the mental health and social resources they require."

For some, collaboration with community-based organizations and health are also key to their objectives, which in turn, may assist in supporting members of this population in the community. For example, the objective in Chatham-Kent, ON is that, "The MCT is a secondary response unit that provides support to front line members, builds and maintains relationships with community partners while maintaining a trust between police and persons afflicted with mental health issues"; whereas in Regina, SK, the objective is to,

"Create an environment and a network between, Regina Police Service, Saskatchewan Health Authority and the community that would maintain an environment of trust and support to produce an efficient access for people struggling with a mental health illness." Moreover, in addition to their specialized mental health responses, some officers in both Vancouver, BC and Victoria, BC are integrated within Assertive Community Treatment Teams (ACT) whose primary objective is to assist individuals in stabilizing in the community. Such teams "… focus on the well-being of clients who are experiencing challenges related to community living, and who have an extensive history of police involvement and high use of health services" (Vancouver Police, 2016). They are comprised of psychiatrists, social workers, nurses, counsellors, therapists, and police officers, and "may assist with finding long-term 24/7 health care, support with life skills, job training, assistance with housing, and help maintaining physical and mental wellness" (Vancouver Police, n.d.). Select officers in Vancouver, BC are also integrated within a dedicated Assertive Outreach Team (AOT) which provides short-term support for individuals with mental health issues when they transition from health or the criminal justice system into the community (Vancouver Police, n.d.)

Furthermore, supporting those in the community can also mean being proactive. One participant provided an example of an analogy as to why it is important to be proactive with mental health:

> I just went to one of their conferences a short while ago, and it's called 'Before Stage 4'. And so, the analogy they draw is with cancer. With cancer, you want to catch it at stage one and stage two because by the time it reaches stage four, there's nothing that you can do anymore. Mental health is not that much different, so if you look at stage four of mental illness, that's somebody who is in crisis. The goal should be to intervene before they hit crisis. Once somebody hits crisis, the only opportunity we can have then is responding to crisis. And I don't think we ever get ahead of the

curve if we're doing that. We need to be way more innovative, and way more intuitive, and collaborating with health teams (Participant 10)

Being proactive may also bring additional benefits, such as officers who develop a rapport

with their clients and are able to influence those who need treatment to seek it:

I'm kind of a bit more assertive because I leave my card and tell someone who lives with schizophrenia, is chronically delusional, and not taking medication – 'I really think you should go to Mental Health' – they are never going to go to Mental Health. It's a very rare that they might. So, it might be just developing that rapport over time – kind of softly introducing to them, 'Look, I'm really concerned, and I hear that you're concerned over people breaking into your house. It's obviously stressful for you. I'd like to help you manage that stress'. And then it usually comes to some kind of voluntary agreement where, 'Would you come meet with a mental health clinician with me and we can kind of get you set up with some programs hopefully to help you manage that stress?' 'Sure, okay'. And then months down the road, they are doing much better because they are medicated and connected with a team […] So, somebody, at some point, has got to be more assertive for the people that are going to fall through a crack (Participant 5)

Another officer indicated that his service conducts post-crisis follow-ups to ensure that

individuals are able to absorb information regarding community-based resources that they

may access:

[We] facilitate subsequent follow-ups if required […] When we speak to people in crisis they sometimes don't have the ability to absorb all of the information that we're giving them, right? So, they're dealing with a crisis, and then you expect somebody to go, 'Okay, I'm going to give all this information, and they are going to completely understand', or the families for that matter. So they don't always have that, so a lot of times we'll say, 'Okay we're just going to de-escalate you today, give you some things you need to do in the next five or six hours, but tomorrow we're going to come back and give you some more information, or at least make sure that you've followed up with the information that we gave you yesterday' (Participant 10)

By following-up in this manner, officers may assist in preventing a future crisis by ensuring

that information they receive regarding community-based support is absorbed. Another

officer suggested that even though being proactive may be 'working upstream', it results

in more appropriate intervention, addresses the root causes for why certain individuals with

mental illness may engage in chronic calls for police service, and reduces the need for

hospital visits for individuals who can be safely supported in the community:

> We also want to work more proactively, so working upstream. We want to have
> that person not have to have a crisis and have a police officer respond, but rather
> have community services step in and intervene more appropriately. By working
> together with community partners, we also help to address our calls for service that
> may be repeat calls for service that are not addressing the root causes, the root
> issues, for that particular call […] But the other thing that we acknowledge is that
> we are also affecting health in a positive way because that person would have [a]
> high number of admissions to hospital, visits to the emergency department, and by
> working together we help to reduce those as well (Participant 8)

Reducing Police Intervention and Hospital Transfers. The third and final theme

related to the objectives of specialized mental health responses is – as alluded to within the

above quote – reducing police interventions and hospital visits, primarily to preserve police

resources and to conserve time by freeing "… up our members from spending hours in an

emergency department unnecessarily" as Participant 7 put it. For instance, part of the

objective of the specialized response in Brockville, ON is to "… reduce unwanted, or

negative police interactions that are traditionally a heavy drain on police recourses";

whereas an interview participant indicated that they address 'nuisance calls' from

individuals not in crisis by connecting them with community-based mental health teams:

> I have clients that maybe haven't reached crisis point in the community, but are
> creating what we typically refer to as, more like, kind of 'nuisance calls'. They might
> call us because they are delusional about people stalking them, or breaking into
> their house – chronically schizophrenic, paranoid kind of type, and just not taking
> medication. So, some of those folks you might get two or three calls a day from
> them, there isn't a crisis, but it's a use of police resources that could be better used
> other places. So, for those clients we try and connect them with mental health teams
> so that they have better follow up, and they have a reduction in their mental health
> symptoms, therefore, a reduction in police calls moving forward (Participant 5)

Consequently, hospital visits are also reduced either due to the reduction in police

intervention through supporting PMI in the community, or by appropriately only

transferring those to hospital that require it. For example, part of the objective in Brantford, ON is that, "Not every person in crisis needs to be taken to the hospital. The MCRRT team helps divert [the] individual from the hospital and find [a] more appropriate supporting agency in the community. This in turn assists the hospital with the volume in their emergency room." Similarly, the objective in Windsor, ON heavily emphasizes emergency department alternatives as well:

> Our team is there to lower the amount of mental health calls for front line officers and lower the amount of visits to the emergency department. This is a system/community issue not just a police issue therefore this partnership [with COAST] has expanded to educating our officers and other services providers with respect to the resources available other than the emergency department…

An interviewee from another service echoed that of Brantford, ON and Windsor, ON:

> … the goal was to reduce the amount of time police were spending at hospitals with mental health apprehensions, and also to reduce the number of presentations at the emergency wards with people who may not necessarily be suitable for a mental health apprehension. But because the police [did] not really having any other mechanisms – or necessarily the right level of expertise – [they] were perhaps apprehending people and maybe they shouldn't have been and taking them up to the hospital (Participant 9)

In sum, the participating police services have indicated a variety of goals and objectives (Table 4), many of which surround three of the aforementioned themes. As will be highlighted in the following section, many of the specialized mental health responses have experienced significant successes in assisting the mental health population within their jurisdictions, but have also experienced some challenges which may hinder their ability to achieve their goals and objectives.

Successes and Challenges of Mental Health Policing in Canada

Successes

Interview participants identified a variety of successes with respect to mental health policing not only at their respective service, but nationwide as well. These successes include better outcomes for those with mental illness who have an interaction with the police, as well as the implementation of specialized mental health responses themselves.

Better Outcomes. In a general sense, participants indicated that police officers are becoming better at interacting with those who have issues surrounding mental health, and consequently, interactions have resulted in better outcomes for PMI. For instance, one participant indicates that frontline officers in their jurisdiction have increasingly utilized other options to help individuals of this population:

> … we're probably having better outcomes now […] Patrol has been doing immense work. I inundate them with all kinds of new information all the time. And I'm seeing more, and more files now where people are incorporating, 'We did a referral here, or we transported them there', and that's really encouraging for me to see because that patrol member is kind of listening to what's available in the community, and finding value in connecting folks so that we don't have these repeat occurrences (Participant 5)

Another officer from another service echoed a similar thought, and alluded to that officers exercise patience and understanding now in comparison to what occurred 'back in the day':

> Well, I think, for the most part, our frontline officers are better equipped to deal with them than we were back in the day. I've been policing for almost 30 years now. So, any mental health training I got, we got at the calls. We weren't trained in mental health and recognition of signs and symptoms or even possible resolutions to them. We just, for the most part, dragged people to the hospital every single time, and the hospital sometimes had the capacity to hold the people and sometimes they didn't. We do a much better job at recognizing symptoms of mental health […] 'This person is suffering from mental health. It's obvious they're not listening to what I'm telling them what to do, so that's why they're not doing what I'm telling them to do. And I'm not going to get upset about that and use force, or even deadly force possibly, and come to some kind of better resolution where we'll at least be able to get them into some treatment' (Participant 10)

Implementation of Specialized Mental Health Responses. Other officers added that the implementation of specialized mental health responses, or even simply an officer in a mental health role, has enabled their service to further assist PMI who require assistance. For example, one officer describes how their role has been able to dedicate time to help PMI:

> … the creation of mental health positions within police departments has helped us to have enough time – like in my job, I have a client load of 110 people. That's completely unmanageable from a very detailed-oriented perspective, but at least it gives me enough time that I'm not taking patrol calls – I'm not a slave to the radio – so that I can actually focus on more case management. And having a dedicated person is really beneficial to that effect, because there is no way I can do this work, while taking patrol calls and working on the road. It would be impossible (Participant 5)

Another officer highlights how specialized responses assist in actually getting help for PMI, as opposed to tying up police resources:

> … these mental health crisis teams, I think are beneficial when you have them because it takes that load off of the patrol officers a little bit more, and the benefit of that is that also helps the triage of the patient a lot quicker […] You know, you could be tied up, and the problem is, it's ongoing where your members could be tied up for hours and hours at the emergency only for the person to be released. So, there's a lot of frustration and a lot of, you know, resources that were being tied up needlessly quite frankly. So, these crisis teams, these integrated crisis teams, can triage quicker and try to get them the help that they need versus sitting with them for hours, and hours, and hours tying up resources (Participant 1)

Alternatively, participants have identified that some jurisdictions which do not have the funds or resources to implement a specialized response, but realize that they require a different approach to addressing mental health calls, may compose an altered response that fits within their resourcing or funding constraints:

> You have to come up with a scalable model that works for your department. I know one location, they didn't have the ability to have a full time mental health nurse, but they rotated with having a pager, and when a call came in, if they could get to the scene, they would. If they couldn't, they could go to the hospital and meet them at the hospital, or sometimes they could come to cells and find out in the morning… (Participant 2)

Successes of Specialized Mental Health Responses. Moreover, specifically with respect to specialized responses, 13 of the 17 services with a specialized response identified a variety of factors which are crucial to their success. The predominant factor identified by nine services (69%) was partnerships with health and community-based services; having the right officers who are interested in the response was the second most common factor identified by four services (31%); training as well as funding/resources were each identified by three services (23%); establishing rapport with PMI was identified as a factor by two services (15%); and finally, other, less prominent factors such as training/supporting frontline officers, support from upper management, and availability, among others, were each identified as factors by a single service (7.7%).

However, achieved successes which specifically pertained to, and resulted from, the use of these responses were identified as inter-agency cooperation and community-based referrals, awareness of mental health, helping frontline, decriminalization, and trust between the police and those in the interaction.

Inter-Agency Cooperation and Community-Based Diversion. As noted above, collaboration and partnerships with services, such as health and community-based mental health services, is seen as a crucial factor for success of a specialized response. One officer emphasizes the importance and realization that the mental health system and the police cannot function without one another with respect to mental health:

> The health authority, with respect to mental health, cannot function without police, and certainly police cannot function without mental health teams. So, we need to work together – collaboratively. The criminal justice system is not a place for these folks to go, the criminal justice system is not equipped to deal with these people, jail is not the answer for these people. They do not get treatment in prison, they get victimized in prison, [and] they get brought out of prison without any plans in place whatsoever – it just lands them right back on the street, and the whole revolving door starts all over again (Participant 9)

Such partnerships can ultimately result in community-based referrals or plans where people

are assisted in the community as opposed to taken to the hospital. For instance, this officer

discusses how diversions away from the hospital has pleased the hospital staff:

> The diversions from our emergency department, just those numbers alone, have
> impressed the psychiatry and the emergency staff, because we keep track of who
> we've diverted – like who we would have normally taken or who police would have
> taken – but [the co-response] was able to get them to their doctor… (Participant 6)

In addition, the same officers also expands on how their response's partnership with a

housing program which focuses on helping those with complex needs – including mental

health – has increased the quality of life for these individuals:

> We also work with the housing program for people that are chronically homeless,
> and also live with mental health and addictions – a series of complex needs – and
> get them into a housing-first model, and then that brings down the calls for service
> and brings down the use of all of the services. But more importantly, that person
> has a better quality of life. They might not be cured of their addiction, but at least
> if you put them into a harm reduction model they're doing less damage to
> themselves, and their chances of exposure are probably way less as they've got a
> warm bed to sleep at night. […] We had three males – well four, there was a fourth
> one – all have been housed, and our calls for service for those calls has dropped by
> hundreds – by hundreds. So, it's quite amazing (Participant 6)

Furthermore, as identified by another officer, calls for service can be decreased,

particularly those calls for service that originate from chronic callers, by working with

community partners to establish plans:

> One of the huge areas we've had a lot of success is with people in the past who were
> generating hundreds and hundreds of calls. So, the repeat, chronic callers. The
> ability to put in place an effective plan, with community partners, that has all but
> eliminated, or reduced, sometimes call loads by 90-95%. So, big impacts from
> people generating 300 calls one year to generating one call the next year for just
> putting an integrated plan in place (Participant 4)

In sum, inter-agency partnerships help establish a coordinated response, which ultimately

provides a better understanding of those who may require help:

> You have people with expertise, the psychiatric nurses, and connection to the
> psychiatrist, and Community Services. So, there's better linkages there. Better

understanding of the clients because we can paint the picture with our police information and health information, so we have a better response to that person's individual needs, because you understand them better (Participant 8)

Also, inter-agency partnerships help foster a client-centred, community-based response as opposed to a reactive response, even though these specialized responses can react to a crisis when required:

> To me it's a client-centered approach. Policing traditionally is incident driven, 'Here's an incident, boom. We deal with it, and we're done', and the focus isn't so much on the person. This is more person focused, it's more community-focused, it's, 'How can we stabilize this person in the community? To get them the help that they need?'. So, it's client-centered, and that client-centered approach is likely to reduce the recidivism with the same member, either in criminal conduct or community disorder because of their crisis (Participant 7)

Mental Health Awareness. Another success of specialized mental health responses is with respect to how mental health awareness, as well as officers' own mental health, has grown in recent years. For instance, this officer states that because of the creation of the specialized response, other officers have come into her office to get help with their own mental health:

> … a big spinoff of [the co-response] that we didn't see coming – while I sort of did but didn't – was just our members. Our members that will come in the door and shut the door, and just say, 'I'm having a rough go. Who can I call about this?'. We have a program here that's 100% thorough and wonderful, and the people can go there too, but I think sometimes they feel trusting of who's in our office, and just at that time you need to just unwind and talk to somebody. So, since people know that I do this work, even when I was back as the resource officer for schools, people still came into my office and say, 'This is what I'm experiencing' (Participant 6)

