

Vancouver Police Mental Health Strategy

**A comprehensive approach for a proportional police response
to persons living with mental illness**

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VANCOUVER POLICE DEPARTMENT
Beyond the Call

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Executive Summary

The Vancouver Police Department (VPD) has been proactive over the past 30 years regarding incidents involving mental health, implementing a number of programs and initiatives to improve outcomes relating to police interactions with persons living with mental illness. In 1978, the VPD implemented 'Car 87,' an integrated response model partnering a police officer with a mental health professional. That program continues today, and has served as a model for many other police agencies to copy. It has been further augmented with other initiatives to focus on youth and chronic offenders, and more specialized mental health programs.

Over the past five years, the VPD has publicly reported on the dramatic increase in the incidence of police interactions with persons living with mental illness (see Appendix – A). There has also been a number of high-profile incidences of violent crime associated with an apparent mental health factor, highlighting gaps in the continuum of care and in the system generally. That is not to say that mental illness is a causal factor in violent crime. Rather, persons living with mental illness are more likely to be a victim of crime, rather than the perpetrator. These drivers have led to the VPD enhancing its service delivery and actively participating in broader multi-disciplinary teams, with health care providers, to deliver proper community-based mental health support for those in need.

While these initiatives have all proven valuable in terms of client needs and reduced police interaction, and can each be supported as effective through evidence-based research, a broader *Mental Health Strategy* will serve as an overarching approach for the VPD. It is intended to account for the significant impact that can result from persons living with mental illness coming into contact with the police, and set forth a framework on how the VPD models its interaction with this segment of the population. In addition, it is important to acknowledge that most mental-health-related calls to the police involve persons with concurrent disorders – a mental illness and substance abuse problems.

This *Mental Health Strategy* is framed around the core values of the VPD, and the principles of justification, proportionality and intrusiveness. It is designed to provide clear and concise information about the VPD's position and intent, and to serve as a framework to support operational deployment, organizational partnerships, education and training initiatives, and a commitment to the community relative to its interactions with persons living with mental illness.

Finally, this *Mental Health Strategy* was not developed in isolation. The VPD has consulted with partners in the mental health community, in an effort to include their perspectives on this jointly-shared social challenge. Input was received from numerous stakeholders and partner organizations, including Vancouver Coastal Health, the Canadian Mental Health Association, the City of Vancouver, and mental health professionals from St. Paul's Hospital, Vancouver General Hospital, and UBC Psychiatry. In addition, a consultation session with the Persons with Lived Experience Committee, Mayor's Task Force on Mental Health and Addiction resulted in meaningful feedback from this affected population.

VPD Approach

The VPD has long-acknowledged that mental health, mental illness, and the associated patient care are all the primary responsibility of health care providers. Further, there are numerous other social factors that influence the behaviour of persons living with mental illness, and the likelihood of success with their care plan. These factors include access to housing, poverty, education, substance use and misuse, etc.

In the traditional sense, the VPD is focused on public safety and law enforcement. Its mission is to be “Canada’s leader in innovative policing, maintaining public safety, upholding the rule of law and preventing crime.”¹ However, the very nature of police work is challenging, with police officers frequently confronted by traumatized individuals or traumatizing circumstances. As such, the VPD is committed to:

1. The best training to better understand mental illness and to effectively respond to incidents where a person living with mental illness is in a state of crisis and in need of care;
2. Providing support to police officers who may themselves be experiencing loss, trauma or violence, through mentoring, peer support, or therapy from a mental health professional; and,
3. Systematically reducing stigma within the Department, and serving as a role model for the community where persons living with mental illness are accepted as individuals within society and not subject to differential treatment.

Police officers regularly come into contact with persons living with mental illness, including a majority who concurrently struggle with substance abuse, some who are not receiving necessary medical care and community support, and a small number who may be in a state of crisis. Given these inevitable interactions, the VPD has proactively worked to provide care and mitigate risk by collaborating upstream with health care partners in an effort to get these vulnerable persons the support they require.

The overarching objective for the VPD is client-focused and recovery based, meaning that the individuals themselves often need support, housing, and medical services, and do not usually require more traditional enforcement measures associated to a police department. This objective aligns with the strategic direction of Vancouver Coastal Health which focuses on patient-centered care.²

The VPD is intent on diverting persons living with mental illness away from the criminal justice system when the circumstances of the criminal activity are minor in nature, have little immediate impact on the community at large, and are grounded in the individual’s mental illness. This approach aligns with the Diversion Framework set forth by the Canadian Mental Health Association.³ As a part of that broader

¹ Vancouver Police Department (2011). *2012-2016 Strategic Plan – Vancouver Police Department*. Found at <http://vancouver.ca/police/assets/pdf/vpd-strategic-plan-2012-2016.pdf>

² Vancouver Coastal Health (2015). *2015/16 – 2016/17 Service Plan*. Found at http://www.vch.ca/media/Service%20Plan_2015_2016_FINAL_October_2015.pdf

³ Hall, N and Weaver, P (2008). *A Framework for Diversion of Persons with a mental Disorder in BC*. Canadian Mental Health Association BC Division. Found at <http://www.cmha.bc.ca/files/DiversionFramework.pdf>

commitment, the VPD has reassigned existing personnel away from other areas of policing, in order to address this growing responsibility to public safety in our community. Further, the VPD has collaborated with many stakeholders in health care, health research, and government to develop client-focused solutions that reduce the incidence and lessen the impact of interactions with the police. However, these collaborative solutions must include sufficient capacity within health care to respond to a high-needs population and expanded community services to serve chronic patients effectively, while respecting the rights of persons living with mental illness and de-escalating conflict to ensure that use of force is the last line of defence.

Access to Care versus Criminalization

Through all of the research and reports coordinated by the VPD, it is apparent that the majority of people who are living with mental illness and who come into negative contact with the police require some form of access to care or community support. In some instances, the seriousness of the incident and the need to maintain public safety will require a criminal investigation and potential criminal sanctions. However, in many instances the actions of the individual are minor, or of a nuisance nature, and driven by a state of crisis attributable to mental illness.

In all such cases, the VPD is committed to pursuing access to care through health care providers, and proactive follow-up with supportive multi-disciplinary teams that focus on the well-being and recovery of the individual. By working with the health care system, and ensuring individuals receive the requisite care for their illness, recidivism and future negative police contacts should diminish dramatically.

Partnering with Stakeholders

The VPD has long-recognized that great things can be accomplished through effective partnerships with the community, government, and the private sector. In spite of the fact that mental health and wellness, and addictions treatment, are the responsibility of the Ministry of Health (and the Ministry of Children and Family Development in cases where youth are involved), the very nature of the increasing incidence of police involvement with persons living with mental illness precipitates the VPD driving change to improve the quality of care for this vulnerable group.

