IMPROVING THE POLICE RESPONSE TO MENTAL ILLNESS IN THE COMMUNITY

by

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A thesis submitted in partial fulfillment of
the requirements for the degree of

MASTER OF ARTS
in
CONFLICT ANALYSIS AND MANAGEMENT

ROYAL ROADS UNIVERSITY

October 2003

Your file Votre référence
ISBN: 0-612-83352-6
Our file Notre référence
ISBN: 0-612-83352-6

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ACKNOWLEDGMENTS

This project could not have been completed without the valuable support and assistance of many individuals within the New Westminster Police Service, New Westminster City Hall, and in particular my colleagues at Royal Roads University.

In completing this major project I would like to take this special opportunity to thank Darryl Plecas for his tireless and always inspiring encouragement. He has this way of keeping the "torch burning". I would also like to extend thanks to:

- Chief Constable Lorne Zapotichny, New Westminster Police Service, who sponsored and encouraged this very important area of research.
- The sworn frontline members of the New Westminster Police Service who took time out of their hectic schedules to complete the survey offering their honest opinions and recommendations.
- The civilian members, who often do many thankless tasks, for providing the needed guidance on accessing files during the review process.
- The SPSS data entry personnel.
- Maureen P. Foley, for her expertise and support during the writing segment of this project.
- My parents Roy and Elaine, and friends, Gerda, Marcie, Mary, and Jennifer who always urged me to press on.
- My dear husband Paul, who looked after the girls and me during this academic journey. For this, I am most appreciative.

N.B. The views expressed in this project are those of the author and do not necessarily reflect those of the organizations named within.

INTRODUCTION

This thesis addresses improving police responses to the mentally ill in the community of New Westminster. In suggesting how the New Westminster Police Service (NWPS) can be apprised of appropriate approach and services to the mentally ill, the following research questions are offered:

1. What is required to help the NWPS work with the mental health system to improve communication, training, information sharing, and the referral system to provide a better service to the community of New Westminster?
2. What are the barriers and challenges that the NWPS faces when responding to individuals with mental disorders in the community?

CHAPTER ONE – BACKGROUND STUDY OF THE PROBLEM

This initial inquiry into my research in British Columbia alluded to the difficulty I experienced when locating any one expert who has taken charge of an issue of this nature. Thus far, I have been unable to find research within the local policing community where there have been actions in finding sustainable solutions with regard to the continual increase in the police call load. There are few programs that have placed a mental health worker and a police officer together to attend calls, but there has not been any studies conducted to demonstrate that this action has reduced the increase in police call load.

From my personal experience in law enforcement it appears that the mental health system frequently sends clients in the direction of the law enforcement system; hence, there is evidence that the police forward the same clientele back into the mental health system. This cyclic burden does not help when it comes to the educational or treatment programs for "victims" who are caught in this political cycle.

As do other police agencies, NWPS must respond to persons suffering from mental disorders. Since 1998, NWPS has experienced a 155% increase in Mental Health Act (MHA) cases relating to the apprehension of the mentally ill in the community. These apprehensions are in accordance with Sec. 28 MHA: an involuntary admission to a psychiatric facility by persons with a disorder who may be a danger to themselves or others.

Frontline police officers are increasingly requested by New Westminster Mental Health (NWMH) to assist psychiatric nurses while they conduct field assessments. This practice is due to the potential for violence and the client not wanting to submit to the assessment. The police officers also find themselves attending residences to verify the welfare of the mentally ill, and may or may not discover whether there is non-adherence to taking prescribed medications. This augmentation of increased calls has placed extraordinary demands on frontline police officers.

The years of deinstitutionalization in B.C. appear to have impacted the continuum of care for persons with mental disorders and placing the responsibility of care back into the community has developed some challenges. Unfortunately, there are continual governmental cutbacks in community health services, specifically emergency after-hours mental health services.

The police service is and appears to be readily available to respond to people and their needs 24 hours per day, 7 days per week. It is my assertion that the police availability of this "after-hours trend" shall continue, causing an enormous amount of responsibility to conveniently fall upon the laps of those frontline police officers who have not been expertly trained in the field of mental health. It is further asserted that the mental health system is not aware of the level of increased burden on police. It is anticipated that this study will assist the Mental Health system in understanding what the frontline police officer is facing on a daily basis.

With the downsizing and closure of New Westminster mental institutions and hospitals akin to Woodlands and Riverview, many frontline police officers perceive that persons with mental disorders are living in our communities without the support and preventative care that many of them require. This belief then lends itself as a possible explanation as to why the City of New Westminster has experienced a rapid increase in calls over the past five years.

With this potential large population of persons suffering from mental disorders living in New Westminster and when they are not faring or coping well and are in crises, the police solely are continuously placed in a situation to have to respond, especially without the expertise to do so. If one were to call the mental health after-hours emergency services phone number, more times than not they will only get an answering service with a recorded message that requests "If this is an emergency, please call 911." Sgt. Brian Smith, of the Los Angeles County Sheriff's Office (LASO) reported similar experiences stating that, "So many of the mental health programs in counties throughout California have been eliminated that many of the mental health clinics tell callers requesting crisis service to simply call 911." (Sampson and Scott, 2000, p.117)

Police officers report that they too are unable to access a mental health worker for information and assistance due to this unavailability. This issue has now evolved to the point where there is a lack of integration or collaboration when dealing with persons with mental disorders living in the community.

Raymond R. Corrado, is a professor and researcher from Simon Fraser University. In 1994, his findings indicated that there was a need to coordinate the role of police officers with mental illness resources, namely emergency services, for the mentally ill. However, in the policing community of New Westminster there have been ad hoc attempts but no formal effort to develop a collaborative or effective approach to bring the law enforcement system and the mental health system together.

According to Nancy Wolff, at Rutgers University, "little research has been directed toward understanding the relationship between law enforcement and mental health systems" (1998, p. 134). It is my intention that this project will explore how the NWPS can better research, prepare and educate itself for its involvement.

This project also proposes to reveal better methods to assist in being more effective when law enforcement and mental health employees work together on current mental health challenges and issues presently encountered within the City of New Westminster.

NWPS Approach to Citizens Within the Community

The NWPS has an expectation within the community to achieve for its citizens a safe environment in which to live. With the increased demand of Section 28 MHA calls it is anticipated that there will be a perceived increase of risk for violence for all concerned during these calls; presently there is no known plan in effect between NWPS and the SFHA to handle this risk. In conversation with a number of psychiatric nurses, they

suggest that the success of a mentally disordered person living in a community depends on the support available to maintain the person in a low risk condition.

For many unexplained reasons, mental health clients are often not coping or responding to treatment while living independently out in the community and this usually becomes notable when they reach a crisis situation due to their level of 'decompensation'. When a person suffering from a mental disorder decompensates, it is usually an indication that the person is not able to care for him/herself and may not be sleeping, eating or responding well to medical treatment. A crisis situation for a person with a mental disorder could also include a response where a police officer may be compelled to use physical force during an arrest or, in rare situations, make the decision to use lethal force. However if the latter occurs, this often results in devastating effects for all concerned. The aftermath of a police shooting of a mentally disordered person not only impacts the community but also the victim's family and police member's family.

There are persons with mental disorders who live quiet, unobtrusive lives. Unfortunately, they are unnoticed by mental health personnel until their situation becomes a crisis. To the extreme, police officers may attend repeat calls to a person who appears disruptive and annoying; they do so without recording any details and do not feel they are in any position to initiate problem-solving interventions. One such individual has had over 60 recorded case files where NWPS officers were dispatched in a three-year period. Complaint-taker and dispatcher personnel have, on numerous occasions, screened many more calls from this subject to avoid sending police

members for a "visit". The assumption held is that the police cannot do anything for them, mental health is not doing anything for them, so unless they are going to do harm to themselves we will not send anyone. These repeat incidents occur in other policing agencies also, as documented by the LASO. In a three-year period, sheriffs had spent over 100 hours on investigations/calls involving one particular subject. What was interesting was that "no single patrol officer or detective had handled more than a couple of incidents." (Sampson and Scott, 2000, p. 120) So the few incidents are not seen by the individual officer as problematic. What is not detected until much later is how many other officers are fielding the same calls.

Currently the NWPS and the mental health system do not have any formal methods for addressing situations like the ones described. The collaboration of the two systems would be significant if problem-solving initiatives were to be explored. Other very important opportunities would also exist to develop formal agreements for communication and information sharing.

It is also anticipated that this study will address the nature of these calls that are most prevalent in New Westminster, so as to assist the NWPS in its response. Of the modest research available, it has shown that the individuals involved in the calls frequently have personality disorders or emotional issues; consequently, problems will range from disturbance, public intoxication, homelessness, domestic violence, suicide, or homicide. (Bellah, 2002). This study should reveal most specifically what NWPS officers are presented with on a regular basis.

Challenges faced by the NWPS

Viewing through the lenses of a frontline officer, it appears that the mental health system model alone is powerless to provide preventative medical intervention and that it is only seen to respond to medical crisis and emergencies. I personally am not familiar with what the mental health system offers in preventative care. Perhaps a better understanding of the system's mandate and role would assist. For instance, it would be interesting to find out how many mental health workers are required to set out into the field and the extent of their case loads.

NWPS officers attend a variety of calls every day including calls that are classified as Sec. 28 MHA. Examples of the common calls for police service include:

- residents in apartment communities or rooming houses reporting alleged disturbances
- suicidal concerns, violent behaviour, and requests by relatives to check the welfare of a consumer
- police standing by and keeping the peace for mental health workers while they conduct an assessment on the individual consumers reporting suspicious circumstances, perhaps later to be determined unfounded.
- paramedics requesting assistance before attending a consumer's residence in fear of a possible violent confrontation.

What is unknown at this time is: What are the most prevalent types of calls and how confident are the police officers in handling such calls? It has been estimated that a majority of the previously mentioned calls for service require that minimum of two police

officers attend, for approximately one to two hours to attempt to resolve the issue temporarily.

It is my intention to reveal how often NWPS officers conclude these duties, by conducting follow-ups or making referrals to mental health personnel (After Hours Emergency Mental Health). These personnel are qualified psychiatric nurses (mental health workers) who, when not too busy, are available to speak directly to clients or police via telephone or provide mobile intervention at the location of the mental health subject between the hours of 4 pm. and midnight. However, even with this service available, it is after these hours that police will not be able to work in conjunction with these mental health workers. As mentioned previously, there are issues when one calls this service if they only receive a recorded message.

