THE VICTORIA POLICE DEPARTMENT AND RESPONSE TO PEOPLE WITH MENTAL ILLNESS

By

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We accept this thesis as conforming

to the required standard

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ABSTRACT

The purpose of this project is to provide the Victoria Police Department (VPD) with recommendations and identify strategies to enhance its response to people with mental illness. Using action research, members of the VPD Primary Response Division were surveyed. Key findings were that VPD members' knowledge base regarding mental illness is varied, the VPD and Vancouver Island Health Authority (VIHA) interface is critical, collaborative initiatives between VPD and community agencies are vital, training and education in the area of mental illness is considered valuable, and a lack of community resources is a critical factor in criminal behaviour. Recommendations include establishing a steering committee, establishing service agreements to enhance the relationship with VIHA, developing policy to ensure the longevity of any initiatives and agreements, developing a post-academy training schedule and curricula for the members of VPD, and continuing to support community partnered initiatives.

DEDICATION

Dedicated to Donna Fetterley

Her love, light, and laughter will always remain with us.

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I would like to acknowledge the many contributors to my success.

This project would not have been envisioned or created without the wisdom, encouragement, and support of Donna. I also acknowledge the support of my family, and especially my mother, Gisela Puetz, in motivating me to complete the project. I appreciate the on-going encouragement I have received from Donna's family throughout this lengthy and trying time.

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CHAPTER ONE – FOCUS AND FRAMING

"Alone we can do so little; together we can do so much" (Keller, as cited in Warner, 1992, p. 133).

The purpose of this project is to provide the Victoria Police Department (VPD) with recommendations and to identify strategies to enhance its response to people with mental illness who are experiencing psychiatric issues in the community.

With the advent of psychiatric facility closures and the social effects of deinstitutionalization, the VPD, like many other police agencies, is encountering larger numbers of mentally ill individuals in the community (Council of State Governments Justice Center, 2002; Lamb & Weinberger, 2005). Because of this new demand on police services, the traditional roles of policing need to be reviewed and revised, with a focus on collaboration with other community agencies becoming prevalent in response to this challenge.

As a community psychiatric nurse, I have worked extensively with the VPD as a crisis responder, consultant, policy planner, and trainer, initially as an external agent for the BC Ministry of Health and later as an employee of the regional Vancouver Island Health Authority (VIHA). I recognize the skills used by police officers in interacting with people with mental illness and support enhancing these skills to provide the best response in any given circumstance. In order to fully understand the situation facing the VPD in assisting the mentally ill, I asked the following research question: "How can the collaborative working relationships between the Victoria Police Department and community agencies serving persons with mental illness be enhanced in order to better serve the community?" I also explored the following subquestions:

1. What is the current knowledge base of frontline police officers regarding mental illness? (Note: A current knowledge base must be determined to facilitate collaborative working relationships.)
2. What policy is needed to support collaborative working relationships?

The Opportunity and Its Significance

The VPD has been providing safety and security services for the citizens of Victoria, British Columbia (BC), since 1858. It is the oldest police department west of the Great Lakes and was actually in existence before Victoria was incorporated as a city (Victoria Police Department [VPD], 2005b). As a west coast pioneer town, Victoria has seen its share of newcomers seeking a new life, either in the various gold rushes or in escapes from the inclement weather of the east. The transient population brought with it social issues, and it was up to the VPD to deal with persons who were *non compos mentis*: not in their right minds. There were a great number of individuals who came west, many of whom became destitute or deranged when their plans fell short and they were left with nothing. VPD officers have traditionally and pragmatically been "psychiatrists in blue" for over 140 years and continue to be first responders to those in psychiatric crisis.

Historically, the VPD has had various resources at its disposal to assist it in dealing with people who are mentally ill. The Colquitz Mental Hospital was built in 1919 and was intended as an asylum for people with mental illness on Vancouver Island. It is now known as the Vancouver Island Regional Correctional Centre (VIRCC), and despite now being a provincial jail continues to house many people with mental illness. The Royal Jubilee Hospital (RJH) was established in 1890, and after the closure of the Colquitz Mental Hospital became a resource for treatment of people with mental illness. In 1971, the Eric Martin

Pavilion at the RJH was built, and since that time has treated people with mental illness in Victoria. In 2001, all local health services were merged and VIHA was created. It is mandated with providing a broad range of psychiatric services to the citizens of Victoria and the surrounding communities. Most recently, a new urgent psychiatric assessment and treatment component, the Archie Courtnall Centre, was added to the RJH.

One of the programs melded into VIHA was the Emergency Mental Health Services (EMHS) team. EMHS was created in 1991 to assist in dealing with people discharged from Riverview Hospital in Port Coquitlam, BC, who returned to Vancouver Island. EMHS was designed to be an assessment and referral team, composed of nurses and social workers and tasked with connecting people in crisis to appropriate resources. It relied on the VPD to provide safety for the team and the clients, including enforcing emergency provisions of the BC Mental Health Act (MHA) (Government of British Columbia, Ministry of Health, 1996, 1999) when a person's rights needed to be suspended temporarily for psychiatric assessment and treatment. In 2005, the VPD and VIHA collaborated on the creation of a new form of this team, with VIHA staff and VPD members responding jointly to calls as the Integrated Mobile Crisis Response Team (IMCRT). Both agencies provide funding and logistics for this team and have set policies to guide it.

Of the many professional committees I have been involved in, two were created specifically to deal with issues of policing and people with mental illness. The first was the Police/Mental Health Liaison Committee in Victoria, which I chaired. It was comprised of representatives at the staff sergeant level of the seven police agencies on lower Vancouver Island. A local initiative, the committee met monthly to enhance the relationships between police and mental health service providers, including the Emergency Room (ER) at the RJH,

where people are taken or directed to for the assessment or treatment of mental illnesses. This group was disbanded in 1999 due to leadership changes at VIHA.

The second committee is the Canadian National Committee for Police/Mental Health Liaison (CNCPMHL). The CNCPMHL, a subcommittee of the Canadian Association of Chiefs of Police, was created in 2002 to bring people together to share knowledge and to create opportunities for change. This committee continues to hold conferences yearly, growing larger with every event. The theme of the 2006 conference was "Emerging Partnerships," illustrating that the need for collaboration is being recognized nationally. Through my engagement in these two groups, I have come to understand that many officers share concerns in responding to people with mental illness and that there are interventions, tools, and policies being developed to help police make decisions when faced with an individual in psychiatric crisis.

I believe that the VPD will benefit from an analysis of its ability to interact with those in psychiatric crisis and that the analysis will validate the services it has been providing to the community over the years. VPD members are concerned about the increasing number of calls and recognize that they may be less able to respond to the needs of the community without exploring and enhancing collaborative efforts with external community agencies such as VIHA. Further, enhanced knowledge and skills through training and support could increase the quality of interactions between police offers and people with mental illness and decrease the time spent dealing with people with mental illness, making officers more available for the traditional role of the police—providing safety and security for the public.

Systems Analysis of the Opportunity

Successfully navigating people with mental illness through various and sometimes convoluted systems to receive assessment and treatment if needed can be difficult. Any intervention that involves *involuntary assessment*, assessing someone's psychiatric presentation against his or her wishes, is directly affected by legislation. The VPD is a municipal police force and is governed by the BC Police Act (Province of British Columbia, 1998), which was most recently amended on July 1, 1998. The following section of core values taken from the code of professional conduct regulation within the act is an example of how it impacts this project:

> This Code is to be interpreted as affirming that all police officers
> (a) accept the duty to act without favour or personal advantage,
> (b) are committed to treating all persons or classes of persons equally, regardless of race, colour, ancestry, place of origin, political belief, religion, marital status, family status, physical or mental disability, sex, sexual orientation, age or economic and social status, and
> (c) agree to uphold rights and freedoms guaranteed or protected by law. (Province of British Columbia, 1998, section 3)

One can see that the under this act, the police are mandated to treat all persons equally, including those with mental disability. An example of the authority that the BC MHA (Government of British Columbia, Ministry of Health, 1996) grants on officers can be found under emergency procedures:

> **28** (1) A police officer or constable may apprehend and immediately take a person to a physician for examination if satisfied from personal observations, or information received, that the person
> (a) is acting in a manner likely to endanger that person's own safety or the safety of others, and
> (b) is apparently a person with a mental disorder. (p. 141)

Section 28 (1) describes the power of an officer to detain, apprehend, and transport persons who fulfill the two criteria outlined in the subsections. This section of the MHA is

used frequently by the VPD, and people apprehended under it are colloquially known as "Section 28s." In Victoria in 2004, there were a total of 889 apprehensions (VPD, 2004b). Frustration can ensue when officers follow their mandate and make an apprehension, only to become bottlenecked at the ER. Under the MHA, the officer must remain at the hospital until a physician assesses the apprehended person. The average wait time for this process is two to four hours (VPD, 2004b). There can be multiple apprehensions waiting at the ER, tying up police resources. It is in this area that collaborative agreements can make a difference to all parties. The hospital and the VPD need to invite one other to look at their mandates and then make positive cooperative changes to assist each other. Wheatley (2005) states, "Collaboration requires a change of mind set from turf protection and entrenched mandates to one of shared problems and fluid roles in finding solutions" (p. 70). The hospital physicians and the police share the legislated mandate to assist those who fall under the MHA and thus need to collaborate.

Another act that must be included in this discussion is the Freedom of Information and Protection of Privacy Act (FOIPPA), enacted in 1996 (British Columbia Ministry of Labour and Citizens' Services, 2005). This legislation is in place to protect the personal information of citizens, yet allows the sharing of information on a "need-to-know basis" and for continuity of care. An illustration of this is that a police officer can tell a physician details about an intervention in order for the physician to make better decisions about the future care of the apprehended individual. The physician, although bound by rules of confidentiality, can share information with police if that information is required to enact an apprehension or to avert a crisis for the person with mental illness. The VPD must show caution and concern in this area due to the ramifications that an inappropriate disclosure of personal information

could have for an individual. I will go further and state that given that this project involves persons with mental illnesses in conflict with the police, FOIPPA is as important as any other act governing the scope of this project.

Organizational Context

As described earlier, the VPD has been providing safety and security services to the city of Victoria for over 140 years. As of February 1, 2005, there were a total of 209 sworn officers and 73 nonsworn (civilian) staff, for a full strength of 282 members (VPD, 2005a).

Of the different responsibility areas within the VPD, this project focuses mainly on the Primary Response Division, colloquially known as "patrol." Patrol is broken into four watches lettered A, B, C, and D, each with approximately 26 members. The patrol division has a reporting structure that is relatively uncomplicated. The patrol supervisors report to the Officer in Charge of the Primary Response Division, who in turn reports to the Deputy Chief. The Deputy Chief reports to the Chief Constable, who reports to the Municipal Police Board, comprised of the mayors of Victoria and Esquimalt and seven appointed members. In addition to that defined structure, there is also the Office of the Police Complaints Commissioner (OPCC), which is "responsible for overseeing complaints against municipal police to ensure they are handled fairly and impartially" (Office of the Police Complaints Commissioner [OPCC], 2005, ¶ 1). The OPPC came into being as a part of the new Police Act of July, 1998.

The VPD has recently reviewed and rewritten its mission and vision statements. The statements are worded to provide a broad view of the VPD mandate. The VPD mission statement reads, "The Victoria Police Department, in partnership with the communities of Victoria and Esquimalt, is dedicated to maintaining peace, order and public safety through

crime prevention and law enforcement, thereby promoting a safe, harmonious community" (VPD, 2004a, p. 8). The VPD vision statement maintains that

> The Victoria Police Department strives to maintain a safe, vibrant community for those who live, work and visit in Victoria and Esquimalt. To achieve this vision, the Department will provide a flexible response to effectively meet current and emerging community needs within available resources, ensure there is a highly trained, well-equipped, coordinated team of police, civilians, reserves and volunteers, and maintain a high degree of community and internal support and participation through open, two-way communication. (VPD, 2004a, p. 8)

In today's reality, it is easy to describe a shared vision, but it may prove difficult to achieve that vision. This is what Senge (1994) describes as *creative tension*, "the tension between vision and reality" (p. 226). The VPD describes its ideals in its mission and vision statements, but given current levels of funding and other resources, it requires assistance from other agencies. Other agencies are also in agreement that it takes the shared resources of multiple agencies to achieve their goals. VIHA (2005) describes its values in detail on its Web site and includes a section called "Partnership and Collaboration":

> We recognize that delivery of health care services is complex and relies on the connection and collaboration of many. We work in partnership and share responsibility with our colleagues, clients, communities, and municipal and government organizations to integrate services and improve population health. (Vancouver Island Health Authority [VIHA], 2005, Values section, ¶ 5)

The statements of the VPD and VIHA clearly illustrate the mandate to work collaboratively with other community members to provide a safe living environment for the citizens of Victoria and Esquimalt and to alleviate the creative tension generated by their visions.

CHAPTER TWO – A REVIEW OF THE LITERATURE

Police members today are responding to calls involving the mentally ill in record numbers (Laberge & Morin, 1995). There have been a variety of reasons put forward to explain this phenomenon, including the downsizing and closing of many psychiatric hospitals across North America, commonly known as *deinstitutionalization* (Hoff, Baronosky, Buchanan, Zonana, & Rosenheck, 1999; Solomon & Draine, 1999; Teplin, 1983), and increasingly, liberal mental health laws (Lamb & Weinberger, 1998) combined with the tightening of civil commitment statutes (Schellenberg, Wasylenki, Webster, & Goering, 1992). Regardless of what the aetiology are for the increase in dealings with mentally ill persons, the fact remains that police are being called upon more and more to be "psychiatrists in blue" in the community.

The focus of this literature review is not on the causes of the situation today, but on three strategies and their components that may alleviate some of the issues around the increased workload. The three strategies presented in this review of the literature include *collaboration*, *training*, and *diversion*.

Firstly, I will explore the topic of collaboration between agencies, focusing on three concepts that enhance collaboration. The first is colloquially called the "Memphis Model" of crisis response. It is not important because of the outreach model itself, but because of the emphasis that it places on community buy-in and inclusion of community stakeholders in designing the project and running the team. Also, I will look at the Victoria IMCRT outreach team that is working collaboratively with Victoria police and other regional police forces. Lastly included in the collaboration section is the use of steering committees to assist in

designing and then operating programs to help police and community agencies in working with the mentally ill.

The second section of the review covers training issues for police and external agencies. I will discuss the different types and levels of training provided for police members, as well as compare what some studies suggest should be provided to what local forces actually receive.

Lastly, the review will cover the concept and practice of diversion, which may assist in providing longer-term solutions to the increase in mentally ill persons in the community. In this section, I will review different forms of diversion including jail diversion, court diversion, and the use of specialized mental health courts.

Section 1: Collaboration

"Police simply cannot achieve meaningful reforms alone, no matter how well trained" (Council of State Governments Justice Center, 2002, p. 35).

Collaboration is one aspect of partnerships wherein members of separate groups or agencies contribute to reach a shared goal. This is different than cooperation, where shared issues and needs are discussed across agency borders to reach problem-solving decisions in the short term. One issue with cooperation efforts is that they are largely based on personalities and informal "handshake" agreements, which work in the short term but are less likely to withstand staffing turnovers or changes in leadership. Collaborative teams sit down together and identify solutions to shared problem areas, taking responsibility and ownership of the process and creating policies to make a long-term impact on the problem areas.

When resources become stretched and workloads increase, many agencies look to partnerships to deal with issues that cross over between services. Throughout North America,

police agencies are evaluating and implementing new collaborative efforts with external agencies to attempt to deal with the increased responsibility of policing the mentally ill, and reports indicate that mobile mental health crisis teams are becoming widely accepted (Geller, Fisher, & McDermeit, 1995, p. 893). There has been a shift in the treatment of the mentally ill that has placed an added onus on police services, and there are more people in the community with a wider range of mental health issues than ever before. The social policy and concept of deinstitutionalization, coupled with more liberal mental health laws, has dramatically reduced the number of patients at large mental health facilities over the past decades (Lamb & Weinberger, 1998).

