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VANCOUVER POLICE DEPARTMENT

POLICING VANCOUVER'S MENTALLY ILL: *THE DISTURBING TRUTH*

Beyond Lost in Transition

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For

The Vancouver Police Board and
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GLOSSARY OF TERMS

BET (Beat Enforcement Team)

Six squads of police officers who are responsible for working exclusively in the Downtown Eastside, conducting patrols of the area, primarily on foot.

Car 87

A Vancouver Police constable teamed with a Registered Nurse or a Registered Psychiatric Nurse to provide on-site assessments and intervention for people with psychiatric problems. The nurse and the police officer work as a team in assessing, managing and deciding on the most appropriate action.

CAD (Computer Aided Dispatch)

The primary tool used by call takers and dispatchers to electronically create and manage events, to dispatch police officers to incidents and to provide them with updated information.

Director's Warrant

If a committed patient on leave is recalled and does not return, or leaves without having been discharged, or if extended leave conditions are breached, the Director may issue a warrant that requires police to apprehend the person and return him/her to the hospital.

ERT (Emergency Response Team)

A team of police officers who are specially trained and equipped to tactically respond to high risk incidents (often described as "SWAT"). The negotiator squad often works in concert with members of the ERT to resolve situations using effective communication skills.

NCRMD (Not Criminally Responsible by Reason of Mental Disorder):

A finding by the court that an individual accused of a criminal offence was incapable of understanding the nature and potential consequences of their actions at the time the crime was committed due to a mental disorder.

PRIME (Police Records Information Management Environment):

The electronic records management system for police in British Columbia. ¹

EDP (Emotionally Disturbed Person)

PRIME defines an EDP as a subject who appears to be mentally unstable and who might pose a threat to an investigator, him/herself or others. ²

¹ Wilson-Bates, F. (2008). Lost in transition: How a lack of capacity in the mental health system is failing Vancouver's mentally ill and draining police resources. Glossary of terms.

² Police Record Information Management Environment. British Columbia Records Management System. Reference Manual. p.207

EXECUTIVE SUMMARY

On February 4, 2008, the Vancouver Police Department (VPD) released a powerful and groundbreaking report titled “Lost in Transition: How a Lack of Capacity in the Mental Health System is Failing Vancouver’s Mentally Ill and Draining Police Resources.” A key research finding was that on average one third of all police calls for service in Vancouver involved one or more persons apparently suffering from a mental health issue. Case studies of individuals in frequent contact with the police and the Criminal Justice System also illustrated the lack of capacity in the mental health system.

The 2010 LIT report follows up and builds upon the original findings of the 2008 report while also examining other areas of concern. Quantitative data and case studies are used to illustrate the challenges faced by the mentally ill and the police, society’s de facto 24/7 mental health workers. The 2010 report contains four main components and like the 2008 LIT report, is the official position of the VPD and the Vancouver Police Board.

The 2008 Lost in Transition (LIT) report made seven recommendations that included a mental health care facility that could accommodate moderate to long term stays for chronically mentally ill individuals, increased services for people who are dually diagnosed and an “Urgent Response Center” (URC) where individuals could be assessed and triaged from the street, as well as a continued increase in supportive housing in Vancouver. Other recommendations included a records system much like police PRIME for the mental health system, and improved data collection by police in BC. Finally, it was recommended that St. Paul’s Hospital (SPH) and Vancouver General Hospital (VGH) review their admission process for individuals apprehended under the Mental Health Act (MHA) by police to reduce police wait times at hospitals.

The 2010 “report card” notes that some two weeks after the report’s release, the provincial government announced a new provincial facility, the Burnaby Center for Mental Health and Addictions (BCMHA) which opened July 1, 2008. The BCMHA offers

a voluntary model of care for concurrent disorder/dual diagnosis patients with an average stay projected at 9-12 months and is currently full (100 beds) with a waiting list of some 300-plus people. In 2010 an additional 40 pre- and 40 post-transitional treatment beds were added to the BCMHA model of care. The URC was identified as one of three priorities relative to housing and treatment and health needs; however, funding and a physical site for a URC have not been allocated. The City of Vancouver and provincial government have made significant progress with respect to housing with some 2855 new, and to be built, housing units coming on line. The three-year Federal Mental Health Commission of Canada "At Home/Chez Soi" project will also bring 300 new housing units on stream. This project will examine selected population cohorts of the concurrent disorder or complex client population and compare the outcomes of different housing and treatment models. It is unknown what progress has been made to establish a more effective mental health records system to assist mental health workers in accessing information about patients both within and between health authorities as well as provincially, whereas the VPD, RCMP and other municipal police have adopted a PRIME template to better capture mental health related data and track benchmarks across BC. Extended wait times for police who have apprehended people under the MHA continues to be an issue with the average wait time being one hour 11 minutes with there still being outliers of some four to five hours at both hospitals. Other progress includes the transformation of the existing VPD/Mental Health Emergency Services (MHES) Car 87 into a unit that can address concurrent disorder or dual diagnosis clients.

One finding in Part Two of the report is that there is a high level of daily contact requiring information exchange and cooperation between police and health services in Vancouver with some 16,500 citywide such calls for service in 2009. Data from a 2007 Severe Addiction and Mental Illness (SAMI) chart also reveals the scope of the mental illness and substance abuse in BC with some 260,069 severe cases including substance use disorder, major depression, bipolar disorder, and schizophrenia.

The VPD's attempt to refer individuals to the BCMHA between January and November 2009 using the existing Car 87 service was a failure. Of the 42 individuals, 19 were categorized as "treatment source will follow up with potential BCMHA referral." This meant the subject was receiving some form of treatment in the community and the subject might be asked by their community based treatment service if they wished to voluntarily go to the BCMHA for treatment. In May 2010 the VPD discovered that Health had closed all of the files. A subsequent analysis determined that between the time the VPD referred a given individual to Car 87 and May 2010, these 19 subjects had 619 documented police contacts where they were suspects, or suspects chargeable, or charges recommended or charged with a criminal offence or listed as being involved in a mental health incident. In addition, 5 of the 19 (26%), were victims in eight incidents including assault, assault with a weapon, uttering threats and robbery with a weapon.