This study will also reveal the NWPS frequency of Sec. 28 MHA calls for service where officers must respond between midnight and 0830 hours.

The Commission of Inquiry into Policing in British Columbia in 1994 requested that Raymond R. Corrado identify and examine issues related to the interactions of the police when responding to the mentally disordered. Corrado reviewed a 1993 project that was conducted by Claire Cooper for the RCMP/Mental Health Liaison Committee. Cooper interviewed frontline constables and Non-Commissioned Officers in fourteen detachments in BC, including the Greater Vancouver suburbs. From his findings, Corrado identified several points that describe the various challenges and issues that may be revealed in this study,

For example, Corrado (1994, p.5) reported in his findings that:

- after a person has been arrested under Section 28 of the Mental health Act police members routinely wait two to three hours at hospital emergency rooms
- if there are no secure rooms available, the police officer is responsible for finding another bed at another hospital
- there are recurring calls for police to handle the chronic community concern patient who may be dual diagnosed (suffering from a mental disorder and a substance abuser) and may be repeat patients
- lack of education from mental health workers on how to handle clients with dual diagnosis.
- when patients do not need hospitalization but stabilization, there is a lack of shelters to house the transient mentally ill.

From this study, I intend revealing whether these issues still exist today and to what extent. This will be very helpful in advancing the police response to persons with mental disorders in the community.

The impact that the NWPS has on persons with a mental disorder

The impact on a person with a mental disorder relying on the police for assistance is two-fold. If a subject appears to have a mental disorder and displays behavior that provides an officer the grounds to arrest under Sec. 28 of the MHA (where they pose a threat to endanger him/herself or others), the officer can apprehend without a warrant and take the person to the hospital for an assessment. Conversely, if this person does not state the "magic or key words" that tell the officer their life or the lives of others are

endangered, police must find alternative methods to assist. Currently, as a frontline officer, the alternatives are unknown by the majority of members. This outcome is more prevalent, and without working in conjunction with the mental health workers by sharing valuable information or having a shelter to which to send patients when in crisis, the person with an apparent mental disorder does not receive the required consistent intervention.

Reasons for increases in Section 28 MHA calls

The proposed program of downsizing "institutions" was to have persons with mental disorders live in the community and have support mechanisms, including relying on family support, in place to assist them in maintaining a stable quality of life.

In her Abstract, Nancy Wolff' states, "deinstitutionalization has transformed a centralized system of the mental health care into a loosely structured system" (Wolff, 1998, p. 133). Wolfe further implied that with the service agencies becoming specialists and autonomous, one would believe that each service should have made the whole system much more efficient. Unfortunately if mental health, housing, social services, medical, and law enforcement are not working cooperatively with each other, the networking and the "system" fails.

In 1996, the decision to downsize Riverview hospital was "suspended by the Minister of Health following concerns that the community mental health systems were not yet sufficiently developed to support additional patient placements from Riverview." (Davies,

2000, p. 4) Regarding housing issues, when on duty in February 2003, I was dispatched to attend a public housing property (100-unit high-rise apartment community) for a complaint of suspicious circumstances. Unrelated to this matter, surprising information was obtained from the on-site landlord regarding mental health residents within the property.

The landlord had been managing this public housing apartment community since the early 1990s. During this time Riverview hospital reduced its beds and the government sympathized with the clients/patients and decided to provide housing for them. This on-site manager was required to set-aside 15% of the 100 units for the ex-Riverview patients. However, this percentage has increased and to date this high-rise houses 35% of those suffering mental disorders. Police attend this high-rise for numerous calls regarding the behavior of some of these residents, but currently this information is not passed on to the nurses or case managers who may be providing support for these clients. For the crises that do occur, the on-site manager, like the police, is not trained to respond in a way that may be appropriate for the person in crisis.

Simon Fraser Health Region (SFHR) is comprised of Burnaby, New Westminster, Coquitlam, Port Coquitlam, Port Moody, Pitt Meadows, and Maple Ridge. According to a team leader of Fraserside Emergency Mental Health Services, he advised that of the 3,900 calls made to EMHS during April 1, 2001 to March 31, 2002, 42% initiated in the City of New Westminster. (R. Nyberg, R.P.N. personal communication, 2002). These numbers are astounding considering that the population of New Westminster is

approximately 56,000, compared to SFHR'S larger communities. It was further explained that Section 47 of the MHA allows certified patients of Riverview hospital 60-day extended leaves. These persons (or subjects) are allowed to leave hospital but with the expectation and responsibility that they make arrangements to see their doctors. For various reasons, appointments are missed and medication issues begin leading to crisis situations. In that one-year period where there were 60 cases of extended leaves, 78% had to be returned to the facility within 45 to 60 days. (R. Nyberg, RPN, personal communication, 2002). The complicating issue with this is that there are no requirements to keep that patient's bed available, therefore there are re-admitting difficulties. Where then do these patients reside until a bed is available? My assertion is that they are forced to find temporary housing with friends, relatives, emergency shelters, or end up living on the streets.

On June 17, 2002, a decision by the Fraser Health Authority reduced by 3 hours per day the Emergency Mental Health after hours' services, amounting to 21 hours per week. Upon examining the issues as stated, it would be difficult to disagree that all of these factors contribute to the reasons why police calls for service for persons with mental disorders have increased in New Westminster.

Conflicting perspectives of the roles played by NWPS officers and Mental Health personnel

The main conflicts between a mental health worker and law enforcement officer are the differing perspectives that each role encompasses. When I initially decided to conduct this research, my focus was on revealing the perspectives and attitudes of frontline

officers in responding to Sec. 28 MHA calls, e.g., to reveal the extent to which they are willing to resolve issues.

It is anticipated that the results of the survey and the case file reviews will assist in developing an intervention and improve methods for the NWPS to be better able to handle the nature and extent of the issues that exist. It is also projected that the results will contribute to the content of a recommended training program designed collaboratively by mental health workers and police. One of the goals would be to see that a partnership would be developed to assist in improving the way services are delivered to people with apparent mental disorders living in the community. The limitation of this study was that we did not survey the mental health workers' perspectives, who, it is assumed have their own perceptions of how prepared they are and what they would be willing to do to enhance their working relationship with the police. In Chapter Two, I will review various policing models, e.g., traditional policing vs. community policing. This may further assist in understanding within what framework or structure the NWPS officers work. In addition, included will be a review of the styles of policing that may influence how frontline officers respond to Sec. 28 MHA calls for service.

Relevance of the Proposed Topic

As mentioned previously, 42% of the after-hours EMHS calls in the SFHR are associated to clients in the New Westminster area. With a large concentration of persons with apparent mental disorders living in the community, it is no surprise to see that there was an increase in calls to the NWPS over the past five years. A recent

review of the number of police calls for service specifically labeled as Section 28 MHA investigations, revealed the following:

1998 – 271 cases
1999 – 380 cases
2000 – 484 cases
2001 – 690 cases
2002 – 705 cases

These numbers do not include the numerous cases that are labelled "Assist General Public". Persons with mental disorders may be in contact with police for incidents that would not be classified as Sec. 28 MHA calls. For example, the NWPS may have attended calls for service where there was no Section 28 MHA apprehension but that a person with an apparent mental illness was involved in some other non-criminal matter. (Landlord tenant dispute, bylaw issue) The number of calls captioned as Sec. 28 Mental Health Act is anticipated to increase, which would argue the need by the NWPS for more support, training and education by mental health personnel when encountering these community members.

Through the results of this study, the NWPS will have a better understanding of the options that may be taken to assist in improving the police and mental health system's cooperation to deliver a service to the community. With these results, the SFHA may also take a proactive role and prioritize the request for more resources in New Westminster. Finally, the results of this project will also help the NWPS better understand the level of competence frontline members have when handling crisis situations relating to Sec. 28 MHA incidences. There have been many studies that

recommend increased training for police, but what is to be determined is the specific needs of this training.

CHAPTER TWO - REVIEW OF THE LITERATURE

Introduction

This literature review summarizes the major issues and difficulties relating to persons with mental disorders who find themselves in contact with the law due to the previous 30 years of de-institutionalization. Where research was available, specific emphasis had been placed on the response to these issues by police agencies.
I began my review by familiarizing myself with the history of these issues dating back to the early 1970s. This review includes published articles from periodicals, journals, books and personal communication with police officers, emergency mental health workers, and police academy personnel.

Keywords often used to described the 'subjects' with whom NWPS deals during Section 28 MHA calls for service include: mental health consumer/patient; persons with an apparent mental illness; mentally ill and emotionally disturbed persons (EDPs). Through this review of the literature, deciding on what to call persons or 'subjects' with mental illness was confusing and various literature differed on the naming of those involved. My earlier reviews referred to subjects as EDPs, and are why it was used in my survey 'questionnaire' for the frontline police officers. As I discovered through my research, the most preferred way to refer to the subjects in Sec. 28 MHA calls is persons or subjects having a mental disorder. For the purpose of this report, I will refer to persons or subjects as having a mental disorder. This is supported by the information provided through a website called, Police Intervention in Mental Illness in

Crisis (PIIMIC). This specialized website is located in the Police Academy section of the Justice Institute of BC website (August 18, 2003).

- This literature review will be divided as follows:
- review of the New Westminster Police Service documents.
- issues surrounding the mentally disordered in the community,
- how this poses a challenge for the NWPS
- research conducted by other agencies, and
- what further needs to be done to improve the NWPS response to those with mental disorders

As I see it, the overriding goal of this project is to provide information that will be helpful in implementing strategies to improve the police response to the increasing number of Section 28 MHA calls for service.

Review of the New Westminster Police Service Documents

The New Westminster Police Service is comprised of 104 sworn police officers and approximately 40 civilian personnel. It is one of eleven municipal police services in British Columbia. For the purposes of this project a review was conducted of the most current policy for Sec. 28 MHA responses and the NWPS Mission, Vision and Values for 2002.

The review of policy for the NWPS's response to those with mental disorders is very brief and describes the Mental Health Act law (Sec. 28) which gives police officers the authority to make apprehensions. There is no information with regards to the utilization

of other community resources such as Emergency Mental Health After-Hours, the Assertive Community Treatment team (ACT) or other services provided through the Fraser Health Authority in New Westminster. Neither the NWPS nor Mental Health system personnel have ever formally set any goals or objectives relating to the challenges and issue of policing those with mental disorders.