Helping Frontline. Helping frontline officers has also been a success experienced by services who have a specialized response. For example, this officer believes that they have brought down the frustration for frontline by addressing and helping with mental health related calls:

> I think that we've brought some of the frustration down for Frontline, because we've been able to go to a call and say, 'You know what? We'll take Mr. Joe here, we'll

look after him, and you're free to clear'. So that really does help people. Even consulting over the phone and helping people make decisions on what to do next with a call with somebody (Participant 6)

Similarly, another officer indicates that the specialized response as his service helps train the frontline:

Presentations training, so just by our, either own personal training or just throughout volume of experience dealing with primarily mental health crisis situations, all day, every day, we're able to pass that on to training - to patrol officers, either short duration or full day training days (Participant 4)

Decriminalization. Moreover, another officer highlights that a success of not only his specialized response, but specialized responses across Canada, is that they push the understanding that the criminal justice system is not the correct place for individuals with mental illness:

I think some of the more positive benefits that we are having across the country is, as leaders in pushing the concept that the criminal justice system is not the right place for these people, and working collaboratively with the health teams to mitigate some of the challenges that they have (Participant 9)

Another participant discusses that their specialized response also assists Crown Council in their jurisdiction by providing information which can assist in constructing a court-structured strategy to help manage the individual:

… risk reduction to the community by partnering with Crown Council and local mental health teams, so individuals that are arrested who have significant mental health issues, but have also committed a violent crime, being able to provide Crown Council with a background from all of the police contacts and gathering information from the hospital and mental health partners, and putting all of that information forward to the courts, they're able to better come up with a court-structured strategy to manage that person (Participant 4)

Trust. The final theme discussed by participants with respect to successes of specialized responses is trust that is established between the officers on the response and those who come into contact with those officers, as discussed by one officer:

> I think the biggest benefit that I see is there is more of a trust in the community with the people that we're working with. They phone us, they interact with us, they stop by the station to talk to us, they're people that said they hated police and would never... If they've had a bad experience, and then they've had been treated well, or with respect and dignity, they're more likely to call (Participant 6)

In sum, mental health policing in Canada, as well as the use of specialized mental health responses, have exhibited a significant amount of success which not only assists the police in improving interactions with this population, but also assists members of this population to receive care that they may require. Unfortunately, there are still a significant amount of challenges endured by Canadian police, as well as specialized responses, in the context of policing PMI.

Challenges

Participants identified a variety of challenges with respect to mental health policing in Canada. These challenges pertain to both frontline mental health policing, as well as specialized mental health responses, and include high calls for service and chronic interactions with PMI, a lack of social supports and resources for those with mental illness, as well as challenges that Canadian law enforcement face internally with respect to policing PMI.

Calls for Service and Chronic Interactions. Akin to the reasons for implementing a specialized response, one of the first challenges identified by participants with respect to policing PMI in Canada was the issue that this population generates a high number of calls for service, which, as identified by this officer, can take a significant amount of time:

> I think the challenges are that these calls for service are going up. I know they always say, 'crime is going down', 'your file count is going down', and 'crimes, etc.' but it seems as though the mental health component is going up. And the reality is, these calls do take some time, so it could be, from start to end, four hours – you've gone, you've done this, and you've got the information, and you've driven into [city], and you wait around, and you come back (Participant 2)

Another officer echoed the same issue by indicating that mental illness can potentially

account for a large portion of a service's calls:

> … we are dealing with an increasing number of disturbance calls involving mental
> health crisis, suicidal persons, [which] are certainly trending up. If you look across
> Canada, I've heard reports that police are dealing with someone in a mental health
> crisis – or where mental health is at least a factor – in as low as 5% and as high as
> 20% of calls. So, if you look at a service like [service name] who had almost 80,000
> calls for service last year, if we're on the high-end we're looking at 16,000 calls?
> Potentially? If you looked at the 20% (Participant 7)

In addition to high calls for service from this population, there is the related issue

of chronic calls from the same person, or group of people, which adds to the high number

of calls for service. This officer describes how his service had an interaction with the same

person 23 times in one year, leading to frustration for officers:

> … you're dealing with the same person – or people – over a period of time. So,
> there's a lot of frustration in trying to get… I'll give you an example. There's one
> particular person here that we've dealt with 23 times this past year […] It was the
> frustration of having to detain them under the involuntary psychiatric treatment act,
> [and] taking them to the hospital only for them to be released and go back to, you
> know, say, the bridge in [city] […] and some of the people were successful in
> committing suicide after the fact (Participant 1)

Similarly, another officer believes that there are two sides of the mental health population

– those who engage with the help being offered to them, and those who refuse to engage

with any help and consequently cause several hundred calls for service in one year because

there is no one else who can respond to them:

> The people who are experiencing mental illness in the community, those who want
> to engage with the help that are being offered them, I think for the most part do a
> pretty good job of coping in society […] And then there are those who have no
> insight into their mental illness and/or refuse to engage in any course of treatment,
> or take their medications as prescribed – just refuse to engage in any help that is
> being provided. Those are the ones that we're left to deal with as the police because
> they refused to engage, they will not get better, they remain as sick or become more
> sick as time goes by, and then we're left to deal with that population because the
> community resources don't have the people, the will, and the resources to chase
> these people down and constantly stay on top of them […] So, the police are left to
> deal with those people. So there's a sort of two-sided – or two aisles of population

– the ones that want to get help and do a pretty good job – […] and there's that population that we see sometimes 150 times, 200 times a year (Participant 10)

High and chronic calls for service can be further exacerbated within jurisdictions which have a high transient population. For example, this officer indicates how his jurisdiction can have far more people than what the service is staffed for:

> We're a core city, so unfortunately, we're staffed as a police department to deal with 10,000 people […] but the trouble is we are a core city, so at any given time we can have 17,000 people in our town, and that's people with and without mental illness. So, we are dealing with more than our share of calls (Participant 3)

Consequently, because the transient population is not within the same jurisdiction at all times, officers indicate that it is difficult to care for these individuals who may be in the jurisdiction of one health authority and police service one day, and in the jurisdiction of another health authority and police service another day: "… the integration and collaboration among, you know, people that move from one area to another area, or they're back and forth, they live in a couple different places, and how to share care for those individuals. That's challenging" (Participant 8). Another officer from another jurisdiction echoes the same challenge:

> … We just recently got this train here, so it's rapid transit, so we are seeing a bit of a shift with a more transient population because we're within half an hour of [location]. So, we are seeing some more clientele in that regard, but typically in [city], they are repeat clients for us. That's really when my job comes in more successfully to – hopefully – have the amount of time to connect them more properly with social services, and just do more intensive follow-up. Were able to do that with our regular population in [city], very challenging to do with our transient folks who are here today, not here tomorrow… (Participant 5)

Lack of Social Supports and Resources. The high and chronic calls for service may be even further exacerbated in jurisdictions which lack social supports and resources for people with mental illness. When survey participants were asked whether they agreed that there were adequate mental health services within their jurisdiction, only four services

(17.4%) (Vancouver, BC; Brockville, ON; Chatham-Kent, ON; Peel Region) either agreed or strongly agreed; four services (17.4%) (Winnipeg, MB; St. Thomas, ON; York Region, ON; Saskatoon, SK) neither agreed nor disagreed, and the remaining 15 services (65.2%) either disagreed or strongly disagreed that there were adequate mental health services within their jurisdiction.

Those that neither agreed nor disagreed, or either disagreed and strongly disagreed, further elaborated on the consequences of inadequate mental health services[8]. These services identified that inadequate mental health services can result in an increased police demand (n = 7; 41.2%), less appropriate care (n = 6; 35.3%), lack of/no options for help this population (n = 5; 29.4%), a strain on the community and police resources (n = 3; 18%), homelessness and substance abuse (n = 3; 18%), long hospital wait times (n = 2; 12%), negative interactions (e.g., tragic use of force) (n = 2; 12%), and criminalization (n = 1; 6%).

Many of these consequences are faced by participants of this study. For example, one officer discussed the limited room available at the local hospital, which can become an issue when faced with high call volumes that result in subsequent apprehensions: "There's only one room at the hospital, and it's not uncommon for us to pick up one and be dealing with him at the hospital and go out and grab another one and come up to the hospital and they don't have space. That's difficult" (Participant 3). In another jurisdiction, officers at times have to drive to another hospital in another city because the local hospital may be unequipped to handle certain patients:

> We do have a hospital locally here – [name of hospital] – however, they are a smaller community-based hospital, and they're not set up... They would probably

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[8] The response rate for this question was 89.5% (n = 17)

be fine with the 'no flight risk' cooperative suicidal individual, but someone in a drug-induced psychosis, etc., etc., they don't have a lot of facilities, and simply don't have the staff to work around that. They're not what we consider 'designated', so we do drive to a different city, to a larger hospital facility [where] they are equipped for it (Participant 5)

However, this challenge does not appear to be unique as this officer indicates that their local hospital is reluctant to accept certain individuals as well:

Certainty a lot we're seeing are mixed mental illness diagnosis mixed with drug use, specifically a lot of crystal methamphetamine, causing psychosis, and the hospitals are reluctant to admit those patients who've used drugs, even if there does appear to be other underlying issues. So that population of mixed mental health and drug using (Participant 4)

Transport to hospitals can also result in an additional challenge of long wait times before the individual is admitted or let go. Of the 23 services who participated in this study, only six (26%) (Nelson, BC; Brantford, ON; Durham Region, ON; Windsor, ON; Charlottetown, PEI; Mont-Tremblant, QC) indicated that their hospital wait time is an hour or less. Three services (13%) (Annapolis Royal, NS; Peel Region, ON; Regina, SK) indicated their wait was between four to five hours; one service (4%) (Winnipeg, MB) indicated their wait was more than five hours; whereas the remaining 13 services (57%) indicated that on average, their hospital wait times are between two to three hours.

Furthermore, a lack of resources or community-based mental health services can also leave PMI, particularly those who do not meet the criteria for a mental health act apprehension, stuck with nowhere to go:

P: We have one shelter that's in the jurisdiction over, and if it's reached capacity, they'll be obviously turning people away. So, say if we're looking for basic need/light housing, we're pretty much hooped for people. So, stuff like that is difficult. So, resourcing can be really tough to assist folks, especially if they're not meeting that criteria for an apprehension under the mental health act, in which case, then it's kind of the hospital's responsibility from the social services side. But if they're not apprehendable, then it's like, 'Okay, what are we doing to assist this person such that in an hour from now, they are not in the same crisis?', and sometimes there is very little that can be done for folks

I: What do you do in that situation? When they can't be apprehended but there's a lack of options? They are kind of stuck in the middle

P: Yeah, and that's unfortunately exactly it. Sometimes if there is no place like shelters, or friends, or anything that people are able to transport to – because that can be a reality – sometimes it's transporting them just to a Tim Hortons and literally buying them a coffee out of our own pockets just so they can stay warm for the night. These are poor solutions for a global problem. And they are very temporary because tomorrow that same person is homeless again (Participant 5)

This officer further added that without basic pillars, and resources which can help provide those pillars, it is very difficult to help stabilize individuals in the community:

… if I think of my sickest folks, and people who have done well, and those still struggling to do well – the ones that aren't doing well are the ones that are chronically homeless or constantly evicted from their place of residence. When you don't have that simple stability, or your basic pillars, right? Your nutritional needs, your housing needs, all those things. How do we expect someone to comply with mental health treatment? That's just completely unrealistic, so until we address those kinds of major issues, very difficult, I think, to stabilize folks in the community (Participant 5)

Whereas with respect to those who cannot be stabilized in the community, particularly due to reasons pertaining to the individual and not resources, another officer believes that the 'pendulum' post-institutionalization has swung too far leaving those who cannot be managed in the community without access to involuntary treatment facilities:

One thing we have learned – that I have learned – over the years is that despite everybody's best efforts, there still continues to be the population of individuals who, I think, just simply cannot be managed in the community[…] Some of it comes down to money, [but] some of it also comes down to some philosophical applications in the different national and provincial health authorities, where just this idea that 20 years ago – 25 years ago – people were being locked up in mental health institutions, and in some cases maybe not appropriately so […] I think this pendulum had swung so far in one direction and all of a sudden there was a whole scale swing of the pendulum back the other way, and so now the lack of facilities to be able to have involuntary, secure mental health facilities where people can be treated are very few and far between (Participant 9)

Moreover, availability of those from the mental health system can be a challenge as well. This challenge can be faced by police services where mental health specialists do not have the flexibility to attend a call if needed:

> Often the mental health clinicians don't have work issued cellphones, so they're desk line only, and they're often tied up in appointments. Their often on a pre-scheduled full day of cases so they don't have flexibility to just leave the office and go do a crisis response or outreach response (Participant 4)

Similarly, availability can be a challenge faced by PMI who require psychiatry as wait times can be very long and, at times, can result in chronic calls for service:

> I know wait times for psychiatry help... I mean, they base it, I guess, to a certain extent on the severity of the situations that people are dealing with, but sometimes people are waiting for six, eight months, or a year to see a psychiatrist. And that's, for the most part, I would say unacceptable because we see them maybe 20, or 30, or 100 times before they even get to the psychiatrist because they're not getting the help that they need (Participant 10)

Another officer states that their specialized response does have access to a psychiatrist through the local health authority, but the psychiatrist is not available when they are needed by officers of the response:

> … that office has a psychiatrist that we have access to for a couple hours a day where we can slot in appointments, and we can take people there on emergency basis. But our problem is, it's always booked up, we can never get in because all these teams have that same access. That's our biggest barrier – is no access to psychiatry when we need it (Participant 6)

Standardization of Police Approaches to Mental Health. In addition to mental health resource issues that are challenging for Canadian police services when attempting to PMI, some interview participants have also identified that there is little standardization with respect to mental health approaches and training for Canadian police officers. For example, this officer suggests that national strategies, such as the one put forth by the Mental Health Commission of Canada, should be mandated and could be tailored to community needs:

> The Mental Health Commission of Canada put forward a mental health strategy, but it's a strategy that's not binding, it's just a 'this would be ideal', but it's not something that says, 'you are mandated to do this', and of course that's tied in to funding […] But I think if there was like a national strategy that was mandated, if we had provincial strategies, if there was kind of a more as much of a standardized approach would be great, even though those approaches would have to be tailored to each community for the specific needs for that jurisdiction. I think those kinds of things would be important (Participant 8)

Another officer also echoes the same view – standardization which is tailored for each community:

> Maybe it's one person fulfilling a variety of roles, or in larger urban centres, those roles are more clearly separated and defined. But either way, some sort of standardization as far as 'each community will provide a collaborative, specialized mental health response. And, in order to do so, that response will consist of…' Even if it's a police officer that has… You know, is just a regular 911 in a rural officer, or in a big city with 10 specialized mental health officers, that they will receive training… Additional training in crisis communication, de-escalation… They will receive additional training in signs, symptoms, awareness, suicide, risk assessment intervention, and… Yeah, those are sort of the key ones. So, standardization, regardless of the size and scope of the program. Some sort of standardization (Participant 4)

Furthermore, another officer suggests using Coleman & Cotton's (2014) TEMPO model – discussed within Chapter Two – as a guideline for standards, but admits that governing the standards nationwide may also pose as a challenge:

> There was a report done by Terry Coleman and Dorothy Cotton a couple years back, you might be familiar with it, where they talked about TEMPO 1, TEMPO 2, TEMPO 3. I think that they've hit the mark, like that's accurate. But there's no way to govern that. There is no way to go across Canada and say, 'Are your officers a TEMPO 300?'. But when I relay to my management the qualifications I think that we need here, I refer to that document, because to me it's got some weight, it's got my thoughts too. It gives at least a guideline for standards. So, I think that that's one of the things that needs to be worked on is sort of a governance of standards, or an overseeing (Participant 6)

Challenges of Specialized Mental Health Responses. Participants also identified challenges which specifically pertained to the use of specialized mental health responses, such as hours of operation, large jurisdictions, documentation, staffing and funding for

specialized responses, sharing best practices and evidence-base, as well as a lack of understanding and misunderstanding with respect to specialized responses.

