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Canada

BALANCING INDIVIDUAL SAFETY, COMMUNITY SAFETY, AND QUALITY OF LIFE

A conference to improve interactions between police and people with mental illness

CANADIAN ASSOCIATION OF CHIEFS OF POLICE | MENTAL HEALTH COMMISSION OF CANADA

COMPREHENSIVE REVIEW

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EXECUTIVE SUMMARY

At an historic two-day conference in Toronto, Ontario in March 2014, co-hosted by the Canadian Association of Chiefs of Police (CACP) and the Mental Health Commission of Canada (MHCC), stakeholders from policing, mental health, criminal justice, and people with lived experience of mental illness came together to discuss how to improve interactions between police and people living with mental illness.

The conference sought to address the following key issues:

- How to prevent crisis
- How to better respond to crisis
- How to improve interactions with other aspects of the criminal justice system post police interaction
- How to measure progress

Promising practices were shared and key themes identified, including the importance of involving people with lived experience of mental health problems and mental illness and paying attention to the workplace mental health of police personnel and the impact of stigma. Other promising practices include:

EFFECTIVE EDUCATION AND TRAINING

Police in Canada want to collaborate with community and mental health agencies to focus on prevention and de-escalation, rather than use of force. A report prepared by Dr. Terry Coleman and Dr. Dorothy Cotton identifies several best practices, including:

- Inviting people with lived experience of mental illness and mental health practitioners to participate in curriculum development
- Choosing instructors who have an understanding of mental health issues

In the United States, the Crisis Intervention Team (CIT) model is showing promise. A 2008 National Institute of Mental Health (NIMH) study found that CIT-trained officers in Chicago:

- Were more likely to direct calls to mental health services
- Made fewer arrests
- Used less force

NEW MODELS OF COMMUNITY SAFETY

In the past several years, innovative, recovery-oriented programs have evolved across Canada to improve outcomes for, and interactions with, people living with mental illness. The most successful models ensure participants have a safe place to live and are supported by teams including police, health care providers, mental health workers, and peers with lived experience.

In Saskatchewan, collaborative models for community safety and wellness are showing how this approach can reduce recidivism, increase public safety, and improve quality of life for people living with mental illness.

AN ISSUE THAT AFFECTS ALL CANADIANS

In any given year, one in five people in Canada experiences a mental health problem or illness.

Given these numbers, it is not surprising that serving people living with mental health problems or illness has become a core part of policing. The vast majority of persons with mental illness are more likely to be victims of crime than perpetrators, with those in crisis 23 per cent more likely to be victims of violent crime than the general public.

In Vancouver, the Assertive Community Treatment (ACT) teams supporting RainCity Housing include a combination of police, nurse practitioners, psychiatrists, substance abuse counsellors, and social workers. These teams take a Housing First approach — providing people with a place to live first and then offering recovery-oriented services and additional support for underlying issues, such as addiction and mental illness, which best meet the needs of the individual. This is proving to have a significant benefit for both clients and the community.

When police who are trained in mental health intervention are paired with mental health service providers, the strain on emergency rooms is reduced, fewer arrests and charges occur, and individuals are taken to emergency rooms only when appropriate.

The conference profiled model programs from five jurisdictions, shining a spotlight on the unique ways police and mental health and community service groups can complement each other's work.

PROMOTING WORKPLACE MENTAL HEALTH

Police personnel must prioritize their own mental health if they are to serve their communities effectively. Unfortunately, admitting to having a mental health problem or mental illness is still perceived by many in the field as a career-limiting move. This raises the question of how well police are caring for their own.

Police leaders must put the mental health of officers at the top of the agenda. The most successful programs are those in which leadership sets the tone — speaking openly about mental health, encouraging participation in wellness programs, and facilitating collaborations that de-stigmatize mental health issues in the workplace.

Stigma around mental illness is pervasive and not unique to police services. However, in law enforcement, stigma is compounded by the perception that a mental illness could be wrongly construed as weakness in a profession where toughness is prized. Defeating stigma is key to improving interactions, making police better colleagues and better equipped to act as first responders.

The Calgary Police Service provides high quality, culturally sensitive mental health services for police personnel and their families to help normalize their own experience of mental health issues, while building understanding toward members of the public experiencing similar problems. The cost of the program is offset by savings in sick leave expenditures. In 2012, sick leave for staff who eventually accessed psychological services cost the Calgary Police Service $208,000. Following treatment, 42 per cent of those who accessed the services no longer required sick leave.

RECOVERY, REHABILITATION, AND QUALITY OF LIFE

While people with mental illness are more likely to be victims of crime than perpetrators, they are over-represented in Canada's correctional system, suggesting the criminal justice and correctional systems deserve closer examination.

The *Hope Not Jail* project in Halifax is studying how people come to be involved with the criminal justice system. Looking at a variety of social factors — including family, housing, gender, and culture — researchers interviewed people with firsthand experience of the system, inquiring about their "tipping points and turning points."

Involving people with lived experience, allied organizations, health service providers, and corrections staff is key to improving criminal justice system interactions. The same is true for "journey mapping" — diagramming and documenting how people experience the system.

The Canadian Mental Health Association in British Columbia is currently focusing on re-entry into the community and community corrections, believing that is where the greatest return on investment can be realized.

MEASURING OUTCOMES AND SUCCESS

Communication and collaboration are essential to improving interactions between law enforcement and people with mental illness. And while all concerned parties, including mental health organizations, community service organizations, police, the courts, corrections, etc., need to be engaged in this discussion, how do we ensure everyone is speaking the same language?

Furthermore, how can we measure and evaluate efforts to ensure better outcomes? One example is Ontario's *interRAI Brief Mental Health Screener*. This is a tool that builds relationships and communication between police services and hospital staff.

Its use enables hospitals to accept transfers of care from police more quickly by pre-establishing grounds for admittance. This translates into less time spent in waiting rooms for those in need of help, and for officers themselves.

In Vancouver, collaboration between police and Vancouver General Hospital has resulted in the Assertive Community Treatment (ACT) program. The goals of ACT are to reduce hospital wait times and improve quality of life for those with mental illness.

AFFECTING CHANGE

We need to seek "whole system" solutions. The categories of concern around mental health are not distinct: police, health care and mental health services, peer support, the courts, corrections — they all overlap, and each one needs to examine how it addresses mental health issues. Canada already has a blueprint for system improvement — the MHCC's *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* — which acknowledges the overlap and calls for collaborative action to safeguard the mental health of all Canadians.

Following this groundbreaking conference, the MHCC and the CACP issued a joint statement agreeing that the following conclusions should stand as the official record from the conference:

1. Work collaboratively toward a new national framework for police training and education that would be adopted by CACP and its membership.
2. Joint release of the updated TEMPO report (police education and training) and continued dialogue on implementation of the recommendations therein.
3. Increased focus on the mental health of police officers and mentally healthy workplaces for all police personnel.
4. Work with Statistics Canada and other key organizations to address measurement of police workload related to calls involving mental illness, and consider the collaborative development of new tools for data collection and analysis.
5. Share the results of the conference through the release of the conference report as part of a shared commitment towards ongoing collaborative learning.
6. Central to any next step will be the continued inclusion of people with lived experience of mental illness as vital stakeholders in the discussion between the mental health and police leaders..

The involvement of people with lived experience of mental illness is key to fulfilling each of these commitments.