Policy changes within the police service may be shaped differently when the doors are opened to the outside. Authors, Ron Ashkenas, Dave Ulrich, Todd Jick, and Steve Kerr (2002) in their book, The Boundaryless Organization, describe that, "to achieve success in the 21st century, organizations must confront and reshape the four types of boundaries" (p. 10) vertical, horizontal, external, and geographic that are present in everyday operations.

Vertical boundaries represent layers in an organization such as floors and ceilings, and within the police structure this could be described as hierarchical boundaries. There are differing levels between those working on the frontline through to those in higher ranking positions. In boundaryless organizations, there is the thought that every employee has a good idea and can contribute, regardless of rank or position.

Horizontal boundaries exist between sections or units in an organization, such as walls between rooms. Sometimes these units maximize their own goals to the exclusion of the overall goals of the organization. Ashkenas et al. state, "Processes that permeate

horizontal boundaries carry ideas, resources, information, and competence with them across functions, so that customer needs are well met." (2002, p.10)

External boundaries are barriers between other agencies, or the "outside world" of that organization. For instance, in policing, there are special interest groups, community groups and other services relevant to the uniqueness of police responses. Ashkenas et al. further describe that "these differences lead most organizations to some form of we –they relationship with external constituents". (2002, p.11) Traditional organizations tend to draw clear lines between insiders and outsiders. Geographical boundaries are more for the organization that operates in different markets around the world. In a municipal police organization, this would not be prevalent.

> When vertical, horizontal, external and geographic boundaries are traversable, the organization of the future begins to take shape. When the four boundaries remain rigid and impenetrable… they create the sluggish response, inflexibility, and slow innovation that cause premier companies to fall. (2002, p.12)

The Mission, Vision and Values Statements of the NWPS affirm the following:

Police and Community:

Partners for Safety and Pride

- reduce crime, violence and fear
- build morale and teamwork
- foster positive and employee work environments

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- build morale and teamwork
- foster positive and employee work environments

This is a very general affirmation that must rely on the Vision Statement to propose how this is to be accomplished. The Vision Statement proposes that the NWPS move increasingly towards "Comprehensive Policing", which includes:

- maximizing enforcement strategies
- problem oriented policing and neighbourhood policing practices
- promoting community involvement
- training and encouraging all members as leaders to realize the vision of "everyone a leader".

The remainder of the Vision Statement is focused on internal operations of the organization.

When investigating which one of the NWPS Statements encompasses the type of service provided by police officers when responding to Sec. 28 MHA calls, one needs to understand the meaning of problem-oriented policing and what community policing entails.

Research information provided in a 1995 study called "Changing the Organizational Culture: Community Policing in British Columbia" was conducted by Jayne Seagrave of Simon Fraser University. This provided some brief operational terms describing "Community Policing" and "Traditional Policing":

Community Policing:

> … a recognition and acceptance of the "the community" in influencing the philosophy, management and delivery of police services. (Murphy and Muir, 1985 in Seagrave, 1995)

There are four broad principles to community policing:

(i) a commitment to a broader problem oriented policing philosophy and a move away from crime fighting;

(ii) decentralization, new patrol tactics and two-way communication between police and citizens;

(iii) police react to citizens' definitions of their problems, and

(iv) police helping neighbourhoods help themselves by serving as catalysts. (Skogan, 1990, p. 5 in Seagrave, 1995)

Although there are many researchers who have shared varied definitions of the term community policing, for the purposes of this paper Seagrave's definition was offered to provide the reader a basic idea of the concept. Seagrave's study also provided a definition for the term "Traditional Policing".

Traditional Policing:

> A bureaucratic, reactive, hierarchical system which implements policing policies that have been developed within the organization, with little influence from external agencies. Traditional police agencies are reactive 'line' types of organizations; police officers respond only when called to do so by a citizen and are not proactive nor do they undertake self initiated policing. (1995, p. 5)

In identifying these two models of policing, it will be interesting to determine what framework or structure the NWPS frontline officers are working within when responding to the calls regarding the mentally disordered. Very interestingly, in Seagrave's study,

she asked Chief Constables and Officers in Charge to describe their officers. These leaders acknowledged them "to be traditional response to call officers and articulated a conflict of interest between traditional and community policing philosophy." (1995, p. 372)

Policing Styles

Policing styles of individual officers should also be taken into consideration. Due to differing policing styles, conflicts can often occur between officers and the public or in this case, mental health workers. There is plenty of literature that describes policing styles and Greenberg and Ruback (1982) as cited by Geerinck and Stark, (2003, p. 8) provide four examples of the types of styles that are prevalent in policing: The 'crime fighter', 'social servant', 'law enforcer' and 'watchman.'

The crime fighter's focus is on capturing criminals, and he/she is often aggressive by nature. The opposite of the crime fighter is the social servant, whose primary focus is to help people. A conflict may arise between these two styles, as the crime fighter may be hostile or aggressive with witnesses, while the social servant would be offended by this approach, as they support the individual's rights.

The law enforcer is satisfied in enforcing bylaws and all aspects of the law, and could be described as semi-aggressive. The watchman style is characterized by an officer who does not do more than is necessary, and conveys an uncaring attitude (Geerinck and

Stark, 2003, p.8). The significance of these styles will influence how NWPS officers respond to Sec. 28 MHA calls.

Issues surrounding the mentally disordered in the community

During my initial review I began to discover that there is plenty of information calling attention to difficulties experienced by mental illnesses in many communities. It is reported that a high number of individuals involved have personality disorders or emotional issues. The problems reported range from disturbances, public intoxication, homelessness, domestic violence, suicide, or homicide. (Bellah, 2002, p. 48).

By drawing on the information reported by others that have explored these apparent difficulties, such as the police department in Memphis, TN and 30 police departments nationwide (Crime Control Digest, 2002, p. 3) a clearer understanding of their responses and philosophies will be afforded. The most noteworthy response was made by the Memphis Police Department as a result of a 1988 shooting involving a person suffering mental illness. (Crews and Cochran, 1989) The controversial inquiry into the shooting revealed numerous recommendations but most importantly focused on the fact that their police officers required specialized training in dealing with citizens who have a mental disorder.

The literature clearly shows that Memphis took the lead role in providing the necessary commitment to training frontline patrol officers. It was not too long after the launch of the

Memphis program that other police agencies began to question whether their shootings involving the mentally ill were necessary. (Van Blaricom, 2000).

As mentioned in Chapter One, large-scale policy changes over the years have resulted in this era of deinstitutionalization of the mentally ill e.g., downsizing or closing of psychiatric hospitals. As a consequence, more rigid civil commitment criteria and community mental health support programs are required. (Engel and Silver, 2001, p. 225) At the same time, policing policies have also changed. Community-oriented and problem-oriented policing has contributed to increases in police handling of the mentally ill for minor disturbances. (Engel and Silver, 2001, p. 226) Without the use of mental health resources and support to handle these crises at all hours and with Police agencies providing 911 emergency access 24 hours per day seven days per week, complaints or calls made to the police are a convenient means towards 'downloading' a problem that the community needs to resolve.

As referred to in Chapter One - Relevance of the Proposed Topic, the NWPS had many calls for service that increased from 271 in 1998 to 702 in 2002. With these increases and very little training on how to better respond to these calls relating to the needs of people with mental disorders, frontline officers in the community have experienced additional difficulties. It takes approximately two officers to attend to one Section 28 MHA call. When the individual is apprehended and transported to the psych unit, these officers normally have to wait approximately one hour before the doctor assesses the patient. If the doctor commits the individual to the healthcare facility, the officers can

leave feeling that the individual will be cared for but if the individual is not committed, the officers do not have any recourse other than getting into their police vehicle and driving away. Often there are no emergency shelters or other means of support to assist at these times and, unfortunately, due to recent restructuring, After-hours Emergency Mental Health is not an available service after midnight.

Lack of an appropriate/sufficient response by the community/government/ agencies to difficulties experienced

As mentioned previously, in 1994 Dr. Raymond R. Corrado was given the challenge of examining issues related to the policing of the Mentally Disordered through the Commission of Inquiry into Policing in British Columbia. To date, the Justice Institute of B.C. (JIBC) provides eight hours of classroom training only for police recruits. Adding simulation experiences to the classroom theory, academy personnel estimate a total of approximately 20-24 hours of training. The delivery of the content can vary, depending on the facilitators. Dr. Corrado recommended that the JIBC provide a regularly scheduled course for police members of all levels of experience and years service regarding "the identification of the mentally ill, including recommended procedures to avoid discriminatory and/or violent responses and information concerning how to access the appropriate community responses". (Corrado, 1994, p.12) To date this recommendation has not come to fruition.

The Justice Institute of BC is longing to provide a training program that would encompass all policing agencies in the Province, including the RCMP, the eleven Municipal departments and other independent police agencies.

As mentioned in Chapter One, in 2002 the JIBC took a very positive step within its web site by providing information on mental illness and Police Intervention in Mental Illness in Crisis (PIIMIC). While this very valuable and informative site is virtually unknown by the members of the policing community, I was pleased to find it in my research. PIIMIC was initiated by the BC Association of Chiefs of Police – Mental Health Committee (headed by the then Superintendent of Surrey RCMP Jamie Graham, now Chief of Police, Vancouver) and Richard Dolman, a provincial director of the BC Schizophrenia Society.

There have been a small number of ad hoc responses by policing agencies to develop their own "role call" training programs, such as the City of Vancouver and New Westminster. The goal of a Provincial mandate delivered through the JIBC would assist in developing standard policy on curriculum delivery. In conversation with Roger Nyberg, he was concerned that the recent reduction in the available service to the SFHR would further place an extraordinary demand on the NWPS in the years to follow. He has predicted that the NWPS will take on an additional 300 cases per year. If this comes to fruition, other communities will also feel this impact. This would support the need for the policing community abroad to get together to consider strategies to meet this challenge. The Canadian National Committee for Police/Mental Health Liaison (Coleman, 2002) has made an effort to allow police to achieve this with a yearly conference.