As such, many mentally ill people are living in poorly resourced areas of cities, such as the downtown core, as well as in family homes, apartments, and smaller mental health facilities such as group homes. Within an institution, it is easier to manage crisis situations, as there is typically a broad range of services available in one place; nurses, security personnel, and secure side rooms are all available when mental illness becomes overwhelming for a person. In the community, there are no such immediate remedies other than police and urgent response social agencies. People with mental illness are spread throughout the community and are generating increasing numbers of calls to the police. They are either in psychiatric crisis, committing petty crimes, or breaking social mores (e.g., urinating on the street). Given all of these factors, it makes sense to pool resources, utilize external experts through partnership agreements, and share the load.

Identification of the Need

The Consensus Project (Council of State Governments Justice Center, 2002) in the US has identified collaboration as a key solution to shared issues and has dedicated a chapter in its 2006 report to improving collaboration.

> People with mental illness who have become involved (or are at risk of becoming involved) with the criminal justice system frequently have multiple needs that can be addressed only though the collaborative efforts of several agencies working within the constraints of diverse systems. (Council of State Governments Justice Center, 2002, p. 188)

An example of this type of collaboration is the Memphis Model of response to the mentally ill. The Memphis, Tennessee, police department uses specially trained members to respond to calls involving the mentally ill. It has developed strategies and policies through collaborative efforts, including having agencies such as the local hospital take the mentally ill person from the police and having mental health organizations train officers for in-the-field evaluations and responses.

There are identifiable roadblocks for agencies that want to develop collaborative groups or policies. These include functional language issues such as unique terminologies, mandate differences, and the sharing of sensitive information. For police services and mental health stakeholders, the issue of confidentiality is a hurdle that can be cleared, but what is required from any collaborative group is good knowledge of information privacy laws and existing practices. The types of information that agencies gather are for specific purposes and are extremely sensitive. In BC, FOIPPA allows for the transfer of information between parties so long as it is used consistently for the purpose for which it was originally collected (British Columbia Ministry of Labour and Citizens' Services, 2005). For instance, if mental health workers assess a mentally ill person as being at imminent risk due to psychotic

symptoms, and they cannot safely transport the person to a physician, the mental health workers can share clinical information with police to assist in safe apprehension and transport. No formal agreement need be in place for this to occur, and it is common practice throughout the province. Where diligence in information sharing is more acutely necessary is in inter-organizational planning groups where select persons' cases may be discussed in order to formulate a best response to the situation.

Collaboration can occur on multiple levels and can be used to different degrees to achieve common goals. I will describe three types of collaborative efforts to illustrate this concept: the Memphis Police Department Crisis Intervention Team (CIT), the Victoria IMCRT outreach team, and the creation and use of police-mental health steering committees.

Memphis Crisis Intervention Team

CIT programs are designed for law enforcement officers who come into contact with people with severe mental illnesses in the community, so those officers can recognize the signs and symptoms of mental illnesses and respond effectively and appropriately to people who are experiencing psychiatric crises. The CIT is a community-based collaboration between law enforcement, the National Alliance on Mental Illness (NAMI), which is a US national agency, mental health consumers, mental health providers, and local universities to help law enforcement officers handle incidents involving mentally ill people. After community mental health agencies, family members of those with mental illness, and consumer advocacy groups assisted in defining a curriculum, the CIT members received 40 hours of specialized training in mental illness and the local mental health system provided free of charge by these groups. The training focuses on recognizing major mental illness,

assessing risk, and providing practical techniques for deescalating crises (Cochran, Deane, & Borum, 2000).

The Memphis model. Major Sam Cochran of the Memphis police is a champion for his department's model of crisis intervention: the CIT. The Memphis model was one of the first to use specially trained officers within the force to respond to calls involving issues with the mentally ill. Out of a total force of 1,800 members, approximately 180 patrol officers have volunteered to be a part of the CIT. In 1997, these CIT officers responded to 6,940 calls, of which 3,261 involved transporting individuals to mental health services (Steadman, Deane, Borum, & Morrissey, 2000). A memorandum of understanding was created to identify the roles of each agency so that the project could run at no cost to the City of Memphis.

Data from the Memphis CIT program reveal that the program has produced a number of positive outcomes. These include sharply reduced arrest rates of people with mental illnesses, significant reductions in injury rates to officers responding to "mental disturbance" calls, dramatic decreases in the amount of time officers spend responding to mental disturbance calls, and very high rates of police officer satisfaction concerning the disposition of cases involving people with mental illnesses who are in crisis (National Alliance on Mental Illness [NAMI], 2006).

The collaboration does not need to stop with curriculum design and training. In Toledo, Ohio, for example, members of the Projects for Assistance in Transition from Homelessness (PATH) team are available as a resource to officers, performing assessments and identifying local trends in the homeless population (The CIT Messenger, 2004).

Crisis Response Teams

The second model of collaborative crisis response is currently employed in Victoria. This model of crisis intervention blends responders and is funded by police and Mental Health Services, as well as by Child and Youth Mental Health Services (D. Lynn, personal communication, October 10, 2006). Based on the models developed by Hamilton, Ontario, health services, and similar to Vancouver's Car 87 program, it pairs mental health clinicians with plainclothes police members who respond together to psychiatric crises. This model is used extensively throughout Canada and the United States (Geller et al., 1995).

Background of IMCRT. The Victoria IMCRT is jointly funded by the VPD, with other regional police departments and the Royal Canadian Mounted Police [RCMP] contributing by providing auxiliary members to the team. The local Saanich Police Department also contributes one full-time member. IMCRT originated with the EMHS team of health care professionals, started in 1990 to respond to mental health-related crises in the community. In 2002, the EMHS coordinator and a representative from the VPD attended the first national police and mental health liaison conference in Montreal. At that time, information was presented on the Crisis Outreach and Support Team (COAST) mobile crisis response team from Hamilton, Ontario, and the EMHS and VPD representatives decided to start a process of actively exploring how a more formal and operational partnership could be developed between the police, existing EMHS services, and child and youth mental health services (D. Lynn, personal communication, October 10, 2006).

The intent was to use the COAST model of service as a template upon which to build an integrated mobile crisis model that was tailored to the needs of the local community. In 2003, a business plan was developed and proposed to the Victoria Inner City Health Initiative

(VICHI), a committee comprised of representatives from many downtown service agencies. This plan was presented to the Area Chiefs of Police committee and to Mental Health and Addictions management. Support was widespread for a 6-month pilot project that was soon thereafter expanded to a 1-year pilot project. The project was called IMCRT and commenced in November, 2004, with two full-time child and youth clinicians and two full-time police officers assigned to the new team. They now respond as a team to community members experiencing psychiatric crisis and have been enriched by the collaborative nature of the team. The IMCRT police members are a major resource to other members of the VPD, providing collegial contact and information on strategies for working with the mentally ill. In addition, IMCRT has been requested to provide enhanced training to communications staff, the Greater Victoria Emergency Response Team Negotiators, new recruits, and existing patrol members in the form of roll call presentations and increment training sessions (Lynn, 2006).

Steering Committees

"The primary purpose of a project steering committee is to provide overall guidance and direction for a single project, or set of projects" (ITtoolkit.com, 2005, ¶ 1). There is limited published information on the use of steering committees available for comparison. However, there are many initiatives that use steering committees, such as the Consensus Project (Council of State Governments Justice Center, 2002), to assist in the development and ongoing management of the subsequent relationships once programs have been developed.

Benefits of committees. Steering committees can create an atmosphere of collaboration between agencies that may otherwise work in their own "silos," isolated from

other community agencies. When members of different agencies come together, there is opportunity for open communication and understanding of other agencies or programs working with similar populations in the community. There is also opportunity for the development of joint protocols to assist in the operational aspects of agencies, such as response protocols between a hospital emergency room and police members bringing someone to the hospital for evaluation. According to Major Cochran, what really makes the Memphis CIT program effective is the development of a collaborative framework and continued use of community partnerships. "The partnership between the police department and the medical center's psychiatric emergency department is a key element in the program's effectiveness, and procedures were developed jointly" (Cochran et al., 2000, p. 1315). The emergency department immediately accepts all referrals by the police, eliminating any conflicts about patient selection and minimizing officers' waiting time, an achievement due in part to the efforts of the steering committee that created the protocol.

There are also protocols for developing and maintaining training platforms for community members, police, and hospital-based personnel. Over the past 5 years, many communities have developed protocols to address issues between police, mental health programs, and ERs. Excellent examples of such protocols are found on the Canadian National Committee for Police/Mental Health Liaison (PMHL) Web site at http://www.pmhl .ca/en/procedures.html.

Enhanced communication. Another benefit that can be identified is the openness of communication. Not only can members of steering committees communicate directly with one another, instead of by telephone or e-mail, but they can develop a shared language that can break down barriers to communication. Many professions have languages that have

evolved internally, with colloquialisms that are understandable in their agencies alone. There are many examples of this in the cultures of mental health clinicians and police alike. Stringer (1999) speaks of *constructions*, or "created realities that exist as integrated, systematic, sense-making representations" (p. 45). When groups of people meet together regularly and communicate openly, they create these constructions, the shared meanings and truths of the group.

Types of committees. Steering committees can be highly structured in nature, or less formal and ad hoc. Highly structured committees meet on a regular schedule with identified agendas and terms of reference, generally with fixed membership for consistency. Other committees are called to convene when issues arise that need to be worked out between community stakeholders, with membership being based on who can assist with a particular issue.

Major Cochran describes both forms of committees in Memphis. Initially, the mayor of Memphis created a task force to design the CIT. Its membership included many community stakeholders such as educational representatives from the two local universities, family and mental health advocates, mental health professionals, hospital representatives, and of course, police members. Major Cochran describes how this committee devolved into a less structured format once the program was fully developed, with stakeholders still meeting regularly as issues or opportunities arise (S. Cochran, personal communication, November 8, 2006).

In 2005, the BC Chapter of the Canadian Mental Health Association (CMHA) initiated a project called "Building Capacity—Mental Health and Police Project" (Canadian Mental Health Association [CMHA]–BC Branch, 2006). Six communities across BC were

tasked to find solutions to issues at a local level in order to develop better responses to those with mental illnesses. Each community created a steering committee to identify problem areas and then develop action plans to attempt to address these issues. The steering committees drew members from the police, mental health services, local hospitals, community agencies, families of those with mental illness, and at least one person with mental illness. The BC branch now reports that all six committees were able to fulfill their initial goals and have made some commitment to continue working together.

Section 2: Training for Police Agencies

"I want the first person who touches me to be educated" (McKinney, as cited in the Council of State Governments Justice Center, 2002, p. 214).

The Need for Training

It was noted previously that there are increasing numbers of interactions between police and those with mental illnesses, with percentages of calls related to issues with mental illness ranging from 7–15% (Borum, Deane, Steadman, & Morrissey, 1998). Regardless of the reasons for the increase (e.g., deinstitutionalization, liberal mental health laws, or decreasing resources), it falls upon police officers to address the needs of all community members. These members include those with mental illness and those impacted by others with mental illness. Of all the situations police encounter, the management of the mentally ill is potentially the most explosive and has been a catalyst of change in the way police are trained. There have been a number of high-profile incidents over the past few years that have highlighted this fact. The fatal shootings of mentally ill individuals by police in major North American cities such as Toronto and Memphis have prompted police service agencies to look

at the way they train their members and to organize their agencies in response to the needs of the mentally ill.

Some agencies have been criticised for failing to provide adequate training or to develop programs to ensure appropriate response (Hails & Borum, 2003; Hill & Logan, 2001). Many officers feel ill-equipped or inadequately supported to deal with people with mental illness and are frequently frustrated in their attempts to connect with professional assistance (Hails & Borum, 2003). This is one reason that there are high arrest rates for persons with mental illness despite the low-level severity of the crimes committed, such as trespassing or disorderly conduct (Bonovitz & Bonovitz, 1981; Borum, Swanson, Swartz, & Hiday, 1997; Teplin, 1984).

Hails and Borum (2003) report that there were early efforts to train officers to improve their responses to persons with mental illness in crisis, finding evidence that officers' knowledge of mental health issues was improved and that their ability to apply that knowledge to identify and communicate about mental illness had increased (Janus, Bess, Cadden, & Greenwald, 1980). In contrast, Lamb, Weinberger, and DeCuir (2002) note that "there is evidence that police training generally is inadequate to prepare police officers to identify and deal with persons with mental illness" (p. 1269).

The study completed by Vermette, Pinals, and Applebaum (2005) suggests that officers are interested in receiving additional training in the area of mental illness. Over 90% of officers reported that they felt mental health training was either fairly important or very important, with 68% stating they would prefer annual training. Cotton's (2004) Canadian study also indicated that most officers accepted the fact that they were mandated with assisting the mentally ill and saw it as an area in which they should receive additional

training. One survey indicated that almost all US police agencies—88%—offer some level of training regarding mental illnesses (Deane, Steadman, Borum, Veysey, & Morrissey, 1999). In contrast, a survey of police forces in Canada found that most jurisdictions outside of major metropolitan areas had no specialized services or training in place (Cotton, 2001).

Types of Training

The Consensus Project (Council of State Governments Justice Center, 2002) reviewed the different levels of training offered to police officers:

1. New skills (basic) training. This type of training is done by the agency after the introduction of a new program or initiative to ensure all members have a basic understanding of the initiative.
2. Recruit training. Training that is required by law to be provided at academies that encompass all aspects of policing. Content and curricula vary with each academy.
3. In-service training. Training offered annually by the department to its members to cover topics identified as important to members. These would include firearms qualifications, new techniques, polices, or regulations.
4. Advanced skills (specialized) training. Training that is provided to select members in order to prepare them for participation in a specialized area of service. The Memphis CIT training is one such example, with members receiving an additional 40 hours of training to be a part of the initiative. (p. 212)

In most police academies, training is weighted towards technical aspects of police work (Alpert & Dunham, 1988). Much of the time, training curricula are designed to teach recruits actual law enforcement—what they will be doing only 10% of the time when they

are on duty (Brandt & Peak, 1995; Mayhall, Barker, & Hunter, 1995). Meese (1993), former Attorney General of the United States, declares,

> The content of police training must go beyond merely preparing officers for the mechanical aspects of police work, and that training should help them to understand their communities, the police role, police history, and even imperfections of the criminal justice system. (p. 6)

Local Academy Training

The Justice Institute of British Columbia (JIBC) Police Academy, which the VPD uses to train its recruits, utilizes a block system of training. There is a total of 3 hours mental health training in Block One, which is 13 weeks in duration. After returning to their home agencies for Block Two, which runs for 5 weeks, recruits return to the JIBC for Block Three, 8 weeks long, where they have the opportunity to bring up experiences from the "street scene" for further discussion and skill development. The Block One curriculum at JIBC is well-defined and is delivered to recruits by the Car 87 officers and their coworkers, Vancouver Mental Health Emergency Services nurses (Justice Institute of British Columbia [JIBC], 2005). The Block One training curriculum includes the following topics: (a) mental illness and psychosis, (b) BC Mental Health Act (MHA), (c) assessing endangered safety, (d) assessing risk, (e) involuntary intervention, (f) MHA terminology, (g) community resources, (h) documentation, (i) chronic callers, and (j) systems issues (JIBC, 2005, p. 2).

A review of the JIBC Block One curriculum (JIBC, 2005), when compared to the recommendations of the Consensus Project (Council of State Governments Justice Center, 2002), indicates several deficits. For instance, 3 hours is far below the standard number of hours adopted by the Consensus Project, which recommends 8 to 15 hours of recruit training. It is certainly insufficient time to cover complex topics such as the different types of mental

disorders, techniques for effectively identifying and handling the mentally ill, as well as the many other topics covered in the Block One training.