KEY TAKEAWAYS

- **People with lived experience of mental illness should be included** throughout the full continuum of activities, from designing and delivering police education and training curricula to developing crisis intervention and community programs.
- **Collaboration is essential** to ensuring police, mental health, health care, criminal justice, corrections, and community organizations make the best use of their respective resources and access the knowledge they need for effective interactions.
- **Collaboration requires information sharing** among agencies and across jurisdictions, while respecting the individual's rights to privacy.
- **A sense of "procedural justice" is key**. When people feel respected and cared for, they are more likely to be cooperative, making interactions safer for everyone involved.
- **Housing, peer support, and access to interdisciplinary support are hallmarks of successful programs**. Interdisciplinary teams should include police, health care providers, mental health workers, and peers with lived experience.
- **Police must have good mental health themselves** in order to serve their communities and interact effectively with people with mental illness.
- **Removing stigma improves interactions and outcomes** by focusing on the individual, not biases or misconceptions about their mental illness.
- **The full continuum of resources needs to be engaged**: mental health prevention and promotion agencies, community service organizations, police, the courts, corrections, and re-entry organizations.

INTRODUCTION:
The Call Must Be Answered

"What we have is not a policing problem or a mental health problem, but rather a societal problem."
Louise Bradley, President and CEO
Mental Health Commission of Canada

Police are trained and conditioned to handle some of the more intense and challenging situations our society has to offer: traffic accidents, family tragedies, domestic disputes, crimes in progress. Their role also puts police on the front lines of response when people experience mental health crises. Yet there is no universal curriculum for police learning how to work with people living with mental illness.

For the sake of everyone involved, police should be well prepared and have adequate support to answer the call when people are in mental health distress. They should also be equipped to play a role in preventing crises as part of a consistent, integrated, efficient system involving criminal justice, corrections, community services, mental health, and broader healthcare services.

So how do we achieve this?

That was the driving question behind a groundbreaking conference in March 2014 co-hosted by the Canadian Association of Chiefs of Police (CACP) and the Mental Health Commission of Canada (MHCC).

TWO DAYS OF MAKING HISTORY

Held on March 25-26, 2014 in Toronto, this conference brought together more than 320 people from all segments of the stakeholder community: police, mental health, criminal justice, and people with lived experience. It marked the first time in Canada that police and mental health professionals have gathered at the national level to collaboratively address policing and mental health issues.

Over the course of the two days, 45 speakers presented the latest research and perspectives on a range of topics — from police education and training and community safety models to workplace mental health for police, post-interaction outcomes for people with mental illnesses, and measurement approaches. As moderator Norman Taylor explained in his opening remarks, the conference design followed a learning framework to produce three types of outcomes:

1. **Instrumental**: Tangible, practical knowledge that can be done and applied in daily work
2. **Communicative**: Mutual understanding of the issues and challenges
3. **Emancipatory**: Types of learning that break people free from existing paradigms and biases

Presentations and commentary were posted during and after the conference to the MHCC's Collaborative Spaces website (www.mentalhealthcommission.ca/English/mhcc-collaborative-spaces) and are available to all meeting participants. Further commentary is available through the conference Twitter feed at #MHPolice.

This report captures important and timely discussions and their positive implications for police, mental health service providers, people living with mental health problems and mental illnesses, communities, and all Canadians. Both for those who attended and those who were unable to participate in the conference, this report is intended to share the understanding of the issues discussed over the two days and help drive positive change to improve interactions.

ACKNOWLEDGING THE SCOPE OF THE ISSUE

Diabetes affects 2.4 million Canadians and is considered an epidemic; yet more than seven million Canadians are living with mental health issues and their problems are not given the same attention.

One in every five people in Canada will experience some form of mental health problem during their lifetime. Vancouver Police Chief Constable and CACP President Jim Chu said interacting with and managing people with mental illness is the "number-one issue" facing police.

Despite the fact that it is not usually top of mind for officers when they join, serving people living with mental illness is a core part of policing. The vast majority of persons with mental illness are more likely to be victims of crime than perpetrators, with those in crisis 23 per cent more likely to be victims of violent crime than the general public.

Chief Chu said that for his police service, partnering with community mental health agencies has decreased negative incidents and improved interventions, averting crisis situations that are not only higher risk but also labour intensive. Police in Canada want education, training, and collaboration with community and mental health agencies to create strategies that focus on prevention and de-escalation instead of the use of force.

Louise Bradley, MHCC President and CEO, noted that we, as a public, ask police officers to continually put themselves in harm's way. She expressed her belief that it is impossible for an officer not to be affected by constant and chronic exposure to what they experience at work. "The least we can do is offer them the tools to protect their own mental health," she remarked.

Ms. Bradley called on all attendees to take this opportunity to share their knowledge and help create a body of evidence-based practices — starting with the education and training that police receive.

"I asked a group of officers, 'How many of you joined the police to work with the mentally ill?' No one raised their hand."

Chief Constable Jim Chu, O.O.M..
Vancouver Police Department
President, Canadian Association of Chiefs of Police

OPENING REMARKS

Chief Constable Jim Chu, Vancouver Police Department; President, CACP

Louise Bradley, President and CEO, MHCC

Norman E. Taylor, Net-L3.com

POLICE EDUCATION AND TRAINING IN MENTAL HEALTH:

Before the First Reponse

> "Somewhere in their initial training and orientation, police need to come in contact with the people they'll be working with on a daily basis."
>
> Dr. Dorothy Cotton, PhD, C. Psych, Psychologist

When people with mental illness are treated fairly and feel respected in their contact with police and other criminal justice and correctional services — when they have a sense of "procedural justice" — they are more likely to be cooperative. That makes interactions safer for everyone involved. To provide that sense of procedural justice, police need education and training in how to more effectively engage with people who have mental illnesses.

PROMISING PRACTICES FOR POLICE EDUCATION AND TRAINING

At the request of the MHCC, Dr. Terry Coleman and Dr. Dorothy Cotton previewed the findings from an upcoming comprehensive review of best practices for police services in preparing police personnel to engage with people experiencing mental health problems and mental illness.

Their study — a follow-up to their previous studies in 2008 and 2010 — included responses from 12 Canadian police colleges and 32 Canadian police agencies, as well as a review of literature from Canada, Australia, the United States, and Ireland.

Police academies do a decent job of "factual training" — teaching personnel how to recognize the signs and symptoms of mental illnesses such as schizophrenia and bipolar disorder — and increasingly emphasize verbal communication and de-escalation. Drs. Coleman and Cotton noted, however, a number of areas in which police education and training could improve:

- **Inclusion of people with lived experience of mental illness in curriculum design and delivery.** Dr. Cotton challenged police services: "if you would consult an ethnic community when an issue arose, why not engage with people with mental illnesses?"
- **Inclusion of mental health practitioners in curriculum development.** This ensures accurate, up-to-date knowledge. As well, connecting police and practitioners helps police know who to call for advice. Many police personnel today don't feel they have someone with whom to confer.
- **Selection of instructors and facilitators.** Trainers are often chosen for logistical reasons and not necessarily outcomes; however, mental health professionals or people from disciplines other than police could be used in these roles. Moreover, use-of-force instructors might be good at training for "use of force" but not de-escalation/defusing and verbal communication, which are vital to understanding the behaviour of people with mental illnesses.
- **Suitability of education and training for adult learners**. Learning programs should use a variety of media for adult learners, not just traditional lecture formats. Techniques such as roleplay (used by Edmonton Police and by police in British Columbia during Crisis Intervention and De-escalation [CID] training)

are powerful. Some larger agencies and police colleges hire educational specialists to design suitable curricula for adult learners. This should be encouraged.