The VPD submits that community based treatment can hardly be described as a "success" given the high number of police contacts exhibited by this cohort and that unfortunately the police concerns regarding chronic individuals in the community who cause harm to themselves and others carry little or no weight in the health system. This implies that the Downtown Community Court must be used as the "entry point" for chronic individuals to access services despite the fact they have to commit a criminal offence in order to do so.

Two case studies, "Bill Taylor," who was featured in the 2008 LIT report, and another individual, "Karl Reid" (not their real names), illustrate the negative impact untreated mental illness and addiction have on the community. Arguably, both individuals (and the community) would be better served by an institutional model of care versus one based in the community.

A February 11, 2010 Ministry of Health news release states that 441 mental health beds have been opened across BC as part of the devolution of Riverview Hospital with further plans to develop and de-centralization the remaining 412 beds within regional facilities. The VPD submits that, given its findings, the need is great and it remains to be seen

whether this plan will provide sufficient capacity needed to address the long term institutional mental health and addiction treatment needs of the many “Bills” and “Karls” police deal with daily.

The City of Vancouver had 69 suicides in 2008 and 84 suicides in 2007. Research into suicide prevention determined that there was not a significant difference in the legal tools police in BC possess to respond to suicide attempts versus what was available in other jurisdictions. A suicide prevention measure has been approved for the Golden Gate Bridge in San Francisco (netting), but this has not been installed due to cost. Locally, a pilot project on the Lions Gate Bridge has resulted in six phones linked 24/7 to the Vancouver Crisis Centre being installed. The VPD suggests that whereas police may feel the health system should “solve” a person’s “mental disorder” and thus solve the “problem” of suicide and suicide attempts, there is no “magic cure.”

Between February 1, 2009 and February 1, 2010 the VPD identified seven suicides committed by subjects who were previously dealt with by police for issues relating to MHA or “Disturbed Person” incidents. Further analysis indicated that these individuals also had a history of having been assessed psychiatrically in a hospital or having been committed at some point during the previous two-year period for mental health issues. There were also 487 suicide attempts where the subjects had previous contact with VPD for mental health/EDP issues and had a history of having been committed, received medical or psychiatric assessment or had been previously listed as missing from an institution. Of these suicide attempts, 18 occurred on bridges. In one case study an individual committed suicide by jumping off a bridge the same day he was released from hospital. In a second incident a patient committed suicide by jumping off a bridge while out on a two-hour pass from a hospital psychiatric unit. The VPD submits that these incidents reflect in part the challenges and uncertainty medical practitioners face in determining whether an individual will take their own life or not, and the police do not have the appropriate expertise to determine whether the mental health system’s response was adequate or not. However, a more public and transparent review process regarding medical practice in this area is lacking and a formal process does not exist to

advise attending physicians either in a psychiatric unit or emergency room of a patient's suicide and the circumstances surrounding the death, so that practices may be informed by any lessons learned.

The VPD's response to a suicide incident and public admission of fault and discipline of two VPD field supervisors was contrasted with the policies of SPH and VGH that result in persons committed under the MHA and under hospital care being able to "walk away" from the hospital. These "walk-aways" resulted in the VPD responding to 126 and 104 missing person incidents at SPH and VGH respectively (230 in total) between February 1, 2009 and February 1, 2010. The average cost of police time cost per call was \$140.03 for a total of \$32,206.91.

Given that the committed individuals were suffering from a mental disorder and "acting in a manner likely to endanger that person's own safety or the safety of others," a missing person call requires a priority response from the VPD. The VPD questions why both hospitals are so relaxed about the safety of not just the committed patient but also the public and community given these criteria for admission under the MHA. These concerns were manifested in three critical incidents in the first half of 2010. The first was a "suicide by cop" scenario, the second a suicide and the third an attempted suicide. All involved psychiatric patients that had gone missing from VGH the same day as the critical incident.

The VPD's key finding is that from a "street cop's" point of view little has changed since the 2008 LIT report. There has been progress and positive outcomes in the areas of supported housing, police record management and analysis, and moderate to long term treatment services for dual diagnosed patients in a quasi-institutional environment (BCMHA). The police, however, are still responding day after day to "difficult to manage" and "treat" chronically mentally ill and addicted individuals on the streets of Vancouver. Other issues relating to suicide, suicide attempts and missing persons consume police resources, frustrate police, and in some cases endanger the lives and safety of patients, front-line police officers, other first responders and the public. From a

“Problem Oriented Policing” perspective the attempts of the police to solve these “problems” are still being hindered by the barriers of information sharing, a lack of system capacity and a lack of apparent will on the part of health system in Vancouver to adapt and change in order to work effectively with the VPD to truly solve these issues in a constructive and sustainable way. The key finding of the first Lost in Transition report was that a lack of capacity in the mental health system is failing Vancouver’s mentally ill and draining police resources; unfortunately, that tragically remains true.

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LOST IN TRANSITION

On February 4, 2008 the Vancouver Police Department (VPD) released a powerful and groundbreaking report titled “Lost in Transition: How a Lack of Capacity in the Mental Health System is Failing Vancouver’s Mentally Ill and Draining Police Resources”. The report provided research showing that on average one third of all police calls for service in Vancouver involved one or more persons apparently suffering from a mental health issue. The report also presented jarring and tragic case studies of individuals in frequent contact with the police and the Criminal Justice System to illustrate the lack of capacity in both the regular and forensic mental health systems.

The purpose of the 2010 Lost in Transition (LIT) report is to follow up and build upon the original findings in LIT and also delve into some additional areas of concern with quantitative data and case studies being used to illustrate the challenges faced by the mentally ill and the police, society’s de facto 24/7 mental health workers. The 2010 report contains four main components. Part One reviews the original 2008 LIT report’s recommendations and any progress to date while Part Two examines the level of daily interaction and information exchange needed between operational front-line police and health services, the quantitative scope of severe mental illness and addiction cases in BC and the attempt by the VPD to refer chronic mentally ill and addicted individuals to the BCMHA. Included in Part Two as well is an analysis of community based mental health and addiction treatment through a police lens. Part Three provides information regarding suicide prevention strategies and an international review of mental health legislation compared to what is available in BC to respond to attempted suicide. Part Three then examines suicide and attempted suicide incidents in Vancouver over a 12-month period between February 1, 2009 and February 1, 2010. Finally, Part Four examines the level of care, safety and security exercised by St Paul’s Hospital (SPH) and Vancouver General Hospital (VGH) relative to individuals who have been committed under the Mental Health Act.