The VPD will continue to partner with mental health stakeholders and effect change in the system. It is imperative, however, that all partners in this continuum provide sufficient resources to meet the demand for service. Where a person receives insufficient services or support, they will ultimately fall back on the VPD as the last line of help, and this can create risk for the individual, the community, and the VPD.

Three key mental health partnerships that have grown over the past few years have been with Vancouver Coastal Health (VCH), Providence Health Care (PHC), and the City of Vancouver.

Vancouver Coastal Health and Project LINK

Following the release of the 2010 report *Beyond Lost in Transition*, the VPD and VCH formalized a long-standing partnership with *Project Link*, committing to work together to improve the quality of life of persons living with mental illness and/or problematic substance use and addiction. Both agencies' leaders and respective Board chairs signed a letter of understanding, committing to take a patient-centred approach to the problem, committing to work together for collaborative solutions, improving how they respond to and interact with the mentally ill, improving policies and procedures, and providing the most expedient and appropriate care for the individuals involved.

A working group was formed from this agreement, including representatives from PHC, and the three organizations continue to work to address gaps in the system and support proper care for the clients.

Accomplishments include:

- Embedding police officers within Assertive Community Treatment (ACT) teams
- Expanding ACT from three teams to five, to support a larger clientele base
- Developing an information sharing agreement and formalized discharge agreements between the police and health, enabling the exchange of critical client information between the two organizations to facilitate proper care for each individual client
- Improved communication with the VPD Chronic Offenders Unit to deliver a coordinated response that ensures the most prolific offenders who are living with a mental illness receive the mental health support they require
- Improved collaboration with the mental health programs provided through the Downtown Community Court
- Improved reporting within the VPD to account for incidents involving a 'mental health factor,' and forming part of a broader early warning system to identify clients at risk
- Improved linkage with St. Paul's Hospital/Providence Health Care, particularly when dealing with ACT clients who come into contact with health care professionals from different hospitals

At the senior leadership level, the Executive and Boards of both the VPD and VCH meet annually to set priorities for the working group for the coming year. Collectively, both agencies identify achievable targets to pursue program change and advancement, all in the interests of the client. By working collaboratively, sharing vital information, and leveraging their partnership, change has taken place, and clients are often receiving better care when needed the most.

Mayor's Task Force on Mental Health and Addictions

The Mayor's Task Force on Mental Health and Addictions was formed in 2013, and designed to support the efforts of VCH, PHC, and the VPD to further their recommendations to the Province following the release of the *Mental Health Crisis* report. The mandate of the Task Force is to:

...help the City, Vancouver Coastal Health, the Vancouver Police Department and other related sectors, including Housing and Justice, to identify high priority, feasible actions that will address the continuum of needs of SAMI

[Seriously Addicted and Mentally Ill] residents. The Task Force will be modelled after the best practice of the Four Pillars Coalition, recognizing the need to mobilize and involve key stakeholders and community.⁴

The Task Force is led by the Mayor and membership is comprised of representatives from health, justice, social development, housing, academia, non-governmental organizations, urban Aboriginal groups, and people with lived experience. This multi-sectoral approach has provided significant input and support to VCH and the VPD, and in September 2014, the Task Force released a comprehensive report that identifies actions to enhance the system of care for persons living with mental illness. Six action areas were identified, containing 23 priority action items to enhance access to quality and effective support services. The six key action areas are:

1. Work better together and address service gaps, utilizing a collective impact methodology and data-sharing model;
2. Convene a peer-informed leadership system to examine best practices relating to health care, housing and community support;
3. Create a greater awareness of mental health and addiction, whereby de-stigmatization will increase access to services, improve chances of recovery, and improve a sense of inclusion and belonging;
4. Develop better support systems for youth transitioning out of care;
5. Focus on wellness for Aboriginal peoples;
6. Enhance addictions knowledge by supporting training and integrating addictions specialists into the existing medical system.⁵

The VPD is a key partner in this initiative, and is specifically committed to enhancing the education and training of all police members, collaborating with the Province of BC and the Justice Institute of BC to develop appropriate training, and working with people with lived experience to further de-stigmatize mental illness.

⁴ City of Vancouver (2013). *Mayor's Task Force on Mental health and Addictions – Terms of Reference*. Found at <http://vancouver.ca/files/cov/Mayors-Task-Force-on-Mental-Health-and-Addictions-Terms-of-references.pdf>

⁵ City of Vancouver (2014). *Caring for All: Priority Actions to Address Mental Health and Addictions*. Found at <http://vancouver.ca/files/cov/mayors-task-force-mental-health-addictions-priority-actions.pdf>

Policy

The Vancouver Police Department is committed to a culture in which persons living with a mental illness and/or substance use will be treated with respect and compassion. Further, the rights of these individuals are equally as important as the rights of others, and the VPD will ensure that procedural justice principles are adhered to. Recognizing that persons' interactions with systems and institutions can create trauma on its own, it is imperative that the underlying mental health issues be addressed, while minimizing the criminalization of the individual.

To accomplish this objective, the VPD is committed to reducing the stigma associated with mental illness within the organization, and delivering robust education and training that focuses on de-escalation strategies and the peaceful resolution of potentially volatile situations without the need to use force. The importance of well-being and the sanctity of life are emphasized and any use of force must also be considered in this context, and not just on whether it is justified or lawful. In addition, the VPD is ultimately seeking to achieve positive outcomes for individuals in crisis, and is committed to working collaboratively with partner agencies to achieve this objective.

Definitions

Access and Assessment Centre (AAC): A single point-of-entry site for adults, into the mental health and substance use system, and located on the Vancouver General Hospital campus. It is a 'designated facility' as described below and staffed 24 hours a day, seven days a week. The AAC began operations in February 2016, and provides a range of services for urgent and non-emergent referrals, crisis line, intake clinicians, outreach, and community psychiatric services.

ACT: Assertive Community Treatment (ACT) is a full-service mental health program, led by VCH, which provides higher intensity and greater frequency support for more challenging mental health and/or substance use clients, where traditional mental health services have been unsuccessful. The VPD is a partner in this program, with police officers embedded into the ACT teams.

AOT: The Assertive Outreach Team (AOT) is a unique mental health program, delivered in partnership with VCH, which provides short-term transitional support for more challenging mental health and/or substance use clients, as they transition from hospital or corrections to primary care service providers.

Apprehension: A term used to describe the involuntarily detention of a person by police under the *Mental Health Act* (MHA), for the purpose of transporting the person to a designated medical facility to be seen by a physician. It is not a form of 'arrest' and there is no criminal implication for the person.

CNT: The Crisis Negotiation Team (CNT) is a key component of the VPD's emergency response mandate. Specially trained members, primarily assigned to front line patrol teams, provide an immediate response capability to conduct on-scene negotiations during any significant crisis event involving the VPD.