Cotton and Zanibbi's (2001) study of Canadian police service members included a cursory review of what most Canadian training manuals (Arboleda-Florez, Crisanti, & Holley, 1998; Calgary Police Service, 2000; Hoffman & Putnam, 2000) provided as topics for training: (a) signs and symptoms of major mental illnesses, (b) indications for the presence of substance abuse, (c) effects of stress, (d) assessing suicidal intent, (e) behavioural management strategies, (f) application of mental health law, and (g) accessing services (p. 4).

While the JIBC is in line with these categories, there are glaring exceptions between the two outlines. For example, the Block One training from the JIBC does not specifically cover substance use vis-à-vis mental illness at all, despite evidence that this is a major factor in the lives of the mentally ill living in the community today: the Substance Abuse and Mental Health Services Administration in the US estimates that 70% of mentally ill offenders have substance use disorders (Lamberg, 2004). One possible explanation for variances in the curricula may be that different people are defining the curricula for recruit training. In a US survey conducted by the Police Executive Research Forum (PERF, as cited in Murphy, 1986), 65% of 172 police departments indicated that they had used outside professionals from local mental health agencies to assist in curriculum development.

In-service Training

There is little published documentation to assist in a review of this type of training. However, the Consensus Project (Council of State Governments Justice Center, 2002) has compiled a chart describing what it believes is a good practice model. In the area of in-

service training, it states that a curriculum with 22 identified content areas and consisting of 20 hours of training should be provided to all members.

IMCRT clinicians have been infrequently providing in-service training to local police departments, including the VPD, when it is requested. The topics provided include a breakdown of major mental disorders, tools and guidelines for intervention, information on local agencies, legal issues vis-à-vis the BC MHA, suicide intervention, and substance use issues. This content favourably compares to the Consensus Project chart (Council of State Governments Justice Center, 2002), covering 14 of the 22 identified areas, some of which are not applicable in Canada (such as US federal laws regarding mentally ill persons).

Advanced Training

Many of the cities that now employ the CIT type of specialized response team provide their CIT members with 40 hours of specialized training. In Memphis, it is completed in a 1-week session. The instructors include physicians, psychologists, licensed social workers, specialists, and police instructors. CIT Academy students receive training in the following areas: (a) introduction to clinical disorders including borderline personality, (b) psychotropic medications, (c) dual diagnosis and substance abuse, (d) legal issues, (e) suicide prevention, (f) elderly and children's issues, (g) the developmentally disabled, (h) community resources, (i) consumer perspectives, and (j) intervention strategies (Council of State Governments Justice Center, 2002, p. 213).

CIT Academy students also complete scenario-based training and testing. They must complete a series of scenarios taken from actual mental health-related cases. Mental health professionals and experienced CIT officers evaluate student performances. A large portion of the academy is hands-on training that is facilitated by site visits. Students interact with

mental health consumers who are high functioning, as well as consumers with civil commitments to treatment and those who are committed to a forensic unit. Students tour various facilities to gain an understanding of the entire mental health system. As one can see, the training content in Memphis is considerably more extensive in scope than local JIBC or in-service training. In Memphis, training is provided free of charge to CIT members by local mental health professionals, family advocacy groups, the University of Memphis, and the University of Tennessee Medical School (Cochran et al., 2000).

Training Providers

With the JIBC providing training for new recruits, there remains the issue of who should provide the training for in-service and advanced training modules. Murphy (1986) states that 69% of departments in the PERF study used local mental health providers as instructors. This is the method used at the VPD and other local police departments, with IMCRT clinicians providing training in clinical information and system navigation for dealing with hospital and mental health-based programs. Memphis police take it further for their CIT members, with training being provided by volunteers from family and patient advocate groups, two local universities, and NAMI.

The Council of State Governments Justice Center (2002) goes on to suggest that the development of a training committee or task force in conjunction with local mental health services may not only broaden the knowledge base of the people providing the training, but may also provide "a mechanism through which criminal justice agencies and mental health practitioners, consumers, family members, and other stakeholders can collaborate to educate personnel" (p. 209).

Section 3: Diversion

"To a great extent, we are dumping our mental health problems into our jails and prisons—there's no question about that" (Satcher, as cited in City and County of Denver Department of Safety, 2006, p. 2).

Since the late 1960s and into the 1970s, there has been an increasing demand on the police and courts to deal with people with mental illness in conflict with the law (Roesch, Ogloff, & Eaves, 1995; Solomon & Draine, 1999; Steadman, Barbera-Steadman, & Dennis, 1994). Much of the research has documented an increase in the number of people with mental illness in the court and jail and prison systems, proportionally related to deinstitutionalization (Hoff et al., 1999; Solomon & Draine, 1999; Teplin, 1983). This has led to the criminalization of people with mental illness; people who were once treated in asylums or hospitals are now arrested and prosecuted for crimes committed while ill (Lamb & Weinberger, 1998). This practice does not fit well with either the criminal justice or the mental health systems. The CMHA–Ontario Branch (2005) states:

> One of the most lamentable outcomes of overburdened community mental health services in Ontario is that people with mental illness are being criminalized, instead of being helped. The police are being forced to stand in as front-line mental health care workers. People with mental illness are increasingly coming into contact with police for minor nuisance crimes, because there is no other help available. (¶ 1)

The ever-rising socioeconomic costs of housing and mental health treatment in jails for people with mental illness has brought about initiatives to divert, or steer away, that particular population from the criminal justice system into more appropriate programs or facilities (Steadman et al., 1994).

Diversion programs have demonstrated potential for increasing positive outcomes for individuals with mental illness by creating connections with community mental health

services, decreasing police contact, reducing the amount of time spent in jails, and decreasing recidivism in criminal behaviour (Borum et al., 1998). Several models of diversion exist, but all incorporate one central component: mental health training of involved personnel (Lattimore, Broner, Sherman, Frisman, & Shafer, 2003). The following is a review of the common types of diversion, including the two standard broad types, pre-book and post-book, with descriptions of typical forms of each.

Pre-book Diversion

Pre-book diversion is a discretionary process on the part of police at the scene who choose alternatives other than arrest and jail (Lattimore et al., 2003). Instead of charging an individual with a crime, they direct him or her into mental health or other treatment without further involvement in the criminal justice system. Because there is no further follow-up or monitoring by criminal justice, the use of pre-book diversion is generally limited to less severe crimes such as shoplifting, trespassing, or loitering (Duff, 1997; Lamb & Weinberger, 1998). When dealing with a call, an officer may decide that an individual is mentally ill and opt for immediate connection to appropriate local mental health services. An officer may evaluate the situation and decide that an individual needs to see his or her family physician and assist him or her to make this happen. The officer may also connect the person to mental health services through the ER on a voluntary basis. This is used frequently when a minor (nuisance) crime has occurred, and the person in need of mental health assistance does not pose any overt danger to himself or herself or others, and is willing to participate.

Training Issues

In order for officers to make a determination of applicable alternate outcomes, there needs to be training in place to help guide them. A person who appears mentally ill to a

mental health professional may not necessarily appear so to police officers, who without adequate training are still laypersons in this topic area (Lamb & Weinberger, 1998). Models of police officer training vary, but one that stands out as exemplary is the Memphis CIT (Steadman, Stainbrook, Griffin, Draine, Dupont, & Corey, 2001). As explained in Section 1, Collaboration, CIT provides 40 hours of training for interested members of the patrol division in responding to mental health-related calls received by the department. The goal of the Memphis program is "to provide diversion at the first interaction between the consumer with mental illness and the police" (Lattimore et al., 2003, p. 38) and to frequently bring individuals to the University of Tennessee Psychiatric Service at the Regional Medical Center.

Beyond CIT

In Denver, Colorado, city officials have developed their own CIT program and have taken further steps with the development of the Crisis Intervention Team Aftercare Partnership (CITAP). The CITAP is a collaborative effort of community agencies, including Colorado Coalition for the Homeless, the Veteran's Administration, Denver Sheriff's Department, probation services, local hospitals, NAMI Denver, the local Mental Health Center, and many others. The components of CITAP are treatment, housing, employment, and education. The initial contact between individuals with mental illness and police officers can set in motion possibilities for either reconnecting the individuals with a case manager, or helping assist them in finding needed resources. One of the stated goals of the CITAP is to increase the efficiency of the interactions between criminal justice system and resources (City and County of Denver Department of Safety, 2006).

Another pre-book diversion model is used by the San Diego, California, Psychiatric Emergency Response Team (PERT). This service serves individuals who come to the attention of law enforcement and are suspected of having a mental illness. Twenty-four outreach teams consist of specially trained police officers and mental health clinicians who respond to calls involving individuals with mental illness. The goal is placement in the least restrictive appropriate environment. In this program, police officers receive 80 hours of initial training in on-scene assessment, community-based mental health organizations, and available hospitals. In the first 2 years of operation, PERT handled 3,000 cases, with only 1% resulting in incarceration. Community mental health facilities assisted other individuals (Bazelon Center for Mental Health Law, 2006).

Mobile Crisis Teams

The most widely used program in Canada and the US is the mobile crisis team, which responds to mental health crisis calls (Deane et al., 1999). Local mental health services or spending authorities operate these teams, with membership being comprised of mental health professionals, including nurses and social workers, as well as nonuniformed police officers. While coordinated by the mental health system, the teams are cofunded by the spending authority and the participating police services.

The Victoria IMCRT follows this model, using a collaborative effort between the health authority and local police departments, with support from the RCMP (Lynn, 2006). This team provides on-scene assessment and linkage to mental health services and other local support agencies as an alternative to arrest for nuisance calls, effectively diverting people with mental health issues away from the courts. This diversion can be voluntary if people are open to intervention, or police officers attached to IMCRT can use the MHA provision to

apprehend individuals and bring them to hospital for further psychiatric assessment and appropriate treatment, should that be indicated.

Post-booking Diversion

Post-booking diversion is a strategy that may be used after police arrest and book a person for committing a crime, generally of the nuisance description. This form of diversion, in contrast to the pre-book type, is a more formalized program of organizational cooperation between multiple agencies (Solomon & Draine, 1999). There are a number of models, but all contain three overarching components: psychiatric screening, assessment, and negotiation between the diversion staff and the appropriate criminal justice personnel with the goal of creating a treatment plan that will either waive or reduce criminal charges or reduce jail time (Steadman et al., 1994).

Broner, Borum, and Gawley (2002) report that post-book diversion programs may be housed in different locations and have different administrative constructs, and they identify three archetypes: jail-based diversion, court-based diversion, and specialized diversion courts.

Jail Diversion

Jail-based diversion is a post-book program that identifies, screens, assesses, and subsequently diverts the defendant from jail. Corrections staff work with the accused and with that person's consent provide the courts with information to assist in the determination of the diversion. Jail staff involved in these types of programs are specially trained, and usually intervene at the pre-trial stage (Lattimore et al., 2003)

Lane County, Oregon, uses this model of diversion with its Co-Occurring Diversion (COD) program (Sherman, 2002). Specially trained corrections officers screen all persons

booked into the jail for mental illness and substance use disorder. If the screening is positive for either, the identified person is further assessed by jail-based mental health clinicians and offered voluntary inclusion in the diversion process. With the agreement of the county prosecutor, identified persons are offered the opportunity to agree to a stipulated plea and attendance at a treatment facility for a predetermined length of time, and upon successful completion of the program, a dismissing of the charges by the presiding judge (Lattimore et al., 2003).

Court Diversion

The concept of court diversion is described as decentralized, with diversion staff working in several courtrooms with judges, prosecutors, and defence lawyers. This can occur at any stage in the legal proceedings in order to provide a case-management and monitoring role between the courts and the appropriate community agencies (Broner et al., 2002).

The State of Connecticut funds court-based diversion through its Department of Mental Health and Alcoholism Services (Frisman, Sturges, Baranoski, & Levinson, 2001). Clinicians from the local mental health centres work in the courts, providing screening and assessment of identified individuals. With a person's consent and cooperation, the clinicians develop a treatment plan, which is in turn negotiated with the prosecutor, defence attorney, and judge. The referral is then made to local agencies and/or hospitals to treat and to monitor, so they can inform the court of progress and ensure follow-up. Although the charges may be dropped at the time of diversion, typically the file remains open for a brief period with a decision not to proceed with prosecution if the individual is cooperating with the diversion effort (Lattimore et al., 2003).

Specialized Diversion Courts

In contrast to the general court diversion programs, there has been the development of specialized courts, such as mental health or drug courts, to deal with populations that have special needs or requirements. The design and operation of the mental health courts are drawn from the older models of drug courts, which originated in Dade County, Florida, in 1989 and have their origins in the concept of specialized courts with therapeutic jurisprudence (Steadman, Davidson, & Brown, 2001). Therapeutic jurisprudence "attempts to combine a 'rights' perspective—focusing on justice, rights, and equality issues—with an 'ethic of care' perspective—focusing on care, interdependence, and response to need" (Rottman & Casey, 1999, p. 13).

One of the original models of the mental health courts was established in 1997 in Broward County, Florida, as an attempt to divert mentally ill persons from the courts and into mental health treatment programs. Since 1997, mental health courts have expanded quickly in the US, with more than 100 operating across the country (Stefan & Winick, 2005). A basic assumption in mental health courts is that with some criminal charges, usually minor in nature but sometimes involving felonious offences, the underlying problem is more a product of major mental illness than of criminality. Therefore, a more effective response is to connect a mentally ill person with mental health treatment.

In contrast to the decentralized approach of the court diversion programs, mental health courts have separate calendars, dockets, and supervision for mentally ill offenders. The staff of the courts (a designated prosecutor, public defender, and a mental health liaison) and the dedicated judge are seen as a collaborative, non-adversarial team, which oversees a person's progress through the court process with some form of monitoring in place

(Steadman et al., 2001). The identified individual enters into a behavioural contract, which specifies what the expectations are and what sanctions are in place for non-compliance, with the team.

Not all advocates for the mentally ill are proponents of mental health courts. Some groups are opposed to this type of problem-solving court because of the apparent segregation of mentally ill offenders from their peers in a separate court process (Stefan & Winick, 2005). Stefan and Winick state, "Protection of rights and administration of justice are not matters for social workers or interdisciplinary teams. Judges need to focus on people's rights, not their best interests" (2005, p. 522). Others feel that mental health courts are coercive, with people agreeing to participate to avoid court sanctions (Seltzer, 2005). Another concern Seltzer notes is that the mental health courts rely on existing mental health programs to assist the courts in diversion options and treatment, when it is these same mental health systems that are the root of the problem, as they are inadequate to effectively treat people in the first place, leading to the initial arrest in many cases. Finally, there is some question as to the fitness of individuals to make good decisions around diversion options. The programs are voluntary in nature, but what if that person is mentally incompetent and displays poor insight and judgement? In Toronto, established mental health courts effectively deal with this issue. The Toronto court, in its fifth year of operation, has a built-in mechanism of determining psychiatric fitness using mental health clinicians in the courts to assess every candidate for fitness and ability to cooperate (Ormston, 2006).

Conclusion

Diversion is a tool available to the different levels of the criminal justice system to assist people with mental illness in conflict with the law. Whether it is prior to potential

charges (pre-book) or after charges have been laid (post-book), diversion is available to assist mentally ill individuals through their legal difficulties. The use of educated officers and mental health professionals is effective in decreasing arrest rates for mentally ill offenders, and when successfully applied, most candidates for post-book diversion have their charges stayed or dropped completely. Differing opinions remain in the arena of diversion strategies, although all agree that the courts are not the place for mentally ill persons to be treated.

Conclusion of Literature Review

In the preceding three sections, I discussed a variety of police intervention strategies for dealing with the mentally ill. While none of the identified strategies address the root problems or the systemic issues behind the increase in mental health calls to police, they do describe viable alternatives to criminal charges where appropriate, or alternative measures for the courts to use if charges are approved and individuals find themselves involved with the criminal justice system.