Hours of Operation. Certain officers indicated that the hours of operation of their specialized response results in no coverage at certain times, or even certain days. This officer indicated that if they receive a call at a certain time, frontline is responsible for the call: "So if we have a call at [time], there's no mental health team available – the officers are responsible for taking care of that themselves. It would be nice to have 24-hour availability – more teams available" (Participant 10). Similarly, this officer echo's the same challenge, but adds that the response is needed more so at certain times and that there are contractual considerations which must be respected in terms of equal work hours for officers of the specialized response:

> … we only have coverage 40% of the time. We don't always have the cover-off officers available or cover-off crisis worker. We have these guys – at least on the patrol side – work a day and a night […] They work a day and a night with each one, so they're not always available 24/7. We've constructed their hours so that, when we did an analysis of the calls, their night shifts are [time] to [time], and their day shifts are [time] to [time]. And we kind of did that with the sense of, 'when are they needed?' But then there's also some contractual considerations that we have to do in terms of an equal amount of nights and days, and all of those kind of things (Participant 7)

Contrastingly, another officer was unsatisfied with the hours that his specialized response worked, and as a result, conducted an analysis to determine which hours would be best for their jurisdiction – the attempt at changing the hours was unsuccessful:

> … they only work [time] to [time] and [day] to [day] […] I had done a breakdown of all our calls, and we found that if they worked […] from [time] to [time] and somebody else from [time] to [time] – if they worked just till [time] […], they would get 50% more mental health calls. And, they just, like... No, it didn't matter (Participant 3)

Large Jurisdiction. Another challenge indicated by some officers was the size of their jurisdiction. For instance, this officer believes "The geography is a big piece. We've got a [number] square kilometer region where we have [a response] available in the south end and [a response] in the north end, so we can't make all the calls" (Participant 10). Similarly, another officer believes that their service's investment into their specialized response is not as good as they expect due to the size of their jurisdiction:

> We're currently reviewing it right now [the specialized response]. I'm not convinced our investment in that right now is as good as it should be. I think the jurisdiction is too big. I don't think we're getting a level of service from the crisis response team that we need. I think the service needs to be expanded, and so we're currently in partnership with the health authority here looking at how we might be able to expand that service (Participant 9)

Documentation. As mentioned by Participant 10, a large jurisdiction can lead to the specialized response not getting to all calls. This issue can also be further exacerbated by documentation, which can take up large periods of time for specialized responses. This officer states that those on their specialized response have to finish paperwork regarding one call before they can move on to another, otherwise they would have to take a day off to catch up on paperwork:

> For every hour you spend with one person, you probably spend two hours [on] documentation. [The health authority] added a couple more things on to our clinician that makes it a little bit more complicated. So, you can't really move on from one call to the next, or stack up a whole bunch of calls, and then do the documentation all at the end, because then you'd be out of commission for a day (Participant 6)

Staffing and Funding for Responses. Another challenge identified by participants is staffing and funding for specialized responses. One officer stated that their response cannot get to certain people "… because we just don't have the manpower" (Participant 6). Another officer highlights that a lack of staffing, because of a colleague being off with a

health issue, has increased demand on other officers who are part of the specialized

response:

> Certainly staffing […] Especially with my colleague off with a health injury over
> the past six months […] So demand from […] patrol officers as they're responding
> real-time to calls in crisis, with calls from all of the different mental health workers,
> teams, housing agencies, hospital workers, social workers looking for advice or
> police information to support their discharge or case plan with somebody, wanting
> to know whether there are recent police events or any concerns. So just staffing,
> and ability to respond to sort of all of the requests… (Participant 4)

In another jurisdiction, the officer states that management realizes that they could expand

their specialized response, but do not have the resources to do so:

> I think management really recognizes that we could expand it […], but resourcing
> wise, we just don't have the budget – or anything – to support that at that time. I
> think there's recognition we could be having a couple more people up here, but
> within the same sense we're limited within what we get funded for officer positions
> from the city (Participant 5)

Lack of Understanding and Misunderstanding. A lack of understanding from

management was also identified as a challenge by a participant. This officer acknowledges

that they were fortunate with good management, but stresses that other jurisdictions may

not be as fortunate, and may have management which may want to criminalize mental

health:

> … [a] lack of understanding from management about what needs to happen. I think
> frontlines see it, but sometimes management might not. I'm that fortunate that I had
> a string of management that did see things clearly, and that our Police Board of
> Commissioners also fought to keep, and expand, the [specialized response]. So, I
> think for some areas that might be a barrier. There's [still] too much thinking that
> you punish addictions and you punish mental health because it's their own fault that
> they are this way. I think that lack of an education, and lack of understanding, and
> lack of empathy towards the illnesses and disorders that govern some of the
> decisions that are made. I think that's probably the biggest one, because the stigma
> is still there (Participant 6)

The same officer also highlights that some may not understand what a specialized response

does, or expect the response to do things outside of their mandate:

Sometimes another barrier is […] misunderstandings of what we do, and people expecting us to do things that aren't within our mandate, or the perception that we can just come and fix things. Something's that's taken 20 years... Couple decades of dysfunction and they call the [specialized response], and then they'll say to us later, 'Well, you guys already... Why is this still happening?'. Well, we don't have a magic wand – that's the line I use, I go, 'You know, I wish I did have a magic wand, but it's broken today, so we're going to have to work with these...' (Participant 6)

Sharing Best Practices and Evidence Base. The final specialized-response-specific challenge identified by participants was with respect to sharing best practices on these responses. For example, this officer stresses that police agencies have to do a better job at sharing their successes:

... we need to exploit those best practices in the sense of those integrated teams, or systems that work better with better triaging at hospitals, and what has been done. So, if we come up with something that's great in [city], or something that's been great in [location], well then that should be shared. So, I think we need to do a better job of communicating those successes and those best practices across the province (Participant 2)

Another officer, before establishing their specialized response, attempted to look for any available data from other jurisdictions and was unable to find much – this officer's service ultimately employed a pilot study which was deemed successful:

So, what we did, is we looked at any available data that we could get in the policing world, and quite frankly, police services aren't very good at sharing their data or some of their programs, at least not in a peer-reviewed sense. So, sometimes it's a little bit more difficult to... And we don't publish them typically, so it's tough to dive down and get reports and data because they're not readily available. So, long story short is, we did our own pilot. It was a very successful pilot (Participant 7)

Moreover, the same officer also further suggested that police agencies typically buy into a new program without setting up metrics on how to evaluate the program to ensure effectiveness – this officer especially stressed that effectiveness is crucial as a publicly-funded agency to make sure money is being used properly or saved. This officer's specialized response was able to save about half a million dollars in one year:

> … a lot of police agencies jump in and sort of buy into a new program, but there's not really a lot of metrics set up. It's not a brilliant, evidence-based, a proof-of-concept program. So, what we did is decided that we needed to have some good metrics, and to look at those metrics and decide on what outcomes that we would expect. You know, when you're a publicly-funded agency, and you enter into a new agreement with someone, you still have to be able to prove efficiencies – not just for police, but for health and so on. And we've been able to do that, either social return on investment, or cost avoidance […] So if we were to look at our last year of data it's $400,000 in emergency department diversions, [and] probably $100,000 in arrest diversions (Participant 7)

The same officer continues by saying that more research can illustrate that specialized responses are an evidence-based response, and thus can receive more funding: "I think that's why the more research and the more we can illustrate that co-response is an evidence-based response, the more likely police agencies are able to get funding" (Participant 7). On a similar note, another officer believes that there has been a shift in Canadian policing towards evidence-based policing, however, in order to assess specialized responses, police will need to partner with academia:

> We really have made a shift in policing across the country, but certainly in [city] on evidence-based decision-making. […] Intuitively we know these teams are working, but until police can also determine better ways to gather the statistics, the data, the only way we're going to be able to do it is by partnering with academia. And I think therein lies another very positive relationship for police, is to partner with these research institutions – like yourself, who are interested in studying this – so that we can make sure that what we're doing actually is working, and identify areas where we can improve (Participant 9)

In fact, eight (47%) of the police services who participated in this study that have a specialized response indicated that they would be open to having an evaluation conducted on their response within the near future, which is promising for the evidence base of Canadian research on policing those with mental illness.

Health Issue, Not Police Issue. The final challenge identified by officers of this study, which applies to all of policing, not solely specialized responses, is that interactions

with PMI should not be a police duty. This officer suggests that police respond to mental

health calls because other systems are failing:

> I think the onus on police – because the other systems are kind of failing, and I'm not saying we're the answer to everything, because I don't think we are – but we're just seeing more, and more, and more of it, and I think the expectations for us to have that background knowledge on mental health are, in part, unrealistic, right? It shouldn't necessarily be a traditional police role. As much as I love my job, I think it's been created out of a crisis point of other systems failing our folks in the community that aren't doing so well (Participant 5)

Another officer adds that if officers are tied up with mental health calls, they cannot service

their other citizens:

> We're not the professionals that should be dealing with this. That should be mental health people. The cliental are not getting the service that they should be, and that's no fault of ours. We do what we can with what training we have and what money the province provides us. The reality is we need to be funded better and so does mental health. They have to have some treatment facilities to deal with these individuals because otherwise we do. It has a real impact on our services. If we're tied up with a mental health call, then we're not servicing the rest of our citizens, and that's not fair (Participant 3)

Another officer states that the police have been given the de-facto frontline mental health

response because they have the capacity to have employees out at all times, and at times,

this de-facto role can lead to tragic consequences. This officer believes that it would be

ideal if they were 'put out of business' for mental health responses:

> We do get some training, but we're certainly not practitioners in mental health. We do the best that we can out there. Sometimes, things turn into disasters, and unfortunately in some instances people die as a result of it, right? Who's to say that it would have ended up exactly the same way if a car full of mental health workers had responded to it. Well, they don't have guns, and Tasers, and all those kinds of things. So likely not it wouldn't have happened, and they may have dealt with it better, and things might not have turned out the way they did. But unfortunately, because we're given the frontline responsibility, because there is no one else who can do it, right? Nobody else has the capacity to put cars on a road all day long […] I think if they put us out of business in mental health response, that would be ideal (Participant 10)

Similarly, another officer also argues that the capacity of the police has made them the agency of 'first resort' as those from the mental health system – who are better equipped to address crises – do not make house calls:

> … before 911, policing, I think, was the agency of last resort. People didn't know who to call when someone was in crisis. They would look up every phone number in the book and then they'd call police. But since 911, I'd say that we have become the agency of first resort. It's easy to call, you have 24 hour/7, you get a cop to show up at your door, and we try and help you. But we respond to these calls with not necessarily the appropriate tools with us, and training with us. It's not in our immediate wheelhouse – we're not mental health trained social workers. We are asked to quell crisis, but we don't necessarily have the best tools to do it, and that's [where] a mental health worker, a mental health nurse, a mental health crisis worker is probably better equipped to do that, but quite typically, they don't come to your house when you call (Participant 7)

In sum, as this chapter has suggested, specialized mental health responses – particularly in the form of co-response – have been deployed by many of the participating Canadian police services and in many differing organizational structures in order to attain numerous goals and objectives. These responses have been able to achieve many successes, but unfortunately also endure many challenges, some of which may hinder potential success. In the chapter that follows, the above results will be discussed and recommendations will be provided on how to address the challenges of these responses. Limitations of the current study and future directions for subsequent research will be discussed as well.

Chapter Five: Limitations, Discussion, and Conclusion

As little research has been conducted on these specialized mental health responses, particularly within the Canadian context, the purpose of this thesis was to survey and interview officers from across Canada in an attempt to answer three research questions: (1) Which Canadian police services employ a CIT and/or co-response; (2) what are the elements that make up these responses; and (3) what are the successes achieved and challenges faced by Canadian CIT/co-response teams. Although exploratory in nature, the findings of this thesis highlight several areas for future research and policy changes that will allow Canadian services to become better informed on these responses and how they could be improved. However, before discussing the findings of this thesis, certain limitations must be acknowledged.

First, a low survey response rate has limited the ability to attain a full understanding of which Canadian police services employ a specialized response. While the expectation was not to achieve participation from every Canadian police service, a 22.5% response rate is low, but not irregular from previous policing research (e.g., Coleman & Cotton, 2010a; Huey et al., 2017). Second, the standardized nature of a survey methodology may have prevented participants from elaborating on various unforeseen aspects of their respective specialized mental health response, and thus a full understanding of these responses may have not been captured herein. Third, as identified within Chapter Four, complexities arose when attempting to identify which police services employ a CIT – otherwise known as the 'Memphis Model' or a first responder model – where eight services identified having a CIT, but later in the survey described a co-response. There are three plausible sources for this limitation: (1) the conceptualization of CIT on the survey itself which was derived

from the work of Deane et al. (1999) and lacked an emphasis that CIT is a 'first responder'

or 'frontline' approach (e.g., Dupont et al., 2007; Durbin et al., 2010b); (2) that police-

based specialized mental health response officers (i.e., co-response officers) are CIT

trained, and are technically, as outlined in the survey, "… a group of officers who receive

an extended amount of mental health training (typically 40 hours) and are considered the

'mental health crisis specialists' of their police service", but are in co-response positions

as opposed to CIT positions; and (3) that the eight services who indicated having a CIT

indeed have CIT trained frontline officers, but only elaborated on their co-response within

the survey. The final limitation concerns the participants of this study. As noted within

Chapter Three, participants who held mental health-related positions or were part of co-

responses were particularly sought as they would be the most informed about mental health

policing at their police service. While these participants were extremely helpful and

knowledgeable, their views may not be representative of all officers across Canada,

particularly of officers who are on the frontline and may have different opinions with

respect to PMI and mental health in contrast to an officer who is *specifically* in a position

to assist this population. While this does not undermine any of the results presented herein,

it is important to interpret them with caution, particularly data which originates from an

interview.

        Irrespective of these limitations, however, the findings of this thesis have developed

new and exploratory insights into the under researched area of specialized mental health

responses used by Canadian police services. Prior research has indicated that specialized

responses have been employed in other Canadian jurisdictions, such as Hamilton (Fahim

et al., 2016) and Toronto (Iacobucci, 2014), for quite some time. Yet, little attention has

been given to these responses on a national scale. By surveying all services in Canada, this thesis has been able to provide a wider understanding of these responses than currently available within academic literature. The findings suggest that the use of specialized responses – specifically co-responses – for mental health calls are fairly common at the participating services, but largely differ in terms of structure and organization from jurisdiction to jurisdiction. These differences – such as response type, hours of operation, first or second response – may stem from a whole host of jurisdiction-based factors, such as demographics, geography, availability of community-based mental health services, prevalence of PMI contacts, and more (Butler, 2014; Deane et al., 1999; Durbin et al., 2010a; Reuland et al., 2009).