RESEARCH DESIGN

Methodology

This report is an abridged version of a longer and more detailed report that was originally presented to the Vancouver Police Board in October, 2010. The research methodology uses a mix of quantitative data and quantitative information, primarily case studies with data extracted from three main sources, namely PRIME (Police Records Information Management Environment), CAD (Computer Aided Dispatch), and the “i2 iBase” database application. PRIME and CAD and is a powerful tool used to analyze and investigate the information and find relationships in link and entity data. Collectively, all three systems were used in the collection, collation and analysis of the data for this report. The established time frame upon which the majority of subsequent analyses were based was from February 1, 2009 to February 1, 2010. Rather than examining annual 2009 data it was decided to shift the time frame for data extraction and examination to this 12 month time frame. This was done to account for the potential one-time impact the 2010 Winter Olympics might have on mental health and/or suicide calls. This abridged report will not include the appendices with charts and spread sheets of the main report.

Where are the Police Coming From?

Before continuing it is important to provide some context for the police perspective, their constructive criticism of the health and mental health system as well as police engagement and advocacy across a range of social issues. To some extent police organizations generally adopt a more neutral stance and are uneasy being seen as a critic where government funding and resource allocation are in question.

The VPD’s adoption of community based policing and its related Problem Oriented Policing (POP) approach in the mid 1990’s created profound shifts in the policing culture. The application of POP shifted the practice of policing to include strategies that

could address the underlying causes of crime and disorder with solutions being designed to target root causes, not just the symptoms.

The LIT report and a range of strategies before and since were and are all based on the belief that police must identify the root causes of the “problems” of crime and disorder in the community rather than just respond to the symptoms. This progressive philosophy will by its very nature lead police to “seek out the truth” or “shine the light” on problems in the community as well as possible solutions. This philosophy also results in an understanding that law enforcement and the application of police resources cannot do it all alone and/or policing and law enforcement may not be the best solution; that other agencies must do their part and work with the police to solve these problems.

Therefore, given the problem solving orientation of policing and in considering the LIT finding that on average one third of all police calls for service in Vancouver involved one or more persons apparently suffering from a mental health issue, it is not surprising that the police are frustrated with the components of the health system that respond to addiction and mental health. From a police perspective the system should be responding to and solving the underlying causes of addiction and/or mental health that cause significant negative impacts on those afflicted with these conditions as well as the community in the form of crime and disorder.

Ultimately, police understand that there must be interagency cooperation for problem solving in the community and that broad responses are required. Again, the police are sometimes frustrated by the resistance of other agencies to work with them as well as interpretations of legislation with respect to the sharing of information that would facilitate and streamline case management. In addition, police tend to be impatient with bureaucracy and process due in part to what the author describes as the “tyranny of the now.” The public and others demand the police respond immediately to the latest manifestation of broad multi-layered social, health and legal issues, be it open drug use and trafficking in a neighbourhood or the person with mental health issues standing mid-span on a bridge threatening to jump. As a result the police have become society’s

24/7 de facto front line mental health workers. Therefore, it is this experience and overall context that must be borne in mind when considering where the police are coming from with respect to their concerns and frustrations with the health system, particularly the components of the system that deal with mental health and addiction.

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PART ONE

A Starting Place - The Recommendations

In light of its findings the 2008 LIT report made a number of important recommendations that were rooted in the reality of what is being experienced and observed daily by those on the front-lines of mental health, police, health worker and patient alike. Therefore, a logical place to start is to provide a brief “report card” on these recommendations and any progress to date.

Since the February 4, 2008 release of the 2008 LIT report there has been mixed progress with respect to the report’s seven recommendations. The investment in long-term housing units in Vancouver since 2008 has been very positive with upwards of 2855 potential units having been or soon to be developed. Another positive outcome has been the enhanced ability of the VPD, the RCMP and other municipal police agencies to gather data on all calls for service that are mental health related through the adoption of PRIME based templates. In addition a standardized provincial UCR “Disturbed Person/Att Suicide” call code has been implemented so that across the province there will be better consistency in police reporting. This has and will facilitate further research and establish benchmarks to track change for police in BC. This enhanced ability to gather data and conduct analysis is represented in this report.

Unfortunately, progress on the creation of an Urgent Response Center has been stymied by provincial budgetary challenges and the need to address other health system priorities. In addition, it is unknown what progress has been made with respect to the development of a system, much like PRIME, that would allow BC mental health service providers ready access to the details of an individual’s mental health history province-wide while also addressing privacy concerns. Hospital wait times for VPD members when they apprehend an individual under Section 28 of the MHA have not been improved and efforts to do so have not been fruitful to date. The improvement in

data collection by police will at least allow this issue to be accurately measured on a municipal, regional as well as a provincial basis.

Recommendations for a mental health care facility that can accommodate moderate to long term stays for individuals who are chronically mentally ill as well as increased services for people who are dually diagnosed have been partially addressed through the creation of the Burnaby Centre for Mental Health and Addiction (BCMHA). A November 20, 2009 Globe and Mail article cited the successful case of a patient at the BCMHA who is turning his life around due to model of care provided by the BCMHA . The BCMHA has reported significant reductions in crack cocaine, alcohol and heroin use as well as a fewer number of days involved in criminal activities amongst former patients as well as improved physical and psychological health. In addition, 40 pre-treatment and 40 post-treatment transitional beds have been added to the 100 beds at the BCMHA effectively increasing its capacity to 180. These positive outcomes are tempered by the acknowledgement that there are some 300 people on a waiting list and some 40% of the BCMHA patients will need a high level of support and long-term residential care in order to sustain their recovery in the community.