Car 87: A mental health crisis response car that partners a VPD constable with a registered nurse or a registered psychiatric nurse to provide on-site assessments and intervention for people with psychiatric problems. The nurse and the police officer work as a team in assessing, managing, and deciding the most appropriate action, which may include referrals for community-based mental health follow-up or emergency intervention.

Concurrent Disorder: A term used to refer to co-occurring mental health and substance use problems. This is also sometimes referred to as 'dual diagnoses'; however, this latter term is also often limited to mean a mental illness combined with an intellectual disability.

Crisis: An emergency situation that creates an immediate threat to the physical, emotional, and mental health of an individual. A person may experience crisis during times of stress, in response to real or perceived threats, and/or a loss of control. Symptoms may include emotional reactions such as fear, anger, or excessive giddiness; psychological impairments such as inability to focus, confusion, nightmares, and potentially even psychosis; physical reactions like vomiting/stomach issues, headaches, dizziness, excessive tiredness, or insomnia; and/or behavioural reactions including the trigger of a 'fight or flight' response. Any individual can experience a crisis reaction when normal coping mechanisms are ineffective, regardless of previous history of mental illness.

De-escalate: A communication tactic intended to instill calm into an otherwise dynamic or volatile situation, thereby reducing the necessity or intensity of force to resolve a confrontation.

Designated Facility: A provincial mental health facility, psychiatric unit, or observation unit designated by the Minister of Health, under the MHA. In Vancouver, this includes Vancouver General Hospital, St. Paul's Hospital, UBC Health Sciences Centre Hospital, BC Women's Hospital and Health Centre, BC Children's Hospital, Mount St. Joseph's Hospital, and G.F. Strong Centre.

Elopee: A person on unauthorized leave from a designated facility. A police officer has the authority to apprehend the elopee and return the elopee to the designated facility, provided the elopee has been away from the facility for less than 48 hours. If the elopee has been absent for more than 48 hours, the director of the facility must issue a Form 21 Director's Warrant for the police to have the authority to apprehend the elopee and return the elopee to the designated facility.

Form 4 Medical Certificate: A certificate completed by a physician and issued under Section 22 of the MHA for involuntary admission to a designated facility. Two Form 4 Medical Certificates must be issued by the physician in order to hold a person for more than 48 hours.

Form 21 Director's Warrant: An apprehension warrant issued under Section 39 or 41 of the MHA for a person recalled from a doctor-approved leave from a designated facility, or a person who has eloped from a designated facility.

MHA: The *Mental Health Act* is Provincial legislation that ensures '... the treatment of the mentally disordered who need protection and care...' The MHA provides authority, criteria, and procedures for the involuntary admission and treatment of patients, and contains protections to ensure that these provisions are applied in an appropriate and lawful manner.

MHES: Mental Health Emergency Services is a program operated by VCH, and is designed to deliver community-based interventions during mental health emergencies, relieving the pressures that are often placed on police and area hospitals. MHES staff partner with VPD members to form Car 87.

MHU: The Mental Health Unit is a VPD unit within the Youth Services Section that coordinates the supervision and deployment of police officers for ACT and AOT. The MHU is focused on a collaborative approach to addressing mental health and/or substance use in the community.

Mental Disorder: A term used in the MHA, but not defined within the Act. It is described as, 'a disorder of the mind that requires treatment and seriously impairs the person's ability to react appropriately to the person's environment, or to associate with others.'

PHC: Providence Health Care is the organization that operates St. Paul's Hospital and Mt. St. Joseph's Hospital in the City of Vancouver. PHC is a separate legal entity from Vancouver Coastal Health Authority (VCH) and provides many services in partnership with VCH across the mental health and substance misuse continuum of care.

Section 28: The section within the MHA that provides the authority for police officers to apprehend a person and take them to a physician for examination if the person is acting in a manner that is likely to endanger themselves or others, and apparently has a mental disorder.

SPH: St. Paul's Hospital

VCH: The Vancouver Coastal Health Authority is one of the five regional health authorities providing direct and contracted health services in BC. The region that VCH is responsible for includes Vancouver, Richmond, North Vancouver, West Vancouver, the Sea-to-Sky Highway, the Sunshine Coast, Bella Bella, Bella Coola, and the surrounding areas.

VGH: Vancouver General Hospital

Procedures

VPD members will often come into contact with individuals who are living with a mental illness. In some instances, those individuals may be in a state of crisis and pose a risk to themselves, the responding police officers, and/or the general public.

Section 28 of the MHA provides that;

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.⁶*

This section of the MHA allows for considerable police discretion, as it provides the police officer with the authority to apprehend. However, with the wording '*may apprehend*,' the police officer has the ability to pursue a number of other courses of action, depending on the circumstances involved.

History has shown that police interactions with persons living with mental illness, and who are in crisis, sometimes have the potential for violence. Occasionally, the mere presence of the police can elevate the tenor of the interactions and complicate communication further. These interactions frequently require a police officer to make difficult judgement decisions about an individual's mental state and his/her intentions. They require specialized communication skills and techniques geared to resolving each situation, while minimizing the instance of physical harm to the individual, the public, and the police.

To that end, the goal in every interaction is de-escalation. Police officers are expected to recognize behaviour that is characteristic of mental illness or a crisis, and the VPD is committed to ensuring that all of its members are trained in this skill. Through effective de-escalation techniques, the safety of all involved in the interaction is the paramount priority, and should guide the resolution of each unique situation as safely as possible.

Initial Patrol Response

Police officers are regularly called to incidents that involve persons living with mental illness. However, only a trained mental health professional can diagnose mental illness and even they can have difficulty with such diagnoses. VPD members are not expected to diagnose mental illness, but they are expected to recognize behaviours that are indicative of a person affected by mental illness or in a crisis. In addition, there is the added complexity of assessing risk when the circumstances of an incident suggest the potential for violence or danger.

⁶ Mental Health Act [RSBC 1996] Chapter 288. Found at: http://www.bclaws.ca/civix/document/id/complete/statreg/96288_01

Risk assessment is a critical skill in police work. When interacting with individuals affected by mental illness or crisis, VPD members shall continually assess risk throughout their interactions with the individual involved. That risk may be to the individual, to the responding VPD members, and/or to the general public. However, most persons living with mental illness, or who may be in crisis, are not dangerous. These individuals may only present 'dangerous behaviour' under certain circumstances or conditions, which may be controllable during their interactions with the police. It is a combination of the observed behaviours of the individual and the perceived risk to those involved that will guide the course of action taken by the police.