Situation is particularly acute in British Columbia

As previously outlined, the data indicating the increase in calls for service in New Westminster has developed some new challenges for police administrators and the officers involved. The writer feels it is just a matter of time before one of the NWPS officers is forced to become involved in a victim-precipitated homicide. Rick Parent of the Delta Police Department analysed 58 documented incidents in British Columbia during 1980 to 1994, where police were confronted by a potentially lethal threat. In 27 of these incidents, officers responded by discharging their firearms and killing a total of 28 people. He concluded that half of those cases were victim-precipitated homicide. The other 31 documented incidents were handled with less lethal force options. He described that the police were confronted in a "deliberate manner by people who were suffering from one, or a combination of, suicidal tendencies, mental illness, and substance abuse." (Parent, 1996, p. 1)

Case in point, on August 5, 2003 in Vancouver a 'mental health care team' comprised of a psychiatric nurse and a police officer were requested to attend a call for a male who was cutting himself with a knife. The request was made by the male's family. The team entered the home with the permission of the family and when they approached the male, he confronted them with a knife. The team tried to talk to him, but it was reported that he advanced on them. The police shot him with the Taser gun (less lethal weapon used to incapacitate the subject with 50, 000, volts of electricity, but it was ineffective). The police had no other option and the male was shot and killed. (Skelton, 2003)

When frontline officers of the NWPS have been given the training required to respond to these situations most appropriately, and if there is a tragedy such as this one, the NWPS, the community, the families involved and all others concerned, will see that with all the training and expertise, that this result was the only option left. In the above case, the Vancouver Police Department were in a position to send specially trained officers with a psyche nurse and made efforts to use their expertise, they were unable to connect with this male. The fact that the Taser was available and presented shows that the police are well aware of the possible violent risks that can take place when responding those with mental disorders.

What does this mean for the NWPS and, in particular, why be concerned?

As mentioned earlier, Roger Nyberg identified that in one calendar year in the SFHR, Emergency Mental Health services after-hours took over 3,900 calls. From these numbers it was revealed that of those calls, 42% came from New Westminster. As of June 17, 2002, the government reduced the Emergency Mental Health Services' time availability, which will directly impact on the NWPS and its workload.

Police officers, including myself, have expressed concern that they have not received the adequate training and skills to properly handle the mentally ill. Therefore, the writer believes that more definitive and specific training should be implemented and developed to ensure that officers do receive the correct training to better respond to the needs of the mentally ill and prepare concise and informative reports. It has also been noted that information sharing and available resources are not communicated amongst the mental

health workers and the NWPS on an ongoing basis. This is another area that needs attention to improve NWPS response to such calls.

Larry Brubaker (2002) conducted a 20-year study of fatal encounters in the use of deadly force. His study identified the negative ramifications for officers that are involved in fatal shootings. He indicates that many of the officers were not prepared for the psychological impact upon themselves, their families and the department after such an event. (Parent, 1996; Brubaker, 2002)

Although there have not been any empirical studies to prove this, there are reports that officers often leave policing after such an event.

Recommendations on how the NWPS might better able address the situation

Researchers have identified four models of Police/Mental Health System Cooperation as revealed in a report from the Canadian National Committee for Police/Mental Health Liaison, (December 2002, p. 9) Crisis Intervention teams where a selected few officers are specially trained; a comprehensive advanced response, where all officers are trained; mental health professionals who co-respond and mobile crisis team co-responders. At this time there isn't any research indicating that one model works better than another as it depends on the size of the police service, the availability of mental health resources, previous training of officers, existing hospital and police relations. The Memphis Tennessee Police Crisis Intervention Team (CIT) has received many favourable reviews and support from other police agencies regarding their response to

those who are mentally disturbed. (Steadman, Deane, Borum, Morrissey, 2000) However, it has appeared that from these positive reviews, these other agencies including Memphis only became interested in the literature when a tragedy took place (mentally disturbed person is shot and killed). I would like to see the design and implementation of a similar program in an attempt to avoid such tragedies.

Nancy Wolff's (1998) research examines the challenges posed by systems specialization as illustrated by the difficulties of coordinating the roles of the mental health and law enforcement agencies working with people with severe mental illness, and outlines the challenges faced by the law enforcement and mental health systems in collaborating to provide a better service to the community. Further, Wolff explains the conflicts that are at hand between the two systems and presents recommendations for changes. To date, I have been unable to locate studies illustrating that by following these recommendations they will be able to manage the conflicts that exist.

Conclusion

I was unable to locate any literature where file reviews were conducted on Section 28 MHA apprehensions/calls in a police service in British Columbia. Interviews and questionnaires of police officers have been conducted in the past, with complaints outlined. Unfortunately, I could not locate information that focused on providing solutions to improving the response by members of the New Westminster Police Service.

On May 5, 2003, I sent an email to the Executive Director of the Ministry of Health Services requesting information about how mental health services plans to include the police in its delivery of service. I received a reply from the Director of Planning and Systems Development on July 30, 2003 expressing an interest in collaborating services. This contact was unaware of the increase in Sec. 28 MHA apprehensions experienced by the NWPS. It was recommended that I contact the Manager of New Westminster Mental Health Services to further discuss this issue and the opportunities to work together. The Director further revealed that she was unaware of any studies particular to this issue being conducted in the New Westminster area.

CHAPTER THREE - METHODOLOGY

Introduction

The objective of this study was to explore, from their perspective, the conflicts experienced by frontline NWPS officers when responding to calls for service regarding the mentally disordered. I feel that in order to develop strategies for the barriers and challenges revealed, it is important that frontline officers participate in this process.

To fulfill the objective of this project, a participant-driven, action-oriented research process has been chosen. Kirby and McKenna (1989) discuss how action research poses a challenge to traditional forms of knowledge creation. For instance, traditional methodologies study a subject or phenomenon from a distance, whereas action researchers work in partnership with individuals or communities. Action research encourages researchers and participants to identify barriers or concerns with the goal of creating positive change. This is a more community-oriented process, which signifies a more holistic, collaborative approach to working with partners in the community. This approach is a perfect fit for exploring the barriers that frontline police officers experience as a separate entity from the mental health system.

An action-oriented research methodology such as this lends itself to a constructivist paradigm. This perspective says "we actively construct reality on the basis of our understandings" (Palys, 1997, p. 412). As a result, it was important to design a survey that would allow the officers the opportunity to give their opinions using their experiences. By focusing on collecting data using this method, the experience and

perspectives coming from the frontline officers becomes the central focus of the research.

Keeping in mind that the overriding goal of this project was to improve the police response to the mentally ill in the community, a survey was developed and a review of a sample of case files coming to the attention of the NWPS was conducted. The case file reviews were conducted to reveal the types of calls officers face on a daily basis whereas the surveys allow the officers to estimate and give their opinions about their collective experiences. I felt that it was important to compare what the frontline officers' report in the survey and what could be learned from the case file analysis. Once the information was reviewed an analysis was made of the findings.

Action Research Paradigm

To fulfill this objective, as described previously, an action research paradigm was chosen to address this inquiry. Action research is interactive and designed for continuing development (McNiff, 2000) and is performed in the field taking into account the viewpoint of those closely associated to the inquiry. Likewise, Depoy and Hartman (1999) argue that persons most closely connected to a situation are perhaps most qualified to examine it. In this inquiry I used a combination of qualitative and quantitative methods.

Methodology

One of the methods was to design and complete a questionnaire, also known as a survey instrument. Then, an explanatory covering letter from Chief Constable Lorne Zapotichny was sent out via email to frontline officers (Appendix A). The **first component** of this project involved developing a police officer survey that was designed for this project and accepted by the Royal Roads Ethics committee (Appendix B). When designing the questions, it was important to ask questions that would reveal what the officers face when responding to Sec. 28 calls, what barriers that frontline officers experience if any, and what the attending officer saw as important in implementing strategies for improvement.

The decision to personally hand-deliver the surveys allowed me to provide a face to face explanation of what the study is anticipated to accomplish. I attended four separate "parades" (meetings held before the commencement of their working shift) providing an explanation to the officers outlining the purpose of the study. Each officer was also given a consent form to review and sign. Once the survey was completed police members were directed to seal them in a brown envelope and return them to a mail slot in the police office. The consent form was to be returned separately to the same mail slot. This was intended to assist with maintaining anonymity. (Appendix C)

As in any research process, confidentiality during this research, in a stigma-oriented focus such as mental illness, was very important. The participating police officers and mental health subjects (of the case file reviews) were assured that their involvement in

the process remained confidential. The information received either from or about them was recorded using a codification method.

The **second component** of the project involved reviewing the particulars of a sample of Section 28 MHA cases coming to the attention of the NWPS during 1999 to 2002, and a random sampling of every one-in-five cases for each year was selected.

1999: 78 cases = 17%;

2000: 96 cases = 21%;

2001: 141 cases = 31%;

2002: 140 cases = 31%.

This represented approximately 20 % of the total cases for the past four years (455). Each file was reviewed and the information was recorded on a coding sheet that was developed. (See Coding Manual: Appendix D).

This coding sheet had eighteen variables of required information that would be statistically analyzed. The variables included: Gender, age, source of complaint, number of officers assigned, time spent on the call, time and day of week, location, nature of incident, narrative report, use of force by the subject or police, medication, symptoms present at time of attendance, drug involvement, outcome and prior police calls for service for this subject. (Code Box Appendix E) was also designed to assist with recording details from the police case files. Samples of approximately 10 cases were reviewed to see if the coding manual or code box needed adjusting. It was determined that as a location of incident, bridge, as in "Patullo Bridge" should be added.

Data collected was coded and entered onto a statistical package for Social Science (SPSS) Version 10.0 database for analysis. It is expected that the case review analysis would provide details explaining what the police face on a daily basis.

A **third component** of the project involved compiling a listing of current and former listings of resources used in New Westminster to assist with the Section 28 MHA cases. This listing was developed by acquiring information the SFHA, historically charged with dealing with Section 28 MHA cases.

With the results of the case file reviews, the police officer survey, and resource list in hand, a **fourth component** of the project related to the recommendation that the stakeholders involved established an advisory committee which could provide guidance reporting the development of at least three needs which I anticipate being addressed:

1. A training program for individual officers
2. A policy respecting the police response
3. A review of the resource needs issue, for policing mental health consumers (make a case to City Council, Police Board and SFHA for training assistance and resource issues).

Research Ethics

The ethical considerations for this project were very minimal with no issues. There was only one area that required consideration while conducting research using an action

research method. Within the context of the law enforcement system and the mental health system, free and informed consent to participate was of interest.