PART TWO

The Scope of the Problem

The Interaction of Policing and Health Services on the Street

In late 2008 the VPD and VCH began work on the Integrated Street Response Project (ISRP). The intent was to create a service model that allowed police to readily access and make referrals to health services on the street 24/7 as well as support the implementation of an Urgent Response Centre. The work on this project ended in 2009 due to VCH budget restraints. An analysis was conducted of both mental health-related police calls for service as well as other calls where it could reasonably be assumed that one, there would be operational need for police and a given health service to interact and cooperate and two, a need to exchange information. The results illustrated the high

level of daily contact requiring information exchange and cooperation between police and health services with citywide calls for service numbering some 16,500 in 2009.

Mental Health and Addiction in BC

Coupled with this is a profound quantified need for mental health or addiction treatment versus available capacity. A “Finances Fact Sheet” produced by the BC Alliance on Mental Health and Addiction noted that “approximately 136,000 adults in BC have a severe addiction and/or mental illness, and between 8,000 and 15,500 of these people are street homeless and another 26,500 are at imminent risk of homelessness”.³ Data provided by the BCMHA (Severe Addiction and Mental Illness in BC- SAMI/2007) revealed the scope and immensity of the problem facing police and health services with some 260,069 severe cases in BC across a range of conditions that includes substance use disorder, major depression, bipolar disorder, and schizophrenia. In addition, based on information released by the Ministry of Health in 2010, there are 441 long term institutional beds that have been devolved from Riverview provincially with an additional 402 beds to be developed and distributed regionally. Clearly there is a great need for treatment but the necessary capacity is lacking and very difficult to achieve given the numbers above.

Attempted Police Referrals to the BCMHA

The lack of institutional and quasi-institutional (BCMHA) bed capacity simply point toward the need for more effective community based treatment services. In an attempt to set up a parallel non-criminal referral process to the one used by the Downtown Community Court (DCC) between January 2009 and November, 2009 the existing VPD/Mental Health Emergency Services (MHES) partnership unit Car 87 referred 42 individuals for potential assessment and follow up referral to the BCMHA.

³ Sheridan, G. (June 16,2010). BC Alliance on Mental Health/Illness and Addiction. Finances Fact Sheet. From the Centre for Applied Research in Mental Health and Addiction. (2008). Housing and support for adults in BC with severe addictions and/or mental illness.

The individuals were selected by the VPD after their files were reviewed by the police officers assigned to Car 87 and the Sergeant who oversees their work. In addition, there was consultation with the VPD Chronic Offender Unit and police officers in the Downtown Eastside, as well as consideration of police calls for service, criminal offences, and any known mental health and/or addiction history relating to the subjects. The one positive outcome of this process was learning that four of the 42 individuals had already been referred to the BCMHA. Another 11 individuals could not be located, or had no fixed address. Of the 42 people, 19 individuals were already receiving community based treatment of an unknown description and the “treatment source” would possibly follow up with the patient to determine if they wished to be referred to the BCMHA. The VPD checked back with Health in May 2010 to update the status of the files. It was determined that all of the 42 files had been closed without the VPD being advised. The key finding was subsequently determining that across the referral dates spanning January to November 2009, the 19 people had been involved in 619 documented police contacts as a suspect, a suspect chargeable, or charges recommended, charged with a criminal offence, or listed as being involved in a mental health incident. In addition, five of the 19 individuals were found to be victims in eight violent incidents. The PRIME definitions for these “Entity Role Codes” are the following.

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CHARGED: An Information or a Summary Offence Ticket has been laid or issued against the subject by the unit or agency with jurisdiction.

SUSPECT CHARGEABLE: A subject for whom grounds exist to support the recommendation of a charge but police choose against this course of action.

SUSPECT: A subject that is believed to be involved in the commission of a crime or statute breach but charges have not been laid.

A victim is defined in PRIME as “a subject that has suffered as a result of the commission of an offence or the breach of a statute.”⁵

⁴ Police Record Information Management Environment. British Columbia Records Management System. Reference Manual. p.206.

⁵ Police Record Information Management Environment. British Columbia Records Management System. Reference Manual. p.206.

These findings underscore the incongruent nature of the police problem policing philosophy and the orientation of the health system toward solving the broader issues of mental illness and addiction in the community. The police encountered the 19 individuals in some 619 incidents where they potentially victimized other citizens through criminal offences and/or engaged in behaviours that caused disorder and a level of apprehension, tension or fear in the community. From a health perspective a given individual is being “treated” whereas from a police perspective the effectiveness of that treatment is being questioned if that the individual is still offending and causing harm to the community. This also illustrates the disconnect between how the effectiveness of community based treatment is assessed and the actual behaviours exhibited by these chronic individuals on the street. To be clear the 19 individuals were not a random sample but their very selection and referral to health underlined the concern and priority the police felt about their negative and harmful behaviour both to themselves and others in the community. Unfortunately and sadly, the closure of the files communicated in an indirect way to the VPD that its concerns carried little or no weight with the health system. Additionally, the failure of the non-criminal referral process through Health ensures that the only pathway available for referral to services in the form of the Downtown Community Court (DCC) was for an individual to commit a criminal offence. Given the pressure on Health to identify and fund non-institutional treatment resources in BC, a focus on the type and outcomes expected of treatment must be a consideration with one outcome being a reduction in police contacts. This is where the reduction in number of days spent engaged in criminal activities amongst former patients cited by the BCMHA is an important treatment outcome that is being measured. It remains to be seen whether a similar outcome can be delivered through other community based treatment models. The findings of the VPD appear to show otherwise.