- **Suitability of training for diverse target groups**. In addition to first responder police officers, mental health learning should be relevant to cadets, field training officers, supervisors, managers, leaders, joint response units, crisis negotiators and others. The MHCC's 2014 *TEMPO: Police Interactions, A report towards improving interactions between police and people living with mental health problems* provides a multi-level learning framework for these different audiences.
- **Assessment of outcomes**. Data relative to education and training outcomes are scarce. One possible solution might be to conduct satisfaction surveys throughout the mental health community to determine if police learning is perceived as effective.
- **Communication between academies and police agencies.** Larger police colleges and academies that provide basic training do not always communicate with the receiving agencies/detachments about potential gaps in learning, such as understanding local mental health legislation.

Education and training are ultimately only part of the solution, not the complete remedy. Improving interactions between police and people living with mental illnesses — especially those in crisis — demands what Coleman and Cotton call an integrated "systems approach" involving the full spectrum of agents, agencies, and expertise, including people with lived experience.

POLICE AND MENTAL HEALTH TRAINING

Day 1, Feature Segment 1

Dr. Terry Coleman, M.O.M., PhD, Public Safety Consultant

Dr. Dorothy Cotton, PhD, C. Psych, Psychologist

Dr. Amy Watson, PhD, Associate Professor, University of Illinois at Chicago

Marc Desaulniers, Manager, Centre for Disciplinary Knowledge, École Nationale de Police du Québec

MODERATOR: Norman E. Taylor, Net-L3.com

LESSONS FROM THE UNITED STATES

Speaking to the U.S. experience, Dr. Amy Watson shared her research on one specific approach to training for and responding to interactions with people in crisis: the Crisis Intervention Team (CIT) model.

It has been reported that 10 per cent of police calls respond to incidents involving people with serious mental illnesses. These calls are perceived to involve higher risk, leading to arrests and sometimes fatal use of force. The CIT model was initiated by police, but has been further developed collaboratively by police, mental health advocates, and other stakeholders to enable diversion from the criminal justice system and greater safety for all.

The CIT program involves 40 hours of specialized training in the signs and symptoms of mental illness, de-escalation techniques, dispatch routing (to direct calls to trained officers), and available resources and options.

Going beyond just training, it also involves establishing a single point of entry to psychiatric services, partnerships with community providers and people with lived experience, and changes in police and health provider policies and procedures. Today there are some 2,700 CIT programs active worldwide, including at all levels in the United States. In some jurisdictions, advanced training for working with juveniles and military veterans is also available, along with refresher and in-service training.

POWERFUL OUTCOMES

While CIT programs are difficult to study, in part because data from police agencies are difficult for researchers to access, in Chicago — where 1,700 officers have been CIT trained — a 2008 National Institute of Mental Health (NIMH) study found that CIT-trained officers directed 18 per cent more calls to mental health services than their non-CIT peers, made fewer arrests, and used less force even when encountering greater resistance. As a result, the community expressed higher levels of confidence

> "Successful interactions need a systems approach, not just education and training."
>
> Dr. Terry Coleman, M.O.M., PhD, Public Safety Consultant

> “Contact with people with lived experience makes training stick. Even five or six years after going through CIT training, officers will say, ‘I remember that panel’ or ‘that roleplay’.”

Dr. Amy Watson, PhD, Associate Professor, University of Illinois at Chicago

in the police department’s response to mental health disturbance calls.

One key element of CIT training is its use of roleplay scenarios. In Chicago, early efforts involving the use of professional actors did not work well, but once the CIT coordinator connected with a community mental health arts group, the role-playing component became highly effective.

Dr. Watson’s current research involves speaking with officers who identify mental health calls on shift, as well as the subjects of the call-for-service to see if they meet the criteria of serious mental illnesses, then following those subjects (with permission) over 12 months to observe the course of their lives and any further interactions with police. This is partly to explore the question of repeat responses, which might belie ineffective linking to mental health services.

Dr. Watson acknowledged that there are challenges with the CIT model. In Chicago, services are not available equally across the city. Mental health budgets are under pressure. And three-quarters of individuals brought to hospital are not admitted, suggesting the need for a clinician to be available to consult with officers. One idea currently on the table is training all patrol officers in CIT, although some feel only officers who want to respond to mental health calls should be trained.

AN IMMERSIVE, WEB-BASED APPROACH

Marc Desaulniers, Manager of the Centre for Disciplinary Knowledge at the École Nationale de Police du Québec (ENPQ), presented a unique, interactive modular web documentary for police on how to interact successfully with people with mental illnesses. Featuring five hours of video and nine themes — including crisis dynamics, suicidal tendencies, and how to connect with someone in crisis — the comprehensive documentary exposes viewers to a wide range of perspectives: police, people with lived experience, experts from the mental health field, and others. The presentations are structured to support live training, with countdowns so trainers pause the videos and engage with students. The presentation is specific to Canada. It is currently available in French only, but the ENPQ is actively seeking partners interested in translating it to English.

QUESTIONS FROM THE FLOOR

"How close are we to evidence-based training?"

WATSON: We're not quite there. With CIT, there is some evidence the training is helpful, but we don't have a handle on the other elements.

COLEMAN: The U.S. is closer; Canada is still a long way from evidence-based practice. We rely on other countries, which doesn't always translate.

COTTON: Police personnel aren't always trained in research design. In Alberta, you see police working with researchers, but it can be hard for "outsiders" to go into police agencies. We might want to think about partnerships between academics and police, bringing the two worlds together.

"I want to know my police service is providing appropriate levels and standards even if I don't know the details of training. What about national standards?"

TAYLOR: There are different kinds of standards, which is important. Standards are not a decree. Look at ISO: it is something to aspire to. Some people thought TEMPO was a one-size-fits-all framework, but it's not. It's comprehensive and can be modified.

COLEMAN: TEMPO is excellent for gap analysis even if the program itself isn't adopted. I hope it or something similar would become a standard measure for programs, with allowance for the programs themselves to be adjustable to local realities. There has been some discussion that instructors could submit nominations for awards of excellence to recognize good training.

COTTON: Another option is certification at the individual officer level for basic competencies.

NEW MODELS OF COMMUNITY SAFETY:
Collaboration is Critical

"We are moving from *need to know* to *need to share*."

Tom North, Manager, Open Government, Policy and Strategic Planning Division, Ministry of Community Safety and Correctional Services

OPPORTUNITIES ARISING FROM NEW MODELS OF COMMUNITY SAFETY

Day 1, Feature Segment 2

Dr. Brian Rector, PhD, RD, Psych., Executive Director, Research and Evidence-Based Excellence, Saskatchewan Ministry of Justice, Corrections and Policing

Dave Nelson, RPN RSW, Executive Director, Saskatchewan Mental Health Association

Tom North, Manager, Open Government, Policy and Strategic Planning Division, Ministry of Community Safety and Correctional Services

Heather Gilmore, Peer Specialist, RainCity Housing

Jodie Foster, Family Nurse Practitioner, Team Leader, ACT Team, RainCity Housing

Moderator: Sergeant Brent Kalinowski (Retired)

Innovative, outcome-focused programs have evolved across Canada over the past several years to improve outcomes for and interactions between police personnel and people with mental illnesses. In the most successful models, clients have safe places to live, engage in peer support, and receive interdisciplinary support from teams including police, health care providers, and mental health workers. Collaboration of this magnitude requires the sharing of time, goals and — crucially — information. Knowledge exchange is essential.

RISK ASSESSMENT AS A KEY STEP TOWARD PREVENTION

Saskatchewan's collaborative, risk-driven models for community safety and wellness provide an example of how inter-agency collaboration can be effective to reduce recidivism, increase public safety, and improve quality of life for people living with mental illness.