Palys (1997) explains that free and informed consent requires the freedom to choose whether or not to participate in a process, which can be problematic when "captive audiences...are used, and/or when the researcher has some implicit or explicit power over prospective participants... ". (p.96) In the police service, members may have felt compelled to participate by virtue of their supervisors and most especially because the research was sponsored by the Chief Constable of the organization. It was made clear from the onset that they did not have to participate if they so desired.

CHAPTER FOUR – STUDY RESULTS

Introduction

In this chapter I will review the results of the case file reviews and the frontline police officer surveys. The case files revealed how and what actually took place during the calls and from the survey responses, NWPS officers told us what they are experiencing when responding to Sec. 28 MHA calls.

It was discovered that frontline police officers respond in the exact manner that they were trained too. They were trained to respond using a traditional law enforcement approach in a very reactive policing environment. This will be very evident as the results are reviewed and concluded with statements provided by the officers themselves. Further to this discovery, by using this response the NWPS officers are not effective and do not see themselves in a position to do anything to provide assistance to those who require a mental health response.

Case File Reviews

The 451 cases reviewed for this project, which represents a 20% sample of Sec. 28 MHA cases for the past four years, only represents a minimum number of actual contacts that police encounter with the mentally disordered. In the police data gathering system, calls are classified and 'scored' by incident. It is important to note for example, that in a case where a subject calls police with a complaint about peculiar behaviour, it may have been scored as "Unspecified Assist". This classification captures all police incidents that are difficult to categorize. Further to this, if a subject has been arrested for

a criminal offence, the case will be scored as break and enter, cause disturbance, or theft under.

The case file reviews were very time consuming as a random sampling of one-and-five cases for each year in a four-year period were selected. As mentioned previously in Chapter 3, the years reviewed were for 1999, 2000, 2001 and 2002. These files were obtained electronically through the police database. All were printed out and the process of coding the specific information was conducted for data entry.

In terms of the characteristics of the subjects, the findings revealed that 54% of the cases were male subjects (240 calls) and 46% of the cases were female (207 calls). The average age of the subjects was 40 years old (no difference for male or female).

Prior police calls for service for subjects

Prior police calls for service for males is one call and for females it is five. It would be worth further study to determine why this is so. This information could support other research indicating that women with mental disorders are more vulnerable and because of this may be victimized more often.

The source of the complaint

The case reviews tell us that the sources of the complaints are generated largely by a cross section of community members requesting assistance to respond to persons with a mental disorder. (*Table 1*). Sources of the complaints were by strangers, business owner/property references, friend or acquaintance, spouse/partner, parent, sibling or

other family members, and observations by police. For a very small number of cases, I was unable to locate any information in the report to indicate who made the call to police.

Table 1: Source of the call to Police

Source	Percentage*
Other community members	33
Mental Health Worker	24
Person with a mental disorder	16
Emergency Services Paramedics	12
Other Police Agencies	6
Victim	5
Police observations	2
Don't know who called	1

*percentages have been rounded to the nearest whole number

A further one-third of the calls were generated by request for assistance by "mental health workers" and Emergency health Services (EHS) (Paramedics). Of these calls, 16% were initiated by persons with mental disorders and 6% were requests for assistance by other police agencies. It is interesting to note that "proactively" only 2% were initiated by NWPS officers themselves, or more operationally known as creating an "on-view" file.

Time spent on Calls and Number of Officers assigned to one case:

Officers spent an average of 53 minutes per call. Of those cases,

- 54% required 2 officers, each operating two separate police vehicles.
- 22% required 1 officer and would not be unusual if the officer is only to attend the hospital to obtain a "Warrant of apprehension" for an elope;
- 16% required 3 officers
- 4% required 4 officers and,
- 4% required 5 officers

Day of Week

The calls were spread out throughout the week, but it was interesting to find that most calls seemed to take place on Wednesdays. For persons relying on social assistance, this day, also referred to as "Welfare Wednesday", is the day that they receive their social assistance cheques. (*Table* 2). This could warrant further study to determine why more calls to police take place on Wednesday and the lowest numbers of calls take place on Thursdays.

Table 2: Day of the Week that most calls take place

Day of week	Percentage*
Sunday	15
Monday	15
Tuesday	13
Wednesday	19
Thursday	10
Friday	14
Saturday	14

* Percentages have been rounded to the nearest whole number.

Time of Call

Section 28 MHA calls for service take place throughout a 24-hour day. What was interesting was that 18 % of the calls take place between midnight and 9:00 am. (When there is no access to after-hours emergency services). From 9:00 a.m. to 5:00 p.m., police respond to 38% of the calls. The busiest time for officers is when they first come on night shift, 45% of the calls take place between 5 pm and midnight. (*Table* 3). The peak hours for responding to calls are at 8 pm with a percentage of 10%.

Table 3: Time of Sec. 28 MHA calls

Time of Call	Percentage*
12 Midnight to 0:900 am	18
0:900 am to 5 pm	38
5 pm to Midnight	45

*Percentages have been rounded to the nearest whole number

Location

The location most commonly attended by police 58% of the time is at the subject's home. (*Table 4*). Of the other Sec. 28 MHA incidents 14% were attended to on the street. Another 10% of the incidents were generated from a hospital setting. Incidents involving commercial or business locations took up 6% of the calls. In extreme cases, subjects would bother patrons either inside the store, or just outside the location. This was seen by the business owner or representative to be disruptive to their business and perceived as frightening or intimidating by some customers.

New Westminster police officers find themselves attending the "Bridge" for suicide attempts for 5% of Sec. 28 MHA calls. These calls usually require lengthy negotiation by police with the subject and are not resolved without impacting the Lower Mainland with traffic 'gridlock". The police will shut down the bridge completely in order to control the scene for the safety of all involved. The resources used in these calls require a minimum of three cars to stop traffic on the New Westminster side of the bridge, and an additional car from the neighbouring municipality to stop traffic on the opposite of the bridge.

Two members are usually up on the bridge deck with the subject. EHS and fire are usually on standby as well as search and rescue personnel in the water below. These cases can be time consuming ranging from 2 hours to 7 hours.

Table 4: Locations Most Commonly Attended By Police

Location of Call	Percentage*
Subjects home	58
Street	14
Hospital setting	10
Other Commercial or Business	6
Bridge	5
Other's home	4
Bar / Restaurant	2
Don't know	1

*Percentages have been rounded to the nearest whole number.

Nature of Incident

The nature of the incident as recorded from the case file information tells us that the majority of incidents that NWPS are requested to attend are for suicide threats or attempts. (*Table 5*). The information reviewed in those files was not very descriptive in the method used or attempted to use to take ones life. For example, in a case of attempted suicide by ingesting pills, there was no information on what kind and/or how many.

The second number of incidents coming to the attention of police was "other" – not classified, with 14%. As I continued to review files, it was soon discovered that not included in the coding manual was a classification for calls received from the subjects themselves. The subject was most likely experiencing an episode of paranoia, hallucinations or delusions and would call police to report that some one was out under their deck in the backyard. Or other examples would include subjects calling to report that someone was in his/her home and was going to harm him/her. Police attend and strategically set up a "perimeter" and treat the call as if it was a criminal investigation such as break and enter or trespassing. After discovering that the call was "unfounded", from a law enforcement perspective, the police members leave and go on to the next call.

Calls received from hospital facilities in the city of New Westminster amount to 13% where subjects are reported as "Elopees". This is where subjects leave the psychiatric hospital without permission and are still in treatment. Warrant of apprehensions will

have been signed by a doctor giving police the authority to return the patient to the hospital. Police are required to attend the reporting facility to obtain further details, photos and the signed warrant for the police master file. Of all the Sec. 28 calls reviewed, 10% of the incidents were described as disorderly or disruptive. Mental health workers called police for 9% of the incidents to standby while they conduct a mental health assessment.

Table 5: Nature of Incident Requiring the Attention of Police

Nature of Incident	Percentage
Suicide Threat or Attempt	38
Other – not classified	14
Elopee / Warrant of Apprehension	13
Disorderly / Disruptive behaviour	10
Mental Health Assessment	9
Threat of Violence To Others	8
Neglect Of Self-Care	4
Nuisance (Loitering/panhandling)	1
Interfering With Business	1
Public Intoxication	.2

*Percentages have been rounded to the nearest whole number.

This information from Table 5 tells us that the NWPS is attending to calls that clearly require a mental health approach, not the traditional law enforcement approach. In order to answer my original research questions of "what is required to help the NWPS work with the mental health system to improve communication, training, information sharing,

and the referral system to provide a better service to the community of New Westminster, we have to address how the NWPS are responding. Repeat calls to persons with mental disorders will occur by continuing to use this 'traditional' response. In order to be better able to work with the mental health system, the NWPS will have to begin with training to provide a better understanding as to why it will be important to change this response. The NWPS along with the mental health system will be challenged to find a way, as first responders, to have persons directed more quickly into the mental health system where they can be provided the follow up care and treatment required.

Narrative Reports

When reviewing the case files, it was astounding to see that 84% of the police reports were concluded in 229 characters or less. (Approximately three typed written lines of information or less). This further supports that NWPS officers are using a law enforcement approach for their response to Sec. 28 MHA cases. (See *Table* 6 for details). For the remaining reports, 16% recorded information using a narrative report. In revealing some of the reports that included a narrative (short or otherwise), the investigating officers were able to provide enough information in a very succinct and concise manner that enabled me to answer the coding manual.

Table 6: Narrative Reports

Narrative Reports in file	Number of files	Percentage*
Yes	73	16
No	381	84

*Percentages have been rounded to the nearest whole number

Use of force (by subject)

While attempting to record this variable of use of force by subject, without more than 229 characters, there wasn't enough information to conclude whether the subject was passive, aggressive, uncooperative, or compliant. With this challenge, I was only able to take the information recorded by the officer in the report to answer the five areas describing whether use of force was used by the subject. It is to be noted that although I have the operational experience and knowledge of what may have taken place in the case, I would only record what was written in the report. (*Table* 7)

Table 7: Use of Force By Subject (as indicated in the report by Officer)

Use of force	Percent*
None	80
Violence	11
Edged Weapon	5
Threat	4
Gun	.4

*Percentages have been rounded to the nearest whole number.

From the cases presented, 80% of the reports indicated that the subject was not involved in the use of force. The traditional law enforcement response prepares officers for the violence. It is clear by the case reviews that less than 20% of the calls require a response that deals with safety, security and public order, and deals with individuals that require a mental health response.