Case Studies

A related issue is whether certain chronic individuals should be in community based treatment or an institutional model of care. The VPD examined case studies of two very

difficult to manage individuals, Karl Reid and Bill Taylor (not their real names) who were the number one and two referrals amongst the 42 individuals the VPD made through Car 87. Mr. Reid was the one person who had actually already been at the BCHMA. Unfortunately his treatment was unsuccessful and after several “walk aways” he never returned. Mr. Taylor was also a prominent case study in the 2008 LIT report and was amongst the 19 individuals receiving treatment in the community. In the report Detective Wilson-Bates wrote:

In the 1970s Bill was found not guilty by reason of insanity for attempting to kill someone in BC. He spent ten years in a psychiatric facility as a result of this incident and was then released onto the streets of New Westminster where he wreaked havoc until 2003 when he moved to Vancouver. Bill is a daily challenge for the VPD and has had 145 documented incidents with police between 2003 and 2007. In addition to being mentally ill, addicted and physically disabled, he has a personality disorder and engages in attention-seeking behaviour, often waiting outside of the VPD jail and assaulting passersby in an effort to get arrested and gain entry.....

One thing that people involved in Bill’s life, such as his mental health worker and staff at his residence, agree on is that he is not successful living in the community. They believe that he requires a lengthy stay in an institution where his medication could be stabilized, his drug addiction addressed, his physical needs evaluated and his future considered. While none of these individuals philosophically support institutionalization of the mentally ill, they do recognize that Bill’s current situation is not working for anyone, particularly for Bill himself.⁶

In 2008, Bill was still on the street with 20 documented police incidents with nine of these incidents resulting in charges. He was also listed as a suspect chargeable in three incidents and a suspect in two incidents as well as one Emotionally Disturbed Person (EDP) incident. The incidents include five breaches of probation, three mischief incidents, three incidents of causing a disturbance, two assaults, one breach of peace, and one mental health incident. From late January 2009 to May 2010 he had 37 police contacts. Nearly all of these were with the VPD with two incidents being with the Transit Police Service. The incidents where Bill is listed as a suspect or a suspect chargeable

⁶ Wilson-Bates, F. (2008). Lost in transition: How a lack of capacity in the mental health system is failing Vancouver’s mentally ill and draining police resources. pp. 37-38.

or recommended for a charge, or charged include: one arson, eight assaults, one breach of bail conditions, six cause a disturbance incidents, one disturbed person, one Mental Health Act, two mischief incidents, two public mischief incidents and one sexual assault. Of these incidents, Bill was charged with sexual assault, mischief, arson, six assaults, two public mischief charges, one cause a disturbance charge, and one breach of bail conditions charge.

Karl Reid lives in supported housing in the DTES. He is unemployed, on social assistance (disability), and utilizes crime to supplement any legitimate income he obtains. He primarily commits property crimes in the DTES. However, some of Karl's criminal activity also takes place in a nearby municipality where he grew up. PRIME lists Karl as "caution" because of contagious disease, mental instability, and violence. He is associated to 197 PRIME entries in total. In 2008 alone he interacted with the VPD on 128 occasions documented in formal General Occurrence (GO) reports as well as 25 street checks. The GOs involved almost the entire spectrum of offences. These include: break and enter, possession of stolen property, breach of conditions, theft, narcotics possession, suspicious persons, property found, theft from motor vehicle, trafficking cocaine, warrant executions, breach of the peace, causing disturbances, Mental Health Act, robbery, collision with non-fatal injury, DNA Identification Act, mischief, possession of break-in instruments, and traffic bench warrants.

Both Mr. Reid and Mr. Taylor are chronic offenders whose behaviours continue to negatively impact the community as well as absorb and drain health and police resources. Their behaviour is sometimes violent, or has a tenor of violence, and Bill is often a victim of violence given his verbal and otherwise aggressive behaviour towards others on the street. They are amongst a number of chronic individuals who are likely not suitable for treatment at the BCMHA due to their extremely difficult-to-manage behaviour, yet they are still in the community. It is a legitimate question then to ask whether they and other chronic individuals (and the community) would be better off if they were involuntarily committed to an institutional model of care. It is also a legitimate

question to ask whether there is sufficient capacity in the institutional model of care for these very difficult to manage individuals.

PART THREE

Suicide

Scope of the Issue

The City of Vancouver had 69 suicides in 2008 and 84 suicides in 2007. The total number of suicides in BC was 478 in both years. Any suicide is a tragic event that affects family, friends and often first responders such as police, fire services and ambulance personnel. Incidents of suicide and suicide attempts in Vancouver continue to challenge the mental health system and the VPD's ability to respond before, during and after a given individual's mental health crisis. If an individual is truly intent on taking their own life it is extremely difficult to predict when they will make a suicide attempt and/or stop them from doing so over an extended period of time without the person remaining involuntarily committed in a highly secure environment. Attempted suicide incidents, particularly on bridges, tax police and other resources and sometimes place police officers and other first responders at risk.

With respect to preventative measures the VPD determined that the legislation in BC authorizing police to involuntarily apprehend suicidal persons and deliver them to the care of the health system is comparable to other jurisdictions nationally and internationally. It was also determined that proposals for nets under bridges have been considered with this measure having been approved for the Golden Gate Bridge in San Francisco. However, a net has not been installed due to funding constraints. In Vancouver six phones on the Lions Gate Bridge that are connected 24/7 to the Vancouver Crisis Centre have been installed as a pilot project.

The VPD found that between February 1, 2009 and February 1, 2010 there were seven suicides committed by subjects who had previous MHA or “Disturbed Person” contacts with police. These individuals also had a history of having been assessed psychiatrically in a hospital or having been committed during the previous two-year period for mental health issues. The VPD also determined that there were 487 suicide attempts where subjects had previous contact with VPD for mental health/EDP issues and also had been committed, received medical or psychiatric assessment or had been previously listed as missing from an institution. Of these 487 attempted suicide incidents, 18 occurred on bridges.

The VPD examined three cases where individuals experienced a period of hospitalization after being apprehended by police under Section 28 MHA and then committed by a physician. Sadly, after periods of hospitalization all three people committed suicide; one the same day as being released, a second while out of hospital on a two hour pass and a third some 17 days after their release. The three cases reflect the challenges and uncertainty medical practitioners face in determining whether an individual will take their own life or not. In addition, the police certainly do not have the expertise to reach any conclusions as to whether the mental health system’s response was adequate or not. What is clear, though, is that there is a lack of a more public and transparent review process regarding medical practice in this area to determine if there was anything further that could have been done or should be done differently in the future. It is also unclear what process, if any, is in place so that the attending physicians, either in a psychiatric unit or emergency room, are advised of a patient’s suicide and the circumstances surrounding that death. The author has been advised that currently there is no consistent or standardized mechanism that informs physicians when a patient commits or subsequently attempts to commit suicide.