With respect to *why* services employed a specialized response, the answers are fairly similar across all services. The reasons identified are high volume and chronic calls mental health calls, and a realization that the police needed to improve how they address these calls. As co-responses are generally associated with enhanced outcomes (Iacobucci, 2014; Kirst et al., 2014; Lee et al., 2015; Rosenbaum, 2010; Shapiro et al., 2015) it is not surprising that such a response was selected by the participating services in order to facilitate improvement and mitigate mental health calls, which are typically identified as a source of frustration for officers (Wells & Schafer, 2006) and a burden on police resources (Canadian Association of the Chiefs of Police, 2015). Similarly, the goals and objectives of these responses appear to interrelate with *why* the responses were implemented in the first place. These were identified as assisting PMI, supporting PMI in the community (and its associated factors such as collaboration with community-based resources, connecting PMI to these resources, proactive outreach, post-crisis follow up, case management, etc.),

and reducing police intervention and hospital transfers – all of which have the ability to improve PMI contacts and mitigate high volume and chronic calls (e.g., Bonkiewicz et al., 2014; Fahim et al., 2016). Although these findings are new at a micro level as previous research has not explored the goals and objectives of specialized responses from service to service, these findings largely mirror the overall concept and objectives of the co-response model in general (Lee et al., 2015; Shapiro et al., 2015).

Fortunately, many participants identified significant successes achieved through the use of their specialized responses, such as inter-agency co-operation and community-based diversion resulting in less calls for service, mental health awareness, helping the frontline, decriminalization, and a building of trust between officers and PMI. Within these successes, as well as elsewhere in the results, we also see many factors which are indicative of the policing strategies discussed within Chapter Two – community policing, risk management, procedural justice, and evidence-based policing. Herein, many of these strategies are intertwined in an attempt to assist PMI who come into contact with co-responses in Canada. For instance, through the lens of community policing, services establish partnerships with health authorities, mental health professionals, and community-based mental health services in order to deploy a co-response and to forge links for PMI diversion into more appropriate care away from the criminal justice system or even the hospital. While at the scene of an interaction, officers conduct a risk assessment, in consultation with their co-response partner, to determine if a PMI is to be apprehended or diverted to community-based mental health resources. By means of the latter option, as well as proactive outreach and follow up, co-responses are able to forge rapport and trust with their PMI clients to the point where they do not fear to reach out to the co-response,

which, again, is suggestive of procedural justice principles. And finally, the use of evidence-based decision making with respect to co-response deployment, which will be further discussed below, was emphasized by participants who supported that more research be conducted on these responses.

This evidence of intertwining policing strategies within co-response deployment in Canada not only contributes to the under researched area of policing literature, but also highlights the complex, multi-level conceptualization that certain aspects of policing may encompass. By utilizing such a conceptualization to operationalize and theorize about policing, a deeper understanding of police responses, duties, or even the institution as a whole may be developed. Therefore, future evaluative studies on specialized responses should consider this multi-level conceptualization in order to fully understand the intertwining strategies at play within these responses, and how the use, under development, or omission of one strategy affects the success of the response.

Despite the successes, however, participants also identified *many* challenges faced by their specialized responses, some of which appear to originate internally (e.g., structure), while others appear to originate externally (e.g., lack of community-based mental health resources). Unfortunately, the identified challenges may significantly undermine the ability of these specialized responses to achieve their indented objectives and successes, thus these challenges – discussed in detail below – must be addressed through either further research or policy adjustments.

First, there appears to be a need to modify mental health training for Canadian police officers. While the present study did not thoroughly explore this area, prior research has indicated that mental health training is unstandardized and differs in terms of content

and length from jurisdiction to jurisdiction (Cotton & Coleman, 2008; Coleman & Cotton, 2010a). Participants particularly identified that standardization is a challenge within contemporary mental health policing in Canada and suggested the need for a mandated national mental health strategy which could facilitate standardization, as well as establishing standards with respect to specialized mental health response deployment that may be tailored to certain jurisdictional qualities (e.g., urban and remote areas). In accordance with a suggestion provided by one of the participants, if a governance of standards – or a mandated mental health strategy – were established, Coleman & Cotton's (2014) TEMPO model would be the ideal guideline for standardized mental health training across the country. As briefly discussed in Chapter Two, TEMPO is a tiered training module ranging from 'TEMPO 100' that is comprised of basic mental health training, up to 'TEMPO 400' which includes specialized training, such as CIT and/or co-response (Coleman & Cotton, 2014). Some services already employ a similar tiered module, such as Halifax (Appendix 1), but mandating nationwide TEMPO-like training can ensure consensus, from coast-to-cost, that all officers, and officers in specialized positions, are trained in accordance to a particular standard of training. These standards can also be modified for a tailored approach for certain needs and resources of a given jurisdiction. For example, by establishing measures – such as the average number of PMI calls and budgeted service funds for these calls – certain TEMPO requirements can be adjusted to incorporate differences in these measures, while still facilitating standardization.

In addition, such widespread standardization may also facilitate knowledge improvement and attitudinal changes within policing with respect to mental health. While some participants indicated substantial improvement in this area, one participant suggested

that some frontline officers may be unaware of the duties and abilities of co-response. Further, the same participant identified that some services may also have management that prefer to criminalize mental health and mental illness, and as a result, may be less willing to support intervention measures such as specialized responses. Negative attitudes within policing towards PMI have been well documented and originate for a variety of reasons, namely because PMI calls are considered not to be a police matter (e.g., Iacobucci, 2014; Schulenberg, 2016). However, specialized responses, such as CIT, have been labeled as a 'log in the fire' which have the ability to initiate positive change with respect to attitudes, beliefs, stigma, and the police culture (Watson et al., 2011). Therefore, TEMPO – which emphasizes the deployment of specialized responses – as a standardized nationwide module would undoubtedly have the ability to be *many* logs in the fire to facilitate knowledge generation about responses to PMI and attitudinal improvements among all Canadian officers.

Second, there are issues which pertain to the structure and organization of specialized mental health responses. These were identified as not being in operation 24/7, large jurisdictions, and documentation procedures. Unfortunately, these challenges significantly limit the reach that co-responses are able to have because they are not able to respond outside of their hours of operation; large jurisdictions may be difficult to cover, particularly in instances with one co-response team and two simultaneous PMI calls on opposite sides of the jurisdiction; and exorbitant amounts of documentation may prevent co-responses to move on to the next PMI call if documentation from the previous call is incomplete. Beyond the challenges specifically identified by participants, additional structural challenges pulled from the results are that some services only have one co-

response, they are a secondary response, and/or that officers are assigned to these mental health-specific positions.

It is widely known that specialized responses only attend a small percentage of all mental health calls because of some of these aforementioned challenges (e.g., Durbin et al., 2010b; Iacobucci, 2014; Schulenberg, 2016; Steadman et al., 2000). However, certain changes can mitigate many of these challenges. For instance, establishing several co-response teams that have 24-hour coverage would allow for greater reach at all times and better coverage in larger jurisdictions. Similarly, making co-responses a first response, as opposed to a response requested by frontline officers, would also allow for greater reach to PMI in need, and would also allow for the most appropriate person (i.e., mental health specialist) to be on the scene as quickly as possible (Iacobucci, 2014). Further, services should also consider making co-response positions for officers voluntary as opposed to assigned. CIT elements emphasize that this ensures that the most appropriate officers are placed in these positions (Dupont et al., 2007) which ultimately benefits PMI. Finally, documentation has been raised as an issue in prior studies where officers and mental health specialists collected different information (Kirst et al., 2014). However, herein, the *amount* of documentation appears to be the issue. Currently, software such as *HealthIM* (2017) has been developed in order to help officers of certain Canadian police services assess the risk factors of PMI they come into contact with, and allows them to make informed decisions on next steps for PMI (e.g., apprehension vs. diversion, etc.). *HealthIM* (2017) also allows for paperless recordkeeping and syncs contact data between police and hospital databases. Undoubtedly, adopting such a program could eliminate the need for both the officer and mental health specialist of a co-response team to complete documentation, consequently

cutting down the time spent and amount of documentation, and allowing the co-response

to move onto the next PMI call with little delay.

Third, and likely the most pertinent issue, is a lack of mental health resources for

PMI. Overwhelmingly, most participants identified that there is a significant lack of

community-based mental health resources and access to the mental health system for PMI

within their jurisdictions. This lack of resources and access has led to not enough rooms in

hospitals, extremely long hospital wait times for officers, no help for PMI who may require

assistance but do not fit apprehension criteria, little or no access to psychiatry, and much

more – all of which contribute to high calls for service and chronic interactions. In Canada,

only 7% of all health spending is devoted to mental health (as cited in Iacobucci, 2014),

which unfortunately contributes to the lack of resources and access to the mental health

system for PMI. Over three decades ago, within the context of PMI criminalization in the

United States, Teplin (1984) wrote:

> … the mentally ill must not be criminalized as a result of inadequate funding for
> the mental health system […] a long-term commitment to funding mental health
> care is required. In this way, the most appropriate and effective treatment programs
> may be provided within the least restrictive setting possible. We must make policy
> modifications and allocate the appropriate resources in order to see that the civil
> rights of the mentally ill are protected and, in doing so, provide the most humane
> and effective treatment available (p. 802)

Revisiting Munetz and Griffin's (2006) Sequential Intercept Model (Appendix 2), the

"ultimate intercept" for diverting PMI out of the criminal justice system is an accessible

mental health system. Yet, presently, Canadian mental health funding and resources do not

strive too far off from what Teplin (1984) described in the American context so many years

ago, and no indications have been made that changes to funding would occur in the near

future – even though more funding is undoubtedly required.

Because of the underfunded mental health system resulting in inadequate care and subsequent PMI calls for service, officers have become de-facto mental health professionals (Compton et al., 2014a). Consequently, to fulfill these roles, services have employed part of the second intercept on the Sequential Intercept Model (Munetz & Griffin, 2006; Appendix 2) pre-arrest diversion programs, otherwise known as CITs and/or co-responses. Unfortunately, some participants suggested that their specialized responses are also underfunded and under resourced, which may prevent any expansion and negates some of the aforementioned recommendations. This may be in part due to the understanding that addressing PMI should be a health issue, not a police issue. While no participants negatively interpret PMI calls as not 'real' police work (Coleman & Cotton, 2010b; Iacobucci, 2014; Schulenberg, 2016), they simply believe that the police are not the most appropriate response to PMI and suggest that more mental health specific resources need to be funded and implemented in order to put the police 'out of business' with respect to responding to these calls. Therefore, it is plausible that there may be a reluctance from the police to spend more money and resources on an issue that they believe should be addressed by the mental health system, especially since PMI calls are already a burden on police resources.

Ultimately, there appears to be two underfunded approaches meant to assist PMI in Canada – the mental health system and resources, and specialized police responses. The best solution would be to increase funding for the mental health system which would result in better care for PMI and less police contacts; however, as this has yet to occur, even several decades post-de-institutionalization, this solution is unlikely. An alternate solution would be to increase funding for co-responses. While this may appear as an ineffective

solution without a properly funded mental health system and resources, or an infeasible solution with raising police expenditures (Conor, 2018), it is not entirely without merit. As suggested by participants in the previous chapter, even with the current lack of access and resources, the co-responses of the participating services have achieved many successes, namely community-based diversion and subsequent decreases in PMI calls for service. These successes consequently decrease the use of police resources and could undoubtedly be enhanced with more co-response funding.

While there may be some reluctance on behalf the police to fund co-responses because PMI contacts are not considered a police issue, the amount spent to implement or expand co-responses have the potential to be miniscule in contrast to the savings achieved through implementation or expansion. For instance, one participant indicated that through an evaluation on their co-response, they were able to determine that in a single year they were able to save $400,000 in emergency department diversions and $100,000 in arrest diversions. Simply reinvesting even part of the $100,000 savings by establishing more co-responses could potentially increase these emergency department and arrest diversion savings. In addition, as argued by one participant, even engaging in research and evaluations that show such positive outcomes and cost savings can contribute to making co-responses an evidence-based practice, thus resulting in more co-response funding for police agencies. Unsurprisingly, however, herein lies the same issue that fueled the reason for conducting this thesis on specialized responses in Canada – there is very little research, especially from an evaluative perspective as most police services have established these responses on the premise that they are a 'best practice' as opposed to an effective practice (Coleman & Cotton, 2010a).

In sum, *much* more research on these responses in Canada is required. There are a plethora of areas that scholars could explore, such as whether the responses are achieving their intended objectives, outcomes for PMI, training for specialized officers, stigma and attitude changes following implementation of a specialized response, determining CIT deployment, assessing differences between co-response types (i.e., mental health-based vs. police-based), optimal structure and organization (e.g., hours of operation, first or second response, voluntary/assigned, etc.), specialized responses within the TEMPO module, and documentation practices, to name a few. While more research is not the ultimate solution to the challenges faced by Canadian co-responses, determining if these responses are indeed successful and measuring their outcomes is the best place to start. By doing so, an evidence base can be established with respect to these responses that can inform scholars and services on how to deploy effective responses and how to best address these challenges. In addition, evaluations which also demonstrate cost and resource savings may result in more funding and subsequent response expansion, thus potentially leading to even further cost and resource savings. However, most importantly, future research, as well as implementation or expansion of co-response would be most beneficial to PMI because research would inform services on how to effectively use these responses to the benefit of PMI; whereas implementation or expansion would increase the likelihood that PMI come into contact with a specialized team who is most knowledgeable on how to appropriately assist and divert them to the most appropriate resource.

References

Canadian Association of the Chiefs of Police (2015). 'The Dollars and Sense of Policing, Public Safety and Well-Being in Your Community' White Paper, Ottawa, Ont.: Canadian Association of the Chiefs of Police Research Foundation (1982) Inc.: https://www.cacp.ca/index.html?asst_id=960

Beck, U. (1992). *Risk Society: Towards a New Modernity.* Newbury Park, California: SAGE Publications.

Beck, U. (2002). The Terrorist Threat: World Risk Society Revisited. *Theory, Culture & Society, 19*(4), 39-55.

Berg, B. L., & Lune, H. (2012). *Qualitative Research Methods for the Social Sciences* (8th Edition). Upper Saddle River, New Jersey: Pearson Education Inc.

Bittner, E. (1967). Police Discretion in Emergency Apprehension of Mentally Ill Persons. *Social*
    Problems, 14(3), 278-292.

Blevins, K. R., Lord, V., & Bjerregaard, B. (2014). Evaluating Crisis Intervention Teams: possible impediments and recommendations. *Policing: An International Journal of Police Strategies & Management, 37*(3), 484-500.

Bonfine, N., Ritter, C., & Munetz, M. R. (2014). Police officer perceptions of the impact of Crisis Intervention Team (CIT) programs. *International Journal of Law and Psychiatry, 37*(4), 341-350.

Bonkiewicz, L., Green, A. M., Moyer, K., & Wright, J. (2014). Left alone when the cops go home: Evaluating a post-mental health crisis assistance program. *Policing: A International Journal of Police Strategies and Management, 37*(4), 762-778.

Boyce, J., Rotenberg, C., & Karam, M. (2015). Mental Health and Contact with Police in Canada, 2012. *Juristat.* Statistics Canada Catalogue no. 85-002-X.