When responding to an incident involving a person exhibiting behaviours attributed to mental illness, or in a mental health crisis, VPD members should consider all of the following strategies to manage the situation, for the safety of all involved:

- Evaluate the nature of the incident and determine the necessity for police intervention;
- If police intervention is necessary, determine the best method to communicate with the individual involved, including consideration for the existence of a language barrier;
- Evaluate the need to involve other police officers for cover and inform a supervisor when an expanded response is required;
- Evaluate the need for specialized resources, mental health professionals, and/or the assistance of those with specialized training in crisis intervention;
- Consider engaging the assistance of a family member or caregiver of the affected individual, who can often provide insight and perspective on the behaviour, and may be able to serve as an advocate or possess the authority to involuntarily commit the individual; and,
- If it becomes necessary to apprehend the individual under the MHA or to take them into custody as a part of a criminal investigation, develop and communicate a plan that considers the most effective options to safely resolve the incident.

However, it is important to note that many of these incidents occur suddenly, and can be exceptionally dynamic and evolve quickly. This landscape frequently requires police officers to respond immediately, interact with a person with very limited background information, draw on their own life experience and training, and take actions in an uncontrolled environment that are in the best interests of public safety, and for the protection of both the individual and the police officers involved.

When working towards an appropriate resolution to a call involving a person exhibiting behaviours attributed to symptoms of a mental illness, or in a mental health crisis, VPD members will consider the totality of the circumstances involved, including the behaviour of the individual and the proportionality of the response. Following are acceptable resolutions or dispositions that may be appropriate:

- *Non-engagement*: When a member determines that police engagement in the first instance will result in undue safety concerns for the individual, the public and/or the members involved, it may be acceptable to not engage with the individual at all. In such instances:
 - Members will notify a supervisor and the supervisor shall attend the scene;

- The supervisor shall consult with the Duty Officer in all instances where a decision is made to not engage with the individual;
- The individual shall not be left alone, and another suitable support person should be in place and willing to assist the individual; and,
- A police report will be submitted that clearly identifies the circumstances of the event, reasons for the police to not engage with the individual, the identity of the individual who took responsibility to provide care to the individual, and follow-up strategies and referrals identified to ensure the individual receives the support they require.
- *Disengagement:* When continued contact with the individual will result in undue safety concerns for the individual, the public and/or the members involved, it may be acceptable to disengage from further police action. In such instances:
 - Members will notify a supervisor and the supervisor shall attend the scene;
 - A plan will be developed, under the direction of the supervisor, to make contact with the individual at a different time, or under different circumstances; and,
 - A police report will be submitted that clearly identifies the circumstances of the event, actions taken by the police, reasons for the dis-engagement, and follow-up plan and referrals identified to ensure that the individual receives the support they require.
- *Delaying Custody:* When a member determines that taking a person into custody under the present circumstances may result in undue risk to the individual, the public, and/or the members involved, it may be appropriate to delay custody. In such cases, members will notify a supervisor and develop a plan, in consultation with health care practitioners and/or a family member or caregiver, to determine a safer time and method to take the person into custody.
- *Director's Warrant:* When the individual involved is named in a Form 21 Director's Warrant, members will apprehend the individual and arrange transportation to the hospital or designated facility identified in the warrant.
- *Apprehension:* When the circumstances are present to meet the requirements of Section 28 of the MHA and a Criminal Code arrest is not required, members will apprehend the individual and arrange transportation to a hospital or designated facility for examination by a physician.
- *Arrest:* When there are reasonable grounds to believe that the individual has committed a serious criminal offence, members will proceed under the lawful authority of the Criminal Code, affect an arrest, and ensure subsequent examination by a physician in the Vancouver Jail to assess and refer to mental health support.

The VPD will not engage in the practice of *voluntary transports* (solely at the request of an individual). If an individual does not meet the criteria for an apprehension, members will not provide transportation to a hospital in a police vehicle. The responsibility rests with the individual to get himself/herself to the hospital, and the VPD will limit their involvement to assisting the individual with other methods of transportation (EHS, family member, mental health professional, etc.).

Crisis Negotiation Team

The VPD Crisis Negotiation Team (CNT) is an important asset to assist Patrol members with critical incidents, usually involving persons living with mental illness and in crisis, and their role is one of

advanced crisis de-escalation and negotiation. The team is comprised of 24 members and one full time coordinator (team leader). All but the coordinator have primary duties elsewhere in the VPD, with the majority working in Patrol.

CNT members are all experienced police officers who are readily available to assist front line policing, where the vast majority of all contacts with persons living with mental illness occur. These members regularly engage with suicidal individuals, including persons actively attempting to jump off bridges and structures, as well as with armed and barricaded persons threatening harm to themselves or others.

All CNT members complete an 80-hour basic VPD Crisis Negotiation course, modelled after a course offered at the Canadian Police College (CPC). This local program incorporates elements of the CPC national course, the FBI negotiator training program, and the UK National Negotiator Course. The VPD course emphasizes scenario-based learning, specifically designed to reflect and reinforce the concepts taught throughout the program.

CNT members are required to complete a 40-hour refresher course once every five years, offered at the CPC. In addition, there are six mandatory CNT training days throughout the year. These facilitated sessions include incident reviews, discussions on training, deployment issues, and presentations on local and relevant topics. In addition to the mandatory training days, CNT members participate in a number of multi-agency training scenarios throughout the year. A unique element to the VPD CNT program is the existence of a full-time coordinator. The consolidation of training, selection, team leadership, performance management, and academic research has allowed the VPD to develop the program to meet the unique challenges faced in Vancouver.

Supervision

Patrol supervisors have a significant role in the initial police response to persons living with mental illness who are in crisis. While they are seldom the first members to come into contact with these individuals, they will frequently become aware of their members doing so. When members come into contact with a person living with mental illness and who is in crisis, and a robust police response is required, the sergeant shall:

- Take control of the call and advise the responding members and Dispatch that they are monitoring the incident;
- Determine the need to attend at the incident, and particularly if the matter becomes protracted;
- Ensure sufficient Patrol resources are in place to effectively contain the scene;
- Ensure an ambulance is readily available;
- Determine the need for additional resources at the scene, including the assistance of mental health professionals;
- Monitor the interactions between the responding members and the individual, and continually assess the circumstances, the behaviour of the individual, and the proportionality of the police response, to ensure the needs of the individual are best served to get them help;
- Ensure proper reporting is completed at the conclusion of the incident;

- Notify the Duty Officer of all incidents in which the individual is injured as a result of police actions, regardless of the seriousness of the injury.

Specialized Mental Health Response

While many individuals first come into contact with the VPD through the initial Patrol response, the VPD has additional members working in specialized assignments to provide a targeted response to support individuals with the greatest risk, due to mental health and addiction concerns. The Mental Health Unit and the Police Community Response Unit are staffed with specially trained police members who focus their work to support persons living with mental illness. These members work in partnership with health care practitioners who specialize in mental health.