PART FOUR

A Duty of Care

On the afternoon of September 19, 2006 the VPD were advised via E-COMM that a male had cut himself in an apparent suicide attempt. For a number of reasons there were delays in responding to this call with it taking more than an hour for the first VPD units to attend. The male had indeed cut himself causing a critical blood loss and the police were initially unable to access the male's apartment as it was barricaded. The responding police officers were eventually able to enter the residence but once inside efforts to save the male's life were unsuccessful. On March 28, 2007 the VPD's Chief Constable attended a media conference and issued a public apology to the victim's family and made a transparent admission that the VPD had failed to exercise an appropriate duty of care in responding to this call. The E-Comm operator involved in the incident had her employment terminated and two VPD field supervisors were subsequently disciplined.

This example of public service accountability and transparency stands in sharp contrast to the VPD's findings with respect to the level of care, safety and security exercised by SPH and VGH relative to individuals who have been committed under the Mental Health Act. The VPD undertook an analysis of missing person calls from the two major hospitals in Vancouver, VGH and SPH, due in part to the VPD having to respond repeatedly to incidents where psychiatric patients had simply walked away. This was also a historical issue with senior VPD managers in past years having suggested to VGH and SPH that simply locking the doors at the respective psychiatric units and wards and staff becoming more conscious about monitoring the whereabouts of patients might help solve this problem.

Between February 1, 2009 and February 1, 2010 there were a total of 176 missing person calls at SPH and 143 at VGH. Of these calls there were 157 and 126 "MHA-related MPERS Calls for Service" respectively. However, from the VPD's perspective

the most important data was the 126 and 104 incidents at SPH and VGH where the missing person” was a committed patient at the hospital” (230 calls in total). These are incidents where the missing person had been committed under the MHA and were under the direct care and control of either SPH or VGH. Of the 126 calls at SPH, 22 people had two or more instances where they went missing. The VPD also determined that there were 22 people represented in 48 incidents of the total 126 incidents at SPH individuals who had gone missing at least two times. There were 12 such people represented in 33 of the total 104 incidents at VGH.

The VPD’s concern with having to respond to a total of 230 calls where the “missing person” was a committed patient at the hospital is rooted partly in the language and intent of the legislation. The standard for police apprehension and presumably hospital admission and committal is having a “mental disorder” and “acting in a manner likely to endanger that person's own safety or the safety of others”. Given that a physician has committed an individual under the provisions of the Mental Health Act, it follows that they must indeed pose a risk to their “own safety or the safety of others”. Given this context and the duty of care it imposes, the VPD must make the call a priority for response and assign sufficient resources to locate the “elopee” who has walked away from the hospital psychiatric unit or ward.

The above discussion may seem academic were it not for the real tragedies that have taken place. Fortunately, during the 12 months where data was gathered no one committed suicide and only one of the 230 missing persons was actually engaged in an apparent suicide attempt where they were located mid span on bridge some two months after they had gone missing. Sadly, between February 1 and August 1, 2010 there have been three critical incidents involving VGH patients that underline the risks and tragic outcomes related to hospital security practices with respect to committed psychiatric patients. In one incident a suicidal male was apprehended by police and committed under the MHA. He walked away from VGH the same day and was reported missing. The police located him at home but upon apprehension he pulled out a knife with a 6” blade in close proximity to the police officers. Both officers drew their service pistols and

ordered him to drop the knife. Fortunately he complied and was taken into custody thus averting a potential “suicide by cop” situation. In the second incident a patient in the psychiatric ward at VGH with “fresh air” privileges walked away and some 25 minutes later committed suicide by jumping off a nearby building. In the third incident a committed psychiatric patient at VGH with a previous history of attempting suicide by slashing his neck walked away from the hospital ward. He attended a nearby shopping complex, purchased a knife, walked outside and then began slashing at his neck and wrists. Fortunately, the male survived this suicide attempt.

Although the VPD understands that psychiatric units and wards are not “jails”, the issue of missing persons that are committed patients at the hospital is a longstanding “problem” that needs to be solved. It is a natural and logical presumption for the police, particularly given their underlying problem solving philosophy, to suggest that better security and monitoring as well as better scrutiny and judgment in the issuing of passes, combined with locking the doors of the psychiatric unit, might result in fewer missing person calls and an overall reduced risk to patients and the public. While the VPD accepts its very public and accountable duty of care in responding to these incidents and others involving suicidal individuals, the VPD’s findings indicate that the care, safety and security exercised by SPH and VGH relative to individuals who have been committed under the MHA, or the public for that matter, is not an organizational concern or priority.

Quantitative analysis can illustrate and help define the parameters of issues and problems the police function in a world where day to day operational experiences, successes, failures and frustrations shape thinking and perspective. The police operate to some extent, subject to the “tyranny of the now”. The case studies presented in this report tell a story and often paint a more accurate picture of how a given system interacts with and responds to human beings and their needs. The last case study examined the case of Mr. Smith who was turned away repeatedly from both VGH and SPH with SPH being the primary hospital involved. Mr. Smith had a number of police contacts and other instances where he was not admitted to hospital. On January 31,