Boyd, J., & Kerr, T. (2016). Policing 'Vancouver's Mental Health Crisis': A Critical Discourse Analysis. *Critical Public Health, 26*(4), 418-433.

Brink, J., Livingston, J., Desmarais, S., Greaves, C., Maxwell, V., Michalak, E., . . . Weaver, C. (2011). *A Study of How People with Mental Illness Perceive and Interact with the Police.* Alberta: Mental Health Commission of Canada.

Butler, A. (2014). *Mental Illness and the Criminal Justice System: A Review of Global Perspectives and Promising Practices.* University of British Columbia: International Centre for Criminal Law Reform and Criminal Justice Policy.

Canada, K. E., Angell, B., & Watson, A. C. (2010). Crisis Intervention Teams in Chicago: Successes on the Ground. *Journal of Police Crisis Negotiations, 10*(1-2), 86-100.

Coleman, T. G., & Cotton, D. (2010a). *Police Interactions with Persons with a Mental Illness: Police Learning in the Environment of Contemporary Policing.* Ottawa: Mental Health Commission of Canada.

Coleman, T. G., & Cotton, D. H. (2010b). Reducing Risk and Improving Outcomes of Police Interactions with People with Mental Illness. *Journal of Police Crisis Negotiations, 10*(1-2), 39-57.

Coleman, T., & Cotton, D. (2014). TEMPO: A Contemporary Model for Police Education and Training About Mental Illness. *International Journal of Law and Psychiatry, 37*, 325-333.

Compton, M. T., & Chien, V. H. (2008). Factors Related to Knowledge Retention After Crisis Intervention Team Training for Police Officers. *Psychiatric Services, 59*(9), 1049-1051.

Compton, M. T., Bakeman, R., Broussard, B., Hankerson-Dyson, D., Husbands, L., Krishan, S., . . . Watson, A. C. (2014a). The Police-Based Crisis Intervention Team (CIT) Model: I. Effects on Officers' Knowledge, Attitudes, and Skills. *Psychiatric Services, 65*(4), 517-522.

Compton, M. T., Bakeman, R., Broussard, B., Hankerson-Dyson, D., Husbands, L., Krishan, S., . . . Watson, A. C. (2014b). The Police-Based Crisis Intervention Team (CIT) Model: II. Effects on Level of Force and Resolution, Referral, and Arrest. *Psychiatric Services, 65*(4), 523-529.

Compton, M. T., Broussard, B., Hankerson-Dyson, D., Krishan, S., & Stewart-Hutto, T. (2011a). Do Empathy and Psychological Mindedness Affect Police Officers' Decision to Enter Crisis Intervention Team Training? *Psychiatric Services, 62*(6), 632-638.

Compton, M. T., Broussard, B., Hankerson-Dyson, D., Krishan, S., Stewart, T., Oliva, J. R., & Watson, A. C. (2010). System-and Policy-Level Challenges to Full Implementation of the Crisis Intervention Team (CIT) Model. *Journal of Police Crisis Negotiations, 10*, 72-85.

Compton, M. T., Demir Neubert, B. N., Broussard, B., McGriff, J. A., Morgan, R., & Oliva, J. R. (2011b). Use of Force Preferences and Perceived Effectiveness of Actions Among Crisis Intervention Team (CIT) Police Officers and Non-CIT Officers in an Escalating Psychiatric Crisis Involving a Subject with Schizophrenia. *Schizophrenia Bulletin, 37*(4), 737-745.

Compton, M. T., Esterberg, M. L., McGee, R., Kotwicki, R. J., & Oliva, J. R. (2006). Crisis Intervention Team Training: Changes in Knowledge, Attitudes, and Stigma Related to Schizophrenia. *Psychiatric Services, 57*(8), 1999-1202.

Conor, P. (2018). Police Resources in Canada, 2017. *Juristat*. Statistics Canada Catalogue no. 85-002-X.

Constantine, R. J., Robst, J., Andel, R., & Teague, G. (2012). The Impact of Mental Health Services on Arrests of Offenders with a Serious Mental Illness. *Law and Human Behavior, 36*(3), 170-176.

Corbin, J., & Strauss, A. (2015). *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory* (4th ed.). Thousand Oaks, CA: SAGE.

Cornell Law. (n.d.). *Parens Patriae*. Retrieved June 28, 2017, from Legal Information Institute: https://www.law.cornell.edu/wex/parens_patriae

Cotton, D. (2004). The attitudes of Canadian police officers toward the mentally ill. *International Journal of Law and Psychiatry, 27*, 135-146.

Cotton, D., & Coleman, T. (2006). *Contemporary Policing Guidelines for Working with the Mental Health System.* Canadian Association of Chiefs of Police, Ottawa.

Cotton, D., & Coleman, T. (2008). *A Study of Police Academy Training and Education for New Police Officers Related to Working with People with Mental Illness.* Mental Health Commission of Canada and the Canadian Association of Chiefs of Police, Ottawa.

Cotton, D., & Coleman, T. G. (2010). Canadian Police Agencies and their Interactions with Persons with a Mental Illness: A Systems Approach. *Police Practice and Research, 11*(4), 301-314.

Creswell, W. J. (2011). Controversies in Mixed Methods Research. In N. K. Denzin, & Y. S. Lincoln, *The SAGE Handbook of Qualitative Research* (4th Edition, pp. 269-283). Thousand Oaks, California: SAGE Publications Inc.

Crocker, A. G., Hartford, K., & Heslop, L. (2009). Gender Differences in Police Encounters Among Persons with and Without Serious Mental Illness. *Psychiatric Service, 60*(1), 86-93.

Deane, M. W., Steadman, H. J., Borum, R., Veysey, B. M., & Morrissey, J. P. (1999). Emerging Partnerships Between Mental Health and Law Enforcement. *Psychiatric Services, 50*(1), 99-101.

Demir, B., Broussard, B., Goulding, S. M., & Compton, M. T. (2009). Beliefs about Causes of Schizophrenia among Police Officers Before and After Crisis Intervention Team Training. *Community Mental Health Journal, 45*(5), 385-392.

Desmarais, S. L., Livingston, J. D., Greaves, C. L., Johnson, K. L., Verdun-Jones, S., Parent, R., & Brink, J. (2014). Police Perceptions and Contact Among People with Mental Illness: Comparisons with a Great Population Survey. *Psychology, Public Policy, and Law, 20*(4), 431-442.

Dupont, R., Cochran, S., & Pillsbury, S. (2007). *Crisis Intervention core elements.* The University of Memphis School of Urban Affairs and Public Policy, Department of Criminology and Criminal Justice. Memphis, TN: CIT Center.

Durbin, J., Lin, E., & Rush, B. (2010a). *A study of hospital emergency service use, crisis service delivery and police response after mental health systems enhancements.* Toronto: Centre for Addiction and Mental Health.

Durbin, J., Lin, E., & Zaslavska, N. (2010b). Police-Citizen Encounters That Involve Mental Health Concerns: Results of an Ontario Police Services Survey. *Canadian Journal of Community Mental Health, 29*(29), 53-71.

Durham Regional Police. (n.d.). *Mental Health Unit*. Retrieved July 2, 2017, from Durham Regional Police: https://members.drps.ca/internet_explorer/our_organization/unit.asp?Scope=Unit&ID=78

Ellis, H. A. (2014). Effects of a Crisis Intervention Team (CIT) Training Program Upon Police Officers Before and After Crisis Intervention Team Training. *Archives of Psychiatric Nursing, 28*, 10-16.

Engel, R. S., & Silver, E. (2001). Policing Mentally Disordered Suspects: A Re-examination of the Criminalization Hypothesis. *Criminology, 39*(2), 225-252.

Ericson, R., & Haggerty, K. (1997). *Policing the Risk Society.* Toronto, Ontario: University of Toronto Press Incorporated.

Fahim, C., Semovski, V., & Younger, J. (2016). The Hamilton Mobile Crisis Rapid Response Team: A First-Responder Mental Health Service. *Psychiatric Services, 67*(8), 929.

Fisher, W. H., Roy-Bujnowski, K. M., Grudzinskas Jr., A., Clayfield, J. C., Banks, S. M., & Wolff, N. (2006). Patterns and Prevalence of Arrest in a Statewide Cohort of Mental Health Care Consumers. *Psychiatric Services, 57*(11), 1623-1628.

Forchuk, C., Jensen, E., Martin, M.-L., Csiernik, R., & Atyeo, H. (2010). Psychiatric Crisis Services in Three Communities. *Canadian Journal of Community Mental Health, 29*, 73-86.

Franz, S., & Borum, R. (2011). Crisis Intervention Teams may prevent arrests of people with mental illness. *Police, Practice and Research, 12*(3), 265-272.

Furness, T., Maguire, T., Brown, S., & McKenna, B. (2016). Perceptions of Procedural Justice and Coercion During Community-Based Mental Health Crisis: A Comparison Study Among Stand-Alone Police Response and Co-Responding Police and Mental Health Clinician Response. *Policing*, 1-10.

Geller, A., Fagan, J., Tyler, T., & Link, B. G. (2014). Aggressive Policing and the Mental Health of Young Urban Men. *American Journal of Public Health, 104*(2), 2321-2327.

Geller, J. L. (2008). Commentary: Is CIT Today's Lobotomy? *The Journal of the American Academy of Psychiatry and the Law, 36*, 56-58.

Ghebreslassie, M. (2017, July 4). *Andrew Loku inquest calls for 24-hour crisis intervention teams, but how do they work?* Retrieved July 4, 2017, from CBC News: http://www.cbc.ca/news/canada/toronto/andrew-loku-inquest-calls-for-24-hour-crisis-intervention-teams-but-how-do-they-work-1.4187173

Girard, V., Bonin, J. P., Tinland, A., Pelletier, J. F., Delphin, M., Rowe, M., & Simeoni, M. C. (2014). Mental health outreach and street policing in the downtown of a large French city. *International Journal of Law and Psychiatry, 37*, 376-382.

Gray, J. E., Hastings, T. J., Love, S., & O'Reilly, R. L. (2016). Clinically Significant Differences Among Canadian Mental Health Acts: 2016. *The Canadian Journal of Psychiatry, 61*(4), 222-226.

Greenland, J., & Alam, S. (2017). Police Resources in Canada, 2016. *Juristat*. Statistics Canada Catalogue no. 85-002-X.

Hanafi, S., Bahora, M., Damir, B. N., & Compton, M. T. (2008). Incorporating Crisis Intervention Team (CIT) Knowledge and Skills into the Daily Work of Police Officers: A Focus Group Study. *Community Mental Health Journal, 44*(6), 427-432.

Hartford, K., Heslop, L., Stitt, L., & Hock, J. S. (2005). Design of an algorithm to identify persons with mental illness in a police administrative database. *International Journal of Law and Psychiatry, 28*, 1-11.

HealthIM. (2017). *Digital Mental Health Strategy*. Retrieved from https://healthim.com/

Hough, M., Jackson, J., Bradfrord, B., Myhill, A., & Quinton, P. (2010). Procedural Justice, Trust, and Institutional Legitimacy. *Policing, 4*(3), 203-210.

Huey, L. (2016). What One Might Expect: A Scoping Review of the Canadian Policing Research Literature. *Sociology Publications, 36*.

Huey, L., Blaskovits, B., Bennell, C., Kalyal, H. J., & Walker, T. (2017). To What Extend to Canadian Police Professionals Believe That Their Agencies are

'Targeting, Testing, and Tracking' New Policing Strategies and Programs? *Police Practice and Research, 18*(6), 544-555.

Iacobucci, F. (2014). *Police Encounters with People in Crisis.* Toronto Police Service, Toronto, Ontario.

Kirst, M., Narrandes, R., Pridham, K. F., Yogalingam, J., Matheson, F., & Stergiopoulos, V. (2014). *Toronto Mobile Crisis Intervention Team (MCIT) Program Implementation Evaluation Final Report.* St. Michael's Hospital. Toronto: Centre for Research on Inner City Health.

Kirst, M., Pridham, K. F., Narrandes, R., Matheson, F., Young, L., Kiedra, K., & Stergiopoulos, V. (2015). Examining implementation of mobile, police-mental health crisis intervention teams in a large urban centre. *Journal of Mental Health, 24*(6), 369-374.

Kisely, S., Campbell, L. A., Peddle, S., Hare, S., Pyche, M., Spicer, D., & Moore, B. (2010). A Controlled Before-and-After Evaluation of a Mobile Crisis Partnership Between Mental Health and Police Services in Nova Scotia. *Canadian Journal of Psychiatry, 55*(10), 662-668.

Lamanna, D., Kirst, M., Shapiro, G., Matheson, F., Nakhost, A., & Stergiopoulos, V. (2015). *Toronto Mobile Crisis Intervention Team (MCIT): Outcome Evaluation Report.* Centre for Research on Inner City Health and St. Michael's Hospital, Toronto.

Lamb, H. R., & Bachrach, L. L. (2001). Some perspective on deinstitutionalization. *Psychiatric Services, 52*(8), 1039-1045.

Lamb, H. R., Weinberger, L. E., & DeCuir Jr, W. J. (2002). The police and mental health. *Psychiatric Services*, *53*(10), 1266-1271

Lind, E., & Tyler, T. R. (1988). *The Social Psychology of Procedural Justice.* New York, NY: Plenum.

Lipson, G. S., Turner, J. T., & Kasper, R. (2010). A Strategic Approach to Police Interactions Involving Persons with Mental Illness. *Journal of Police Crisis Negotiations, 10*(1-2), 30-38.

Livingston, J. D., Desmarais, S. L., Greaves, C., Parent, R., Verdun-Jones, S., & Brink, J. (2014a). What Influences Perceptions of Procedural Justice Among People with Mental Illness Regarding their Interactions with the Police? *Community Mental Health Journal, 50*, 281-287.

Livingston, J. D., Desmarais, S. L., Verdun-Jones, S., Parent, R., Michalak, E., & Brink, J. (2014b). Perceptions and Experiences of People with Mental Illness Regarding

their Interactions with Police. *International Journal of Law and Psychiatry, 37*, 334-340.

Menzies, R. J. (1987). Psychiatrists in Blue: Police Apprehension of Mental Disorder and Dangerousness. *Criminology, 25*(3), 505-521.

Morabito, M. S. (2007). Horizons of Context: Understanding the Police Decision to Arrest People with Mental Illness. *Psychiatric Services, 58*(12), 1582-1587.

Morabito, M. S., Kerr, A. N., Watson, A., Draine, J., Ottati, V., & Angell, B. (2012). Crisis Intervention Teams and People with Mental Illness: Exploring the Factors that Influence the Use of Force. *Crime & Delinquency, 58*(1), 57-77.

Morabito, M. S., Socia, K., Wilk, A., & Fisher, W. H. (2017). The nature and extent of police use of force in encounters with people with behavioral health disorders. *International Journal of Law and Psychiatry, 50*, 31-37.

Morabito, M. S., Watson, A., & Draine, J. (2013). Police officer acceptance of new innovation: the case of crisis intervention teams. *International Journal of Police Strategies & Management, 36*(2), 421-436.

Munetz, M. R., & Griffin, P. A. (2006). Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness. *Psychiatric Services, 57*(4), 544-549.

Murphy, C. (2007). "Securitizing" Canadian Policing: A New Policing Paradigm for the Post 9/11 Security State? *The Canadian Journal of Sociology, 32*(4), 449-475.