Medication

There was no information available concerning prescribed medication in 90% of the reports. Further to this, reports of non-adherence of medication were only reported in 5% of the cases.

Table 8: Medication Information from the case files

Information regarding medication	Percent*
No information available concerning prescribed 'meds'	90
Subject or other reports non-adherence with prescribed 'meds'	5
Subject or other states has been taking prescribed 'meds'	3
Subject or other states has been prescribed 'meds' but unsure about adherence	2
Subject or other states has not been prescribed medication	.2

"Meds" used in this context, refers to any medication that is prescribed to the subject that would treat a mental disorder

Symptoms present at time of attendance

The lack of information regarding the symptoms was very surprising (*Table 9*). If the NWPS is considering working with the mental health system, then the recording of specific information in the files is crucial. If information sharing were to take place, with the report writing practices that stand today, the NWPS would not be in any helpful position to offer any information of value to the New Westminster Mental Health case

workers. This change in approach will enhance the communication that is very much remiss at this time.

Table 9: Symptoms Present At Time of Attendance By Police

Symptoms	Percentage
Don't Know	59
Depressed (feelings of worthlessness & sadness)	12
Belligerent or uncooperative (hostile and angry)	11
Disorganized or bizarre behaviour	4
Confused / disoriented	4
Delusions	4
Unusually frightened or scared	3
Hallucinations	1
Disorganized speech (incoherence)	.2
Manic (elevated/expansive mood, distractible, flight of ideas)	.2

Drug involvement

While examining this response in *Table* 11, 81% of the reports reviewed did not have any information pertaining to drug involvement. The investigators (writers) either don't know or have not recorded this important information.

Table 10: Drug Involvement (by subject)

Drug information from report	Percentage
Drugs	12
Alcohol	4
Both	4

Use of Force (by officer)

Only 5% percent of the cases indicated any kind of use of force.

Table 11: Use of Force by Officer When Responding To Calls

Was Use of force used?	Percentage
No	95%
Yes	5%

Outcome

In general, the officers' estimates of outcome came quite close to actual figures: an actual 51% for subjects transported to the hospital – 54% estimated by officers an actual 28% for No action resolved at scene, - 31% estimated by officers; however, an actual 6% for Crisis intervention at scene – 25% estimated by officers – which may be due to officers not recording information explaining the action taken.

Table 12: Outcome

Outcomes	Percentage
No action taken, resolved at scene	28
Transport to RCH psyche emerge (Sec 28 Involuntary)	25
Transport to RCH psyche emergency (voluntary)	13
EHS transports to psyche emerge from the scene	13
Crisis intervention at scene	6
Transport to other facility	5
Police escort subject to local mental health centre.	3
Police notify after hours mental health for follow-up	3
Unfounded Sec. 28 MHA allegations	3
Admit to hospital for medical (non-psyche) reasons	2
Arrested for a criminal offence	1

Survey Results

The survey respondents were frontline police officers who are currently assigned to general duty patrol or who have recently left patrol and transferred to another assignment. The respondents replied to the questions reflecting on their perceptions of what they experience while responding to Sec. 28 MHA calls. Of the 47 officers given the surveys, 33 returned them for a 70% response rate. One third of those respondents has university degrees. There was an average of 13 years of service for those officers participating in the survey and, according to information obtained from the Human Resources section of the Corporation of the City of New Westminster, this is consistent

when compared to the average 14 years of service of all NWPS members. (Pahau, Georgia, Assistant to the Director of Human Resources, Corporation of the City of New Westminster, personal communication, 2003).

The officers were requested to recall the past six months and estimate how many calls involving emotionally disturbed persons (EDPs) that they attend to during an average workweek. (EDPs will also be referred to as 'subjects' or persons with a mental disorder) The average was 5.4 calls. This would be the equivalent of one call per shift.

Each member was asked to think of the last 10 subjects that they had contact with and indicate the characteristics observed. As Table 13 shows, 70% of the respondents perceived that they witnessed persons with an apparent mental disorder "exhibiting irrational behaviours". The officers also reported that during attendance, the subjects were not in the company of another person 62% of the cases. The officer's also estimated that 60% of those subjects were not taking their prescribed medication. If you examine the top five characteristics, the officers are telling us that they are attending these calls and are faced with people that are not in need of a law enforcement approach, but a specialized mental health approach. The subject lives a lone, displaying irrational behaviour, not taking their medication, living arrangements unkempt, feeling or threatening suicide.

Table 13: Officers' Estimate of the Percentage of EDPs Who Show Selected Characteristics

Characteristics	Percentage
Exhibiting irrational behaviours	70
Not in the company of another person	62
Not taking their prescribed medication	60
Living in unkempt living conditions	57
Threatening suicide	48
Threatening violence	39
Under the influence of alcohol	32
Were a threat to their immediate community	31
Under the influence of illegal drugs	28
Posed a threat to Officer's safety	21
Were a threat to their partner or spouse	19
Were a threat to a friend /acquaintance	18
Were a threat to a stranger	18
Were a threat to another family member	17
In possession of a weapon	13

In over 56% of the cases, the officers report that the outcomes are usually providing on-scene crisis intervention or no action taken/resolved at scene. This response can only be a temporary solution with no opportunity of follow up by mental health personnel, because of the traditional law enforcement response mode. (*Table* 14)

Table 14: Officers Report How EDPs are Responded To

Response	Percentage
No action taken/ resolved at scene	31
On scene crisis intervention	25
Sec. 28 apprehension and taken to psychiatric ward	54

The next area of the survey asked the respondents to circle one answer that best describes how they feel. Using a Likert scale (Very unprepared, Somewhat unprepared, Neither, Somewhat prepared, and Very prepared). The respondents were asked, "how well prepared do you feel when handling people with mental illness in crisis?" 82% stated "somewhat prepared" and 9% stated "Very prepared". No one respondent felt "Very unprepared". This is very incongruous as the case file reviews showed that NWPS officers clearly are unable to identify symptoms of what is occurring with the people with whom they come into contact during Sec. 28 MHA calls.

The next series of questions also used the Likert scale (*Table 15*) in which the data tells us that the NWPS officers are really not aware of how little they actually do during Sec. 28 MHA responses. For instances, 55% of the respondents feel that the Police service is "Somewhat effective". Once again, this discrepancy is supported by the lack of report writing of observable symptoms, medication non-adherence, drug involvement and use of force.

Table 15: Officers' Perceptions of How Effective the Police Service is when Handling EDPs in terms of accomplishing the following objectives

Objectives	Very ineffective	Somewhat ineffective	Neither	Somewhat effective	Very effective
Meeting the needs of people with mental illness in crisis	9%	24%	6%	55%	6%
Keeping people with mental illness out of jail	12%	24%	15%	42%	6%
Minimizing the time officers spend on these types of calls	21%	49%	9%	21%	0%
Maintaining community safety	3%	21%	9%	58%	9%

The survey also gave the respondents an opportunity to describe "how easy it was to admit a person with mental illness to the psychiatric ward when necessary". Overall, some 55% of the respondents found it "Somewhat difficult" and 21% found it "Somewhat easy". Only 18% found it "Very difficult".

A final question revealed that 42% of the respondents felt that they received "Somewhat adequate" amount of information about the subject in crisis during Section 28 MHA calls to safely do their jobs (or respond). Of the respondents 30% said "Somewhat inadequate".

Respondents' Answers to Four Police Survey Open-ended Questions

The Police surveys gave the respondents an opportunity to answer four questions:

What, in your opinion, are the key elements to effective police response to persons with mental illnesses (e.g., what would you need to do your job well?)

The NWPS officers offered many individual opinions in answering the above question. What was very clear was that the majority of the respondents requested the need for more training and education as first responders. Here is what NWPS officers have told us:

> "Better education for members about prescribed medications"
>
> "Better education and information about the types of mental illnesses police encounter"
>
> "Update/annual training from credible mental health professionals"
>
> "More education in terms of Sec.28 MHA apprehension 'rights' "
>
> "More knowledge of specific mental illness options when subject not posing danger"
>
> "Better training, more resources"
>
> "Training in how to identify these persons as compared to the alcohol/drug influenced persons"
>
> "Education and access to contacts to call for assistance outside the police community"

These comments speak to better training, but very few were able to suggest specifically what the training might look like.

What do you feel is the single most difficult or frustrating factor you encounter when you attempt to respond to calls involving people with mental illness in crisis?

The respondents identified a few issues that they felt were most difficult or frustrating when they attempt to respond to calls involving people with mental illness in crisis. The first most notable issue is the 'process' that officers must go through once they apprehend a person under S. 28 MHA and attend the Royal Columbian Hospital (RCH) psyche emerge. The officer is expected to wait a significant period of time before the patient is seen by a doctor. The officers then find that the subject is then released soon after. NWPS members describe this as the "revolving door syndrome". This is what some of the officers told us about this:

> "Sec. 28 arrest, waiting for an extended time, and then they are released almost immediately"
>
> "The attitude at RCH. Very frustrating to bring someone in and then have them released an hour later"
>
> "Knowing that although we may intervene chances are their time at hospital will be minimal".
>
> "Lack of cooperation from RCH admitting staff. Members are told to stay with the subject until assessed by a doctor. We should be able to fill in the "score sheet" have the triage nurse ok it, and leave the person for security".
>
> "Wait at RCH for both police and patient".
>
> "Knowing that there is little help we can give. Knowing people that are found on the outside railing of a bridge will likely be released the next day and back on the bridge again".
>
> "When arresting under Sec. 28, the lack of assistance by RCH. i.e. (sic) time waiting to admit, combined with the fact that they are discharged so quickly".
>
> "Waiting at hospital for too long. Revolving door aspect where mentally ill patients walk away from institutions; warrants issued; returned; walked away; warrants issued".

"RCH psyche emerge!"

A second issue identified by the respondents relates to what to do with a person who is not Sec. 28 MHA but is in need of help. Officers claim there is a lack of effective support, after care or follows up by mental health personnel and/or hospital. They also made mention of a lack of available shelters that are safe. NWPS officers told us that they were further frustrated with the following comments:

> "Attending multiple calls to same address/ person (revolving door) released from medical facility with no solutions to problem".
>
> "The fact that I have probably dealt with the same person only a week ago and all the person needs is a safe place to live with medical attention. They should not be living alone".

A third area of frustration expressed by NWPS members is that they report not being able to access an on-call mental health worker who can access the 'subjects' file and provide important background info 24/7.