CHAPTER THREE – CONDUCT OF RESEARCH

As stated in Chapter One, the purpose of this research project was to answer the research question, "How can the collaborative working relationships between the Victoria Police Department and community agencies serving persons with mental illness be enhanced in order to better serve the community?" In order to achieve this outcome, I used a tripartite approach to data gathering and evaluation: an advisory group, a group survey, and four post-survey interviews.

This chapter discusses the research approach for the project, identifies the project participants, describes the research methods and tools used in the project, and explains the study conduct itself.

Research Approach

In this project, the research method used for information gathering was action research, which seeks to make a difference and produce change, not just observe and analyse. Stringer (1999) talks about the researcher getting actively involved with the people involved in the study and participating openly. Glesne (1999) speaks to the traditional method of data gathering: "Subjectivity has long been considered something to keep out of one's research, something to, at the least, control against" (p. 105).

Stringer (1999) describes the basic action research process as a cycle of gathering data, exploring and analyzing, and planning and reporting. This cycle often repeats one or more times. This action research process was observed throughout this project, in all three phases. The first instance was in the advisory group, which gathered thoughts and ideas from the experiences of the participants, discussed the implications of the experiences vis-à-vis the

design of the survey, and incorporated feedback from the group analysis to create the action piece, the final survey questionnaire.

The second phase was the survey. One of the advantages of surveys is that they can describe individual observations from a large sample of people (Colorado State University, 2005). The survey used was quantitative and qualitative in nature, seeking statistical data as well as opinions and personal knowledge about specific topics. Quantitative research methods, while perhaps simplistic, were appropriate, because it was important that the project was "grounded in the day-to-day realities of the people being studied, [with] a preference for applying phenomenology to the attempt to understand the many 'truths' of reality" (Palys, 2003, p. 423). I invited VPD members to participate in the group survey and provide data, which I in turn analysed and themed. This process created a body of data to be explored further by the interviewees. The third phase included the analysis of the themed data by the interviewees and myself and I incorporated the discussions as the final data in this report.

Project Participants

There were many people involved in the evolution and completion of this project. There was the advisory group, invited by letter (see Appendix A) to convene for the purpose of designing the survey. Additionally, there were two groups of participants that contributed to the research data: the survey participants and the post-survey interviewees. I invited these persons to participate through letters outlining the project and its goals (see Appendixes B and C, respectively).

Advisory Group

The purpose of the advisory group was to utilize the knowledge and experience of local police members, mental health professionals, and community agency members. These experts are from different disciplines and fields, bringing a richness of scope and insight into the situation. Participants in the advisory group included (a) project sponsor VPD Inspector Darrell McLean, (b) the police member of the IMCRT, (c) the civilian coordinator of the IMCRT, (d) a civilian member of the IMCRT, (e) a representative from the Mental Health and Addictions portfolio to bring in the issues of substance use and mental health, and (f) myself as group facilitator. I selected this group based on my professional experience with each member, having an understanding of each one's role over time and through repeated interaction.

Survey Participants

I conducted the survey with patrol members of the VPD and distributed 96 surveys. Included in the 96 surveys were non-patrol, operational members higher in the reporting chain in relation to the patrol members, up to and including the Deputy Chief Constable. All of these additional participants had previous frontline experience, and I offered them participation on a voluntary basis using the same letter given to the frontline members.

Post-survey Interviewees

I designed the post-survey interviews to glean the opinions and thoughts of potential policy makers, or at the least potential policy influencers, in the two systems of the VPD and VIHA. The added purpose was to explore more deeply the data provided by the survey and to elicit the reflections of the interviewees to provide a more fully developed picture of the data results. The selected interviewees from the VPD were Inspector McLean (internal project

sponsor) and Acting Inspector Les Sylven (VPD Communications Department), both of whom were working within the organization on issues of community collaboration. Inspector McLean recommended Acting Inspector Sylven's participation in the project.

The VIHA participants were Mr. Devin Lynn, Program Coordinator–Mental Health Access and Crisis Response Services and coordinator of the IMCRT, and Mr. Graham Sanderson, manager of the Risk Management portfolio for VIHA. I included Mr. Lynn due to his extensive background in the field of emergency psychiatric outreach and his development of the IMCRT team in conjunction with Inspector McLean. Mr. Lynn recommended Mr. Sanderson, because they participate together in select committees at VIHA dealing with issues of risk and policy involving new programs or ideas being developed.

Research Methods and Tools

I used two methods of data gathering, a large group survey and post-survey interviews.

Surveys

Surveys represent one of the most common types of quantitative, social science research (Colorado State University, 2005). In survey research, the researcher selects a sample of respondents from a target population and administers a standardized questionnaire to them. Using surveys, it is possible to collect data from large or small populations, which fit the goals of this project. Surveys have a number of identified strengths, including low cost, ability to describe characteristics of large populations, flexibility in design, use of standardized questions, and potential for high reliability and low observer subjectivity.

A comprehensive true-or-false knowledge survey developed by Dr. Cotton in Ontario is available in the public realm (Cotton & Zannibi, 2001) and I used it as the base for the

"knowledge" portion of the survey administered to the VPD members. For this study, I applied written surveys to the target population: the VPD patrol division. Dr. Cotton's surveys experienced a return rate of approximately 30% (Cotton & Zanibbi, 2001), so I believed that surveying approximately 100 members would provide the study with a statistically significant number of responses.

The advisory group designed the survey to capture the general knowledge of frontline officers regarding mental illnesses and their opinions on accessing and utilizing community resources, including what they perceived as working and what could be evaluated for change. I gave the members of the advisory group copies of Dr. Cotton's survey beforehand and asked them to consider which questions they thought were most applicable to VPD members. After we agreed upon the most applicable questions, we crafted several open-ended questions to capture VPD members' opinions regarding community resources and attached them to the revised survey as Part B. Once we designed and completed the final survey, I sent it to all advisory group members via e-mail to ensure authenticity and accuracy.

Interviews

Interviews enable individuals to express their opinions and describe their situations (Stringer, 1999). There are a number of advantages to conducting personal interviews. Palys (2003) suggests that the most significant advantages to using the interview are its versatility and its ability to get direct comments from a participant. Other advantages include having more control than in focus group settings. Since interviews capture a single person's responses, they may be less structured and better adapted to let the respondent determine the direction of the interview, and they allow the respondent to share a great deal of information (Morgan, 1997). I used a form of *topical interviewing*, which "focuses more on a program,

issue, or process than on people's lives [and furthermore is a] search of opinions, perceptions and attitudes towards a topic" (Glesne, 1999, p. 69). Interviews also carry additional benefits including a "greater likelihood of developing rapport with participants" (Palys, 2003, p. 155).

Effectiveness, Trustworthiness, and Validity

The survey and interview, when combined with the knowledge and experiences of the members of the advisory group, work together to address issues of trustworthiness. One of the important elements of using qualitative data is trustworthiness. Glesne (1999) states, "The use of multiple data-collection methods contributes to the trustworthiness of the data" (p. 31). To describe the use of many methods, she uses the word *triangulation*, a term taken from surveying and navigation. In addition to contributing to trustworthiness, triangulation provides a richer understanding of the data, which may be regarded as more believable.

Glesne (1999) speaks of time being a major factor of research trustworthiness. In this project, it was an important aspect in gleaning the true feelings and thoughts of the three participant groups. I have spent years developing relationships with all three groups of project participants, creating an atmosphere of credibility and trust. Although the project ran only for a few months, the relationships underpinning the process were sound and reciprocal in their level of trust. Even the survey participants were aware of my background and years of experience, lending credibility to the process and an added assurance that they would participate more fully, a point supported by Glesne: "When a large amount of time is spent with your research participants . . . they are more likely to be frank and comprehensive about what they tell you" (1999, p. 151).

Validity is also an important aspect of any research project. Creswell (1998) describes eight procedures that assist in providing validity to qualitative research:

1. Prolonged engagement and persistent observation;
2. Triangulation;
3. Peer review and debriefing;
4. Negative case analysis;
5. Clarification of researcher bias;
6. Member checking;
7. Rich, thick description; and
8. External audit. (Creswell, as cited in Glesne, 1999, p. 32)

Of the eight procedures, this project has incorporated seven. Prolonged engagement with the research participants is definitely present. I have described the use of triangulation as a component of this research. I undertook peer review using the psychology staff at my office to reflect and provide feedback and input into this body of work. I discuss researcher bias and the monitoring of subjectivity. I conducted member checking—sharing the final draft of the survey with the advisory team and transcriptions of the interviews with the appropriate interviewees to ensure accuracy and proper representation. I employed a rich form of writing that engages readers and allows them to enter the realm of the research context through descriptive language. I used external auditors, including the project supervisor and peers, to examine the process and product.

Study Conduct

Advisory Group

I created the advisory group by inviting participants. Once formed, the members of the group reviewed the study designed by Dr. Cotton and chose 20 of the 60 questions on that survey to incorporate into our own. The stated purpose of that exercise was to choose the

most locally appropriate questions. The group also worked together to create eight open-ended questions that sought to capture the thoughts and ideas of the VPD members regarding their interactions with the mentally ill and external agencies in Victoria.

Surveys

The survey asked VPD members how they perceived the roles of external agencies, such as the local hospital, and what strategies could be devised to assist the mentally ill in accessing and navigating these agencies. I presented the survey designed by the advisory group (see Appendix D) to the members of the patrol division on day two of their rotation, for a total of four presentation periods (patrol watches A, B, C, and D). Inspector McLean identified this time as the most opportune to hand out the survey, as members were already aware of what their workload and specific assignments were from the day one shift. At this time (0630 hours, day two of the rotation), there was opportunity for members to fill out the survey at the pre-shift meeting or later if they chose to do so.

There was a letter accompanying the survey explaining the voluntary nature of participation and indicating that the VPD sanctioned the survey and that it could be completed on duty (see Appendix A). Members checked off a box at the beginning of the survey to indicate such voluntary participation. They could indicate withdrawal by not completing the survey, which was anonymous so members could not be identified as non-cooperative. I administered the survey on paper, with envelopes for sealing the completed survey. A sealed box marked "Completed Surveys" and with a slot in the top was available for members to drop their envelopes in and was located in the members' training area. Inspector McLean handed out the surveys to the non-patrol participants and those completed surveys were also placed in the sealed box.

Interviews

After the group survey was completed, I conducted a series of four interviews with manager-level personnel at the VPD and VIHA to deepen the analysis of the themed results of the survey. I conducted the interviews to elicit "real" perspectives from the members of the two organizations, "to grasp the natives' point of view, to realize their vision of their world" (Malinowski, as cited by Stringer, 1999, p. 68). I sent letters to the interview participants outlining the purpose of the project and the interview (see Appendix C). Once the participants agreed to the interview, I sent them the themed data from the survey for perusal and consideration prior to the interview. I based the interview format on the *grand tour* concept of eliciting broad topics, coupled with *mini tour* questions to focus the topics down to a finer detail, as described by Stringer (1999). I previously proposed an outside time limit of 90 minutes per interview.

I conducted the interviews in a comfortable setting at the interviewees' workplace and recorded them for accuracy. Given the open-ended format chosen for the interviews, I sought and received permission from the participants to record the interviews on audiotape. This type of permission-seeking behaviour increases trustworthiness. By tape recording the interview, I had information that could expand and clarify the handwritten responses. The tape recorder also captured a more complete response to the open-ended questions and allowed me to replay the information if there was a question as to a particular response. Most importantly for research data, independent evaluations of the same interview could be made. I had transcripts professionally developed and offered each interviewee the opportunity to review the transcripts prior to publication to test for and ensure trustworthiness and accuracy.

Data Analysis

Glesne (1999) states, "Data analysis involves organizing what you have seen, heard, and read so that you can make sense of what you have learned" (p. 130). Once the surveys had been completed, I analysed the results using two distinct methods. The knowledge section of the survey was quantitative, so I inputted and analysed the raw scores using the Statistical Package for the Social Sciences (SPSS) (version 12.0.0). I used a bivariate correlation program, Spearman and Pearson, to provide correlations between data fields, and also used frequency percentages.

For the open-ended questions, the written responses on the survey could be classified according to the specific question, generating eight sections. I manually themed each section, determined percentages, and compiled bulleted lists of relevant participant quotes.

After recording the interviews, I had them transcribed to written format. Once this was completed, I e-mailed them to each interviewee for clarification and accuracy, again deepening the element of trust. I stored all data gathered from the surveys and interviews either electronically under password protection or, in the case of the raw data, locked in a filing cabinet to be destroyed after 3 years.

Ethical Issues

In a project of this type, there are many areas that require the protection of the participants and the population they serve through adherence to ethical principles.

Royal Roads University (RRU), as with any learning institution, has policies and guidelines for ethical considerations in action research, which are contained and described in the *Research Ethics Policy* (Royal Roads University [RRU], 2004) and *Policy on Integrity and Misconduct in Research and Scholarship* (RRU, 2000). The policies are guided by the

Tri-Counsel Policy Statement (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, Social Sciences and Humanities Research Council of Canada, 1998), which outlines principles of ethical research. The purpose of these policies is to protect all parties involved in the research: participants, researchers, and universities.

1. The Respect for Human Dignity

Stringer (1999) defines dignity as "people's feelings of autonomy, independence, and competence" (p. 24). In the advisory group and with the survey participants and post-survey interviewees, there were opportunities to maximize dignity through adherence to the guidelines that RRU applies to research. I supported, included, and validated the opinions and thoughts of the participants by giving them the opportunity to review their contributions and clear up any discrepancies. At no time were people belittled or their opinions discarded as unworthy of consideration.

2. Respect for Free and Informed Consent

Because of the nature of the agencies, the subject matter, and the research methods that were used in the project, I fully informed all participants of the purpose of the methods used and what would happen to the data once collected. Glesne (1999) speaks to three areas in considering informed consent: voluntary participation, awareness of any negative impact that could affect participants' well-being, and awareness that the participants can withdraw at any point in the research. I provided all participants with a consent letter, which addressed these ethical concerns in a preamble. It also stated that signing the form implied consent for the ethical use of the data gathered by the advisory group, the survey, and the post-survey interviews.

3. Respect for Vulnerable Persons

It is difficult to see any of the members of the research groups as vulnerable, but the opportunity to look closely should be taken. Group members from the field of mental health or the ER might have felt uncomfortable in a group that could highlight some shortcomings in their respective areas. I made sure during the advisory group process that members could contribute without fear of reprisal from others.

4. Respect for Privacy and Confidentiality

It is important that participants of action research interventions are protected from any possible negative outcomes of participation. For this reason, I kept the survey participants anonymous and did not share their responses outside the research project group. I also protected the advisory group and discussed the issue of privacy and confidentiality in writing in the consent form preamble and verbally before the group began its work. The post-survey interviewees were advised that they would be named in the project and consented to this approach.

5. Respect for Justice and Inclusiveness

I invited all members of the patrol division to complete the survey. It would not have been ethical to exclude anyone from the opportunity to contribute to this project. It may be that some members did not wish to participate, but that is differentiated from being excluded in the first place.

6. Balancing Harms and Benefits

Given that the advisory group was chosen wisely and supported effectively, and that it designed the survey in a manner that secured privacy and anonymity, there was minimal risk of harm. Advisory group members felt comfortable discussing difficult topics because of

the value that is placed on their knowledge and experience and because of the importance of the research. I took steps with the interviewees to ensure security, inclusion, and accuracy before and after the interviews.

7. Minimizing Harm

I paid attention to the potential for harm during the course of this project. I took all necessary precautions to safeguard individuals' personal dignity and to provide anonymous responses when that was applicable. I protected information as required. I used all forms around permissions and consents appropriately and stored them accordingly in a locked drawer. Additionally, the RRU Ethics Committee for MALT learners approved the project proposal, providing a measure of scrutiny regarding harms and benefits.