The province found that while chronic offenders represent a small percentage of the total offender population, they consume a disproportionate amount of time and resources. Dr. Brian Rector explained how Saskatchewan's Ministry of Justice – Corrections and Policing Division is working to change that. In partnership with the Saskatchewan division of the Canadian Mental Health Association (CMHA), it has established the Justice Community Support Program (JCSP).

Today, as part of the police risk-assessment process, a team working with Saskatchewan's high-risk and chronic offenders reviews each client's pattern of offence and recidivism, nature of offences, and relevant unique circumstances — from culture and language to developmental disabilities — so that prevention and risk-management approaches can be tailored to the individual.

Those approaches have two primary components: risk *management* — steps that can be taken immediately to address the risk as it exists; and, risk *reduction* — rehabilitation interventions that can be introduced to decrease the likelihood of a crisis or the chance of re-offending over time. Dr. Rector acknowledged that this kind of prevention model requires increased capacity (i.e., more people) in police, mental health, and social services teams.

Dave Nelson of the Saskatchewan CMHA explained how the JCSP seeks to maintain clients' mental health and promote engagement of community-based treatment and services while addressing risk factors that promote offending and re-offending.

Case workers at JCSP focus on "stabilizing the basic needs" of high-risk and chronic offenders who have been diagnosed with a mental illness, brain injury, or addiction. Workers ensure these offenders have a safe place to live, nutritious food to eat, the right medications, and the proper ID to access a full range of

social services. The program is regarded as innovative in its area and a powerful example of collaboration at work, involving police, mental health, addictions services, and others.

THE IMPORTANCE OF INTEGRATED INFORMATION

Open Government Ontario enables collaboration by collecting, synthesizing, and sharing information from multiple ministries and programs. Built on three pillars, Open Government Ontario aims to promote open dialogue, ensure government-collected data are "open by default," and that performance measures for government programs and services are routinely and proactively disclosed.

The Ministry of Community Safety and Correctional Services' flagship Open Government initiative is an implementation of an Ontario Crime Prevention Strategy that promotes multi-sectorial responses to complex societal issues and helps Ontario communities plan for local crime prevention, community safety, and wellbeing. With data shared openly across communities, the initiative will make it possible to cross-reference and analyze multi-agency data. Open Government Ontario is working on an agreement with Statistics Canada to link individual-level data across larger data sets.

Presenting on Open Government Ontario, Tom North described a further Ministry of Community Safety and Correctional Services project looking specifically at reviewing police interactions with persons with mental illnesses – baselining current policies, practices, and training; reviewing coroner jury recommendations over the past 25 years; and, describing the legislative framework related to police interactions. A second phase of the project will look at a wide range of issues, from learning approaches to multidisciplinary response teams to funding mechanisms that can improve outcomes.

DEALING WITH SOCIAL DETERMINANTS

In Vancouver, the Assertive Community Treatment (ACT) teams supporting RainCity Housing include a powerful combination of police, nurse practitioners, psychiatrists, substance abuse counsellors, and social workers, who take a Housing First approach, which is proving to have significant benefit for both clients and the community. By combining housing and supports, ACT teams are improving the physical and mental health of their clients, and empowering them through choice and social inclusion. By providing places to live and wrap-around, recovery-oriented supports, they improve interactions with the criminal justice system, while reducing the number of emergency visits, and the need for police interventions.

EFFECTIVE APPROACHES TO CRISIS INTERVENTION

There is no shortage in Canada of innovative, often collaborative programs that are improving the ways police engage with people who have mental health problems and illnesses.

When police who are educated and trained in mental health intervention are paired with mental health service providers, the strain on emergency rooms is reduced, successful diversion increases (with fewer arrests and charges), and individuals are taken to emergency rooms more appropriately. As well, by means of collaboration, police can access health sector resources so they are not carrying all the costs of providing high-quality responses to the needs of people with mental health problems.

Model programs from five jurisdictions were profiled at the conference, shining a spotlight on the unique ways police, mental health, and community service

> "Housing First is the precursor to maintaining client mental health and overall community safety, as homelessness is a prime motivator for crime and has a profound influence on physical and mental health."
>
> Jodie Foster, Family Nurse Practitioner, Team Leader, ACT Team, RainCity Housing

CRISIS INTERVENTION SERIES

Day 1, Showcase Segment 1

Sarah Burtenshaw, COAST Mental Health Worker, St. Joseph's Healthcare, Hamilton

Inspector Randy Graham, Hamilton Police Service

Inspector Sheilah Weber, Greater Sudbury Police Service

Staff Sergeant Craig Maki, Greater Sudbury Police Service

Maureen McLelland, RN, BScN, MHSc, CHE, Administrative Director, Mental Health & Addictions Program, Sudbury Mental Health & Addictions Centre, Health Sciences North

Detective Stéphane Quesnel, Mental Health Unit, Ottawa Police Service

Sergeant Erin Partridge, Vulnerable Persons Team and Police and Crisis Team,

Community and Youth Services, Calgary Police Service

Anne-Marie Batten, RN, Real Time Crisis, Toronto

Constable Scott Mills, Social Media Officer, Corporate Communications, Toronto Police Service

Moderator: Norman E. Taylor, Net-L3.com

groups can complement each other's work. Emerging from the presentations were several key considerations for organizations seeking to adopt similar approaches.

1. **Everything starts with the needs of the community.**
   The model has to fit. Sudbury, for example, which covers the largest geographic area of any city in Canada, and which receives fewer than two mental health-related police calls per day, would find a "ride-along" program like Hamilton's COAST to be impractical.
2. **Organizational buy-in is key.**
   From leadership on down, all organizations involved in a collaborative initiative must be committed to the process.
3. **Partnership can increase available resources.**
   Jurisdictions have been able to leverage health system dollars to support police work (e.g., in Ontario, Local Health Integration Networks; in Alberta, Alberta Health Services).
4. **Follow-up is essential.**
   Post-implementation, it is important to take stock of results (of processes, as well as ultimate outcomes) and identify potential areas for improvement.

INITIATIVES AT A GLANCE

JURISDICTION & PARTNERS	GOALS	PROGRAM(S)	OUTCOMES
Hamilton, Ontario • St. Joseph's Healthcare • Hamilton Police Service	• Effective interactions • Shorter hospital wait times • High-volume crisis response	**COAST – Crisis Outreach and Response Team** • Plainclothes officers in unmarked car accompanied by mental health professionals • 24/7 crisis line • Specialized teams: child and youth, adult, dementia	**COAST – Crisis Outreach and Response Team** • 4,500 requests for service/yr.
		Crisis Intervention Training • 40-hour training for frontline officers, focused on de-escalation	**Crisis Intervention Training** • 272 trained officers in Hamilton • 700 trained officers in broader region • Higher hospital admission rates
		Transfer of Care • Unacceptable wait times for ~1,800 people a year brought to hospital by police • New process established by senior committee of police and hospital staff • After 30 minutes, if person is deemed low risk, officers can leave with nurse approval (based on paperwork) • If an issue, officer returns	**Transfer of Care** • 90 per cent of cases reduced from 183 minutes to 74 minutes • Zero requirement for officers to return to hospital because of escalation
		Mobile Crisis Rapid Response • Focused on high volume of downtown calls • Mental health professionals arrive in cruiser with uniformed officer	**Mobile Crisis Rapid Response** • Nearly exceeded annual target call volume (250) in first 16 weeks with 228 calls answered
Sudbury, Ontario • Sudbury Mental Health and Addictions Centre • Health Science North • Greater Sudbury Police • Canadian Mental Health Association (CMHA) • Families of people with lived experience • Aboriginal representatives • Community representatives • Sudbury Local Health Integration Network (LHIN)	• Shorter hospital wait times • Less burden on emergency department • Better access to community-based mental health care	**Community-based Crisis Response Model** • Downtown crisis centre open seven days a week, 365 days a year until 10 p.m. • 24-hour voice service with live operators doing triage • CMHA worker onsite in hospital emergency department to support people or refer them offsite • Six-stage community risk triage scale • Mandatory training for 300 police officers in partnership with CMHA	• 18 per cent fewer emergency room visits in year one • 62 per cent increase in uptake of community-based option • 40 per cent more visits by mobile team to homes and community sites • Mental health apprehensions down by 21 per cent • Hospital acceptance rate of patients increased from 46 per cent to 95 per cent

INITIATIVES AT A GLANCE Continued...