Can you think of anything the mental health system could do to be more responsive to police officers in responding to crisis calls involving persons with mental illness?

NWPS officers identify a number of areas that the Mental Health system could do to be more responsive to them. Overwhelmingly, they told us that they require immediate access to an on duty Mental Health worker available 24 hours, who would be in a position to provide background information and to attend calls with members if required. This was also described as "establishing a crisis outreach and support team" or teaming a trained police officer and psychiatric registered nurse together. This team would

provide continuity on follow-up care to monitor the treatment process and any repeat calls.

Secondly, review policies at hospital requiring members to sit and wait with patient until they see a doctor. Here is what the officers told us in the survey:

> "Provide more detailed criteria on what they will treat and not treat rather than releasing people before we have even left the parking lot. It wastes our time, deranged persons time, and the hospitals time".
>
> "More direction/policy on the role of the police officer at the hospital - where does the police officers role end and the doctor's start?"
> "More assistance from Mental health staff"
> "Clarification on 'presenting EDPs to a physician and leave them at the hospital"

How do you feel about conducting risk assessments of EDPs at the street level?

Over half of the respondents felt positive about conducting risk assessments of EDPs at the street level. This is a contradiction to what has been discovered from the data. The other half was very candid in revealing that they didn't feel comfortable or trained enough to do this. In fact NWPS officers don't see themselves in a position to do anything about the mentally ill. This incongruity is supported by the lack of recorded information in the reports (No narrative reports in 84% of the cases) regarding observable symptoms (59% of cases don't indicate any symptoms) medication (90% reports don't have any information available regarding prescribed meds). Some of the comments reported by the respondents reflected this sentiment. This is what they told us:

> "I am usually not able to describe the behaviour to medical staff".

> "I feel under trained and think that the psyche department at Royal Columbian hospital should train us and this would lead to a closer working relationship and allow us to work more efficiently and assess patients more accurately."
>
> "I don't think I am properly trained to perform this duty"
>
> "no problem, until you try to convince a doctor what a police officer sees on the street."
>
> "need more training."
>
> "not very comfortable, but do it all the time."
>
> "not our place too – not trained in this capacity."

While reviewing all 33 responses to this question I recorded the year's service and education levels attained by the respondents. It was interesting to note that when it comes to Section 28 MHA calls, NWPS officers at all levels of education and years service are requesting more training and assistance.

Summary

In summary, the results of these case reviews and comments from the officers in the surveys suggest the following:

(1) Police use a traditional law enforcement response for those suffering from an apparent mental disorder. This perpetuates the repeat calls.

(2) Two officers spend on average 53 minutes at a Sec. 28 MHA call and 84% of the officers conclude their reports by writing three lines or less.

(3) Requirement for training by mental health personnel in the area of recognizing symptoms and recording them in the police reports.

(4) This information of recorded observable symptoms must find its way to case workers in order to solicit a quicker response by mental health services to those in need.

(5) Policies for NWPS must be revisited to change the response from a traditional law enforcement response to community policing model of service delivery.

(6) In order to remove barriers and challenges, the New Westminster Police Service will be required to work in a collaborative manner with the mental health authorities.

CHAPTER FIVE – SUMMARY AND RECOMMENDATIONS

Introduction

This research project has been undertaken to improve the NWPS response to mental illness in the community. The intent was to reveal what is required to help the NWPS work with the mental health system to improve communication, training, information sharing, and the referral system. It was also initiated to provide a better understanding of the barriers and challenges that police officers face each and everyday with the hope that these issues can be alleviated to some degree. With the findings, all stakeholders involved may be in a better position to cooperate with each other to provide a better service to those with mental disorders living in the community of New Westminster.

Chapter One describes the challenges and issues faced by the NWPS when responding to the ever increasing calls involving the mentally disordered. It also discusses what may happen if action is not taken to improve these issues and work towards a collaboration of the two systems.

Chapter Two looks at the NWPS's documents, reviewing the most current policy with respect to the guidelines and expectations of police officers when responding to calls relating to the mentally disordered. The NWPS Mission, Vision and Values were also reviewed to determine whether the philosophy of the NWPS meets the needs of citizens in the community who are mentally disordered. Reviews of the literature available on the topic and theories that can be applied are also included.

Chapter Three describes the approach and the methodology used to conduct the research, including the development of the survey instrument, ethical considerations and the process undertaken.

Chapter Four presents the findings of this project. The case file reviews revealed a theme of how the NWPS frontline officers respond and what actions are taken. The survey provided frontline officers an opportunity to tell us what they are experiencing out in the field on a daily basis and to what extent do they feel helpful when handling Sec. 28 MHA cases.

This Chapter will examine the research results and the themes that emerge from the surveys and case file reviews. This new knowledge should assist in suggesting ways to address the research question of "What is required to help the NWPS work with the mental health system to improve communication, training, information sharing and the referral system to provide a better service to the community of New Westminster?" Furthermore, this new knowledge should also assist with suggesting ways to reduce the identified barriers, challenges and limitations that the frontline officers are experiencing when handling Sec. 28 MHA calls.

To begin, as the outcomes of responses were examined the during Sec. 28 MHA calls, the following took place: Half of the cases resulted in police apprehending the subject and transporting to the hospital psychiatric ward. (Half were involuntary apprehensions by police, the other half of the subjects agreed to be transported to hospital voluntarily

by either police or paramedics.) In 28% of the cases no action was taken and was resolved at the scene. For the remaining number of cases, a myriad of different outcomes took place, which was not in anyway appropriate in resolving the issue of repeat calls. The NWPS organization has to ask itself what it is that they are trying to accomplish when responding to Sec. 28 MHA calls.

Through extensive basic training all police officers are well trained as "law enforcers". However, from the survey results, only 55% of NWPS officers perceived that the Police Service is "somewhat effective" in terms of meeting the needs of people with a mental disorder in crisis. It is apparent from the findings that the frontline officers are working within a framework that responds to using the "traditional law enforcement" response. Police officers attend; maintain public order and safety, and when there is no evidence for a criminal charge, the officers leave, writing off the case in three lines or less. When attending to calls for persons with a mental disorder, what these subjects really require is a mental health response. What should perhaps happen is that officers be trained to understand how important their role is in bringing the mental health system into the picture more quickly for those repeat Sec.28 MHA calls. In suggesting improvements in this area, NWPS members could be better trained in what to include in their reports and how to document in a succinct but concise manner by the very system with which they should collaborate.

Communication

In addressing improvements in the area of communication, a number of factors have been identified. First, from the case file reviews it was learned that NWPS officers are spending an average of 53 minutes per Sec. 28 MHA call and in 84% of those cases are concluding their reports with less than three written lines. Further to this, in 59% of the cases reviewed, the officers are not recording any of the symptoms of behaviour present while in the company of a subject. From the findings of the police officer surveys, the respondents estimated that they witnessed persons with an apparent mental disorder "exhibiting irrational behaviours" 70% of the time.

Once again from the case file reviews, 90% of the cases have no information available concerning prescribed medication yet, from the survey information, officers estimated that in more than 60% of the cases, the subject was not taking medication. If a Mental Health caseworker or psychiatric nurse were to request the NWPS to provide information of value about the symptoms of a repeat Sec. 28 MHA subject, it is unlikely that the NWPS would be of assistance. Police officers with specialized training could be more helpful in getting patients into the mental health system sooner, if they were better advised on what specifically would be required to be more helpful. Further, NWPS officers do not have any method of liaising with Mental Health at this time to forward their reports. It is my contention that this may perpetuate the reasons why the recording of information has not been considered as important.

Training

An important part of any training has to include a segment which informs and educates the stakeholders as to why they may consider changing the current system of response in the first place. The NWPS members need to be apprised of the research findings to become familiar with what is actually taking place. They will then be given a review describing the differing policing styles and philosophies of policing, but most specifically the practices of the NWPS, for example "traditional law enforcement" versus the "community policing response". Once this is apparent to the stakeholders, there may be an interest to take further steps to assess the NWPS response.

The survey responses also revealed an overwhelming request by NWPS officers of the need for more training and education in the area of frontline response. Using the findings of the case reviews and having representatives from mental health and police working together would assist with the collaborative design of a specific training program suited to the needs of the NWPS. In order to collaborate with another system the NWPS must make the necessary organizational changes to become boundaryless. The NWPS would focus on allowing an outside agency (namely Mental Health) to become involved with how the NWPS delivers its services to the community.

Information Sharing

Currently amongst the two systems, information sharing has its limitations because of confidentiality issues. There are options available to alleviate this barrier, but it will take all stakeholders involved to decide on which one to pursue.

Referral System

NWPS frontline officers appear to be familiar with the After-Hours Emergency Mental Health Service but have not been able to formally organize a liaison with one person. Therefore, referrals are almost non-existent. This was very evident in the case file review for outcomes, as only 3% of the cases were referred to mental health for follow up by the NWPS frontline officers. This is an area that requires close attention as it is clear that NWPS officers have no knowledge of what services are provided by the Mental Health system in the community. This information has to be included in the training segment to be developed.

Barriers and Challenges

It was apparent from the barriers and challenges expressed through the survey that the NWPS frontline officers would be interested in decreasing the wait time at the hospital and would also increase the likelihood that the person they apprehend under Sec. 28 MHA will receive the proper care. Suggestions to address this issue are available for inclusion into the development of any new policies that the NWPS would like to incorporate. This information can be obtained from a growing resource such as the Canadian National Committee for Police/Mental Health Systems Liaison. What should also be kept in mind as a police organization is that the above challenge is a major systems problem that is not going to be easily addressed solely by a police service.

Another challenge faced by the NWPS as stated in the survey, was the revolving door system. As mentioned previously, perhaps "specific" training by mental health

personnel regarding the precise symptoms and behaviours on which to focus when recording these observations would make it more difficult for the hospital to refuse admitting the subject. If in fact the subject may still be released soon after being admitted, the NWPS will have covered themselves with specific and appropriate reporting and by presenting the subject to the hospital for care.

What to do Next?

The New Westminster Police Service should form an advisory committee of personnel representing both systems. There is a requirement for continued efforts to seek cooperation and input from the mental health system to educate NWPS members on the available resources and how to efficiently access them. This step will most likely be achieved with the support of the NWPS Senior managers and the directors of the Fraser Health Authority. It is anticipated that a model of response that meets the needs of both the NWPS organization and Fraser Health Authority will be suggested in an attempt to address the opportunity for a systems change for responding to persons with mental disorders in crises within the community of New Westminster. When the NWPS and the mental health system work together, it is hoped that they will determine how best this will be accomplished.