There are ten police officers and a civilian analyst, under the supervision of a sergeant, and reporting to the Inspector in charge of the Youth Services Section. The three key functional components of the VPD's mental health response are Car 87, ACT teams, and AOT.

Car 87

The Mental Health Emergency Services 'Car 87' is a joint VPD/MHES program that was created in 1978. Car 87 partners a mental health nurse with a police officer to respond to individuals experiencing a mental health crisis. The program provides referrals, follow-up, and emergency intervention as dictated by the circumstances of each event. The program also receives referrals for clients experiencing a mental health crisis from elsewhere within the VPD, through VCH programs, and from the community.

Crisis intervention through Car 87 typically provides a mental health assessment for clients without a previously documented mental health background. They also receive Form 21 Director's Warrants from community mental health and assist in locating clients for apprehension and for transport to a designated facility. In addition, Car 87 provides support to front line Patrol members and assists the Crisis Negotiation Team with mental health backgrounds when required. The complete team includes psychiatric nurses, a clinical supervisor, support staff, and VPD members. Four full-time police officers, work a four-day shift rotation, covering almost 21 hours every day. The day shift works from 0700 to 1815 hours and the afternoon shift is from 1600 to 0345 hours.

Assertive Community Treatment Teams

Assertive Community Treatment teams, managed by VCH, provide a full-service mental health program to their clients. The first 'full fidelity' ACT team in Vancouver was created in January 2012. The goal of ACT is to provide higher intensity and greater frequency support for severe mental health and/or substance use clients where traditional services have been unsuccessful. It delivers an evidence-based model of care and provides a client-centered recovery-oriented service delivery model in an effort to reduce emergency psychiatric hospital admissions. Services are not brokered to individual agencies. Rather, all service needs for the client are met by the team.

The primary objective of ACT is to prepare the client for a successful transfer to a step-down community service. ACT clients are typically pre-contemplative in their substance use, experience severe functional challenges related to community living, and have an extensive history of police involvement and high

use of health services. Clients demonstrate high-risk behaviour and long-standing complex mental health issues.

ACT teams are comprised of 10 to 12 professionals focused on the well-being of a limited number of clients. Each team, with a maximum caseload of 80 clients, includes psychiatrists, social workers, nurses, vocational counsellors, occupational therapists, recreational therapists, and peer counsellors, among others. A unique feature to the five Vancouver ACT teams, although not a requirement under the British Columbia ACT Standards, is that police members are embedded in the teams. Two full-time VPD members work with the Vancouver teams, on a four-day shift rotation that provides police support seven days a week, between 0700 and 1815 hours.

Assertive Outreach Team

The Assertive Outreach Team is a VPD mental health program, created in March 2014 as an outcome of the SAMI 120-day action plan,⁷ and designed to assist a small cohort of the community that cannot be supported by ACT. This team also involves a partnership with VCH, providing short-term transitional support, from hospital or detention to a primary care service provider. The program addresses the needs of clients with moderate to severe substance use and/or mental health issues while addressing the gap in the continuum of care, while they transition from the health or criminal justice systems back into the community. The goal of AOT is to reduce the incidences of violence and self-harm, prevent further deterioration in the quality of life of the individual, and reduce re-engagement with the criminal justice system while bridging services, through a practice of intensive case management.

AOT functions to connect individuals to their primary-care provider over a one- to two-month transitional period, using a creative and collaborative problem-solving approach. Clients are also typically pre-contemplative in their substance use, experience functional challenges related to community living, and have a history of police involvement and complex mental health issues. The team consists of psychiatrists, nurses, clinical supervisors, and the police.

AOT is more police-intensive than ACT, allowing the team to readily assess risk, proactively locate individuals in risk-laden environments, and provide input and support for future services. Referrals are received directly through recent police interactions, from health services and the criminal justice system, and through an in-house 'Early Warning System' that identifies individuals with increasing mental illness related police interactions.

AOT has an average caseload of 40 clients. Four full-time police officers work a four-day shift rotation, covering 16 hours every day. The day shift works from 0700 to 1815 hours and the afternoon shift is from 1200 to 2315 hours.

⁷ BC Ministry of Health Report (2013), *Improving Health Services for Individuals with Severe Addiction and Mental Illness*. Found at <http://www.health.gov.bc.ca/library/publications/year/2013/improving-severe-addiction-and-mental-illness-services.pdf>

Education and Training

The VPD is committed to a robust education and training regimen in order to prepare its members for the inevitable interactions with persons living with mental illness. In 2002, the VPD developed an in-house *Crisis Intervention Training* (CIT) program, based on the *Memphis Model*⁸ for crisis intervention, and ensured that all front line personnel working in Patrol received this course. At the time, it was the only course of its kind available in BC and focused on understanding mental illness, how mental illness can affect behaviour, understanding crises, and included a component of input from people with lived mental health experience.

In 2011, the Province of BC developed a Crisis Intervention and De-escalation Training (CID) course, modelled after the VPD CIT and designed for all police officers in BC. This course effectively replaced the CIT program delivered within the VPD, and provides the most current information available today for all front line VPD personnel. The triennial recertification requirement commenced in 2014, further entrenching the practice of de-escalation and delivering up-to-date information relative to mental health and substance use.

In addition to the mandated training, the VPD provides further education and training to members assigned to specialized positions where there is a greater likelihood of contact with persons living with mental illness, and in particular to members assigned to the MHU, Car 87, CNT, and others whose work may increase their chances of interacting with this community. These additional courses include, but are not limited to:

- Province of BC CID triennial requalification
- Road to Mental Readiness (R2MR)
- Specialized use-of-force training simulations, including randomized de-escalation scenarios, and delivered to uniformed personnel annually as a part of cycle training
- Mental Health First Aid
- Historical Clinical Risk Management (HCR-20) Violence Risk Assessment
- VPD Crisis Negotiation Course
- Canadian Police College Crisis Negotiation course
- Province of BC Standardized Use-of-force Instructor's Course (SUFIC) training and certification, including specialized de-escalation training
- VPD Conducted Energy Weapon operator training, including specialized de-escalation training

Two reports were released in Ontario in 2014 in relation to a number of separate incidents where the police were involved in lethal use-of-force situations with individuals in a mental health crisis. A coroner's inquest into the death of three Torontonians, colloquially known as the *JKE Inquest*, provided 74 recommendations for change to the Toronto Police Service (TPS), the Toronto Police College, the Ontario Police College, and the Province of Ontario, relative to police interactions with persons living

⁸ CIT International. *Memphis Model*. Found at <http://www.citinternational.org/training-overview/163-memphis-model.html>

with mental illness.⁹ In addition, TPS Chief Bill Blair ordered an independent review into his department's interactions with persons in a mental health crisis, and this review was conducted by the Honourable Frank Iacobucci, a former Justice of the Supreme Court of Canada. He made a further 84 recommendations for change in his report *Police Encounters with People in Crisis*.¹⁰

Forty (25%) of the 154 combined recommendations were related to police officer training. The VPD conducted a review of both Ontario reports, and applied a local lens to the recommendations. The VPD is well-positioned relative to the Ontario recommendations, with the VPD satisfying 147 of them at the time of the report.¹¹ The key deliverable from that review is an expansion on specialized training for VPD members, and particularly for those members who are more likely to come into contact with persons living with mental illness. In addition, the VPD made adjustments to the recruiting process, specifically recognizing applicants' experiences relative to dealing with people living with a mental illness. This life experience is valuable in the department's quest to hire the highest calibre applicants, and that life experience may come from either professional or personal experiences.