JURISDICTION & PARTNERS	GOALS	PROGRAM(S)	OUTCOMES
Ottawa, Ontario • Ottawa Police Service • Ottawa Hospital	• Better decisions by police about who to take to hospital • Better decisions about when to involve police and when to involve mental health services	**MHU Live** • Downtown crisis centre open seven days a week, 365 days a year until 10 p.m. • 24-hour voice service with live operators doing triage • CMHA worker onsite in ospital emergency department to support people or refer them offsite • Six-stage community risk triage scale • Mandatory training for 300 police officers in partnership with CMHA	• 18 per cent fewer emergency room visits in year one • 62 per cent increase in uptake of community-based option • 40 per cent more visits by mobile team to homes and community sites • Mental health apprehensions down by 21 per cent • Hospital acceptance rate of patients increased from 46 per cent to 95 per cent
Calgary, Alberta • Calgary Police Service • Alberta Health Services • Community partners	• Partnership with homelessness, addictions, and mental health service partners to provide coordinated response • Specialized teams for intervention and assessment of people with mental health and addictions issues who may not otherwise be served due to safety concerns or inaccessibility	**Vulnerable Persons Team (VPT)** • Two constables in the community participate in strategic planning on issues of homelessness, addiction, and mental health **Police and Crisis Team (PACT)** • Five constables, five mental health clinicians, and a consulting psychiatrist provide secondary response services	• Informed diversion from justice system or hospital • Shorter wait times due to pre-completed assessment • Crisis and case management • Assertive outreach to "unlinked individuals" experiencing homelessness

Toronto, Ontario
• Real Time Crisis
• Toronto Police Service
• GO Transit
• Corrections system representatives
• Health care representatives
• People with lived experience
• Educators
• Community leaders
	• Reduce suicide, which is up 15 per cent in the past 10 years, through effective use of social media (e.g., Twitter, which sees 500 million Tweets per day and has 271 million monthly active users)
	• To be a recognized leader in real-time crisis intervention and a leading authority on the positive and negative effects of social media, connecting real-time professionals in real-time interventions
		Real-Time Crisis
		• EARS model (engage, assess, respond, safety) – listening to social media chatter
		• When indication of crisis (e.g., a Tweet indicating suicide intention):
		  ◦ Respond, "I'm a nurse, can I help?"
		  ◦ Get individual off public platform into private exchange
		  ◦ Perform a mental health risk assessment online
		  ◦ Recommend response based on level of risk
		• Can utilize geotagging to locate individuals
		• Two principals currently, two other volunteers
			• Relieves burden on 911 services in multiple locations when other social media observers see someone in crisis and don't know where they are or how to respond
			• Multiple issues can be addressed: suicide, bullying, domestic violence, sexual assault, human trafficking
			• Movement toward "upstream risk intervention" — responding earlier, sharing information, minimizing risk

MENTAL HEALTH IN THE WORKPLACE:
Walking the Talk

To serve their communities and interact effectively with persons with mental illnesses, police must have good mental health themselves. Yet it is clear that for many in the police agencies, it is still considered a "career limiting" move to admit to struggling with mental health issues — raising the question of how well police are caring for themselves and their own.

CREATING A CLIMATE OF OPENNESS

The fear of having one's career side-lined and being the subject of office gossip keep many police personnel from seeking the help that they need and to which they are entitled.

Police leaders must lead by "coming out of the closet" regarding the need for and benefits of psychological care and counselling during their careers — starting at the top of the house. The most successful programs for officers are those in which leadership leads by example, speaking openly about mental health, encouraging participation in wellness programs, and facilitating collaborations that de-stigmatize mental health issues in the workplace.

Whether it is due to events in an officer's personal life, the impact of the workplace, or the ongoing exposure to trauma, police agencies must treat the mental health of its personnel with the same level of importance as they treat physical health and safety.

Collaboration between those with mental health issues, psychologists, psychiatrists, doctors, social workers, addiction counsellors, and the police is necessary to improve the lives and interactions of those with mental health problems or mental illness and society. Systemic social, structural, and individual stigma are mutually reinforcing. People who have experience of mental health issues are powerful partners in education and training.

HOW TO WEIGH THE COSTS

Dr. Patrick Baillie of the Calgary Police Service suggested that high-quality, culturally sensitive mental health services for police and their families address officers' mental health needs, help normalize their experience of mental health issues, and build understanding toward members of the public experiencing similar problems.

While many might balk at the cost of mental health workplace programs as comprehensive as Calgary's — which includes psychologists, sleep specialists, an occupational therapist dedicated to creating targeted and specific back-to-work programs, a naturopath, yoga sessions, family therapists, and more — Dr. Baillie said organizations pay whether they fund programs to support employees or fund sick time for employees who have no access to support.

"If police can't take care of themselves, they can't take care of the community."

Dr. Patrick Baillie, PhD, LL.B., Consulting Psychologist, Calgary Police Service

CONFRONTING STIGMA: MENTAL ILLNESS IN SOCIETY AND THE WORKPLACE

Day 1, Feature 3

Dr. Patrick Baillie, PhD, LL.B., Consulting Psychologist, Calgary Police Service

Chief Rick Hanson, O.O.M., Calgary Police Service

Ms. Pat Capponi, Lead Facilitator, Voices from the Street

Dr. Jamie Livingston, PhD, Assistant Professor, Department of Sociology and Criminology, Saint Mary's University

Moderator: Mr. Chris Summerville, CEO, Schizophrenia Society of Canada & Executive Director, Manitoba Schizophrenia Society

In 2012, sick leave days for staff who eventually accessed psychological services cost the Calgary Police Service $208,000. Forty-two percent of those who accessed the services had no sick days following treatment.

Police agencies with full-time clinical psychologists on staff — such as Calgary — give officers a safe opportunity to "unpack" and make sense of their experience on the job. Fostering understanding and empathy leads to better interactions and outcomes for all.

LEADERS SET THE TONE

Leaders who are open about mental health "tune-ups," positioning their own mental health as they would the need for an annual physical, help normalize the mental health conversation in the workplace. This style of leadership is sometimes called Management by Walking Around (MBWA).