2010 he was turned away twice (based on police documentation). Mr. Smith was categorized by the attending SPH physician as a known “anti-social” who did not require treatment and would not be admitted to hospital. Mr. Smith was returned to his shelter, barricaded himself in the bathroom, smashed the mirror and toilet and emerged with shards of glass in hand where he was confronted by police. Force, in the form of a Taser, was applied and Mr. Smith was arrested and charged criminally. This facilitated his entry into the Criminal Justice System through the DCC and with that, access to services. What was particularly sad about this entire situation was that Mr. Smith is blind, deaf in one ear, and partially deaf in the other. On February 5, 2010 he made his way out to the common balcony of his new housing placement and attempted suicide with the fall causing serious injuries. The security video showed Mr. Smith feeling his way along the building wall until he found and then climbed over the balcony railing. The VPD followed up with SPH regarding a review and possible de-briefing of the incident but to date a direct response regarding Mr. Smith and what occurred at SPH has not been received. This case illustrates several issues in the system from Mr. Smith being homeless to the lack of a pathway for police to triage Mr. Smith off the street and into some form of stable housing and community based treatment. In seeking mental health treatment the emergency room was the only entry point available to Mr. Smith. It was evident that Mr. Smith’s behaviors fell well outside the “norm” in society, yet they apparently did not meet the threshold needed for an admission to a psychiatric unit at either major hospital in Vancouver. His eventual access to housing and potential treatment cannot be viewed as a “success” as it came at the cost of an escalation of violent behavior that culminated in what was very likely a traumatic encounter with police, an arrest and a criminal charge.

The circumstances of this case sparked frustration and outrage toward the mental health system amongst a number of police officers who dealt with Mr. Smith prior to February 5, 2010. However, a balanced perspective is necessary. As noted at the onset the mental health and primary health systems are staffed by many compassionate, well meaning and dedicated professionals. There is no malice or ill-will being directed toward the mentally ill by health personnel. No doubt many health

professionals are as frustrated as the police are with the capability and capacity of the system to effectively respond to the need on the street. Hopefully, the recommendations to follow in this report will provide a start toward a more effective and responsive model of care both in the hospitals and the community.

CONCLUSION

A key finding of this report is that from a “street cop’s” point of view little has changed since the first Lost in Transition report which found that a lack of capacity in the mental health system was failing Vancouver’s mentally ill and draining police resources; tragically and alarmingly, this remains true. There has been some good progress particularly in the area of supported housing. In addition, police data management and analysis have been improved. The increase in moderate to long term treatment capacity in a quasi-institutional setting for the chronically mentally ill and dual diagnosed population through the BCMHAS also represents good progress being made. However, even with this progress the police are still responding day after day to “difficult to manage” and “treat” chronically mentally ill and addicted individuals on the streets of Vancouver. This points to a need for increased institutional mental health and treatment capacity as well as more effective community based treatment that considers a significant reduction of police contact as an important measure of “success”. All of this must be considered in the context of the quantitative data presented in the SAMI chart. Given this data the relative success of the BCMHA’s model of care really only shines a light on the tip of an iceberg of need.

Other issues relating to suicide, suicide attempts and missing persons continue to consume and drain police resources, frustrate police, and in some cases, endanger the lives of the patients as well as front-line police officers and other first responders. From a “Problem Oriented Policing” (POP) perspective the attempts of the police to solve these “problems” are still being hindered by the barriers of information sharing, a lack of system capacity and frankly, a lack of real will on the part of health system in Vancouver to adapt and evolve in order to work effectively with the VPD to solve these issues in a

constructive and sustainable way. With a few exceptions such as Car 87, the police are still not true partners with Health while police on the other hand also need to be willing to work with Health. While many police traditionalists may think this is not their “job”, the VPD’s problem oriented policing practices combined with the daily operational need to interact and share information with Health clearly indicates that having an effective working relationship is simply part of the police role and a community need.

It is hoped that this report has built upon a broader public concern regarding the long term care of the mentally ill in our society. Despite having been written primarily from a police perspective, it is also hoped that this report will assist health professionals, support organizations for the mentally ill and their families, and other entities in supporting their own work and advocacy on behalf of patients and loved ones. Ultimately the mentally ill and/or addicted in our society are “us”. They may be a spouse, a parent, a sibling, a child or other family member, a friend or a co-worker. We owe it to them to keep working toward more responsive and effective models of care for the mentally ill and/or addicted in our society.

RECOMMENDATIONS

The first part of this report provided an overview and report card on the original seven recommendations from the 2008 LIT report. Whereas there has been progress in some areas all of the recommendations are still relevant and should continue to be pursued. These recommendations again are the following.

2008 Lost in Transition Recommendations (Updated)

- 1. That the Ministry of Health and Vancouver Coastal Health establish sufficient mental health care capacity that can accommodate moderate to long term stays for individuals who are chronically mentally ill.**
- 2. That the Ministry of Health and Vancouver Coastal Health increase services for people who are dually diagnosed.**

As noted in the quantitative data presented in this report the need for treatment is great from a province-wide perspective. The BCMHA has provided some good direction but its 100 bed capacity and 40 pre-treatment and 40 post-treatment beds combined with its ongoing 300 bed waiting list illustrate a capacity gap that is ongoing and needs to be addressed. In addition, there is still a population of chronically “difficult to manage” people on the streets of Vancouver who arguably should be institutionalized rather than being treated in the community. Therefore, recommendations one and two are still relevant.

- 3. That the Ministry of Health and Vancouver Coastal Health establish an “Urgent Response Center” where individuals can be assessed and triaged according to their needs along with additional resources to support the facility.**

This recommendation is still relevant as the police still lack a means to triage people in a non-criminal manner off the street and into services. Currently, the two “entry points” are still through the hospital emergency rooms and the Downtown Community Court. As was illustrated in Mr. Smith’s case study, the inability to gain access through hospital emergency rooms culminated in a violent incident, a police use of force, arrest, criminal charge, entry into the Criminal Justice System through the DCC and eventual suicide attempt resulting in serious injuries requiring significant resources and care from the health system.

- 4. That all levels of government work together to increase supportive housing in Vancouver.**

This recommendation is still relevant. Given the findings of the BCMHA indicating that some 40% of their out-patients will require long term support, a related issue over time will likely be not just the number of units needed to reduce homelessness but also the level and type of support needed. The Mental Health Commission of Canada “At Home/Chez Soi” research project examining selected

population cohorts in order to compare the outcomes of different housing and treatment models will likely provide good information in this regard.

- 5. That the Ministry of Health establish a system, much like PRIME, that has readily accessible details of an individual's mental health history and addresses privacy concerns, for British Columbia mental health service providers.**

As noted, it is unknown what the status of this initiative is. Given the findings of the 2008 LIT report showing that there were profound issues in sharing information across health authorities regarding mental health and addiction medical histories this recommendation is still relevant.