8. Maximizing Benefit

In order to maximize benefit, I ensured that the data gathered from all participants were considered valid and used appropriately in the written report for future consideration and use. Maintaining ethical standards in the project also strengthened the results.

Summary

In summary, I used qualitative and quantitative research methodologies in this action research project. I obtained qualitative data through the use of open-ended questions in the survey and through the interview process. I manually themed these data and organized them into written documents for analysis and comparison. I obtained quantitative data using the survey to gather baseline information about members, including rank, years of service, position, age, and gender. The survey also gathered members' knowledge through true-and-false type questions, and computer analysis programs analysed the data.

I maintained all efforts to conform to the *Tri-Counsel Policy Statement* (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, Social Sciences and Humanities Research Council of Canada, 1998) as required by RRU.

CHAPTER FOUR – RESULTS AND CONCLUSIONS

Study Findings

The study findings provided in this chapter arose from the research methodologies used for data gathering, mainly the written survey. The survey participants are anonymous with no identifiers used. In total, I distributed 96 surveys to all available members in the Primary Response Division, and had a return of 87 surveys. This represents a return rate of 90.6%. Respondents ranged in age from 25 to 55 years, with a mean age of 38 years. Their years of police service ranged from 1 month to 30 years, with a mean of 11.98 years. There were six times as many male survey respondents (73) than female survey respondents (12), with 2 members choosing not to identify gender. The majority of the respondents ranked as constables (79%) connected with the Primary Response Division (70%).

There are five key study findings:

1. The knowledge base of VPD members regarding mental illness is varied;
2. The interface between the VPD and VIHA is critical;
3. Collaboration between the VPD and community agencies is vital;
4. Training and education in the area of mental illness is considered valuable; and
5. A lack of community resources is a critical factor in criminal behaviour.

Now I will discuss each finding in detail below.

Finding 1: The Knowledge Base of VPD Members Regarding Mental Illness Is Varied

The Overall Knowledge Base

As explained in Chapter Three, the survey was in two parts. I designed part 1 of the written survey to capture the current knowledge level of VPD members through 20 true or false questions (Appendix B, Part 1). I found the overall knowledge base as surveyed to be

good, with an average knowledge score of 75% across the 20 questions. I themed the questions into six categories: psychosis, substance use issues, mood disorders, issues with the elderly, ability to cope, and issues regarding violence vis-à-vis mental illness. Although all six categories are important, two (psychosis and substance use) have been highlighted for discussion.

Psychosis. In the survey results, there were many correct responses to the questions regarding psychosis. Question 2, for example, asked, "Severely mentally ill persons are too psychotic to learn new skills. True or false?" and 90.8% of members correctly answered "false" to this question. There were several questions that received much lower rates of correct responses. For example, question 8 of the knowledge part of the survey asked, "If apparently mentally ill people are talking to themselves, it is most likely they are responding to voices or hallucinations. True or false?" This question, relating to external clues of a possible psychotic process, was correctly answered as "true" by only 42.5% of respondents. Another question, 12, asked, "When mentally ill persons' speech doesn't make sense, it is likely their thoughts don't make sense either. True or false?" Only 36.8% of respondents answered this question correctly as "true." The scores to these two questions indicate that knowledge is lacking in regards to signs and symptoms of psychosis.

There is some evidence that members may have knowledge based on societal beliefs as opposed to educated knowledge. Examples of this are found in the responses to question 10 on the knowledge part of the survey. This question asked, "People with schizophrenia may have several distinct personalities. True or false?" Of the respondents, 64.4% correctly answered "false." Where did the "knowledge" of the other 35.6% arise from? The idea that schizophrenics have multiple personalities has been a commonly held myth for many years,

but it is not factual. Therefore, the incorrect responses are most likely based on false perceptions, not on any formal training or field experiences.

Substance use. In part 1 of the survey, I asked members, "Some street drugs can mimic symptoms of mental illness. True or false?" A total of 96.6% of members answered this correctly as "true." Additionally, in part 2 of the survey, 19.5% (17 members) specifically identified substance use as a major factor impacting the mentally ill in Victoria. These responses identified issues of clients self-medicating with non-prescribed or illicit substances as opposed to using therapeutic prescribed medications. The responses indicate that VPD members are acutely aware of the impact of substances on individuals in general and the mentally ill specifically.

What the VPD members said. Some statements implicated drugs and alcohol as destructive for the mentally ill: "Drugs and alcohol really mess them [the mentally ill] up"; "ingestion of illegal drugs [is a problem]"; and "[there is] mixing of medications and illegal drugs." This statement, "prescription and non-prescription drug and alcohol abuse" describes what one officer sees as detrimental. "Drug and alcohol addiction along with mental illness" is another. One participant noted, "I routinely arrest mentally ill people who are committing crimes to support their illegal drug use, which they are using as 'self-medication.'"

Finding 2: The Interface Between the VPD and VIHA Is Critical

"Special Constable" Status

For many years in the Victoria area, trained fire and security guards at the local ERs had the designation of "special constables" as authorized by the BC Attorney General. This enabled them to take custody of MHA-apprehended individuals from police members quickly and legally under the act. In this fashion, persons would be considered still in police

care and custody while waiting for an emergency room physician to assess the person, while police personnel could return to the community to resume other duties. Removed in 1997, the reinstatement of this status for VIHA security remains a major point of contention for VPD members. Of the respondents to question 1 on part 2 of the survey, 8 respondents specifically mentioned special constable status for security personnel as an element of a "good working practice" with VIHA. This clearly indicates that members feel they are waiting too long in the ER providing custodial care.

What the VPD members said. Sample comments on this issue include: "In my opinion, the security officers at RJH & VGH are extremely professional and have more experience in dealing with the mentally ill than police" and "I believe we need to empower hospital security with special constable's status. It shouldn't be the police departments that are burdened with this time-consuming task." Others mentioned that "special constable status is desperately needed for security" and "[the] most important [issue] is reestablishing special constable status for security."

Wait Times

At present, there is no special status for fire or security personnel at the ER. But VPD members clearly identify wait times at the ER as one of the fundamental issues when working with mentally ill individuals: 31% specifically mentioned that time in the ER was an issue for them and that a "good working practice" with VIHA would expedite their release from the ER in a more timely manner. When asked in part 2 of the survey, "Is there a good understanding on the part of mental health providers or others (such as hospital staff) regarding procedures that you must follow as part of your job?", 15% of surveyed members

specifically remarked that the issue of long wait times in the ER was the biggest procedural issue once arriving at RJH with an apprehended individual.

What the VPD members said. A common sentiment voiced by surveyed members is stated clearly by one member: "I believe the biggest complaint for members of Victoria Police is the wait at the hospitals with the patients. It is a huge burden on police resources." Others agreed: "There should be a more expedient way to get the person suffering from a mental disorder through triage." Some members identified needs, including wanting "a system that avoids having constables wait for long periods of time at the hospital watching over Section 28s [people apprehended under the MHA] until a doctor is available." Frustration over perceived misuse of resources is described: "I don't have a problem of starting calls involving MHA patients, but I do have an issue of waiting at the hospital until the ERP [Emergency Room Physician] sees the patient. It's a waste of police resources."

Professional Relationships Between the VPD and VIHA

Many members identified that there is room to improve professional relationships with VIHA staff, especially in regards to the ER staff and physicians. Twenty percent of members stated a preference to have a clearly identifiable contact person in the ER, other than the usual triage staff, to deal with Section 28s. This group of members felt that there was no desire on the part of triage staff to expedite the Section 28s and some members referred to the relationship with the staff as hostile. Further to this issue, 11.5% of members said that they would like to see dedicated doctors and nurses deal with the Section 28s upon their arrival at the ER, possibly through the nearby psychiatric emergency service at the Archie Courtnall Centre, as opposed to triage and the ERPs. Members may be responding to the

treatment they encounter from the triage staff and the ERPs, with 9% perceiving that ERPs are at times disrespectful towards police members.

Addressing some of the relationship issues, members identified a lack of mutual understanding between police and health professionals regarding each others' roles and responsibilities under the MHA, including the necessary interface of police with hospital personnel and its implications. Additionally, 2 respondents (2.3%) specifically requested a "no refusal" policy for police attending RJH with Section 28s, which would improve the relationship to a great degree, but may be pragmatically difficult to achieve in this community. The following thoughts come from Inspector McLean's interview:

> Banned from the hospital, that's another issue. There are chronic users of service that have behavioural issues that cause them to be banned from detox, or from Archie Courtnall, or from the hospital—you have to be able to develop a mechanism to deal with these chronic individuals. Banning them is not the answer. The answer is having this quick response, or some type of high incident management system, or some kind of mechanism to take these real hard core chronic individuals and being able to manage them.

Mr. Graham Sanderson, Corporate Director for Risk Management for VIHA, stated in his post-survey interview, "From a risk management perspective the law does not allow us . . . to ban somebody from seeking health care in Canada, so I'm wondering what the police officers' understanding of that ban is." He agreed that there was a need for further dialogue to clarify the officers' concerns: "But again, I think that education may assist in that concept of being banned by the hospital."

What the VPD members said. When speaking of professional relationships with hospital staff, surveyed members had varying beliefs. "I believe they understand my job and procedures. They don't always agree or like it." One member stated, "ER staff and doctors ignore police until they have no other choice but to help." Another surveyed member

suggested "hav[ing] ER staff at least look like they care about the mentally ill persons we bring in." Serious topics were related by the members on the survey, including the directive to "stop banning the mentally ill from hospital. Provide some sort of options for borderline cases. I've had two borderlines commit suicide after being banned from PES [Psychiatric Emergency Services]." Another member agrees, stating, "A big problem is mentally ill people that police chronically deal with that are banned from the hospital."

Finding 3: Collaboration Between the VPD and Community Agencies Is Vital

The Integrated Mobile Crisis Response Team

The IMCRT program is a recent and visible initiative between the VPD and VIHA. Fifteen percent of the members surveyed specifically responded that the relationship with IMCRT should be maintained and enhanced. Some members remarked that the IMCRT should have expanded hours for daytime outreach. Inspector Sylven also offered this opinion in his post-survey interview:

> IMCRT and EMHS—that program, I don't know anybody who doesn't like it. I think everybody thinks it's fabulous and the only knocks against it are that it should be more; there should be longer hours. We should have more officers involved in that.

There are inherent benefits in the enhancement of the outreach model with IMCRT. Inspector McLean identified a natural outflow of the collaborative process:

> I think one of the excellent aspects of the IMCRT team is the cross-training, and that doesn't occur, for example, with uniformed police officers and emergency room physicians necessarily, or police officers and mental health social workers, or even emergency room physicians and family care givers. I think cross-training and cross-understanding of roles and responsibilities is key to providing the best response for these individuals who suffer from these issues. (Post-survey interview quote)

What the VPD members said. Sample comments from the surveyed members included "EMHS (IMCRT) does not start its shift until 1300 hours. It needs to start earlier,"

and "continue the police and mental health outreach project." These statements show support for the collaborative program.

Community Case Conferences

When asked if collaborative meetings with community partners were valuable, 70% of members responded in the affirmative. They identified several reasons for this, including information sharing, reduction in call numbers with less time spent on frequent callers, increased levels of care, increased efficiency, the development of a service delivery plan, enhanced police representation, and a coordinated response to a community problem.

For those 16% who answered in the negative, reasons cited included inefficient use of police time, potential ineffectiveness, and lack of faith in the process.

What the VPD members said. Many were supportive of this approach, with statements like these: "After a community case conference, the number of dealings with the individual declines dramatically because of the intervention." "If we [can] continue to case conference these people, we can reduce the calls." "We already have a record of demonstrated success with this strategy." And finally, "I believe the last round of case conferences helped immensely." Likewise, impact on resources was mentioned: "If services lined up properly for specific patients, perhaps their encounters with law enforcement [could] be reduced." "Through this the goal would be that these individuals obtain the assistance that they require, without being a drain on police resources." Some members expressed ambivalence towards the initiative: "If community case conferences can assist [in monitoring of mentally ill suspects], then great; otherwise, they would not assist me in the performance of my job." Others were succinct in their statements: "They don't seem to work. I've never had much faith in community care."

Coordination of Services

Members identified a need for coordinated services, which they believe will help with continuity and consistency in assisting the mentally ill. Inspector McLean said in his interview that he saw the community services as spokes in a wheel, but in his perception there was no central body to bring them all together:

> I think that there are lots and lots of folks in this community in terms of service, but there is no hub to coordinate them. I've had discussions with the United Way, for example, because it is trying to look at some type of a community model that allows the coming together of resources in the community to create a bigger whole, by putting them together and making them work in conjunction with one another to update the funding that it is seeking.

Inspector McLean went on to identify a possible reason for a lack of coordination in the community:

> I think there are lots of resources in the community. I think that they are in silos. I think people are protecting their funding and they refuse to relinquish anything that could be combined to generate a greater product for the whole.

What the VPD members said. Members' statements were supportive of more coordination. One commented, "If everyone is on the same page and agrees to a plan . . . the consistency will also help alleviate the 'attention seekers.'" Another said that "[coordination] establishes a lower threshold/larger gateway for contact or assistance" while a third mentioned that "continuity amongst persons dealing with one mentally ill person would help treat the problem."

Information Sharing Between Agencies

A certain amount of information sharing is necessary for any collaborative effort to work effectively. When asked what type of information they needed, members identified different types. They were interested in clinical information, with 42.5% wanting to know the

past history of the client. An additional 16% identified propensity for or history of violence as important and 11.5% were interested in the diagnosis of the client.

Members were also interested in information on how to deal with mentally ill individuals. Sixteen percent of members thought pragmatic therapeutic approaches for certain types of clients could be shared, along with appropriate contact names and phone numbers for external health care providers being provided on small reference cards.

And there was identification of a third level of information sharing: systemic information. Members were interested in knowing contact information for mental health case workers, such as the 9% of members who asked, "What is expected of me?" in expressing a desire for information from hospital staff in order to do their job effectively while in the ER. Another 9% wanted to be informed of a time frame for their remaining time in the ER.

What the VPD members said. Surveyed members want more information, as illustrated in the following statements: "More information available [would be] good," and, "it would be beneficial to give more information and strategies to approach individuals. It would be easier if this information were attached to the databases [i.e., Prime or CPIC]." Finally, one member commented that "information sharing allows all participants to gain a wider point of view."

Finding 4: Training and Education Regarding Mental Illness Is Considered Valuable Education About Mental Illnesses

Members identified in part 2 of the survey that they were open to education and training and thought that there was value to it. There were 12.6% who suggested training for police members, and 7% who recommended training for police and health professionals

regarding each others' roles and responsibilities under the MHA. An additional 9% were interested in knowing more about the behavioural manifestations of psychiatric illness.

Education About Community Resources and for VIHA Staff

Fourteen percent of the surveyed members stated that they required more education about what community services offered, with an additional 5.7% requesting a contact information card for police regarding these services. There were 13.8% of surveyed members who remarked that staff at the ER would benefit from education regarding police procedures around safety and the reality of police resources.

What the VPD members said. "It would be nice to know what the illness is and how to best be able to connect with the patient" was one member's comment. Other members also sought more education on medications and other topics, such as the influence of street drugs: "Knowledge of what medications are used for what illnesses, so when I find them at a home I can know what the person is suffering from, because they won't often tell me." In the same vein, one member stated, "Being able to distinguish an existing mental illness from a drug-induced one, or a combination of both [would be helpful]." Some suggested training topics and frequency in their comments: "Educate hospital staff regarding the drain on our resources caused by a 3-hour wait at ER." Others suggested providing "seminars for staff advising them of safety procedures followed by police when dealing with violent people." They lamented: "Very few staff, including the doctors, know what our job is. The only way to help is to educate." Members seek community knowledge as well: "We don't really know what they [community service agencies] offer." As for frequency of training, members suggested "annual or initial training for new [hospital] staff." And, "perhaps an increment

training session, 4 hours maximum." One member didn't mince words: "More integrated training."