Crisis Intervention and De-escalation

CID training was developed by the Province to ensure that a consistent approach and content is delivered to police officers in BC. CID training is one of the provincially-approved training programs that fulfil the provincial standard on dealing with persons living with mental illness. It is mandatory training for all front line personnel, including supervisors, all police recruits, and all specialized assignment personnel, who are more likely to come into contact with persons living with mental illness. In addition to the training course, there is a triennial recertification requirement, ensuring that all members receive a refresher program and any new information on a regular basis.¹²

The VPD has fully trained all of its front line personnel, and all new recruits graduating from the police academy receive CID training in the academy. The first recertification process started in 2015, and the VPD is now monitoring compliance for those scheduled to complete the recertification, ensuring that this updated training is completed when required.

In addition to the initial CID training and triennial recertification, the VPD delivers practical scenario-based training to operational members through quarterly cycle training days, administered at the Tactical Training Centre. The scenarios involve a full spectrum of police interactions with the public, with actors filling the role of the involved subjects. Many of these scenarios are designed to incorporate

⁹ Eden, D. (2014). Verdict of Coroner's Jury into the death of Reyal Jardine-Douglas, Sylvia Klibingaitis, and Michael Eligon. Found at: <http://www.mcscs.jus.gov.on.ca/stellent/groups/public/@mcscs/@www/@com/documents/webasset/ec167854.pdf>

¹⁰ Iacobucci, F. (2014). *Police Encounters with People in Crisis*. Toronto Police Service. Found at: https://www.torontopolice.on.ca/publications/files/reports/police_encounters_with_people_in_crisis_2014.pdf

¹¹ Vancouver Police Department (2015). *Review of Ontario-based findings from the Iacobucci Review into Police Use-of-force, and the JKE Coroner's Inquest*. A report to the Vancouver Police Board found at: <http://vancouver.ca/police/policeboard/agenda/2015/0716/1507V01-Use-of-Force-and-Mentally-Ill.pdf>

¹² British Columbia Provincial Policing Standards (2015). *Crisis Intervention and De-escalation Training*. Found at <http://www2.gov.bc.ca/assets/gov/law-crime-and-justice/criminal-justice/police/standards/provincial-policing-standards.pdf>

de-escalation techniques, applied in a practical setting. The scenarios are designed to put CID theory into practice, with realistic scenario-based exercises where the successful resolution of the scenario is based on de-escalation and without any use of force by the police officer. In addition, the VPD has drawn on practical experiences learned from police officers in the field, both in Vancouver and elsewhere, and developed training scenarios around these real-life experiences.

De-stigmatization

The stigma attached to mental illness and substance use is often viewed as the biggest barrier to effective change and support for those living with mental illness. The VPD is committed to reducing the stigma of mental illness, and has taken proactive steps, through education and training, to break down these barriers.

The original CIT program introduced the concept of education from people with lived experience, and their inclusion in the design and delivery of the material made significant inroads toward personalizing the issues associated to mental illness. De-stigmatization remains a core focus of the newly mandated CID program. The VPD has further addressed the issues of stigma with the 2015 launch of the *Road to Mental Readiness* (R2MR) program. R2MR is focused on the mental well-being of police officers themselves, and addresses workplace stressors, post-traumatic stress disorder, and peer support. Finally, unfettered access to mental health services for police officers, should they need it, has further served to de-stigmatize mental illness. Opening the minds of police officers to the reality of mental illness in a demanding profession has helped de-stigmatize mental health in the workplace, and generally within the broader community at large.

Further, the VPD had amended its police information check policies and adopted new processes relative to the release of information. Today, an individual's mental-health-related contacts with the police will not be routinely disclosed as a part of that person's request for a police information check. The Department recognizes that these health-related contacts should not stigmatize an individual, and do not define an individual who may be living with mental illness, and the VPD has no role in sharing that information with prospective employers or community/volunteer associations.

TEMPO

In 2010, a learning framework to assist police during their interactions with persons with mental illness was developed by the Mental Health Commission of Canada (MHCC). In 2014, this *TEMPO* framework was revisited and validated by the MHCC, and received national support from the Canadian Association of Chiefs of Police.

TEMPO is not a training tool per se, but an umbrella approach that police organizations can use as a framework to assess their own progress in training, to identify gaps in their existing learning programs, and to use as an aspirational document to create appropriate new learning programs. It is intended to assist

police agencies to make a positive difference and contribute to public safety in regard to police interactions with persons with a mental illness.¹³

The *TEMPO* framework provides a multi-level structure for police training, specific to dealing with persons living with mental illness. Each of the five levels serves to guide the curriculum for specialized training, taking into account different variables for the individual police officers. These variables include length of service and experience dealing with the mentally ill, specialized assignments that may put an officer into contact more frequently with the mentally ill, expert-level training, and specialized curricula to incorporate into use-of-force training.

The VPD is committed to being a leader in policing, and ensuring that its members receive the best training available relative to crisis intervention and de-escalation. To that end, the VPD continues to work with the MHCC and other stakeholders and mental health professional to ensure that the *TEMPO* framework can translate directly to the various types of specialized training that members of the VPD receive.

¹³ Coleman, T. and Cotton, D. (2014). *TEMPO: Police Interactions – A report towards improving between police and people living with mental health problems*. Mental Health Commission of Canada. Found at: <http://www.mentalhealthcommission.ca/English/system/files/private/document/TEMPO%20Police%20Interactions%20082014.pdf>

Conclusion

The *VPD Mental Health Strategy* details the strategic position of the Department, relative to the significant impact that can result from VPD members coming into contact with persons living with mental illness. It is framed around the core values of the VPD and its principles of justification, proportionality, and intrusiveness.

The *Strategy* was developed with valuable input from community stakeholders and mental health professionals, and is designed to provide clear and concise information about the VPD's approach when interacting with persons living with mental illness. It will serve as a framework to support operational deployment, organizational partnerships, training initiatives, and a broader commitment to the community.