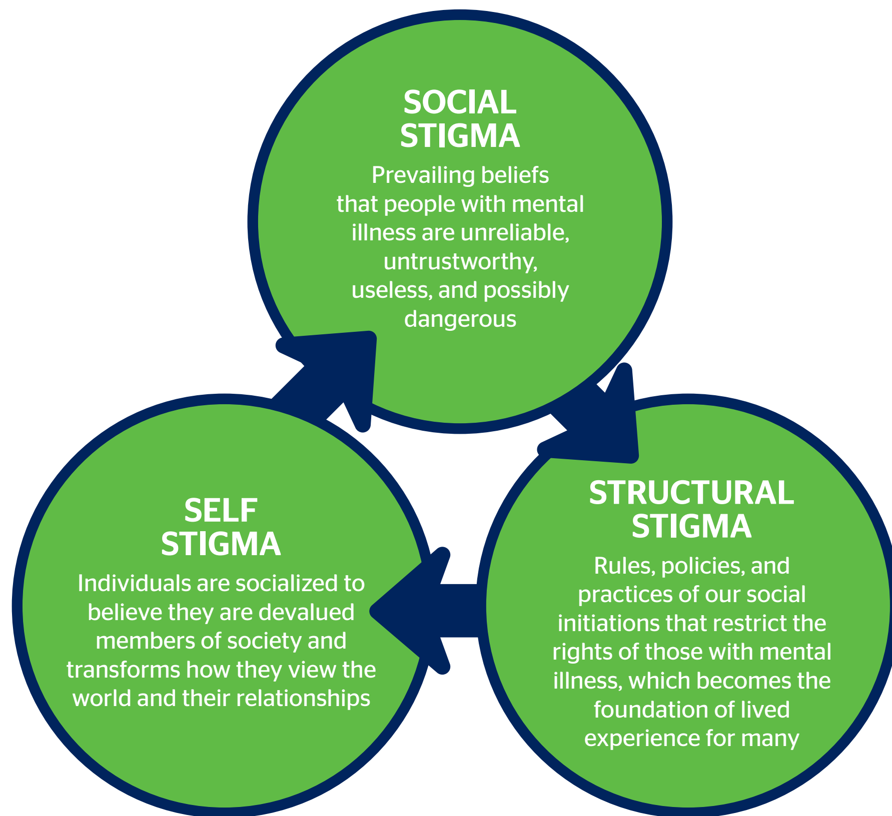
Often, workplace mental health programs are considered only in the context of personnel needing to work through trauma of some kind. What is overlooked, however, is the day-to-day grind of the job itself — the office culture of police that is competitive, pitting partner against partner when it comes to promotions. In addition, officers can feel unsupported by their co-workers and superiors when the media is critical of police action, leaving many officers feeling like "sacrificial lambs" at work and disliked by some of the public for which they work.

It is this feeling, this unspoken and unacknowledged truth of police work, that is costing lives by causing officers to take their own. While partners have "each other's back" on the street, they also need to learn how to take care of one another on an emotional level and have "each other's backs" when it comes to office gossip and politics. Again, leadership has an important role to play here in training officers how to relate to one another beyond "tough talk" and leading in times of crisis.

Chief Rick Hanson of the Calgary Police Service talked about the adoption of a program developed by the Canadian Forces that encourages peers to look out for one another. The program, R2MR (the Road to Mental Readiness), places mental health on a continuum rather than regarding people as OK or not OK in black-and-white terms, allowing officers to discuss how they feel without fear of being pulled off the job or being isolated by their peers. R2MR is in the early stages of adoption and adaptation by the Calgary Police Service and warrants ongoing follow-up regarding outcomes.

DISMANTLING STIGMA

So how do we go from talking about mental health in the police workplace to



addressing mental illness and its associated stigma in the broader context of society? Stigma around mental illness is pervasive and not unique to police services, though perhaps more difficult to break down due to ideas of police being "tough" and in control. Removing stigma allows for better interactions — focused on the individual, not biases or misconceptions about their mental illness — and improves outcomes.

The structural stigma of mental illness is a cycle, with each level feeding and reinforcing the others:

The result is a society continuously designed to further marginalize people with mental illness.

How does this systemic model play out in the real world? First, there is a widely held belief that people with mental illness are dangerous, causing institutions to focus on confinement and exclusion. This discourages some people from seeking help because they do not want to be coerced; they do not get treatment until they are in crisis, and then interact with police, seemingly confirming what the public believed in the first place.

Second, the stigma attached to mental illness compromises privacy. Police in many jurisdictions have historically disclosed people's mental health issues as part of routine background checks, which can cause people with mental illness to be excluded from working and/or volunteering, further pushing them outside of society.

The next question becomes, how do we begin to improve the lives and interactions of those with mental health problems and mental illness and society? The answer is by learning from and listening to those who know it best — those with lived experience.

> "It takes courage to reach out and to bring people to the table. We have a lot to say and an extraordinary amount to offer and number of people who are chomping at the bit to make a difference."
>
> Ms. Pat Capponi, Lead Facilitator, Voices from the Street

THE NEED TO INVOLVE PEOPLE WITH LIVED EXPERIENCE

Ms. Pat Capponi, an author and mental health and poverty advocate, said, “We are capable and powerful partners in program design and delivery, policy formation, training, and education, by being able to speak to and from our experience.” Capponi has used her own lived experience to forge relationships and build education, training, and awareness programs with the Centre for Addiction and Mental Health (CAMH) and police.

Equality of voice, in the development and deployment of these programs that she helped author, was key. Education, advanced degrees, or a badge, she shared, are not worth more and do not trump the value that the perspective of one with lived experience can bring. The voice of lived experience brings integrity and authenticity and builds empathy and understanding.

There is a growing base of evidence that shows listening, collaboration, and reciprocity are effective tools in dismantling the mechanisms that perpetuate stigma.

REFLECTIONS ON DAY 1

Setting the stage for Day 2 of the conference, moderator Norm Taylor acknowledged the high energy and commitment of attendees, and the clear willingness to share and collaborate. Reiterating that the entire event was built on a learning model, Taylor asked, “What are we learning collectively?”

Responses from the floor included:

- **Partnership is critical.** Police have historically tried to do things alone, and across policing, justice, corrections, and health there have been silos. “Obviously with this issue, we need partners.”
- **We need to be more public about our successes.** The work being done across the country is significant. We need to talk about our stories — not be so “Canadian” about them, or worry that because we’re trying new things someone will take our funding away.
- **We need to keep looking for best practices and develop standards.** Different jurisdictions can have consistent, evidence-informed models to adopt, such as TEMPO. The more people use and evaluate TEMPO, it could become a standard.
- **We have to talk about mental health funding.** Funding is not legitimized in the main health care system, which is a reflection of how society prioritizes (or doesn’t prioritize) the issue.
- **We need to involve people with lived experience of mental illness and victims of crimes committed by persons with mental illnesses.** There needs to be better support for victims.

Judges need this education as much as anyone. Courts can do a lot of good, but also harm, if not working collaboratively. Collaboration is essential because isolated, individual efforts can amount to “putting a band-aid on a cancer.”

THE NEED FOR SYSTEM CHANGE:
Promoting Recovery, Rehabilitation, and Quality Of Life

While people with mental illnesses are more likely to be victims of crime than perpetrators, they are over-represented in Canada's correctional system — suggesting the criminal justice and corrections systems deserve closer examination. How do people with mental illnesses interact with the courts? And more importantly, how does the system interact with them?

SEE THE VALUE OF THE PERSON IN FRONT OF YOU

At the end of the day, most people who engage with the criminal justice and correctional systems want to feel respected, valued, and cared for.

The *Hope Not Jail* project in Halifax, Nova Scotia, is one initiative trying to get at a human understanding of how people come to be involved with the criminal justice system. Looking at a variety of social determinants — including family, housing, gender, and culture — researchers have interviewed people with firsthand experience of the system, inquiring about their "tipping points and turning points," as Dr. Crystal Dieleman put it. That is, what was going on in their lives when things started to go badly and when did they start to experience recovery?

Two-thirds of the way through its mandate, the project is currently working on its analysis of the stories collected (and compiling them into a digital presentation for sharing, recognizing the power of storytelling to shape ideas and attitudes). The next step will be to create strategic action plans to promote mental health and recovery and reduce criminal justice involvement.

Dr. Dieleman pointed out that interactions with the criminal justice system occur along a continuum and, on the "official" side, are affected by the skills, attitudes, and orientation of the individuals involved. At the centre of the continuum is someone who does his or her job well, is respectful, shares information, and operates within standards of practice. Toward the extremes of the continuum, performance may be better or worse.