Finding 5: A Lack of Community Resources Is a Critical Factor in Criminal Behaviour

Of those that were surveyed, 32% specifically mentioned that the biggest problem facing the mentally ill in Victoria was a lack of resources, causing them to come into contact with the criminal justice system. Although responses were varied, there were specific areas that were identified.

Housing, Homelessness, and Shelters

Twenty-four percent of members identified that there was a lack of suitable or supervised housing for the mentally ill population. Another 17% stated that there was not enough shelter beds for the homeless population, with an additional 7% mentioning homelessness as a major issue for the mentally ill in Victoria.

Treatment and Tertiary Beds

Seventeen percent of surveyed members listed a lack of beds for the mentally ill, including acute treatment beds and detoxification spaces, as a major factor in police involvement with the mentally ill, while 15% of members felt that because of the shortage of treatment beds, there was a cycle of arrest and then subsequent rapid discharge from the ER or the Archie Courtnall Centre. A further 25% of members identified that there was no longer-term care facility for the mentally ill in the Victoria area, which they said placed young and potentially violent mentally ill people on the streets. This is a separate issue from a bed shortage at hospital as it is described as tertiary, or long-term, care.

Lack of Support Services

Nine percent of the survey participants indicated that there was an overall lack of case managers in the community for the number of mentally ill individuals. Sixteen percent mentioned a lack of follow-up or monitoring by mental health professionals, which leads to other issues. For example, an additional 5.7% of respondents cited poor medication compliance as an issue for the mentally ill in the community, and 8% stated that there was a lack of support services in the community.

What the VPD members said. Members were clear about resources in their sample comments. Statements like "Lack of resources! There are not enough beds or facilities to help people" and "front-line services [are] getting tired of dealing with mental health clients" illustrate their frustration. Others stated that there is "a shortage of prompt resources to assist those suffering from mental illness." And members observed that "there are not enough facilities for long-term, 24/7 care for mentally ill people" and that "they [community agencies] are too fragmented and watered down." Members described feeling isolated after normal business hours, wanting "longer hours of operation [for community agencies]." Also mentioned was the fact that there is "not enough structured support to ensure they [mentally ill patients] are taking the proper medications and to step in when the person's mental health begins to deteriorate." "There should be a place for them [the mentally ill] to be monitored, assessed, and treated." And finally, here is one member's thoughts on resources:

> It appears that mentally ill patients are being released by doctors and police end up dealing with these patients time after time. Sometimes police deal with the same patients within a few hours of release from hospital. This is due to the lack of resources or facilities!

Inspector Mclean elaborates on this issue of the mentally ill accessing the wrong resources for treatment:

> One key aspect for me is that because of the high police involvement in mental health issues in the community the criminal process winds up being used as a last resort for those chronic clients. When there are no other options we seek to get the individual before the courts to get conditions in order to manage them. The criminal code is not the correct method of achieving this control. Likewise, we wind up placing individuals in the cell block in order to manage their behaviour when mental health facility options are not there (banned from treatment, barred from service, etc.). (Post-survey interview quote)

Study Conclusions

The main research question was the focus of this study: "How can the collaborative working relationships between the Victoria Police Department and community agencies serving persons with mental illness be enhanced in order to better serve the community?" I also explored the following subquestions:

1. What is the current knowledge base of frontline police officers regarding mental illness? (Note: A current knowledge base must be determined to facilitate collaborative working relationships.)
2. What policy is needed to support collaborative working relationships?

Through the use of the survey and subsequent interviews, answers to these questions have become apparent. The main question is complex but has been satisfactorily answered to the point where the VPD can review its current role as a collaborative agency in Victoria. The subquestions have been answered through the research study findings and literature review.

As a result of the research study findings, I have come to the following three major conclusions:

1. Collaboration is valuable: The VPD is interested in and recognizes the value of working collaboratively with external agencies.

2. Opportunities exist to enhance collaborative relationships: There are opportunities through policy development and service agreements to enhance the collaborative relationship with agencies such as VIHA in order to increase the efficiency of the interface between agencies.
3. Post-academy training is necessary: VPD members require regular intervals of post-academy training in mental illness, approaches in dealing with those with mental illnesses, and knowledge of what resources are available in the City of Victoria and how to access them.

I will discuss each of the conclusions individually below.

Conclusion 1: Collaboration Is Valuable

The ability of the community to adequately provide essentials of care to mentally ill individuals depends on the collaborative and coordinated interactions of all community agencies. As discussed in Chapter Two, the advent of social programs such as social reintegration and the deinstitutionalization of the mentally ill has shifted a major workload onto many community agencies, including police agencies (Lamb & Weinberger, 1998). The following statement is reiterated from the literature review in Chapter Two:

> People with mental illness who have become involved (or are at risk of becoming involved) with the criminal justice system frequently have multiple needs that can be addressed only though the collaborative efforts of several agencies working within the constraints of diverse systems. (Council of State Governments Justice Center, 2002, p. 188)

Through the dialogue of the survey, members have identified that there is a lack of resources in the Victoria community and they believe it bears an extra burden on their day-to-day dealings with the mentally ill. The members have observed that the VPD is the only 24/7 agency responding to the needs of the mentally ill, and have demonstrated through the

survey that they have little knowledge of the roles of other social agencies. Many members acknowledged not being aware of the services offered through these community agencies, with one or two notable exceptions that they access on a regular basis, such as the Salvation Army and Our Place.

It seems that there are many agencies available to help, but these may not be fully understood by the members of the VPD. We can recall Inspector McLean's interview statement mentioned earlier about there being no central coordinating hub for services. This is an extremely important point. Without coordination and communication, mandates may be misunderstood and underutilized.

Inspector McLean also made a statement in his post-survey interview about his opinion on the VPD's ability to be cooperative and collaborative:

> Well, I think our department is ahead of the curve in terms of creating and developing relationships, particularly with health care service providers—everything from our interaction with the Archie Courtnall Centre to the Integrated Mobile Crisis Response Team, to supporting the Sobering Centre, to our work with Operation Divine recently at the church, trying to find suitable, safe, clean housing for street people.

This statement illustrates the desire for the VPD to be a community presence and player.

The majority of surveyed VPD members accepted community case conferences as effective collaborative mechanisms. The post-survey interviewees also supported this type of initiative, as illustrated in this statement made by Inspector McLean:

> I think that community case conferences are the next phase of this whole mechanism. Our crisis response team, the Sobering Centre, and the Archie Courtnall Centre, those are the conduits. . . . If we could sit down with the top 50 or 100 chronic people in the area and look at the volume of service that they are drawing, . . . put them into a coordinated format, [and have] everybody come to the table with offerings and the ability to play and participate; if we could extract those 50 people from this chronic cycle of usage, and put them into a format where they are only drawing 25% of the same resource level, . . . there would be huge savings for the community in terms of

> resources, money, freeing up access in emergency rooms, less ambulance rides, transportation, everything. Less cell block time. Everything.

Mr. Devin Lynn from VIHA echoed this sentiment in his post-survey interview:

> I think that community case conferences are extremely valuable. I think they are valuable because they offer an opportunity for police to share perspectives with health care providers that health care providers are not otherwise going to hear. Police officers see our clients in contexts on the street and in their home environments that we don't necessarily see, so oftentimes it's a missing part of the puzzle, and, conversely, sometimes police officers may puzzle as to why we approach a client in a certain way, and this would provide us with an opportunity to explain the clinical rationale.

One of the methods used by Major Cochran and his CIT designers was to recognize the value of community partners in Memphis, establishing a steering committee or working group to coordinate and fundamentally utilise the potential assets of community agencies. As described in Chapter Two, the City of Memphis created a task force committee to deliver a response to the needs of the city and its police force. Many community agencies were involved in that committee and it provided opportunities to work collaboratively with each other. As an example, a Memorandum of Understanding was created to identify the roles of each agency so that the project could run at no cost to the City of Memphis (S. Cochran, personal communication, November 8, 2006).

Mr. Lynn asserted that there is a need for enhanced community support:

> I think police officers by virtue of their experience are very insightful about exactly what the problem is in the community. And the fact that they identify that there is a lack of resources—I completely agree with that. There is a lack of community-based resources. You deinstitutionalize the mentally ill and we have insufficient resources in the community to look after them. The issue of longer hours is, I think, a very important one. We have too many of our mental health care services that are 9–5, office-based services. I would definitely support . . . more outreach-based services that are going out . . . seeing people in their homes and shelters, wherever they are, outside of normal office hours. (Post-survey interview quote)

Inspector Sylven remarked,

> Your theme of collaboration is without a doubt the key I think. In the next 15 to 20 to 30 years, that's where it's at. So that whole collaborative approach is what this is all about, in my mind, and it's a wonderful thing. (Post-survey interview quote)

Given these assertions, it can reasonably be concluded that there is a need for a coordinating body to fully utilize the scant resources available to community members and agencies.

Conclusion 2: Opportunities Exist to Enhance Collaborative Relationships

One of the most compelling outcomes of the member survey was the glaring need to enhance the interface between the VPD and the local hospital. During his post-survey interview, Mr. Sanderson stated,

> It's critical . . . because for a mental health individual who may also have addiction issues, who may also have other health issues, . . . multiple diagnoses, potentially—unless there is that cooperative and coordinated approach to the care, it really increases the chance that they could fall between the cracks.

As illustrated in the findings, the vast majority of members support a more expedited method of handing off persons apprehended under the MHA to the hospital so that members can return to their policing roles. While perceptions are present that providing hospital security personnel with special constable status may provide this outcome, there are other methods of achieving this. Many police agencies in Canada have established protocols that do allow for a quicker process for handoff, including Winnipeg, Manitoba, and Hamilton, Ontario. Again, excellent examples of such protocols can be found on the Canadian National Committee for Police/Mental Health Liaison (PMHL) Web site at http://www.pmhl.ca/en/procedures.html.

Inspector McLean expressed support for the members' insights:

> And they are also talking about some type of expedited process or procedure, so you have 79% talking about special constable status and then another 31% who are saying that the mechanism could be tweaked, or who knows. . . . My thoughts would be that

> we would enter into agreement with VIHA, saying that within 45 minutes, turnover and approval of medical admission would take place every time we brought a mental health patient in. (Post-survey interview quote)

This approach certainly would need to consider shared policy between agencies.

If we take another look at the Memphis CIT model, we observe that there is a quick handoff and a no refusal policy in place for that team at the local treatment centre. This is identified as a key component of the efficiency and efficacy of that program (Cochran et al., 2000). It is through policy development that enhancement of collaborative relationships will be achieved. As discussed in the literature review in Chapter Two, it is important to formalize initiatives through the use of policy to avoid the initiative failing for reasons such as changes in leadership and personnel. The following statement is from the recommendations made in the Criminal Justice/Mental Health Consensus Project (Council of State Governments Justice Center, 2002) regarding partnerships:

> Successful partnerships depend on collaboration between individuals. Over time, officials in mental health and criminal justice agencies may develop exemplary working relationships that lead to improved collaboration and better service to individuals with mental illness. It is crucial, however, that the leaders of collaborative efforts make an effort to institutionalize their partnership, ensuring its longevity beyond their own tenure. (p. 200)

This can be accomplished through formal policy development, most likely through the use of a steering committee.

Conclusion 3: Post-Academy Training Is Necessary

The study completed by Vermette et al., (2005) suggests that officers are interested in receiving additional training in the area of mental illness. The majority of participants, over 90%, reported that they felt mental health training was either fairly or very important, with 68% stating that they would prefer annual training. Canadian literature supports these conclusions as well. Cotton's (2004) study of three Canadian police agencies indicated that

most officers accepted the fact that they were mandated with assisting the mentally ill as part of their jobs and saw it as an area where they should receive additional training.

When new recruits graduate from the JIBC Police Academy, they will have received 3 hours of formal training in the area of major mental illness. As we have seen in the literature review in Chapter Two, the recommended standard number of hours adopted by the Consensus Project in the US is 8 to 15 hours of recruit training (Council of State Governments Justice Center, 2002). Because of this deficit, there is a need for formalized incremental training for members of the VPD to enhance their knowledge of the issues around mental illness, including access to other services.

Devin Lynn from VIHA opined, in his post-survey interview,

> Obviously training I think is an issue that was reflected somewhat in that data as well—an interest in having a good understanding of mental illness and addictions issues and from my own perspective, I am happy to see that. I think that is something that should be looked at. . . . I believe that the training that police officers get is basic training, and I've heard this from police officers themselves, [that it] is really inadequate when it comes to providing a baseline, a foundation of understanding . . . of what mental illnesses are, and you know, what some of the signs are to recognize that a mental illness is happening. I think that I would like to see increment training have something built in, not just in the enhanced awareness around what some of the conditions are and how police officers can help intervene in such situations in a way that minimizes a risk of escalation, but also the services available.

Mr. Lynn touched on the importance of understanding community resources. He went on,

> I think it needs to be increment training, because our awareness of mental illness is changing all the time. Our services are changing all the time, so you can't just have something in basic training. You need to have something that is updated every couple of years. (Post-survey interview quote)

Mr. Lynn also broadened the topic to include collaboration in the training arena:

> I think that you could have an advanced training that would . . . bring mental health providers together. It would bring addictions counsellors, police officers together. That would bring actual clients into the picture to help provide that training. (Post-

survey interview quote)

He related a successful collaborative experience that he was part of:

> [It] was a panel presentation by mental health consumers, by clients . . . talking very personally and very openly about what it's like for them and what their experiences were like when they were ill versus when they were well and what police officers could do . . . to help them feel safe or help them feel less escalated, more calm. That was a very powerful part of the presentation. (Post-survey interview quote)

Inspector McLean talked about the benefits of cross-training between the VPD and VIHA through collaboration, as described by his statement detailed earlier in this chapter. This view is supported by the Consensus Project (Council of State Governments Justice Center, 2002): "Cross-training efforts, in which members of different criminal justice and mental health agencies educate one another about the basic premises and objectives of their various systems, is crucial to helping bridge these gaps that may stifle successful collaboration" (p. 206).

Inspector Sylven related another pragmatic view on why education on community resources is sought by members:

> I'll bet you that is what the training is about, not necessarily, "I'm interested in the myriad of psychiatric illnesses," but I think . . . the training would be, "Tell me what I need to know so I can be more efficient at this [dealing with the mentally ill]. Who can I call? Who can help me out here? Who can I get to help me with these individuals . . . if they're not about to go before the courts?" (Post-survey interview quote)

Graham Sanderson offered this statement on training in his interview: "It goes both directions. We would want VIHA staff and physicians to understand the role of police and equally would want police to understand the role and operations of the health care staff and the facility."

Scope and Limitations of the Research

Certainly I made all efforts to be as trustworthy as possible during the course of this project, but as with any new study, there are areas that are later observed as incomplete or not as conclusive as had been envisioned. This is true for this study in a number of ways. I used the population that I wanted to survey to its capacity, with a large number of VPD members participating, so from the perspective of scope, I believe the goals were achieved. Certainly, I could have included other police agencies, but that was not the intention of this project as it focussed solely on the VPD. I believe the two research subquestions regarding a knowledge base of members and possible policy to support collaborative relationships have been satisfactorily addressed and will be more clearly defined in the recommendations to the sponsoring agency.

However, there were issues with the survey itself, mostly related to my inexperience with academic rigour and design of surveys. I believe the working group that met to design the survey delivered a product that we could be proud of, but there were deficiencies. I have recognized the issue of subject breadth regarding the knowledge questions. When correlating the responses, it became clear that of the 20 questions we asked in the knowledge section, there was a disproportionate amount of questions regarding psychosis-related issues (nine), and very few regarding other important areas, such as the elderly population (two). In a city such as Victoria, where there is a large number of elderly people, it may have been more inclusive to inquire about the members' experiences with dementia and substance use in the elderly specifically, as it is seen frequently in their work. Dr. Cotton's original survey, from which our questions were drawn, did include more varied questions than ours. There may have been an opportunity to include a wider range of questions than we did.