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APPENDIX A

03-06-20

Gwen Ranquist has been working on her Master's Degree in Conflict Analysis and Management at Royal Roads University since October 2001. As a partial requirement for graduation she is required to complete a major project.

She has chosen to examine the "Police response to mental illness in the community". Over a four-year period, our Service has experienced a significant increase in Section 28 calls relating to the apprehension of the mentally ill. As part of Gwen's study, she requires that members who are currently on patrol or who have recently transferred to other sections complete a short questionnaire that will only take 10 minutes of your time.

Each and every one of you will have a valued opinion and provide important input with all of your collective experiences, both positive and negative. I am encouraging you to take part in this project so that we as an organization can benefit from the findings and assist Gwen in completing her academic requirements.

Gwen Ranquist will be attending your on-shift parades to answer any of your questions and give more specific direction on completion of the questionnaire.

Thank you.

APPENDIX B

Improving the Police Response to Mental Illness in the Community

Directions for Research Participants

This questionnaire asks about your role as a police officer when responding to calls for service pertaining to Sec. 28 (MHA) calls. It should only take you abut 10 minutes to complete. If you would like to discuss it with me, you can reach me at (604) 525-5411

Once completed, could kindly enclose the questionnaire in the envelope provided and return it back to me along with the Research Consent Form. You can seal the envelope and hand it to me personally or leave it in the mailbox marked "Mental Health" in the report centre.
For those of you who will not be in the police office before the **June 26th** return date, please contact me by phone and I will arrange to pick it up in person.

If required, please mail it to:

Gwen Ranquist
B Watch – Patrol Division
New Westminster Police Service,
555 Columbia Street,
New Westminster, B.C.
V3L 1H9
Thank you for your assistance in this project.

1. **How many years service do you have?** _____ **years.**

2. **What level of education have you attained:** _____ High school
   _____ Some College
   _____ Diploma/Certificate
   _____ University Degree

3. **Over the last six months how many calls involving emotionally disturbed persons (EDPs) do you attend during an average workweek?** _____ **calls.**

4. **In your opinion, of the last 10 emotionally disturbed persons that you had contact with, while on duty, how many:**

   a. posed a threat to your personal safety? _____

   b. were a threat to their immediate community? _____

   c. were a threat to their partner or spouse? _____

   d. were a threat to another family member? _____

   e. were a threat to a friend /acquaintance? _____

   f. were a threat to a stranger? _____

5. **Thinking again of the last 10 (EDPs) that you have had, how many were:**

   a. not taking their prescribed medications? _____

   b. under the influence of alcohol? _____

   c. under the influence of illegal drugs _____

   d. threatening suicide? _____

   e. threatening violence? _____

   f. exhibiting irrational behaviors? _____

   g. in possession of a weapon? _____

   h. not in the company of another person? _____

   i. living in unkempt living conditions? _____

6. Once again thinking about those last 10 emotionally disturbed persons, how many were dealt with by:

a. no action / resolved at scene _____

b. on scene crisis intervention _____

c. Sec. 28 apprehension and taken to the psychiatric ward _____

Please circle one for each answer:

7. How well prepared do you feel when handling people with mental illness in crisis?

1	2	3	4	5
Very unprepared	Somewhat unprepared	Neither	Somewhat prepared	Very prepared

8. Overall, how effective do you believe we as a Police Service are in handling people with mental illness, especially in terms of accomplishing the following objectives:

i. **Meeting the needs of people with mental illness in crisis?**

1	2	3	4	5
Very ineffective	Somewhat ineffective	Neither	Somewhat effective	Very effective

ii. **Keeping people with mental illness out of jail?**

1	2	3	4	5
Very ineffective	Somewhat ineffective	Neither	Somewhat effective	Very effective

iii. **Minimizing the amount of time officers spend on these types of calls?**

1	2	3	4	5
Very ineffective	Somewhat ineffective	Neither	Somewhat effective	Very effective

iv. **Maintaining community safety?**

1	2	3	4	5
Very ineffective	Somewhat ineffective	Neither	Somewhat effective	Very effective

9. How easy is it to admit a person with mental illness to the psychiatric ward when it is necessary?

1	2	3	4	5
Very Difficult	Somewhat difficult	Neither	Somewhat easy	Very easy

10. Do you feel you receive an adequate amount of information about the subject in crisis during Sec. 28 calls to safely do your job (or respond)?

1	2	3	4	5
Very inadequate	Somewhat inadequate	Neither	Somewhat adequate	Very adequate

11. What, in your opinion, are the key elements to effective police response to persons with mental illness (i.e. what would you need to do your job well)?

12. What do you feel is the single most difficult or frustrating factor you encounter when you attempt to respond to calls involving people with mental illness in crisis?

13. Can you think of anything the mental health system could do to be more responsive to police officers in responding to crisis calls involving persons with mental illness?

14. How do you feel about conducting risk assessments of emotionally disturbed persons at the street level?

APPENDIX C

RESEARCH CONSENT FORM

Dear Officers:

I am writing to ask for your participation in my research project concerning 'Improving Police Response to Mental Illness in the Community.' I am a graduate student at Royal Roads University in Victoria, British Columbia, in the Master of Arts (Conflict Analysis and Management) degree program. The research project is part of the requirements for the M.A. program and is titled:

"Improving the Police Response to Mental Illness in the Community"

You may check my academic credentials with Royal Roads University by telephoning
Dr. Jim Bayer, Dean of Conflict Analysis and Management Program, Royal Roads University at (250) 391-2568 or Ms. Sandra Lewis, Program Associate, at (250) 391-2654.

As front line officers attending a growing number of mental health related calls, your input will assist our Police Service in better preparing and educating ourselves. The study will enhance current practices and assist us to become more effective when dealing with issues presently encountered within New Westminster.

This document is an agreement for you to take part in this research project. The research consists of a short written questionnaire concerning your experiences and opinions as an officer responding to Section 28 (MHA) calls for service. Your participation in this research project should not take more than 10 minutes.

I will record your information from your completed and received questionnaires. Where appropriate, I will summarize your comments anonymously in the final report. I will not attribute specific comments to you unless you agree to this beforehand.

I will also be reviewing a sample of the Section 28 (MHA) calls that we have attended in the past five years. Using a coding manual to enter the data and then analysing it, it is anticipated that the analysis will provide our police service information that we can use to assist in improving our response in a technical and operational way. A copy of my final report will be made available to you and stored at Royal Roads University.

You are not compelled to participate in my research project. If you decide to take part, you can withdraw at any time with no prejudice to you personally or in relation to your police duties. If you decide to not participate, I will keep this information in confidence and not reveal this to your colleagues or supervisors of your decision not to participate. There is no cost to you to participate.

By signing this letter, you give free and informed consent to participate in my research project.

Name: _____

Signed: _____ Date: _____

APPENDIX D (Coding Manual)

CODING MANUAL

Var #		Variable Descriptions / Codes
1.		Gender 1= male, 2= female
2.		Age
3.		Source 1= EHS, 2 = victim, 3 = deranged, 4= police 5= mental health worker 6= other police agency 7= other com 8 = don't know
4.		Complainant status (refer to code box # 1)
5.		# of officers assigned
6.		Time spent (# of minutes)
7.		Day of week = 1-7 (Sunday to Saturday)
8.		Time = 1-24
9.		Location (refer to code box #2)
10.		Nature of Incident (refer to code box #3)
11.		Narrative report 1 = yes 2 = no
12.		Use of Force (subject) 1 = none, 2 = threat, 3 = violence, 4 = edged weapon, 5 = gun
13.		Medication (refer to code box #4)
14.		Symptoms present at time of attendance (refer to code box #5)
15.		Drug involvement 1 = drugs, 2 = alcohol, 3 = both, 4 = don't know
16.		Use of force (officer) 1 = yes, 2 = no
17.		Outcome (refer to code box #6)
18.		Prior police calls for service for this subject
19.		Investigating officer's pin number

APPENDIX E (Code Box)

Code Box #1 Complainant status	**Code Box #2 Location of Incident**
1 = spouse/partner 2 = parent 3 = sibling 4 = other family member 5 = friend or acquaintance 6 = business owner/ property reference 7 = observations by police 8 = stranger 9 = don't know 10 = not applicable	1 = subject's home 2 = other home 3 = street 4 = bar / restaurant 5 = subjects workplace 6 = other commercial or business 7 = hospital setting 8 = bridge 9 = Don't know
Code Box #3 Nature of Incident	**Code Box # 4 Medication**
1 = Disorderly / disruptive behaviour 2 = Neglect of self – care 3 = public intoxication 4 = Interfering with business 5 = Trespassing 6 = Nuisance (loitering, panhandling) 7 = Destruction of property 8 = Theft/other property crime 9 = Suicide threat or attempt 10 = Threat of violence to others 11 = elope / warrant of apprehension 12 = mental health assessment 13 = other	1 = subject or other states - has not been prescribed meds to treat a mental illness 2 = subject or other states - has been taking medications as prescribed 3 = subject or other - reports recent non-adherence with prescribed meds 4 = subject or other reports he/she has been prescribed meds but unsure about adherence 5 = no information available concerning prescribed medication to treat a mental illness
Code Box #5 Symptoms at time of attendance	**Code Box #6 Outcome of case**
1 = confused / disoriented 2 = delusions 3 = hallucinations 4 = disorganized speech (incoherence, etc) 5 = disorganized or bizarre behaviour 6 = manic (elevated/ expansive mood, distractible, flight of ideas, pressured speech, inflated self esteem) 7 = depressed (loss of interest in activities, loss of energy, feelings of worthlessness, sadness) 8 = unusually frightened or scared 9 = belligerent or uncooperative (hostile/angry) 10 = don't know	1 = no action taken, resolved at scene 2 = crisis intervention at scene 3 = police notify after hours mental health for follow up 4 = police escort deranged to local mental health centre 5 = transport to RCH psych emerge (voluntary) 6 = transport to RCH psych emerge (sec 28 involuntary) 7 = transport to other psych facility 8 = admit to hospital for medical (non psych) reasons 9 = EHS transport to psych emerge from scene 10 = arrested for criminal offence 11 = unfounded Sec. 28 MHA allegations