For service providers, the question is: what kind of impact do we want to have?

CRIMINAL JUSTICE AND THE COURTS' RESPONSIBILITY IN ADDRESSING MENTAL HEALTH ISSUES

The Honourable Judge Raymond Wyant gave an answer to Dr. Dieleman's closing question from his perspective as a member of the Provincial Court of Manitoba. He challenged some recent notions about alternative courts, admitting that while he had championed the implementation of therapeutic courts in Manitoba (which take a holistic, rather than punitive, approach), they have proved expensive for governments and typically process only a small number of people.

More recently, the idea of mental health courts has gained traction in papers and scholarly journals, but Judge Wyant cautioned that these courts can be coercive or keep people in custody for extended periods on remand. He suggested mental health courts still do not address why a person is charged to begin with — or

RECOVERY, REHABILITATION AND QUALITY OF LIFE

Day 2, Showcase Segment 2

Dr. Crystal Dieleman, Principal Investigator, Assistant Professor, School of Occupational Therapy, Dalhousie University, Hope Not Jail Project, Halifax

Robin Campbell, MRM, Dalhousie University, Project Coordinator, Hope Not Jail Project, Halifax

The Honourable Judge Raymond Wyant, Provincial Court of Manitoba

Jonny Morris, MA-CYC, Director, Public Policy, Research & Provincial Programs, Canadian Mental Health Association, BC Division

might need to be charged — and said he was not convinced we do not continue to criminalize people who come into contact with the criminal justice system because of their mental illnesses. He also said he was not sure people with mental illnesses receive the least severe penalty, as required under the Criminal Code.

Finally, Judge Wyant observed it is difficult to "pigeonhole" people with mental illnesses. Some have cognitive difficulties, some may suffer from poverty or homelessness or substance addiction issues. Very focused courts might miss the need for basic assistance: housing, literacy, and addictions services.

What is needed instead is understanding, training, and collaborative effort among agencies that are both internal and external to government, educating everyone involved in how to recognize, access, and work with people experiencing mental health issues. Judges need this education as much as anyone. Courts can do a lot of good, but also harm, if not working collaboratively. Collaboration is essential because isolated, individual efforts can amount to "putting a band-aid on a cancer."

Like Dr. Dieleman, Judge Wyant ended with a series of questions: What do we want from our criminal justice system? What do we need to prosecute, and are there people who do not need to go through the criminal justice system?

CONSIDERING THE CONTINUUM OF CARE

The criminal justice system has three main "intersections:" when people enter into custody, the period during which they are in custody, and when they're released. Jonny Morris of the BC Division of the Canadian Mental Health Association (CMHA) described a research project looking at ways of creating change within that continuum, bringing justice and health closer together.

Involving people with lived experience, allied organizations, health service providers, and corrections staff is essential. So is "journey mapping" — diagramming and documenting how people experience the system. With clear understanding of the current state, a framework can be built that suggests different options at each intersection. CMHA BC is currently focusing on re-entry into the community and community corrections, believing that is where the greatest return on investment can be realized.

Morris noted that change is happening. In 2013, British Columbia health authorities, correctional staff, wardens, people with lived experience, and government representatives joined together to address the fact that while in prison, a person who is approaching psychosis has only one place to go — a solitary cell — which would not be acceptable in the civil system.

The desired future state for British Columbia would be one in which greater diversion occurs, where people in prison can access equivalent mental health care to those in open society, and where release and transition processes are coordinated and integrated — where every door is the right door. As Morris noted, releasing inmates who have mental illnesses with just three days of medication and no doctor is going to have consequences.

MEASURING OUTCOMES AND SUCCESS:
How do we know when we're getting it right?

> "Language is the bridge that will help synchronize the systems."
>
> Dr. Ron Hoffman, Coordinator, Advanced Patrol, Coach Officer & Mental Health Training, Ministry of Community Safety & Correctional Services, Ontario Police College

What do we do when police services and health agencies do not speak the same language? How can we measure and evaluate efforts to ensure better outcomes?

SPEEDING UP TRANSFERS OF CARE

Dr. Ron Hoffman, Ontario Police College, described the interRAI Brief Mental Health Screener (BMHS) as a tool for facilitating relationship building and communication between police services and hospital staff. The BHMS is used when officers encounter someone they have reasonable grounds to believe has a mental health disorder. It articulates the key indicators for a serious mental disorder in the language of health services based on the hospital database, aligned with behaviours common in police apprehensions.

By establishing common ways of describing and understanding behaviour, the criteria for hospitalization versus other types of interventions are clearer. As a result, hospitals are ready to accept transfers of care from police more quickly because the BHMS has already established grounds for admittance. This means less time spent in hospital waiting rooms for those in need of help and police waiting to release a person into the hospital's care.

Barb Pizzingrilli, a registered nurse in the Niagara Region health care system, implemented the BHMS in April 2013 with the Niagara Regional Police. She reported that her hospital found emergency room wait times for police decreased from three hours to less than one hour. Transfers of care accelerated, and program participants reported anecdotally that relations between hospital staff and police have improved.

COLLABORATIVE MEASURES OF SUCCESS AND OUTCOMES

Day 2, Feature Segment 4

Dr. Ron Hoffman, Coordinator, Advanced Patrol, Coach Officer & Mental Health Training, Ministry of Community Safety & Correctional Services, Ontario Police College

Barb Pizzingrilli, RN, BN, MN, CPMHN (C), MBA, Manager, Program Development and Evaluation, Niagara Health System, Assistant Clinical Professor, Faculty of Health Sciences, McMaster University

Rebecca Kong, Chief, Policing Services Program, Canadian Centre for Justice Statistics, Statistics Canada, Co-Chair, CACP Police Information and Statistics Committee

Staff Sergeant Howard Tran, Mental Health Unit, Youth Services Section, Vancouver Police Department

Inspector Ralph Pauw, Youth Services Section, Vancouver Police Department

Linda Stewart, Instructor, Police Academy Recruit Training and Advanced Police Training, Justice Institute of British Columbia

Superintendent Carolyn Bishop, York Regional Police Service

Superintendent Robert Gould, Waterloo Regional Police Service

Inspector Mitch Yuzdepski, Saskatoon Police Service

Moderator: Cathryn Palmer, Edmonton Police Commission, President, Canadian Association of Police Governance

Perhaps the greatest change comes from what Dr. Hoffman referred to as the "synchronizing of the systems:" that when police and health care providers begin to use the same terms of reference and contribute to and access the same databases for information, it eventually filters through to training and education programs for police services — changing the ways police approach their jobs.

As programs like BMHS take hold in various jurisdictions, what is coming to the fore is that most health care agencies do not have community safety articulated in their mandates and work plans. When public safety is not recognized as part of their work, it can be difficult to forge relationships and get the support and uptake needed. This is a significant gap that, when filled, will further support the development of more tools like the BHMS.

DATA SHARING BETWEEN POLICE AND HEALTH SERVICES

In Vancouver, collaboration between police and Vancouver General Hospital has resulted in the Assertive Community Treatment (ACT) program. The goals of ACT are to reduce hospital wait times and improve quality of life for those with mental illness. Hospital wait times are easy enough to measure, but quality of life is more challenging. Improved how, by what measure, and from whose perspective?

The cross-disciplinary ACT team built a comprehensive database of individuals with mental health issues and prior encounters with the police, drawing from multiple sources including the criminal justice system, hospital, social services, and mental health care agencies. Together, these provide a profile of each person in the system, which includes information such as offence patterns, personal history, prescribed medications, known addictions, activities in other jurisdictions, personal triggers for crisis by precipitating events, and time of year.