Acknowledgements

The VPD has long-recognized that policy and practice cannot be developed in isolation. Extensive consultation was conducted with police resources, subject-matter experts, and the mental health community, in an effort to develop a meaningful policy position that fulfils the objectives of the police department, while recognizing the broader role policing plays in the community at large.

This report was reviewed in draft form by the individuals listed below, who were selected for their diverse perspectives, areas of expertise, and broad representation of academic, government, health, and legal organizations.

The reviewers assessed the objectivity and quality of the report. Their submissions, which will remain confidential, were considered in full by the VPD, and many of their suggestions were incorporated into the report. They were not asked to endorse the strategy, nor did they see the final draft of the report before its release. Responsibility for the final content rests entirely with the author and the VPD.

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MaryClare Zak – Managing Director of Social Policy, City of Vancouver

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Appendix – A:

Historical Context

Background

In the late 1970s, the VPD identified a unique demand placed on its members from a segment of the community who were living with mental illness, and frequently coming into contact with the police. In response to this demand, the VPD launched *Car 87* in 1978, a partnership involving a police officer with a mental health professional, whose mandate was to assist those individuals when they came into contact with VPD members, and to build a level of expertise when dealing with such individuals.

Over the years that followed, *Car 87* has been a consistent part of a proactive response in this area, and as demand increased, the VPD increased the number of members assigned to this duty to better service the demand. Presently, there are four police officers assigned to *Car 87*.

In spite of this commitment, demand continued to increase. Persons living with mental illness were coming into contact with the police more frequently, were victimized within the community, and were often involved in criminal behaviour and violent crime. In many cases, these actions were a direct result of their mental illness.

The VPD has always maintained that mental health is primarily the responsibility of health authorities; however, given the nexus to a significant portion of the police workload, the VPD recognized that a multi-agency collaborative response was necessary and pursued an influential role with government and the community to foster change. In 2007, the VPD conducted research into the true picture of mental illness on the workload facing the department, and that led to the first of three reports that identified gaps in service for the mentally ill, and the impact it was having on the police and others in the broader community.

Lost in Transition

In January 2008, the VPD published a report entitled *“Lost in Transition: How a Lack of Capacity in the Mental Health System is Failing Vancouver’s Mentally Ill and Draining Police Resources.”* This report highlights significant gaps in the health care system, and details the overall impact felt by the VPD when dealing with persons living with mental illness who are in crisis.

Lost in Transition provides an analysis of the calls for service where VPD members come into contact with persons living with mental illness. Further, it serves to identify the significant factors that contribute to the frequency of these incidents, and the potential consequences for a mentally ill person who comes into contact with police. Finally, it provides the VPD perspective on capacity gaps in the

mental health system, and how the system is failing persons living with mental illness.¹⁴ This report served as an official position of both the VPD and the Vancouver Police Board. The report garnered significant interest, locally, nationally, and internationally, was a catalyst for improved services, and resulted in an award to the VPD from the BC Schizophrenia Society.

Lost in Transition provided a series of recommendations for health care improvements:

- A mental health care facility that can accommodate moderate to long-term stays for individuals who are chronically mentally ill;
- What has been termed an “Urgent Response Centre” by Vancouver Coastal Health, where individuals can be assessed and triaged according to their needs;
- Increased services for people who are dually diagnosed;
- A continued increase in supportive housing in Vancouver;
- For St. Paul’s Hospital and Vancouver General Hospital to speed up the admission process for police who have arrested an individual under the provisions of the *Mental Health Act* (by negating the need for the emergency physician to initially examine the patient, for example) in the absence of an “Urgent Response Centre,” as detailed above;
- Enhanced ability to gather data on all calls for service that are mental-health-related to facilitate further research on this matter, and to establish benchmarks to track change; and,
- A system, much like PRIME, that has readily accessible details of an individual’s mental health history and addresses privacy concerns, for British Columbia mental health service providers.

Beyond Lost in Transition

In September 2010, the VPD drafted an update report entitled “*Policing Vancouver’s Mentally Ill: The Disturbing Truth – Beyond Lost in Transition.*” This report follows up on the findings of *Lost in Transition*, reaffirms that the police are society’s de facto 24/7 mental health workers, and although some system change occurred over the preceding two years, little had changed from the perspective of the ‘street cop.’¹⁵

This report continued to serve as an official position of both the VPD and the Vancouver Police Board, and provided an updated list of recommendations for health care improvements:

- That the Ministry of Health and Vancouver Coastal Health establish an “Urgent Response Centre,” where individuals can be assessed and triaged according to their needs;
- That the Ministry of Health and Vancouver Coastal Health establish an “Assertive Community Treatment” team model with sufficient capacity to address community based treatment needs, with police as a part of an integrated team;

¹⁴ Wilson-Bates, F. (2008). *Lost in Transition: How a Lack of Capacity in the Mental Health System is Failing Vancouver’s Mentally Ill and Draining Police Resources*. Vancouver Police Department.

¹⁵ Thompson, S. (2010). *Policing Vancouver’s Mentally Ill: The Disturbing Truth – Beyond Lost in Transition*. Vancouver Police Department.

- That Vancouver Coastal Health, St. Paul’s Hospital, Vancouver General Hospital, and the police establish formalized standing bodies with appropriate terms of reference to resolve police-/health-related incidents, and address systemic issues affecting all;
- That Vancouver Coastal Health, St. Paul’s Hospital, Vancouver General Hospital, and the police establish an information-sharing and feedback mechanism so that attending emergency room and psychiatric unit and ward physicians are advised in a timely manner of suicides, suicide attempts, and other critical incidents involving their patients;
- That St. Paul’s Hospital and Vancouver General Hospital speed up the admission process for police who have apprehended an individual under the provisions of the *Mental Health Act* (by negating the need for the emergency physician to initially examine the patient, for example) in the absence of an “Urgent Response Centre,” as detailed above; and,
- That the Ministry of Health makes legislative changes to the *Mental Health Act* to facilitate a speedier health system response and reduce police wait times at hospitals.

Collaboration between the VPD and VCH became more structured following the release of *Beyond Lost in Transition*, and is best highlighted with the 2011 creation of ‘Project LINK,’ a formal partnership between the Boards of the VPD and VCH. Each Board oversees staff responsible for change, and collectively they govern the development of strategies to address all of the recommendations in this report. The overarching objective was to shift from a crisis response model to one that better addresses the existing issues and circumstances related to persons living with mental illness, and prevents individual crises from occurring in the first place.