Another issue that was not addressed was the opinion of the VPD members themselves as to how knowledgeable they felt on the issue of mental illness. A question that asked about their perceptions of their knowledge base and any deficits they believed they might have could have assisted in recognizing areas for future training.

The long answer section of the survey also caused areas of confusion for the members. The wording of some questions was not as clear as it might have been. On question 7, for example, we asked, "Which mental illnesses do you believe you encounter most often in our community as part of your job?" We then listed five possible selections (four major mental illnesses and a choice of "Other"). How to complete the question was obviously not clear to the members. Some ranked the illnesses, while others just checked the one they observed most frequently. Some checked two or three of the five. A clarification of what we were asking should have followed the question itself.

When I decided to include interviews to add depth to the data gathered from the surveyed members, I considered what types of interviews would work to achieve this end. I decided to use the format of unstructured interviews, allowing for the free flow of information. While this did accomplish many of the goals I had for the interviews, I feel that there may have been better results if I had specifically asked particular questions of the participants. When writing up the results, using the interview data to support my conclusions, I felt that the interviewees might have had more information specifically about certain conclusions that I had arrived at. For example, I did not specifically ask Inspector McLean about his thoughts on how training should be explored for his agency.

CHAPTER FIVE – RESEARCH IMPLICATIONS

In order to answer the initial research question, "How can the collaborative working relationships between the Victoria Police Department and community agencies serving persons with mental illness be enhanced in order to better serve the community?", the following chapter will discuss the recommendations that were derived from the study, the organizational implications of the study, and implications for future research.

Study Recommendations

My approach to the study recommendations was to consider the literature review, research study findings, and conclusions in the context of looking at the entire project and the objective of the study, which was to identify, evaluate, and enhance the strategies used by the members of the VPD to respond to people with mental illness experiencing psychiatric situations and crises in the community.

I am making the following four recommendations to the VPD:

1. Establish a steering committee to guide the future direction of the VPD in its interactions, both with people with mental illness and with external agencies that are also tasked with providing services to that population.
2. Establish service agreements to enhance the relationship with VIHA, and develop policy to ensure the longevity of any mental health-related initiatives and agreements.
3. Develop a post-academy training schedule and curricula for the members of the patrol division to be trained incrementally.
4. Continue to support community partnered initiatives, specifically the IMCRT program.

I will discuss these recommendations individually below.

Recommendation 1: Establish a Steering Committee

This recommendation is most vital from my perspective. It is from this recommendation that the others can be achieved, and from which future goals and directions can be established. As demonstrated in Memphis and other locations, the strength of any community collaborative process depends on relationships and communication across agencies. This process serves as the locus of the genesis of initiatives and as the engine that will drive them.

As described in the literature review in Chapter Two, steering committees can achieve success. The CMHA–BC Chapter (2006), in a report called "Building Capacity—Mental Health and Police Project," recommended the establishment of six steering committees in BC communities to identify problem areas and then develop action plans to attempt to address these issues. These committees were struck with members from the police, mental health services, local hospitals, community agencies, families of the mentally ill, and at least one person with mental illness. CMHA reports that all six committees were able to fulfill their initial goals and have made some commitment to continue working together. It is through this spirit of collaboration that goals can be identified and achieved, and I recommend that the VPD invite members from the local service agencies, including VIHA, to participate in such a committee.

Recommendation 2: Establish Service Agreements

VPD members are being held at the ER until a physician assesses the people they have apprehended under Section 28 of the MHA. All parties agree that this process is in need of streamlining. In order to address this long-standing issue, I recommend that the VPD and VIHA establish a subcommittee to work out a service agreement that will allow members'

charges to be seen expeditiously, thereby allowing VPD members to return to service in the community sooner. Members of this subcommittee can access agreements developed elsewhere in Canada as a guide to assist them in finding a solution for the local situation. Examples of these documents can be found at the Canadian National Committee for Police/Mental Health Liaison Web site at http://www.pmhl.ca/en/procedures.html. Included in this list of resources is an agreement, last updated in 2003, between the Vancouver Police Department and St. Paul's Hospital. This is of note as it addresses the same aspects of the MHA of BC that members of the VPD are bound by.

Service agreements are supported by policy, and as such can survive changes in leadership and personnel. Chapter Two noted the need for these agreements, as described by the Criminal Justice/Mental Health Consensus Project (Council of State Governments Justice Center, 2002):

> Stakeholders need to get beyond informal handshake agreements largely dependent on personalities and unlikely to survive staff turnover or changes in leadership. To ensure the lasting, systemic change that this report contemplates, criminal justice and mental health policymakers will need to improve upon initial cooperative efforts, begin to collaborate, and, ultimately, enter into *partnerships*. (p. 188)

Another statement included in the literature review regarding the Memphis CIT bears repeating here: "The partnership between the police department and the medical center's psychiatric emergency department is a key element in the program's effectiveness, and procedures were developed jointly" (Cochran et al., 2000, p. 1315).

Recommendation 3: Develop a Post-Academy Training Schedule and Curricula

As identified through the survey and the post-survey interviews, VPD members are open to post-academy training in aspects of mental illness and in access to services related to the mentally ill. This conclusion mirrors what Cotton (2004) found in her survey of three

police departments across Canada: that police members accept that interaction with those with mental illness is a part of their job, and they are open to more training in that area. At the Police Academy, VPD members do not receive the minimum hours of education and training in the area of mental illness recommended by the Consensus Project (Council of State Governments Justice Center, 2002). While this is a provincial training deficit, the VPD can close the knowledge gap by providing post-academy training and education through increment training sessions. The Consensus Project supports this approach and recommends 20 hours of in-service training for members.

The most appropriate avenue to establish training schedules and curricula is through the local steering committee. The Consensus Project (Council of State Governments Justice Center, 2002) recommends this approach: "A committee or task force . . . provides a mechanism through which criminal justice agencies and mental health practitioners, consumers, family members, and other stakeholders can collaborate to educate personnel in various departments" (p. 209). There is a wealth of knowledge contained in local external agencies that can be formally shared with VPD members. In his post-survey interview, Mr. Lynn from VIHA stated that his IMCRT program is willing to provide training, and he specifically mentioned the BC Schizophrenia Society's "Partnership Program," comprised of people with mental illness who relate their experiences to police members through panel discussion. Another potential contributory agency is the Adult Forensic Psychiatric Services Commission–Regional Programs clinic in Victoria, whose clinicians have experience in providing training and education to community agencies.

Recommendation 4: Support Community Partnered Initiatives, Specifically IMCRT

During the literature review process, it was clear that communities are establishing initiatives to assist police and external agencies in dealing with the increasing workload involving persons with mental illness (Geller et al., 1995). One type of initiative being developed is the mobile crisis response team concept, an idea already embraced by the VPD with the collaborative IMCRT program. Launched in 2004, IMCRT has received support from the members of VPD as observed in the survey and post-survey interviews. IMCRT is currently providing many opportunities for the VPD and mental health personnel, including cross-training and sharing of expertise. It is also incorporating staff and knowledge from other local municipal police agencies as well as the RCMP.

Mr. Lynn from VIHA spoke of "untapped potential" in his interview and said that he has hopes that IMCRT will provide much more to the local police agencies, including formal training for members. He also believes that IMCRT will be able to take some of the load from patrol members once it has an ability to transport apprehended persons to hospital. Also mentioned by survey participants was the ability to communicate more freely with IMCRT as opposed to mental health clinicians alone, because the police members of IMCRT have access to the VPD information systems. So there is already better communication between agencies with IMCRT in place.

One of the issues raised by the survey participants and by the interviewees was that the VPD is the only 24/7 responder to crisis, with the local ER as the only resource available to members during the early morning hours. In my mind, exploring the option of expanding the hours of IMCRT will go a long way in addressing members' concerns.

Organizational Implications

The positive changes as a result of this research project may have already started to be realized. Soon after the survey was completed, there was a series of meetings between agencies concerned with the mentally ill, such as VIHA and the VPD, to try to resolve the problem of the wait times at the ER. The discussions revisited the issue of "special constable" status as described in Chapter Four for VIHA security personnel, but no decisions have been made to date. Were these meetings simply a coincidence of timing, or did the energy of the surveyed members contribute to this process?

Beginning in February, 2007, my employer, Forensic Psychiatric Services Commission—Regional Programs, is reinstating the Mentally Disordered Offenders committee that had historically brought community members together to collaborate and cooperate in regards to specific issues regarding providing service to mentally ill persons. Past membership included members from the courts (Crown Counsel), BC Corrections (including representatives from the local jail and probation services), police agencies, and what is now known as VIHA. The VPD has accepted membership in this committee. Is this a forum that could become a steering committee? Could it be a conduit of change for the VPD?

The answers to these questions are not known at this time, but what is known is that these questions can provide an opportunity for the VPD to begin to explore what is right for the organization. I have every reason to believe that the VPD will carefully consider these recommendations, as it has made clear that it is seeking positive solutions to the increasing workload of providing service to mentally ill people. As Inspector McLean said in his interview, "Finally there is some document or study that is giving us some justification for the thoughts or the ideas or the perceptions that we had." Therein lies the truth. VPD

members and senior staff have known for years what this research has found, and they feel validated by the outcome. Should VPD choose not to implement the recommendations, the struggle with the increasing call numbers and difficult interactions with external agencies such as VIHA ER will continue.

One of the greatest challenges for organizations today is funding the programs they feel are important. It is no different for police agencies, which experience fiscal shortfalls just like other organizations. What I have recommended to the VPD should for the most part be relatively inexpensive to design and create, with the biggest cost being the time spent by senior members in organizing and participating in committees and meetings. If there is commitment from external agencies to provide the training to VPD members, collaborative training agreements can be negotiated with those agencies such as VIHA and Forensic Psychiatric Services Commission at little or no cost. Of course, IMCRT does require annualized dollars to keep running, and if the VPD supports expanded IMCRT hours, an increase in funding may be required. But through ongoing collaboration, it is possible that other funding streams may be found.

Implications for Future Research

Although police response to mentally ill persons is nothing new, the challenges of an increasing workload caused by the downsizing and realignment of other social service agencies are acute. The VPD has already entered into innovative initiatives to try to cope with the demand for service. Because of this, it is a leader in the field regionally and nationally. But collaborative teams only began developing a few years ago, and much is still unknown.

This project surveyed only one police agency in the southern part of Vancouver Island, a geographical area that has a total of six police agencies. I think it is fair to say that the other police agencies share many of the concerns of the VPD, but that they also have unique problem areas of their own. Oak Bay Police Department, for example, may have a higher incidence of encountering people in crisis that are suffering from dementia, as its area's population makeup includes a disproportionate percentage of elderly residents. It would be of benefit to survey select members from all local police agencies to get a bigger picture of the regional situation.

Should this type of information gathering occur in the future, I would recommend using a more specific tool than the one designed for this study. While the survey met the study's goals, it was not wide enough in breadth to obtain truly demonstrative data. Participating members should complete a full survey, possibly the one developed by Dr. Cotton. This approach would allow for fair comparisons of data across police agencies, something that this study's survey cannot accomplish.

Finally, the IMCRT program should compile its data and track any changes in trends regarding service delivery to mentally ill people, in order not only to justify its budget, but also to provide the VPD and other police agencies much needed data on response needs. There is every indication that the number of calls involving the mentally ill will continue to climb, and that will mandate a more collaborative response from the local police agencies. Would having IMCRT available 24/7 decrease the amount of time spent by patrol members in dealing with mentally ill people and interfacing with other agencies such as VIHA? Will there be a decreased demand for the ER and the Archie Courtnall Centre by police services? Data tracking by both the VPD and VIHA could provide answers to these questions.

CHAPTER SIX – LESSONS LEARNED

"We believe, with others, that emotion is the wellspring of human motivation, the 'primary provider of blueprints for cognition, decision and action'" (Salovey, Bedell, Detweiler, & Mayer, 2000, p. 511).

Every worthwhile venture embarked upon has lessons to teach. My personal MALT experience has proven to be no different. I will try to capture what I have learned through this adventure, but in order to do that, I must provide some background into what this experience really became for me.

In early 2003, my partner, Donna, encouraged me to pursue higher education to fulfill one of my career objectives: to return to a supervisory role in a small team of professionals. She was excited about and supportive of my acceptance into the MALT program at RRU and proud of me for going for it. On the day of my attendance at the first residence in 2003, Donna was diagnosed with malignant melanoma. As a nurse, I knew that her life was ending. I did not want to waste what precious time was left for us together by going through school, but Donna would not hear it; I was to continue. To give up on school was to give up on her, and that was not acceptable to either of us. I withdrew from the 2003 cohort and took distance learning courses at home with the cohort, planning on attending first residence in 2004, which I did. The 2004 cohort was supportive of our plight, but I felt alone and isolated in the group. Donna struggled mightily with her cancer and her mortality. On July 1, 2004, at age 40, she passed away.

The next year was and still is a blur to me. I was able to soldier on, trying to complete the program, if for no other reason than that I had promised Donna that I would finish. It was probably not the right reason, but it was a strong one nonetheless. Then, during the second

residence, I fell severely ill with an autoimmune disease that nearly killed me. There is little doubt that the illness is related to my grieving process for the loss of my partner. More months of healing and not working went by, and all the while I dreaded working on this project, which loomed like a tsunami over my head. But time and life go on. I have received tremendous support from my family, friends, colleagues, sponsor, employer, and RRU. The project moved along, and here we are.

Listed below are some of the lessons I have learned. There are others, but I will not include them here as they are personal and for me alone.

1. Motivation: Discover what motivates you; look for it.
2. Use your passion.
3. Take risks and rise to the challenge.
4. Know yourself: Take time to understand how you work.
5. Choose your major project supervisor well.
6. Take advantage of all available opportunities.
7. Never give up.

Motivation

Is motivation a magical and external force that enables us to choose and complete tasks, or is it inherent in human beings? As children, we are motivated by others to learn in a formal framework. We are told what to learn and when to learn it, whether we like it or not. There is extensive research on the impact of this type of learning, and there is evidence that it is not as valuable to the learner as the andragogical, or adult learning, model. Vaill (1996) writes, "Institutional learning is prone to motivation through carrot and stick" (p. 92), describing a system of external rewards and punishments designed to keep learners on track.

When faced with this setting, there is little ownership of the learning, and subsequently little retention of knowledge. Wlodkowski (1993) provides this perspective: "Use the word *motivation* to describe those processes that can (a) arouse and instigate behaviour, (b) give direction and purpose to behaviour, (c) continue to allow behaviour to persist, and (d) lead to choosing or preferring a particular behaviour" (p. 2). This definition provides a wide view, indicating that motivation is ever-present on a continuum, not a trait that manifests itself when called upon. Bender (1997) offers a more succinct, wonderfully simplistic definition in his book *Leadership From Within*: "Motivation = Unfulfilled needs" (p. 55). Does this not capture the true core of what causes us to act? My personal belief is that the highest level of motivation is *intrinsic*, driven by people's needs to better themselves or contribute to a greater good. Kouzes and Posner (1997) describe these needs as *intangibles,* which include "learning, self-worth, pride, competence, and serving others" (p. 41).

I started this project because I wanted to help people that I cared about, the mentally ill in my community. I finished because I needed to show myself that I could. I had to value myself. This poignantly illustrates how motivation may start from external desires and move towards intrinsic needs and values. Values provide us with a dynamic framework through which we look at the world. Knowles, Holton and Swanson (1998) believe that it is the internal drives that hold the most power. They state that increased job satisfaction, self-esteem, and quality of life motivate people. I believe that these things, as well as acceptance and a sense of belonging, motivate me. Wlodkowski (1993) breaks motivation down into four important parts: success, volition, value, and enjoyment. Seekers will be motivated if they "successfully learn what they value, and want to learn in an enjoyable manner" (Wlodkowski, 1993, p. 8).