The database's dashboard interface provides an early warning system that lets police know the wellness status of the top 20 to 30 most vulnerable people by charting their activities, the interplay between factors, and when the ACT team should implement prevention or intervention strategies.

This level of detail can be powerful when it comes to providing a specific and personal prevention or intervention strategy by keying in on the elements that created a previously successful outcome for that client. Of course, such information about any one person's life consolidated in a single place poses risks of its own: in presenting the dashboard, Staff Sergeant Tran was quick to point out that the information is not shared with anyone outside the mental health community.

ASSESSING OUTCOMES

With both ACT and BMHS, police, mental health agencies, social service, and hospital teams are working better together. These programs improve relationships among the various players and prepare them to anticipate and respond to mental health crises in the community. Two significant questions emerge from their work:

1. How can we develop innovative, personal, and evidence-based intervention programs that do not violate the privacy rights of the individual?
2. How do we measure the outcomes of these programs beyond the quantitative to include qualitative results?

Ontario's Open Government, Statistics Canada, and various police jurisdictions feel that by connecting multiple systems that house different types of data, we can create even more robust approaches to prevention and intervention for those with mental illness. But how many people are truly comfortable with, for example, criminal justice, and mental or physical health treatment records being available in one place? Will those with lived experience be more or less likely to seek treatment if they know everything they have ever said or done is available at the touch of a button? Would this onslaught of information in the hands of those meaning to do well result in more or less coercion?

The measurement data presented on these programs shows progress and success, from the perspective of the program deployers; statistics are indicating reduced wait times, better utilization rates of police and health workers, and numbers of people in various programs. What is yet unclear is if anyone is asking the clients about their lived experience as recipients of these programs.

CONCLUSION:
We are all Agents of Change

Communication, collaboration, and breaking down silos are all vital to improving interactions between police and people with mental illnesses. The full continuum of resources needs to be engaged in addressing the treatment of people with mental health problems, needs, and illnesses: mental health prevention and promotion agencies, community service organizations, police, the courts, corrections, and re-entry organizations. All parts must be represented.

A PERSON, NOT A DIAGNOSIS

To close out the formal presentations of the conference, Jennifer Chambers from the Centre for Addiction and Mental Health's Empowerment Council shared thoughts and recommendations from the perspective of people with lived experience. She said her community has been clear that people want to be known as individuals, not by their conditions.

Empowerment Council recommendations based on inquests it has attended include:

- Encouraging crisis resolution and de-escalation, active listening, and keeping distance during interactions
- Including people with mental health issues in planning and training
- Evaluating training for effectiveness
- Having ministerial support for training at the division level, not just in colleges
- Increasing awareness of the influence of on-the-job culture and how it affects the way training is realized on the street
- Addressing stereotypes on all sides (people with lived experience are not immune to them) and reducing prejudice and discrimination
- Expanding services people want to use

Chambers observed that the mental health system is not a panacea for solving criminal justice system problems, saying both systems need to critically self-examine. She also reinforced the importance of focusing on social determinants of mental health. "No one will do well worrying about their next meal," she said. Everyone involved with mental health issues is a potential agent of change: a full collective effort is needed to make the kind of paradigm shift required for lasting improvements.

NEXT STEPS

We need to seek "whole-system" solutions. The categories of concern around mental health are not distinct: police, health care and mental health services, peer support, the courts, corrections — they overlap, and all parts need to self-examine

CONSOLIDATION

Dr. David S. Goldbloom, MD, FRCPC, Chair, Mental Health Commission of Canada; Senior Medical Advisor, Centre for Addiction and Mental Health

Chief Constable Jim Chu, O.O.M., Vancouver Police Department; President, Canadian Association of Chiefs of Police

Chief Matthew Torigian, Waterloo Police Service

Louise Bradley, President and CEO, Mental Health Commission of Canada

Jennifer Chambers, Coordinator, Empowerment Council, Centre for Addiction and Mental Health

Moderator: Norman E. Taylor, Net-L3.com

“We all need to be de-escalated now and then — police and people with mental health issues. We need to see each other as human beings.”

Jennifer Chambers, Coordinator, Empowerment Council, Centre for Addiction and Mental Health

the ways they address mental health issues. Canada already has a blueprint for system improvement — the MHCC’s *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* — which acknowledges the overlap and calls for collaborative action to safeguard the mental health of all Canadians.

Approaches, education, and training, as well as interventions, should be improved and made consistent, with a focus on recovery while teaching people how to build genuine partnerships — all of which demands the active involvement of people living with mental illnesses and mental health problems. In the words of one participant: “Nothing about us without us.”

People need to relate as human beings, on all sides of the issue. The only way to find the balance is through collaboration. Starting immediately, all parties, including governments, must work to improve alignment between the mental health and criminal justice systems.

VOICES FROM THE FLOOR

“Where I am, I am the only police and crisis team … I followed up with 935 clients by myself. I do it all: assessments, stats, documentation. My RCMP partner is transferring out, no one is interested in coming in. I need to delegate. Education is a big piece I’m going back with. This conference exceeded my expectations.”

“There is a whole-system solution that needs to occur. Where do we go from here? There is humility among the leadership sitting in this room. We’re open to hearing where our successes are, where the gaps are in our organizations.”

“Probation and parole services have to be sensitive to the mental and emotional states of youth. Minimum sentences are going up; we have to be careful not to set youth on a correctional ‘career path.’”

“In the mid-1980s in Alberta, when I was advising on community and occupational health, mental health was nowhere on the agenda. We have come a long way. This has been a very full conversation with terrific ideas. If you put people first, the rest is going to happen. We know that with police services: if we look after officers and staff, they can better serve.”

“Information sharing is relevant in so many areas. Electronic health records make it easier. But it has to be strictly regulated. Some people feel safer. Others don’t want immortalization of the worst moments of their lives. It’s controversial. We need to proceed very thoughtfully.”

“Education has to be delivered by police and MH together. Anything that will give us consistency.

“I would love to see a conference engaging the correctional world. I’ve been humbled by the presence of police superintendents here, and would love to see the same in health and corrections. I would also like to see indigenous communities weigh in at the next conference. We’re talking about western ways: what about others?”

“We need to know how people with lived experience feel about information sharing.”

SIX COMMITMENTS

Stemming from the meeting, MHCC and CACP issued a joint statement outlining six commitments to take forward together:

1. Work collaboratively toward a new national framework for police training and education that would be adopted by CACP and its membership.
2. Joint release of the updated TEMPO report (police education and training) and continued dialogue on implementation of the recommendations therein.
3. Increased focus on the mental health of police officers and mentally healthy workplaces for all police personnel.
4. Work with Statistics Canada and other key organizations to address measurement of police workload related to calls involving mental illness, and consider the collaborative development of new tools for data collection and analysis.
5. Share the results of the conference through the release of the conference report as part of a shared commitment towards ongoing collaborative learning.
6. Central to any next step will be the continued inclusion of people with lived experience of mental illness as vital stakeholders in the discussion between the mental health and police leaders.

Central to any next step will be the continued inclusion of people with lived experience of mental illness as vital stakeholders in the discussion between mental health and police leaders.

CALGARY OFFICE
Suite 320, 110 Quarry Park Blvd SE
Calgary, AB T2C 3G3

Tel: 403-255-5808
Fax: 403-385-4044

OTTAWA OFFICE
Suite 600, 100 Sparks Street
Ottawa, ON K1P 5B7

Tel: 613-683-3755
Fax: 613-798-2989

www.mentalhealthcommission.ca

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