Nagin, D., & Telep, C. W. (2017). Procedural Justice and Legal Compliance. *Annual Review of Law and Social Science*.

O'Brien, A. J., McKenna, B. G., Thom, K., Diesfeld, K., & Simpson, A. I. (2011). Use of Tasers on People with Mental Illness: A New Zealand Database Study. *International Journal of Law and Psychiatry, 34*, 39-40.

Oliva, J. R., Morgan, R., & Compton, M. T. (2010). A Practical Overview of De-Escalation Skills in Law Enforcement: Helping Individuals in Crisis While Reducing Police Liability and Injury. *Journal of Police Crisis Negotiations, 10*(1-2), 15-29.

Ontario Mental Health Act, R.S.O. 1990, c.M.7.

Palys, T., & Atchison, C. (2014). *Research Decisions: Quantitative, Qualitative, and Mixed Methods Approaches* (5th Edition). Toronto, Ontario: Nelson Education Ltd.

Phythian, M. (2012). Policing Uncertainty: Intelligence, Security, and Risk. *Intelligence and National Security, 27*(2), 187-205.

Ransley, J., & Mazerolle, L. (2009). Policing in an Era of Uncertainty. *Police Practice and Research, 10*(4), 365-381.

Ratcliffe, J. H. (2011). *Intelligence-Led Policing.* Routledge.

Reuland, M., Schwarzfeld, M., & Draper, L. (2009). *Law Enforcement Responses to People with Mental Illness: A Guide to Research-Informed Policy and Practice.* New York: Council of State Governments Justice Centre.

Rosenbaum, N. (2010). Street-Level Psychiatry - A Psychiatrist's Role with the Albuquerque Police Department's Crisis Outreach and Support Team. *Journal of Police Crisis Negotiations, 10*, 175-181.

Ruiz, J., & Miller, C. (2004). An exploratory study of Pennsylvania police officers' perceptions of dangerousness and their ability to manage persons with mental illness. *Police Quarterly, 7*, 359-371.

Schaible, L. M., & Sheffield, J. (2012). Intelligence-led Policing and Change in State Law Enforcement Agencies. *Policing: An International Journal of Police Strategies & Management, 35*(4), 761-784.

Schulenberg, J. L. (2016). Police Decision-Making in the Gray Zone: The Dynamics of Police-Citizen Encounters with Mentally Ill Persons. *Criminal Justice and Behaviour, 43*(4), 459-482.

Scott, R. L. (2000). Evaluation of a Mobile Crisis Program: Effectiveness, Efficiency, and Consumer Satisfaction. *Psychiatry Services, 51*(9), 1153-1156.

Sealey, P., & Whitehead, P. C. (2004). Forty years of deinstitutionalization in Canada: An empirical assessment. *Canadian Journal of Psychiatry, 49*, 249-257.

Shapiro, G. K., Cusi, A., Kirst, M., O'Campo, P., Nakhost, A., & Stergiopoulos, V. (2015). Co-responding Police-Mental Health Programs: A Review. *Administration and Policy in Mental Health, 42*(5), 606-620.

Sherman, L. W. (2013). The Rise of Evidence-Based Policing: Targeting, Testing, and Tracking. *Crime and Justice, 42*(1), 377-451.

Skogan, W. G. (2006). The Promise of Community Policing. In D. Weisburd, & A. A. Braga, *Police Innovation: Contrasting Perspectives* (pp. 27-43). New York, New York, United States: Cambridge University Press.

Skubby, D., Bonfine, N., Novisky, M., Munetz, M. R., & Ritter, C. (2013). Crisis Intervention Team (CIT) Programs in Rural Communities: A Focus Group Study. *Community Mental Health Journal, 49*(6), 756-764.

Smetanin, P., Stiff, D., Briante, C., Adair, C. E., Ahmad, S., & Khan, M. (2011). *The Life and Economic Impact of Major Mental Illnesses in Canada: 2011 to 2041.* Toronto: RiskAnalytica, on behalf of the Mental Health Commission of Canada.

Somerville, P. (2009). Understanding Community Policing. *Policing: An International Journal of Police Strategies & Management, 32*(2), 261-277.

Steadman, H. J., Deane, M. W., Borum, R., & Morrissey, J. P. (2000). Comparing Outcomes of Major Models of Police Responses to Mental Health Emergencies. *Psychiatric Services, 51*(5), 645-649.

Steadman, H. J., Stainbrook, K. A., Griffin, P., Draine, J., Dupont, R., & Horey, C. (2001). A Specialized Crisis Response Site as a Core Element of Police-Based Diversion Programs. *Psychiatric Services, 52*(2), 219-222.

Sunshine, J., & Tyler, T. R. (2003). The Role of Procedural Justice and Legitimacy in Shaping Public Support for Policing. *Law and Society Review, 22*, 158-172.

Teddlie, C., & Tashakkori, A. (2011). Mixed Methods Research: Contemporary Issues in an Emerging Field. In N. K. Denzin, & Y. S. Lincoln, *The SAGE Handbook of Qualitative Research* (4th Edition, pp. 285-299). Thousand Oaks, California: SAGE Publications Inc.

Teplin, L. A. (1983). The Criminalization of the Mentally Ill: Speculation in Search of Data. *Psychological Bulletin, 94*(1), 54-67.

Teplin, L. A. (1984). Criminalizing Mental Disorder: The Comparative Arrest Rate of the Mentally Ill. *American Psychologist, 39*(7), 794-803.

The Guardian. (n.d.). *The Counted: People Killed by Police in the US*. Retrieved July 2, 2017, from The Guardian: https://www.theguardian.com/us-news/ng-interactive/2015/jun/01/the-counted-police-killings-us-database

The Washington Post. (n.d.). *Police Shootings 2017 Database*. Retrieved July 2, 2017, from The Washington Post: https://www.washingtonpost.com/graphics/national/police-shootings-2017/

Tully, T., & Smith, M. (2015). Officer perceptions of crisis intervention team training effectiveness. *The Police Journal: Theory, Practice and Principles, 88*(1), 51-64.

Vancouver Police. (2016, July 8). *Vancouver Police Mental Health Strategy.* Retrieved from http://vancouver.ca/police/assets/pdf/reports-policies/mental-health-strategy.pdf

Tyler, T. R. (2004). Enhancing Police Legitimacy. *The Annals of the American Academy, 593*, 84-99.

Tyler, T. R. (2006). *Why People Obey the Law.* Princeton: Princeton University Press.

Tyler, T. R., & Mentovich, A. (2011). *Mechanisms of Legal Effect: Theories of Procedural Justice.* Robert Wood Johnson Foundation.

Tyler, T. R., Goff, P. A., & MacCoun, R. J. (2015). The Impact of Psychological Science on Policing in the United States: Procedural Justice, Legitimacy, and Effective Law Enforcement. *Psychological Science in the Public Interest, 16*(3), 75-109.

Vancouver Police. (n.d.). *Mental Health Unit*. Retrieved from http://vancouver.ca/police/organization/investigation/investigative-support-services/youth-services/mental-health.html

Watson, A., & Angell, B. (2007). Applying Procedural Justice Theory to Law Enforcement's Response to Persons with Mental Illness. *Psychiatry Services, 58*(6), 787-793.

Watson, A. C., Angell, B., Morabito, M. S., & Robinson, N. (2008a). Defying Negative Expectations: Dimensions of Fair and Respectful Treatment by Police Officers as Perceived by People with Mental Illness. *Administration and Policy in Mental Health, 35*(6), 449-457.

Watson, A. C., Angell, B., Vidalon, T., & Davies, K. (2010). Measuring Perceived Procedural Justice and Concern Among Persons with a Mental Illness in Police Encounters: The Police Contact Experience Scale. *Journal of Community Psychology, 28*(2), 1-21.

Watson, A. C., Compton, M. T., & Draine, J. N. (2017). The Crisis Intervention Team (CIT) Model: An Evidence-Based Policing Practice? *Behavioural Sciences & the Law*, 1-11.

Watson, A. C., Corrigan, P. W., & Ottati, V. (2004). Police Officers' Attitudes Toward and Decisions About Persons with Mental Illness. *Psychiatric Sciences, 55*(1), 49-53.

Watson, A. C., Morabito, M. S., Draine, J., & Ottati, V. (2008b). Improving police response to persons with mental illness: A multi-level conceptualization of CIT. *International Journal of Law and Psychiatry, 31*(4), 359-368.

Watson, A. C., Ottati, V. C., Draine, J., & Morabito, M. (2011). CIT in context: The impact of mental health resource availability and district saturation on call dispositions. *International Journal of Law and Psychiatry, 34*, 287-294.

Watson, A. C., Swartz, J., Bohrman, C., Kriegel, L. S., & Draine, J. (2014). Understanding how police officers think about mental/emotional disturbance calls. *International Journal of Law and Psychiatry, 37*(4), 351-358.

Watson, A. C., & Fulambarker, A. J. (2012). The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners. *Best Practices in Mental Health, 8*(2), 71-81.

Weisburd, D., & Braga, A. A. (2006a). *Police Innovation: Contrasting Perspectives.* New York, New York, United States: Cambridge University Press.

Weisburd, D., & Braga, A. A. (2006b). Introduction: Understanding Police Innovation. In D. Weisburd, & A. A. Braga, *Police Innovation: Contrasting Perspectives* (pp. 1-23). New York, New York, United States: Cambridge University Press.

Wells, W., & Schafer, J. A. (2006). Officer perceptions of police responses to persons with a mental illness. *Policing: An International Journal of Police Strategies & Management, 29*(4), 578-601.

Wilson-Bates, F. (2008). *Lost in Translation: How a Lack of Capacity in the Mental Health System in Failing Vancouver's Mentally Ill and Draining Police Resources.* Vancouver, BC.

Wood, J. D., & Watson, A. C. (2017). Improving police interventions during mental health-related encounters: past, present and future. *Policing and Society, 27*(3), 289-299.

Wood, J. D., Watson, A. C., & Fulambarker, A. J. (2017). The "Gray Zone" of Police Work During Mental Health Encounters: Findings from an Observational Study in Chicago. *Police Quarterly, 20*(1), 81-105.

Wood, J., Swanson, J., Burris, S., & Gilbert, A. (2011). *Police Intervention with Persons Affected by Mental Illness: A Critical Review of Global Thinking and Practice.* New Brunswick, New Jersey: Centre for Behavioral Health Services & Criminal Justice Research.

Appendix

Appendix 1: Halifax Regional Police Education and Training Matrix
(Coleman & Cotton, 2010, pp. 15-16)

Level	Length / Method of Training	Learning Objectives
100 Level: Basic Police Training	• 3-day training with all 'recruit' classes • 1-day training for lateral hires	• To introduce new police officers to broad categories of mental illness and mental health difficulties specifically as it relates to EDPs • To provide education on appropriate strategies and guidelines for responding to EDPs • To increase confidence, comfort and awareness in responding and resolving EDP presentations • To understand and gain familiarity with the HRP policy and procedure in relation to EDPs and the Involuntary Patient Treatment Act (IPTA) 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
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 • A more interactive presentation with the MHMCT is under consideration	• 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 • To introduce the MHMCT HRP officer triage card for EDPs

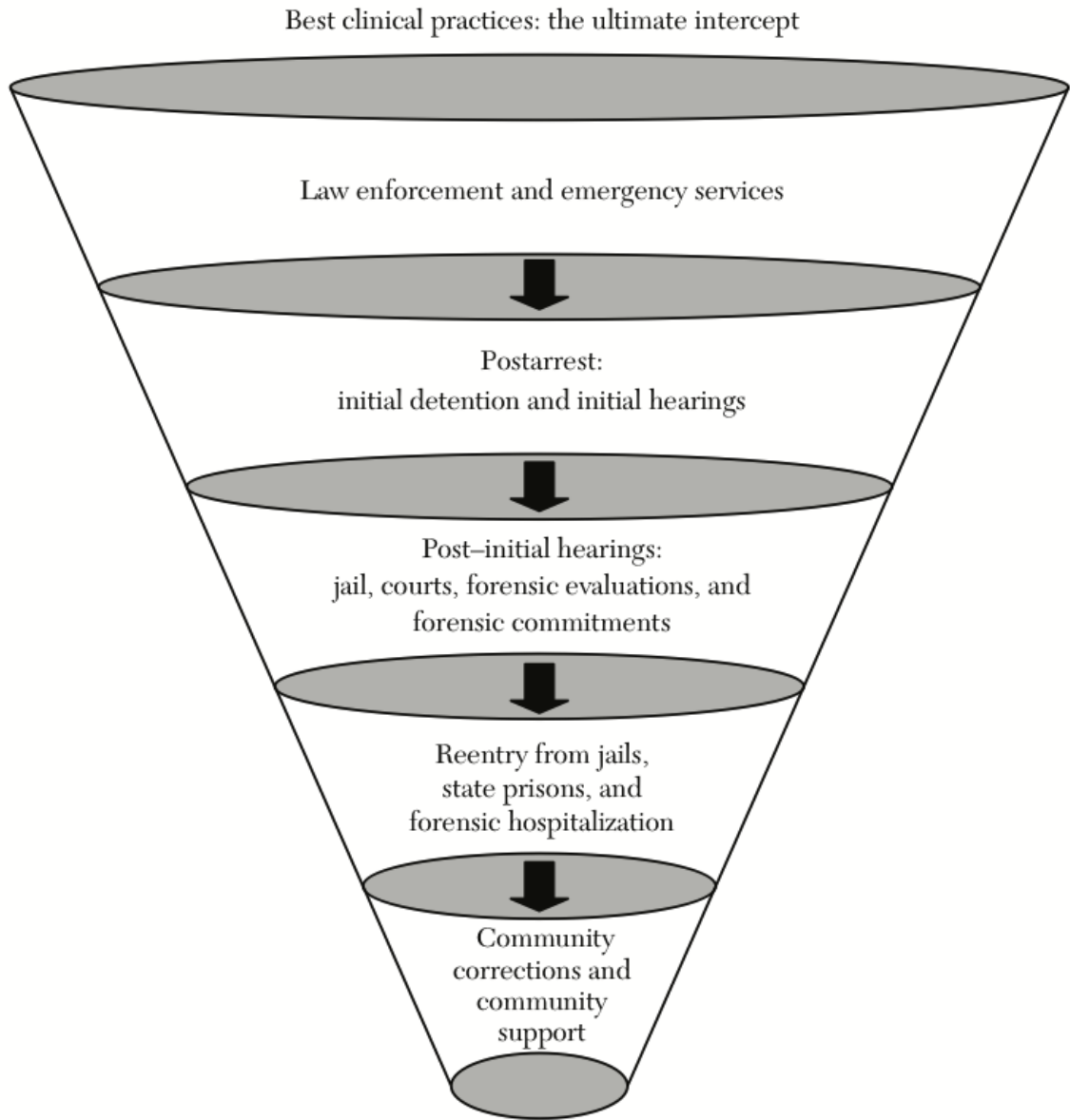|		
300 Level: CIT Training	• 40 hours of education/training • Delivered at least twice per calendar year	• To increase awareness and understanding of mental health issues and particularly better understand the perspective of mental health consumers and their families • To develop and enhance the participants' 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 • 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	• To gain a more in depth working knowledge of mental illness: signs and symptoms, strategies for