I assert that it is important for all learners to recognize where their motivation comes from. Mine comes from within, from a depot of reasons and personal experiences that have motivated me in the past. And yet, I still have a difficult time thinking in future tense. In completing this project, the prospect of getting a better job or promotion was not a motivator for me in the least. I was motivated more by the idea of honouring the past and being able to keep promises that I had made to those people who are important to me.

Use Your Passion

Of the intrinsic motivators, fulfillment of emotional needs is widely regarded as one of the most powerful. Tomkins (as cited in Wlodkowski, 1993) iterates that "emotions are the 'chief movers' of behavior" (p. 54). I have put some thought into this simple statement. If it is true, then I could direct my wealth of emotion into a positive force. I thought about this for quite a while, trying to incorporate what I read into how I felt. Salovey et al. (2000) do not specify which emotions motivate us as humans, so I reflected on what emotions I was feeling. At various times, given my personal circumstances, I was motivated by different and conflicting emotions. As the project developed, it became clear that it was not about the outcome I had envisioned per se, but more about the process of moving toward self-actualization. Here was one huge "A-ha!" moment for me. The purpose of the project was to help me develop into a more complete person.

Take Risks and Rise to the Challenge

The primary motivator for me is simply my desire to be the best that I can be at anything I choose to do. There is documented evidence that increasing competence and mastery of task are powerful motivators. Wlodkowski (1993) identifies challenge as being a necessary component of learning: "Challenges are excellent opportunities for adults to affirm

themselves and to build competence and confidence" (p. 134). I relate challenge to taking risks and pushing the envelope to increase skills and competence. Bender (1997) says that risk-taking is inherent to growth and brings about many benefits, including enhancement of hope and self-esteem, demonstration of capabilities, and an increase in the probability of success. White (as cited in Wlodkowski, 1993) says that human beings "inherently desire to gain competence over their environment. . . . By virtue of being a human being, a person is intrinsically motivated to master the environment and finds the mastery of tasks to be gratifying" (p. 54). I agree.

Know Yourself

When I first began this odyssey, I started out with a plan in mind, but had to evolve in my thinking in order to incorporate new information that I wasn't aware of at the start. Adaptability is what brought people out of the trees, but it is cognitive insight that separates humans from other mammals. During residence at RRU, I had written a plan for my project based on my early assumptions of what was being requested by RRU faculty. This highlighted one of my learning "stretches" or personal shortcomings: I am quick to form an opinion and start to work immediately, sometimes skipping over steps along the way. This is indicated in my Myers-Briggs Type Indicator® assessment as an ENFP (Extroversion, Intuition, Feeling, Perceiving) type personality. The interpretive report included with the assessment suggests that "if you rely too much on your intuition, you are likely to miss the relevant facts and details" (MacLeod, 2003, p. 7). It became clear later on in the process that I should have read and analysed more completely what was being asked and then developed the plan for the major project. If I were to do it all again, I would develop a more

comprehensive and relevant learning plan, which would highlight the actual expected outcomes.

Choose Your Major Project Supervisor Well

A major lesson for me in this process was to choose a supervisor with careful consideration. Early on in the process, I had decided that there was one person out there who truly knew what I was doing and who would be a great benefit to the major project. This person is well respected in her field. She is extremely knowledgeable and published in this project's area of concern, and she has a great amount of energy and passion about the issues in the project. But one important area had been overlooked in my choice for a supervisor: neither of us had any experience with RRU and the way it views the construction and completion of major projects. Early on, we got hung up on small issues that stalled the process of moving along. Coupled with my own fluctuating levels of motivation, this caused delays and friction. In the end, I credit my previous supervisor with realizing that the relationship was not working out and that a change was needed. I am very grateful for her insight. Connecting with a new supervisor with extensive RRU experience immediately changed the process piece of the project and made it possible to complete it.

Take Advantage of All Available Opportunities

This is so important! When I first started this project, I had in mind that I would be able to do everything that was required to complete it on my own. I spent no time thinking about how to have interviews transcribed or how to polish the project up. "I have all the time in the world" was what I thought. Of course, things didn't work out that way. The best laid plans often go astray, as mine certainly did. It is with some acknowledged serendipity that I was able to recognize the folly of my sense of grandeur and agree to involve other people in

my project. I could not have created this body of work without the support and guidance of my colleagues at the Forensic Psychiatric Services clinic in Victoria. I had no concept of how many pages four interviews would consume when transcribed and am very grateful to my transcriber who spent many hours creating documents from audio tapes. And finally, I had help from my editors, who provided a professional finish to the project and saved me many hours by ensuring the project met the standards of the university.

Never Give Up

If something is important to you, for whatever reason, don't give up. It may not be obtainable today or even tomorrow, but you can achieve your goals if you really want to. If you can't find the strength in yourself, borrow it from those around you who are willing to provide it. You can always pay it back later.

Conclusion

So what have I learned? I've learned that emotion is a powerful motivator, whether it is positive or negative. I've learned that others can encourage my heart. I've learned that I can model the way for others regardless of my view of my personal situation. I've rediscovered my ability to respond to challenge. I've learned that the people who are close to you will support you when you need it, without needing to be asked to do so. Most of all, I've learned that my passion, for learning and for living, is still with me and that in the end, it's all about passion.

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APPENDIX A – INVITATION LETTER TO ADVISORY GROUP

To: _____

From: Randy Puetz, RPN

Re: Invitation to participate

Dear Colleague,

I am currently enrolled at Royal Roads University completing a master's degree in Leadership and Training and am undertaking a project sponsored by VPD regarding police interaction with people with mental illness. The goal of the project is to better understand how members resolve mental health calls, what resources are in place for members, and any training issues that could be identified.

As a part of the project, a survey will be designed to elicit VPD members' knowledge and thoughts around interacting with people with mental illnesses, including areas such as training and resources.

Because of your knowledge and background I am inviting you to be a member of a small advisory group that will convene to develop the survey questions. The membership of the advisory group will include members of VPD and Mental Health Services, which includes Alcohol and Drug Services. The group will be scheduled to meet once for approximately two to three hours to design the survey. The time spent working in the group will be your own; there will be no monetary remuneration for participation. Beverages and snacks will be provided.

Participation in this project is completely voluntary in nature, and you can choose to withdraw at any point in the process. For your information, audio recording devices will be used to create transcripts of the meeting for the purpose of accuracy. You will have access to

the transcripts once they are completed and will be able to make any corrections to your contributions that you feel are necessary.

The group will convene at VPD Headquarters on an October date that is convenient for all participants. I would appreciate it if you could forward to me any dates and times that would work for you so that a consensus can be reached.

If you choose, you may check my academic credentials by contacting:

Ms. Nancy Greer

Academic Lead, MALT (Classic) and MBA Leadership Programs

Royal Roads University [telephone number]

I look forward to hearing from you and working with you on this project should you choose to participate.

Sincerely,

Randy Puetz, RPN

Consent For Participation

I agree to participate in the advisory group convened by Mr. Randy Puetz as part of his Royal Roads University master's project sponsored by the Victoria Police Department. I understand that the participation is voluntary in nature and that I can withdraw my participation either verbally or in writing at any time. I also understand that there is no monetary remuneration or other payment for the participation. I also consent to the use of recording devices for the purpose of creating transcripts with the understanding that I will have access to the transcripts for correction to ensure accuracy.

Signature: Date:

_____ _____

APPENDIX B – INVITATION LETTER TO SURVEY PROSPECTS

To: Victoria Police Department members

From: Randy Puetz RPN

Re: Invitation to participate

Dear VPD Members,

I am currently enrolled at Royal Roads University completing a master's degree in Leadership and Training and am undertaking a project sponsored by VPD regarding police interaction with people with mental illness. The goal of the project is to better understand how members resolve mental health calls, what resources are in place for members or could be developed, and any training issues that could be identified and initiated.

In order to gather this information from front-line members, a short survey has been designed by a small group of VPD members and mental health professionals. I am inviting you to participate in this survey, which should not take more than 10 minutes. Members are authorized to complete the survey while on duty.

Participation is anonymous and voluntary in nature, and you can withdraw from the survey at any point. There is a check box at the beginning of the survey where you may indicate that you have read this invitation and agree to participate.

Once the survey is completed the data will be themed into a report with recommendations that will be presented to the Victoria Police Department. The data will also be used for the final report to Royal Roads University as a requirement for completion of my master's degree. The data may be cited in other articles or conferences. There will be no individual identifiers used to ensure anonymity.

If you choose, you may check my academic credentials by contacting:

Ms. Nancy Greer, Academic Lead, MALT (Classic) and MBA Leadership Programs

Royal Roads University [telephone number]

Confirmation of my sponsorship may be obtained through the VPD project sponsor, Inspector Darrell McLean, at [telephone number] or via e-mail at [e-mail address].

If you have any concerns about the project you may also contact me, Ms. Greer, or Inspector McLean.

Thank you for your assistance in this important matter. Any knowledge you can share may help the department and the members in future interventions, planning for training, or identification of resources.

Sincerely,

Randy Puetz, RPN

APPENDIX C – INVITATION LETTER TO INTERVIEW PROSPECTS

From: Randy Puetz, RPN

Re: Invitation to participate in an interview

Dear _____,

I am currently enrolled at Royal Roads University (RRU) completing a master's degree in Leadership and Training and am undertaking a project sponsored by the Victoria Police Department (VPD) regarding police interaction with people with mental illness. The purpose of this research is to determine how the VPD can best work with community agencies that serve persons with mental health issues to successfully work together to meet the training needs of the police officers in regard to working with those individuals, and to enhance and foster current positive working relationships between the police department and the community agencies.

In order to gather this information from front-line members, a short survey has been designed by a small group of VPD members and mental health professionals. I am inviting you to participate in an interview to explore and examine the findings of this survey, which should not take more than 60 to 90 minutes. I believe that your experience and knowledge will assist greatly in understanding the implications of the findings in the survey. Participation is purely voluntary in nature, and you can decline to participate.

The interview will be recorded and transcribed, and you will have an opportunity to read the transcript for accuracy prior to it being included in the final report to RRU and VPD. If you choose, you may check my academic credentials by contacting:

Ms. Nancy Greer, Academic Lead, MALT (Classic) and MBA Leadership programs

Royal Roads University [telephone number]

Confirmation of my sponsorship may be obtained through the VPD project sponsor, Inspector Darrell McLean, at [telephone number] or via e-mail at [e-mail address]. If you have any concerns about the project you may also contact me, Ms. Greer, or Inspector McLean.

Thank you for your assistance in this important matter. Any knowledge you can share may help the department and the members in future interventions, planning for training, or identification of resources.

Sincerely, Randy Puetz, RPN

Consent For Participation

I agree to participate in an individual interview with Mr. Randy Puetz as part of his Royal Roads University master's project sponsored by the Victoria Police Department. The purpose of the interview is to explore and examine the findings of the survey completed by members of the Victoria Police Department.

I understand that the participation is voluntary in nature and that I can withdraw my participation either verbally or in writing at any time, without sanction or penalty. I also understand that there is no monetary remuneration or other payment for my participation. I also consent to the use of recording devices for the purpose of creating transcripts with the understanding that I will have access to the transcripts to ensure accuracy. The audio recordings will be destroyed immediately following the transcription. I understand that feedback will be available to me regarding the final document and its findings should I request it.

Print Name: _____

Signature: _____ Date: _____

APPENDIX D – VICTORIA POLICE DEPARTMENT MENTAL HEALTH SURVEY

Preamble

Thank you for taking part in this survey. Prior to commencing, there are two important steps that need to be completed. One is for you to acknowledge the voluntary aspect of your participation, and the other is to gather some basic information about you as a VPD member.

Step 1

"I have read the letter inviting me to participate in this survey and understand that participation is anonymous and voluntary in nature, with no penalty for not completing the survey."

If the preceding statement is true for you, please check the box: ☐

Step 2

Please provide the following information:

Rank _____

Length of service _____

Position or area of responsibility_____

Your age_____

Your gender (please circle) M F

Thank you. Please go on to page 2 and the survey.

Part 1 – True or False Questions

Please circle the answer that you believe is most accurate.

1. A significant number of persons suffering from schizophrenia also abuse alcohol or other drugs.

   True False

2. Severely mentally ill patients are too psychotic to learn new skills.

   True False

3. Most individuals suffering from both a mental illness and substance abuse do fine in programs dedicated to treatment of substance abuse.

   True False

4. People with mental illnesses are consistently more violent than "normal" people.

   True False

5. When mentally ill people do strange things, it is usually because they are hearing voices telling them to do things.

   True False

6. Mentally ill people are just as intelligent as most people.

   True False

7. Most mentally ill people are easily intimidated and will back down when confronted with a "show of force."

   True False

8. If apparently mentally ill people are talking to themselves, it is most likely they are responding to voices or hallucinations.

   True False

9. Bipolar disorder and manic depression are the same thing.

True False

10. People with schizophrenia may have several distinct personalities.

True False

11. Mentally ill people may injure themselves on purpose (e.g., slash their wrists or take overdoses) without meaning to kill themselves.

True False

12. When mentally ill persons' speech doesn't make sense, it is likely their thoughts don't make sense either.

True False

13. The majority of mentally ill people would not be fit to stand trial if they were charged with a crime.

True False

14. There is no known cure for Alzheimer's disease.

True False

15. Mental illnesses are often caused by stress.

True False

16. People with mental illnesses often have difficulty concentrating.

True False

17. Alzheimer's disease only ever occurs in people over the age of 65.

True False

18. Some street drugs can mimic symptoms of mental illness.

True False

19. Individuals who suffer from a severe mental illness can learn to monitor their own warning signs of relapse.

True False

20. Medications are usually effective in controlling hallucinations and delusions or false beliefs.

True False

Part 2: Open-ended Questions

(Note: For the purposes of saving space, lines provided to participants to write on have been removed.)

1. In your opinion, what would a "good working practice" with Vancouver Island Health Authority (Emergency Room, emergency mental health, detox, etc.) look like (e.g., having a single point person at ER, or having special constable status for security)? List as many as you wish.
2. "Community case conferences" are meetings sometimes convened to discuss shared clients across multiple services. Do you believe that community stakeholders organizing community case conferences for frequently referred people would be helpful to you in the performance of your job? Why or why not?
3. To your knowledge, what other factors cause "bad" behaviours other than mental illness?
4. When interacting with community resources such as the emergency room or emergency mental health services about a person with mental illness, what types of information do you need to help you do your job?
5. From your perspective, what are the biggest problems facing the mentally ill in the Victoria area today?

6. Is there a good understanding on the part of mental health providers or others (such as hospital staff) regarding procedures that you must follow as part of your job? If not, what do you think would help?
7. Which mental illnesses do you believe you encounter most often in our community as part of your job?

   ☐ Psychosis (hallucinations, delusions, and bizarre ideas and thoughts)

   ☐ Bipolar illness (extremely elated mood, boundless energy, mood swings)

   ☐ Personality disorders ("frequent flyers," cutters, no remorse)

   ☐ Depression (low energy, no concern for welfare, may be suicidal)

   ☐ Other_____

8. The following are some community agencies that assist people with mental illnesses:

   - The Open Door/Our Place
   - Swift Street Medical Clinic
   - Courts
   - Forensics
   - 9-10 Club
   - VIHA Day Hospital
   - John Howard Society
   - Salvation Army
   - Capital Mental Health Association
   - Sobering Centre

- Detox
- Victoria Native Friendship Centre
- St. Vincent De Paul
- Victoria Women's Transition Houses
- Laurel House

What are some of the roadblocks to accessing these services? How would you make them better for your purposes (e.g., extended hours)?

Thank you for completing the survey. You should now seal it in the supplied envelope and deposit it into the box marked "Completed Surveys."