- 6. That the police continue to enhance their ability to gather and analyze data on all mental health calls for service in order to facilitate further research and to establish benchmarks to track change for police in BC.**

The police in BC have established the means of gathering the data needed to establish benchmarks. Whereas the VPD has undertaken a significant amount of analysis in regard to mental health data, there still needs to be some direction at the provincial level to direct and coordinate province wide analyses. It is also unknown what capacity and expertise other police organizations have to undertake such analyses. This recommendation is still relevant. The VPD's experience in creating this report indicates that extracting and analyzing data is still a significant challenge and a great deal of work depending of course on the type of questions being asked. The VPD can certainly provide the PRIME based methodology used in this report to assist other police organizations wanting to conduct their own local analysis of mental health related police data.

- 7. That St. Paul's Hospital and Vancouver General Hospital pursue changes in hospital practice to speed up the admission process for police who have**

arrested an individual under the provisions of the Mental Health Act. (By negating the need for the emergency physician to initially examine the patient)

The hospital wait times for police have not improved since the 2008 LIT report. In fact, there was a marginal increase in the average wait times between 2008 and 2009. The VPD has been advised by VCH that in an urban hospital environment the current provisions of the MHA do not support psychiatric admissions being done remotely by physicians with nurses conducting the actual examination and relaying this information as might be the case in a rural setting. This is due to the large number of physicians available in the city. Given the tremendous number of police hours currently being used to secure patients while waiting for a physician to examine the individual, this is still a very relevant recommendation and a reduction in wait times must continue to be pursued.

2010 Lost in Transition Recommendations

- 8. That the Ministry of Health and Vancouver Coastal Health establish an “Assertive Community Treatment” (ACT) team model with sufficient capacity to address community based treatment needs in Vancouver and implement a model similar to the one that exists in Victoria, BC where the Victoria Police Department are part of an integrated team.**

The Victoria Integrated Community Outreach Team (VICOT) model includes an employment and assistance worker, probation officer, police officer, mental health support worker, Vancouver Island Health Authority outreach worker, community outreach worker, administrative support, psychiatric nurse and physician. Though “ACT-like” in terms of practice the VICOT does not use that term. This model supports the ability of the police and health (and corrections) to work in partnership and share appropriate information as well as measure and evaluate the effectiveness of response and treatment across a broader range of

criteria which would include the number of police contacts. Whereas the successful Car 87 VPD/Mental Health Emergency Services model in Vancouver addresses emergency and exigent circumstances, the ACT team model in Victoria is a logical next step in developing a comprehensive response. There is currently a pilot ACT team model in Vancouver but the VPD has not been included in this project.⁷

9. **That Vancouver Coastal Health, St. Paul’s Hospital, Vancouver General Hospital and the police establish formalized standing bodies with appropriate terms of reference at with police, emergency room, and psychiatric unit as well as psychiatric ward medical staff and management with a mandate to monitor, identify, de-brief and resolve critical incidents and other police/health related incidents as well as systemic issues.**

The tone of this report has been constructively critical. Many of the issues raised in this report such as the examination and admission (or non-admission) of patients apparently suffering from a “mental disorder” as well as the safety and security of patients and missing persons are related to hospital policies, procedures as well as medical practice and decision making. It would be extremely valuable for the stakeholders in the hospital and police to have a forum and opportunity to resolve issues and conflicts as well as learn about each other’s issues and practice. Arguably, the participation of physicians is essential since their decisions regarding medical practice have a broad impact on other stakeholders like the police. In addition, hospital managers with sufficient authority and influence need to be represented so that there is some assurance that any decisions and recommendations made at the table can and will be acted upon. The committee would also hopefully spawn a better ongoing working relationship between police and the hospitals so that more immediate issues and

⁷ BC Association of Chiefs of Police Mental Health and Addiction sub-committee meeting. (March 29, 2010).

problems can be responded to in a timelier manner without necessarily having to wait for the next committee meeting to be addressed.

- 10. That Vancouver Coastal Health, St. Paul's Hospital, Vancouver General Hospital establish an information sharing and feedback mechanism so attending Emergency Room and psychiatric unit and ward physicians are advised in a timely manner of suicides, suicide attempts and other critical incidents involving their patients.**

This may be a separate component or it could be addressed through the creation of joint hospital/police bodies as advocated for in recommendation number eight. However, timeliness needs to be considered as a given physician(s) would likely want to be advised as soon as possible of a suicide, attempted suicide or other critical incident involving one of their patients. Any issues relating to the information sharing and confidentiality would also need to be addressed.

- 11. That the Ministry of Health make legislative changes in the Mental Health Act to facilitate a speedier health system response and reduce police wait times at the hospitals.**

While there may not be adequate provisions in the MHA that allow physicians in urban hospitals to grant admissions without actually being present to examine and admit the patient, there may be an opportunity to amend the legislation so that police officers can turn a MHA apprehended person over to a psychiatric nurse or other designated medical person. This does raise issues regarding security and the ability of the nurse and hospital security personnel to maintain custody of the person if they do not wish to remain at the hospital. Whereas the police are authorized, equipped and trained to perform this function there is a cost to this service in terms of an expensive public service and first responder resource (the police) remaining at hospital for many hours, a cost currently not

being borne by the health system. This recommendation is also related to the recommendation seven from the 2008 LIT report.

- 12. That the Coroner review and consider calling an inquest in all suicide cases where an individual received psychiatric and/or mental health treatment within a 30-day period before their death.**

While the VPD is reluctant to make this recommendation, its findings in this report point to a disconnect between appropriate mechanisms of advisement and de-briefing for physicians and related medical staff with other stakeholders such as the police. A related issue is the lack of accountability for hospital security in relation to incidents of suicide. A Coroner's Inquest is not designed to find fault or cast blame; it is designed to determine fact and make recommendations. A detailed and complete police investigation as recommended above would assist the Coroner in making a decision regarding the calling of an inquest.

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