- The one week Capital Health Mental Health Orientation which is delivered to all new mental health staff
- A minimum of four job-shadow shifts with MHMCT

maximizing individual and public safety and appropriate strategies for responding to EDP
- To increase communication skills and strategies to respond to EDP
- To increase skills in reporting observations both verbally and in reports

Appendix 2: Sequential Intercept Model
(Munetz & Griffin, 2006, p. 545)

Best clinical practices: the ultimate intercept

Law enforcement and emergency services

Postarrest:
initial detention and initial hearings

Post–initial hearings:
jail, courts, forensic evaluations, and
forensic commitments

Reentry from jails,
state prisons, and
forensic hospitalization

Community
corrections and
community
support

Appendix 3: 40-Hour Officer CIT Comprehensive Training
(Dupont et al., 2007, pp. 14-15)

1) <u>Didactics and Lectures/Specialized Knowledge</u>
   - Clinical Issues Related to Mental Illnesses
   - Medications and Side Effects
   - Alcohol and Drug Assessment
   - Co-Occurring Disorders
   - Developmental Disabilities
   - Family/Consumer Perspective
   - Suicide Prevention and Practicum Aspects
   - Rights/Civil Commitment
   - Mental Health Diversity
   - Equipment Orientation
   - Policies and Procedures
   - Personality Disorders
   - Post-Traumatic Stress Disorders (PTSD)
   - Legal Aspects of Officer Liability
   - Community Resources

2) <u>One-Site Visits and Exposure</u>

3) <u>Practical Skill Training/Scenario Based</u>
   - Crisis De-Escalation Training Part I (Basic Strategies)
   - Crisis De-Escalation Training Part II (Basic Verbal Skills)
   - Crisis De-Escalation Training Part III (Stages/Cycle of a Crisis Escalation)
   - Crisis De-Escalation Training Part IV (Advanced Verbal Skills)
   - Crisis De-Escalation Training Part V (Advanced Strategies: Complex Scenarios)

4) <u>Questions and Answers</u>

5) <u>Commencement and Recognition</u>

Appendix 4: Survey & Consent Form

Policing Mental Health: An Exploratory Study of Mental Health Training, Crisis Intervention Training, and Co-Response Models in the Canadian Context

Informed Consent: The purpose of this research project is to survey all police services in Canada in order to construct a better understanding of mental health training, programs, and tactics (e.g., CITs/co-response teams) on a national scale, as well as to gather the best practices of commonly used training and programs by Canadian police services. You will be asked a series of basic questions on your service as well as the mental health training, programs, and tactics used at your service. The survey should take approximately 15-30 minutes to complete. Your participation in this survey is completely voluntary. If there are any questions that you do not want to answer, you can skip to the next question or you can exit the survey at any time. The survey is not anonymous, nor confidential as all answers provided will be associated with your police service. No personal information will be collected. The information you provide in this survey will be combined with other participant responses and used in a Master's thesis, presentations, and publications.

The risks involved in participating in this research project are minimal and similar to what you would expect to encounter in everyday life. If forwarded this survey by another individual (i.e., Information Officer), there is an increased risk of your survey responses being linked back to you. If completing this survey during work hours, ensure you have the appropriate permission to do so. Although there are no direct benefits to you for participation in this research, your completion of this survey will help researchers and other law enforcement agencies to better understand mental health policing in Canada. In addition, for completing the survey, I will donate $5 on your behalf to the Canadian Police Association Robert Warner Memorial Fund.

Proceeding with this survey means that you have read the above and understand the nature of this study and agree to participate. You also understand that you have the right to refuse to participate and that your right to withdraw from participation at any time before or during the survey (up until the survey has been completed) will be respected with no coercion or prejudice.

Participant Concerns and Reporting: If you have any questions concerning the research study or experience any discomfort related to the study, please contact the researcher, Christopher O'Connor, at 905-721-8668 ext. 5882 or Christopher.O'Connor@uoit.ca. Any questions regarding your rights as a participant, complaints or adverse events may be addressed to the UOIT Research Ethics Board through the Research Ethics Coordinator researchethics@uoit.ca or 905-721-8668 ext. 3693.

This study has been approved by the UOIT Research Ethics Board REB [REB# 14440] on June 22, 2017.

Letter of Endorsement:

September 16, 2017

To Whom It May Concern:

On behalf of the 1,200 women and men of the Durham Regional Police Service, please accept this letter as an expression of our support for the study on Crisis Intervention Teams and Co-Response Teams. As a service which is committed to providing quality policing to all citizens and improved effectiveness in everything we do, more Canadian research is needed to ensure the most effective application of evidence-based strategies during interactions with those in mental health crisis.

Understanding how police services across the country are implementing CITs and Co-Response Teams is valuable for establishing best-practices and for understanding the benefits of such models for our services and our communities.

Respectfully yours,

Paul D. Martin
Chief of Police

Durham Regional Police Service | Oshawa 905-579-1520
Police Headquarters, 605 Rossland Road East | Toll Free 888-579-1520
Box 911 Whitby, Ontario L1N 0B8 | Fax 905-666-8733

www.drps.ca

Consent to Participate:
By consenting, you do not waive any rights to legal recourse in the event of research-related harm.

1. I have read the consent form and understand the study being described.

2. I have had an opportunity to ask questions and my questions have been answered. I am free to ask questions about the study in the future.

3. I freely consent to participate in the research study, understanding that I may discontinue participation at any time without penalty. A copy of this consent form has been made available to me.

4. I understand that the information of this survey is going to be retained, and I consent to its use in this study as well as future studies/analyses/presentations/publications.

○ I consent to participate

○ I do not consent to participate

Skip To: End of Survey If = I do not consent to participate

1. Which police service are you employed at?

   _____

2. Would you consider your police service to be in an urban or rural area?

○ Urban

○ Rural

○ Our police jurisdiction is a combination of both urban and rural areas

3. Approximately how many officers are employed at your police service?

○ 0 – 100

○ 101 – 200

○ 201 – 300

○ 301 – 400

○ 401 – 500

○ More than 500

4. Are interactions with individuals with mental illness very common, somewhat common, or rare for officers at your service?

○ Very common

○ Somewhat common

○ Rare

---

5. How is mental health training administered to officers at your service (select all that apply)?

☐   Lectures

☐   Seminars

☐   Simulation/role play

☐   Quizzing

☐   Through other training (e.g. Use of Force)

☐   Other (please specify):

_____

---

6. How many hours of mental health training do new recruits at your service receive (either through the police college or through your service)?

○ 0 – 5

○ 6 – 7

○ 8 – 10

○ More than 10

○ Don't know/information not available

---

7. How often do officers get re-trained on mental health?

- ○ Every 0 – 4 months

- ○ Every 5 – 8 months

- ○ Every 9 – 11 months

- ○ Every 1 – 2 years

- ○ Every 3 – 4 years

- ○ More than every 4 years

- ○ Officers do not get re-trained on mental health

- ○ Don't know/information not available

Skip To: 9 If 7 = Officers do not get re-trained on mental health

Skip To: 9 If 7 = Don't know/information not available

---

8. How many hours of mental health training do officers at your service receive every time they are re-trained?

- ○ 0 – 5

- ○ 6 – 7

- ○ 8 – 10

- ○ More than 10

- ○ Don't know/information not available

---

9. Do 911 operators at your service receive some form of training for mental health related calls?

- ○ Yes

- ○ No

- ○ Don't know/information not available

Skip To: 11 If 9 = No

Skip To: 11 If 9 = Don't know/information not available

10. For your 911 operators, what are they trained on with respect to mental health and how is this training conducted?

_____

_____

11. In 2016, approximately how many mental health related interactions did your police service have? Please specify an approximate number.

_____

12. In 2016, approximately how many mental health related interactions involved suicide threats, attempts, or jumps? Please specify an approximate number.

_____

13. In 2016, how many apprehensions under Provincial/Territorial mental health legislation did your service conduct? Please specify an approximate number.

_____

14. Does your service record any of the following information (select all that apply)?

☐   Information on past encounters with individuals who suffer from mental illness or have had a mental health crisis

☐   Outcomes of past encounters

☐   Time officers spend at a crisis situation

☐   Other (Please specify any other information you record with respect to mental health interactions):

_____

☐   Don't know/information not available

15. How do mental health crisis situations addressed by your officers most commonly conclude? Please rank the following options from the most common conclusion to the least common conclusion.

_____ Successful informal de-escalation (without arrest, without referral to mental health service, and without transport to local hospital)

_____ Arrest

_____ Referral to mental health service

_____ Voluntary transport to local hospital/psychiatric facility

_____ Involuntary transport to local hospital/psychiatric facility

_____ Other (please specify):

_____

---

16. With whom does your service have agreements/arrangements with to drop off individuals post-crisis (select all that apply)?

☐ Hospital/psychiatric facility

☐ Mental health services

☐ There are no agreements/arrangements in place

☐ Other (please specify):

_____

---

17. If an individual is transported to a local hospital/psychiatric facility, on average how long do your officers need to wait before the individual is transferred over to the staff at the facility?

○ 0 – 1 hour

○ 2 – 3 hours

○ 4 – 5 hours

○ More than 5 hours

○ Don't know/information not available

---

18. To what extent do you agree that there are adequate mental health services available to people in your jurisdiction?

○ Strongly agree

○ Agree

○ Neither agree or disagree

○ Disagree

○ Strongly disagree

Skip To: 20 If 18 = Strongly agree
Skip To: 20 If 18 = Agree

19. What are some of the consequences of inadequate mental health services?
_____
_____

20. If provided with an unlimited training budget, how could these funds be used to improve interactions between police and individuals suffering from mental illness?
_____
_____

21. How are mental health crises addressed at your service (select all that apply)?

☐   Front-line officers

☐   Designated mental health officers

☐   Crisis Intervention Team (or a variation of) **(A Crisis Intervention Team (CIT) is typically defined as a group of officers who receive an extended amount of mental health training (typically 40 hours) and are considered the "mental health crisis specialists" of their police service.)**

☐   A police-based co-response team (or a variation of) **(A police-based co-response team is typically defined as a team response to a crisis situation by a police officer and a mental health professional (i.e., nurse). The officer and mental health professional work together on shift and response to crises together at the request of first responding officers. Please note that this option does not include mental health-based crisis teams originating out of hospitals.)**

☐   A mental health-based crisis team (or variation of) **(A mental health-based crisis team is typically defined as a team response originating from a local hospital or mental health facility and can respond to crises at the request of first responding officers.)**

☐   Telephone consultation

☐   Other (please specify):
_____

22. If your service **does not** currently employ a CIT and/or police-based co-response team, are there plans to do so within:

○ The next 6 months

○ The next year

○ The next 5 years

○ More than 5 years

○ There are no current plans to employ a CIT/co-response team within the near future

○ Not applicable. My service does have a CIT and/or co-response team

Skip To: 47 If 22 != Not applicable. My service does have a CIT and/or co-response team

23. Why was a CIT/co-response team implemented at your service?

_____
_____

24. Who does the CIT/co-response team report to?

_____
_____

25. How many CIT/co-response teams does your service employ? Please specify an exact number, and if more than one, please specify a reason (e.g., one per division/detachment)

_____
_____

26. In 2016, how many mental health crisis related interactions did your CIT/co-response team have? Please specify an approximate number.

_____
_____

27. In 2016, approximately how many CIT/MCIT interactions involved suicide threats, attempts, or jumps? Please specify an approximate number.

_____
_____

28. In 2016, how many apprehensions under Provincial/Territorial mental health legislation did your CIT/co-response team conduct? Please specify an approximate number.

_____
_____

29. How many individuals are on your CIT/co-response team? (If your service employs more than one CIT/co-response, how many individuals are on each respective team)

○ 1 – 5

○ 6 – 10

○ 11- 15

○ 16- 20

○ More than 20

○ Don't know/information not available

30. Are officers assigned to your CIT/co-response team, or do they volunteer?

○ Assigned

○ Volunteer

○ Officers can be either assigned or volunteer

○ Don't know/information not available

31. Is there a rotational period where officers may only serve on a CIT/co-response team for a select period of time?

○ Yes (why is the rotational period in place and how long is it?):

    _____

○ No

○ Don't know/information not available

---

32. What are the hours of operation for your CIT/co-response team?

    _____
    _____

---

33. What roles/duties do your CIT/co-response team officer conduct while not addressing a mental health crisis?

    _____
    _____

---

34. Is your CIT/co-response team solely utilized for mental health crises? Or is it used to address other situations as well (e.g. individuals under the influence of drugs or alcohol)?

○ Solely used for mental health crises

○ Can be used for other situations as well

○ Don't know/information not available

---

35. Is your CIT/co-response team partnered with a local hospital and/or mental health organizations?

○ Yes

○ No

○ Don't know/information not available

36. How does the CIT/co-response team benefit from this partnership?

   _____

   _____

37. Does your CIT/co-response team refer individuals to mental health services, programs, and hospitals/psychiatric facilities more regularly than non-CIT/non-co-response officers?

   ○ Yes

   ○ No

   ○ Referrals are about the same for both sets of officers

   ○ Don't know/information not available

38. What percentage of crises handled by the CIT/co-response team are for individuals that the CIT/co-response team has encountered in the past?

   ○ 0%

   ○ 1% – 10%

   ○ 11% – 20%

   ○ 21% – 30%

   ○ 31% – 40%

   ○ 41% – 50%

   ○ More than 50%

   ○ Don't know/information not available

39. To what extent do you agree that the implementation of a CIT/co-response
team improves the safety of officers, the individuals involved, and bystanders of a
crisis situation?

○ Strongly agree

○ Agree

○ Neither agree or disagree

○ Disagree

○ Strongly disagree

---

40. To what extent do you agree that the use of a CIT/co-response team positively
Improves police interactions with those in crisis?

○ Strongly agree

○ Agree

○ Neither agree or disagree

○ Disagree

○ Strongly disagree

---

41. What are the differences in training provided to CIT/co-response officers at your
service compared to training provided to non-CIT/non-co-response officers?
_____
_____

---

42. Is your CIT/co-response team the first response to crisis situations or do they get requested to attend a crisis by first responding officers?

○ First response

○ Response is requested by first responding officers

○ Our CIT is a first response, but the co-response team is requested by first responding officers

○ Don't know/information not available

○ Other (please specify):

_____

43. Has implementing a CIT or co-response team resulted in less, more, or the same amount of arrests of individuals with mental illness in your jurisdiction than non-CIT/non-co-response officers?

○ More

○ Same

○ Less

○ Don't know/information not available

44. What factors are crucial to the success/effectiveness of your CIT/co-response team?

_____
_____

45. In a few sentences, what is the overall objective or goal of your CIT/co-response team?

_____
_____

46. Is your service open to having an evaluation conducted on your CIT/co-response
     team within the next 5 years?

   ○ Yes

   ○ No

   ○ Don't know/information not available

Would you be willing to participate in a confidential interview? The interview expands
off this survey by allowing participants to freely discuss police mental health training
with ensured confidentiality of responses which will not be associated with yourself or
your police service. For participating in a confidential interview, I will donate an
additional $10 on your behalf to the Canadian Police Association Robert Warner
Memorial Fund. If you are interested, please provide your email and/or telephone number
in the box below (the answer to this question will not be associated to any of the answers
provided earlier).

_____

_____

Thank you very much for taking time out of your busy day to complete this survey. Your
responses are very helpful in attaining a fuller understanding of policing mental health in
Canada. If you would like a copy of the final report on this research project, please leave
an email in the box below and I will send you a copy once the study is complete. This
email will in no way be connected to your responses. If for some reason you change
emails/jobs, feel free to send me your current contact info at any time or you may contact
the principal investigator to obtain a copy of the final report. Thanks for all of your help
and insights. It is very much appreciated. **Please click the "next" arrow to exit the
survey.**

   ○ Email for final report _____

End of Block: SURVEY BLOCK

Appendix 5: Survey Invitation Email

Hello,

I am attempting to contact the person who is most knowledgeable about mental health training and programs employed at your service as I would like to provide them with a survey link about mental health policing in Canada. Would you be able to forward the below request to the person who you feel is best knowledgeable in this area?

My name is Jacek Koziarski and I'm a Criminology Master's student at the University of Ontario Institute of Technology studying mental health and policing in Canada. You have been identified as the appropriate individual to survey on this topic, therefore, I would like to invite you to participate in my research project. If you feel someone else might be better suited to participate within your organization, please feel free to forward this email to them.

The purpose of this research project is to survey all police services in Canada in order to construct a better understanding of emerging mental health strategies, programs, and tactics on a national scale, as well as to gather the best practices of commonly used training and programs by Canadian police services. This research project will also be the first Canadian study to develop a national understanding of mental health training, programs, and tactics used at your service. The survey will take approximately 15-30 minutes of your time to complete. For completing the survey, I will donate $5 on examined mental health policing from a Canadian perspective, and even less research has examined CITs and co-response teams, therefore, your participation in the study will provide new data and a better understanding of mental health policing in Canada. The overall premise of this research is to inform all Canadian police services nationwide how other jurisdictions address the issue of mental health related interactions within their service. The hope is that this new information may inspire the development of new mental health training and programs within Canadian police services.

For this study, you will be asked to complete an online survey with basic questions on your service as well as the mental health training, programs, and tactics used at your service. The survey will be tied to your respective police service, but will not have any personal identifiers associated with it. I your behalf to the Canadian Police Association Robert Warner Memorial Fund. Please keep in mind that your participation is completely voluntary. The responses given within the online survey will be tied to your respective police service, but will not have any personal identifiers associated with it. I realize that permissions may need to be sought from your police organization if you choose to participate in this research project during your work hours. If so, I am happy to contact the necessary people and obtain the permissions.

If you are interested in participating in this research project or are seeking more information on the project, the direct link to additional information and the survey will be provided below. If you have any questions or concerns, please do not hesitate to contact me.

This study has been approved by the UOIT Research Ethics Board REB [#14440] on June 22, 2017.

Link to Survey: https://uoitsocialscience.eu.qualtrics.com/jfe/form/SV_1X1CcaTuXWNvB5P

Thank you,

Jacek Koziarski

Jacek Koziarski
M.A. Criminology Candidate
Faculty of Social Science and Humanities
University of Ontario Institute of Technology (UOIT)
55 Bond Street East
Oshawa, ON L1G 1B2
Office: DTB 202
Email: jacek.koziarski@uoit.ca; jacek.koziarski@uoit.net

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Appendix 6: Interview Invitation Email

Hello,

Thank you for completing the online survey and for indicating that you are willing to participate in a confidential telephone/Skype interview. I have attached a letter of consent that more fully explains the interview portion of this research project. Please read over the document and let me know if you have any questions. Again, as with the survey, if you choose to proceed with the interview during your work hours and require further permissions to speak with me, please let me know how I can help to obtain needed permissions.

Once you have had a chance to read over the document, and you are still interested in participating in this research project, please sign and send back the consent form with some days/times that might work for you to speak with me.

Before the interview begins, I will go over the consent form with you and you will have an opportunity to ask any additional questions that you might have. At that time, you can choose to continue the interview or withdraw. You can choose to withdraw from the interview at any time up until the interview is completed with no consequences to you.

This study has been approved by the UOIT Research Ethics Board REB [#14440] on June 22, 2017.

Thank you,

Jacek Koziarski

--
Jacek Koziarski
M.A. Criminology Candidate
Faculty of Social Science and Humanities
University of Ontario Institute of Technology (UOIT)
55 Bond Street East
Oshawa, ON L1G 1B2
Office: DTB 202
Email: jacek.koziarski@uoit.ca; jacek.koziarski@uoit.net

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Appendix 7: Interview Consent Form

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Title of Research Study: Policing Mental Health: An Exploratory Study of Mental Health Training, Crisis Intervention Training, and Co-Response Models in the Canadian Context

Purpose and Procedure:

The purpose of this research project is to survey all police services in Canada in order to construct a better understanding of mental health training, programs, and tactics on a national scale, as well as to gather the best practices of commonly used training and programs by Canadian police services. This research project will also be the first Canadian study to develop a national understanding of emerging mental health strategies, such as Crisis Intervention Teams (CITs) and co-response teams. Very little research has examined mental health policing from a Canadian perspective, and even less research has examined CITs and co-response teams, therefore, your participation in the study will provide new data and a better understanding of mental health policing in Canada. The overall premise of this research is to inform all Canadian police services nationwide how other jurisdictions address the issue of mental health related interactions within their service. The hope is that this new information may inspire the development of new mental health training and programs within Canadian police services.

For this study, you will be asked to take part in a phone or Skype interview lasting approximately 30 to 45 minutes in length. The interview expands off the survey by allowing participants to freely discuss police mental health training with ensured confidentiality of their responses. Questions in this interview will predominantly concern mental health training at your service, mental health training for police officers generally, as well as your perspective and recommendations on current and future mental health training for Canadian officers. If there are any questions that you do not want to answer, we may move to the next question or you may end the interview at any time. The interview is confidential as all responses will not be associated with yourself, your police service, or your responses from the survey.

Researcher(s):

Jacek Koziarski, B.A.
Co-Investigator / Student Lead
Candidate for Master of Arts in Criminology
Faculty of Social Science and Humanities
University of Ontario Institute of Technology (UOIT)
55 Bond Street East, Oshawa, ON L1G 1B2
Email: Jacek.Koziarski@uoit.ca
Phone: 905-244-0160

Christopher O'Connor, Ph.D.
Principal Investigator
Assistant Professor of Criminology
Faculty of Social Science and Humanities
University of Ontario Institute of Technology (UOIT)

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55 Bond Street East, Oshawa, ON L1G 1B2
Email: Christopher.O'Connor@uoit.ca
Phone: 905-721-8668 ext. 5882

Tyler Frederick, Ph.D.
Co-Investigator
Assistant Professor of Criminology
Faculty of Social Science and Humanities
University of Ontario Institute of Technology (UOIT)
55 Bond Street East, Oshawa, ON L1G 1B2
Email: Tyler.Frederick@uoit.ca
Phone: 905-721-8668 ext. 5881

Potential Benefits / Risks or Discomforts:
The risks involved in participating in this research project are minimal and similar to what you would expect to encounter in everyday life. If you choose to participate in this project during your work hours, it is recommended that approvals be sought from supervisors to take time out of your work day to participate in this research. However, this will lead to others knowing that you participated in this research project. Alternatively, the interview can be conducted outside of work which would limit the likelihood of others knowing you participated in this research project. There is also the risk that superiors might pressure you to participate, or not to participate, in this research project. Therefore, any write-ups of interview information will not contain any identifying information including names or police services thus minimizing the risk of participation.

Although there are no direct benefits to you for participation in this research, you will be provided an opportunity to speak about mental health policing, training, and programs offered nationally as well as at your police service. For participating in a confidential interview, I will donate an additional $10 on your behalf to the Canadian Police Association Robert Warner Memorial Fund to assist the families of officers killed in the line of duty. The information you provide will seek to advance knowledge about police mental health training and programs in Canada. If you would like a copy of the final report on this research project, please leave an email with me and I will send you a copy once the study is complete. This email will in no way be connected to your responses.

Storage of Data:
The information you provide will be used in a Graduate thesis, presentations, and publications. All interview consent forms, recordings, and transcriptions will be stored digitally, on a password protected computer, and in a password protected folder. All recordings will be destroyed when the interview has been transcribed. The data you provide will only be accessed by the three researchers noted on this consent form. The data will be kept for this study as well as for future studies, analyses, presentations, or publications.

Confidentiality:

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The results of your participation will be strictly confidential and no names (yourself or your police service) or individual identifying information will be maintained. With the exception of the three researchers involved in this study, no one will have access to any of the individual responses. Your responses will be combined with many others and reported in group form. A pseudonym will be used in place of your name/service. Your responses for this interview will in no way be associated with the responses provided in the survey.

Your privacy shall be respected. No information about your identity will be shared or published without your permission, unless required by law. Confidentiality will be provided to the fullest extent possible by law, professional practice, and ethical codes of conduct. Please note that confidentiality cannot be guaranteed while data are in transit over the Internet.

Right to Withdraw:
Your participation is entirely voluntary, and you can answer only those questions that you are comfortable with. You have the right to withdraw from the interview at any time (up until the interview is completed) with no consequences to you. If you so wish, any data you have provided up to the point of withdrawal can be destroyed.

Debriefing and Dissemination of Results:
If you would like a copy of the final report on this research project, please leave an email and I will send you a copy once the study is complete. This email will in no way be connected to your responses. If for some reason you change emails/jobs, feel free to send me your current contact info at any time or you may contact the principal investigator to obtain a copy of the final report.

Participant Concerns and Reporting:
If you have any questions concerning the research study or experience any discomfort related to the study, please contact the researcher, Christopher D. O'Connor, at 905-721-8668 ext. 5882 or Christopher.O'Connor@uoit.ca.

Any questions regarding your rights as a participant, complaints or adverse events may be addressed to the UOIT Research Ethics Board through the Research Ethics Coordinator – researchethics@uoit.ca or 905-721-8668 ext. 3693.

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FACULTY OF SOCIAL SCIENCE AND HUMANITIES

This study has been approved by the UOIT Research Ethics Board REB [#14440] on June 22, 2017.

Consent to Participate:

By consenting, you do not waive any rights to legal recourse in the event of research-related harm.

1. I have read the consent form and understand the study being described.
2. I have had an opportunity to ask questions and my questions have been answered. I am free to ask questions about the study in the future.
3. I freely consent to participate in the research study, understanding that I may discontinue participation at any time without penalty. A copy of this Consent Form has been made available to me.
4. I understand that the information of this interview is going to be retained, and I consent to its use in this study as well as future studies/analyses/presentations/publications.

_____   _____
(Name of Participant)   (Date)

_____   _____
(Signature of Participant)   (Signature of Researcher)

Appendix 8: Interview Guide

<u>Before interview starts:</u> Ask the participant whether they consent to the interview being recorded and go over the informed consent form including plans for transcription and the de-identification of this recorded data.

Part I: Rapport Building

1) Can you tell me a bit about yourself? **(Probe: Current position? Current or previous experience with mental health policing? Previous Jobs? Education?)**

Part II: Mental Health Policing

2) Are there any formal protocols or procedures in place for addressing mental health related interactions at your service? **(Probe: How are possible mental health calls communicated from dispatchers to officers? What do officers do when they witness a crisis during their normal duties? In your experience, what are the different ways that a crisis situation can be resolved?)**

3) How are mental health crises typically resolved at your police service? **(Probe: Is verbal/tactical de-escalation the first method of intervention? Is there a point in crisis de-escalation where verbal/tactical de-escalation is set aside in favour of use of force?)**

4) Have you heard of the term 'psychiatrists in blue'? **(Probe: How do you feel about the term? Is it an accurate label? Are interactions with individuals who have a mental illness or are in mental health crisis a common part of police work?)**

5) Is a Crisis Intervention Team (CIT) or a co-response team employed at your service? **("Yes" Probe: What sparked the implementation of the CIT/co-response team?) ("No" Probe: What are the reasons contributing to no CIT/co-response team? Is it the choice of the service? Funding limitations? Etc.)**
*(**If answer to #4 is "No," skip to Part IV**)*

Part III: CIT/Co-Response

6) What kind of mental health training do your CIT/co-response officers receive? **(Probe: How long is training? How is training conducted [i.e. simulation]? How does their training affect mental health responses? What training works well and what should be altered? Is de-escalation more common among these officers?)**

7) What are some of the challenges your CIT/co-response team faces in your jurisdiction? **(Probe: Lack of mental health services? Lack of an agreement**

with a local hospital for intake? Encountering the same individuals? Is a position on the CIT/co-response team seen as 'undesirable'?)

8) What are some of the benefits of a CIT/co-response in your jurisdiction? **(Probe: More positive interactions with individuals who have a mental illness? Are there less arrests and more diversions to services/hospitals?)**

9) Overall, what is the goal or objective or your CIT/co-response? **(Probe: Is it to improve interactions with individuals who are in mental health crisis? Is it to improve public safety? To improve officer safety?)**

Part IV: Non-CIT/Co-Response Questions *(**Part IV will only be asked in the event that a participant answers "No" to question #4**)*

10) What kind of mental health training do your officers receive? **(Probe: How long is training? How is training conducted [i.e. simulation]? How does their training affect mental health responses? What training works well and what should be altered? Is de-escalation more common among officers with more training?)**

11) What are some of the challenges your officers face when interacting with people with mental illness or those in mental health crisis? **(Probe: Lack of mental health services? Lack of an agreement with a local hospital for intake? Encountering the same individuals?)**

12) What are some of the benefits of training your officers on mental illness? **(Probe: More positive interactions with individuals who have a mental illness or are in mental health crisis? Are there less arrests and more diversions to services/hospitals?)**

13) Overall, what is the goal or objective of mental health training at your service? **(Probe: Is it to improve interactions with individuals who have a mental illness or are in mental health crisis? Is it to improve public safety? To improve officer safety?)**

Part V: Concluding Questions

14) What are some of the main factors that may influence how a crisis situation gets resolved? **(Probe: Do bystanders make responding officers feel as though they need to address the situation fast? Does violence or crisis escalation change how a crisis will conclude [e.g. Arrest vs. transfer to hospital]?)**

15) Generally, what are some of the challenges of mental health policing in Canada? What are some of the successes? **(Probe: Differing mental health curriculums? Differing mental health legislation by province? Is an increasing collaboration with mental health services increasing successful interactions and mental health awareness?)**

16) What are some things that can be improved in terms of police mental health responses in Canada? **(Probe: Better training? Establishing and improving community collaboration? Improving mental health services? Is there anything that your service can improve upon?)**

17) Do you have any questions for me or anything further to add that I missed?

Part VI: Interview Thank You Message

Finally, I'd like to thank you very much for participating in this research project. Your responses are very helpful in attaining a fuller understanding of policing mental health in Canada. If you would like a copy of the final report on this research project, please leave an email with me and I will send you a copy once the study is complete. This email will in no way be connected to your responses. If for some reason you change emails/jobs, feel free to send me your current contact info at any time or you contact the principal investigator to obtain a copy of the final report.

Thanks for all of your help and insights. It is much appreciated.

** END OF INTERVIEW **

Appendix 9: Canadian Police Association Memorial Fund Donation

Canadian Police Association
Association canadienne des policiers

Billing information

Jacek Koziarski
435 Ormond Drive

Receive Updates and Information
I would like to receive updates and information about the fund via Email: **No**
I would not like to receive updates and information about the fund via Email: **No**

Thank you for your donation to CPA-Robert Warner Memorial Fund (#916).

Product	Price	Quantity	Total
Donation	215.00 CAD	1	215.00 CAD
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