Vancouver’s Mental Health Crisis

In September 2013, the VPD released an updated report on what it described as Vancouver’s mental health crisis. This report, prepared in collaboration with Vancouver Coastal Health, builds on the two ‘*Lost in Transition*’ reports, acknowledges some of the change with earlier recommendations, and highlights improved collaboration between the VPD, VCH, and Providence Health Care (PHC).¹⁶ Noting an increasing trend where persons living with mental illness were involved in violent and random assaults on innocent persons, the VPD put forward five recommendations to address this problem:

- Add 300 long-term and secure mental health treatment beds;
- More staff and services at BC Housing sites to support tenants with psychiatric issues and a reduced proportion of this type of tenant;
- More significant support through ACT teams for psychiatric patients living in the community, including those residing in market housing;
- An enhanced form of urgent care (crisis centre) that can ensure consistent and expert care of individuals in crisis situations, located at a Vancouver hospital; and,
- The creation of joint VPD-VCH Assertive Outreach Teams for mentally ill persons who do not yet qualify for ACT teams.

¹⁶ Vancouver Police Department (2013). *Vancouver’s Mental Health Crisis: An Update Report*. Found at <http://vancouver.ca/police/assets/pdf/reports-policies/mental-health-crisis.pdf>

Scope of the Problem

Research conducted for *Lost in Transition* shows that the incidence of MHA apprehensions rose by 490% between 1999 (360 incidents) and 2007 (1,743 incidents). The research supported the hypothesis that 31% of all calls-for-service involved at least one individual who was living with mental illness and that illness was a factor in the police involvement in the incident.¹⁷

Since that time, improved measurement tools to track the *mental health factor* associated to police calls has allowed the VPD to further refine this data, and have a clearer picture on the scope of the problem. Between 2012 and 2013, the VPD experienced an 18% increase in MHA apprehensions.

In addition, health care has provided alarming hospital usage data. For example, in 2009/10, SPH had 63,987 visits to their Emergency Department; this included 5,659 visits (9%) for mental health and/or substance abuse reasons. These visits were made by 3,755 individual patients, for an average of 1.51 visits per patient for mental health and/or substance abuse reasons. Gradual increases have been seen every year, and in the most recent year 2014/15, there were 83,364 visits to the Emergency Department – a 30% increase over five years. This figure included 11,035 visits (13%) for mental health and/or substance abuse – a 95% increase. This was comprised of 6,409 individual patients, for an increase of 71% and an increased average of 1.72 visits per patient. VGH has reported similar increases, with a 30% increase in Emergency Department visits for mental health and/or substance use reasons.

Violence and the Mentally Ill

It is important to note that persons living with mental illness are not typically violent. It is only a small subset of this population who demonstrate a propensity towards violent behaviour, generally those with psychosis, often caused by schizophrenia or a related illness.

However, persons living with mental illness are significantly more likely to be a victim of crime. A study of VPD victimization rates where a mental health factor is involved shows that persons living with mental illness are 23 times more likely than the general population to be a victim of crime. More concerning is the fact that they are 15 times more likely to be a victim of violent crime.

For example, in 2013, VPD members were dispatched to 125,785 calls-for-service, and 106,019 resulted in a general occurrence report being written. There were 15,254 calls (15%) involving a person living with mental illness as a suspect or a victim, and where an individual's mental health played a factor in the incident. Of those calls, 1,573 (11%) were for a violent crime (e.g. robbery, assault, sexual assault, etc.). These trends continued over the following two years. In 2014, 14% (15,413) of the 114,677 dispatched calls with a General Occurrence (GO) report written involved a mental health factor, and 9% (1,336) of those were for a violent crime. In 2015, 13% (14,760) of the 118,042 dispatched calls with a GO report written involved a mental health factor, and 7% (1,067) of those were for a violent crime. While violent crime is generally on a downward trend, there is a consistent mental health factor associated to the violent crime that is reported.

¹⁷ Wilson-Bates, F. (2008). *Lost in Transition: How a Lack of Capacity in the Mental Health System is Failing Vancouver's Mentally Ill and Draining Police Resources*. Vancouver Police Department.

Substance Use and the Mentally Ill

It is also important to note that the majority of people living with a mental illness do not generally come into contact with the police. However, the majority of those that do are generally suffering from a concurrent disorder, i.e., they are mentally ill and also engage in substance use and abuse.

Drug induced psychosis is prevalent in cases involving violence or threats of violence and persons living with mental illness. While the police track a *mental health factor* for all calls-for-service, hospitals track substance use in all patients coming into the Emergency Department. Between 2009 and 2014, VGH and SPH collectively reported a 114% increase in the instances of substance misuse with presenting patients.

Data from SPH shows that the drivers of this increase include a 378% increase in amphetamine-induced psychosis and a 300% increase in marijuana-induced psychosis over the last five years. This is attributable to the increased availability and affordability of crystal meth on the street, and an increase in the toxicity of marijuana in recent years.

Drug-induced psychosis creates a unique challenge for police members. While a significant investment has been made in training front line personnel to respond to individuals in a mental health crisis, the complicating factor of a drug-induced psychosis creates additional risk and uncertainty for all involved.

Police Interactions with Persons Living with Mental Illness

The VPD has seen a steady increase in the number of incidents where their members interact with persons living with mental illness. In the majority of these incidents, there is no crime involved. Rather, these calls represent quality of life issues for either the person living with mental illness or the broader community.

In 2012, the VPD made 3,315 apprehensions under the MHA, a 33% increase over the preceding year. Notably, those apprehensions involved 2,313 unique individuals, meaning 1,002 incidents that year involved a person who was apprehended multiple times in the year. In 2013, the number of MHA apprehensions rose by 19%, to 3,928, and in 2014, it increased a further 13%, to 4,426. There were 2,913 unique individuals apprehended in 2014, meaning that 1,513 incidents involved an individual who had already been apprehended by the VPD that year.

In 2015, the VPD experienced a levelling off of the number of Section 28 apprehensions, rising only 1% over the previous year. However, there is an overall increase of 6% in the total number of MHA apprehensions (4,713) due to a notable increase in Form 4 and Form 21 Director's Warrants. This increase in the number of warrants is a positive trend, indicating that clients are receiving more comprehensive attention from health care to meet their unique needs. There is also an overall increase in the number of calls for service involving a mental health factor, regardless of whether an apprehension under the MHA occurs or not.

Appendix – B:

VPD Policies and Procedures

Section 1.6.24(i) - Apprehensions under the *Mental Health Act*

(Effective: 2016.01.19)

POLICY

Apprehensions under Section 28 of the MHA should occur primarily when a member comes into contact with a person who meets the criteria for apprehension under Section 28 of the *Act* and the person has not committed a criminal offence. There may, however, be occasions where members use their discretion to apprehend a person under the MHA where the offence is minor and non-violent in nature.

Members are advised that it is not appropriate to apprehend a person under Section 28 of the *Mental Health Act* (MHA) when the person has committed a serious or violent offence as there are specific NCRMD (Not Criminally Responsible by Reason of Mental Disorder) provisions within the Criminal Code that address this type of situation. ([See training bulletin](#))

PROCEDURE

1. When members come into contact with a person who meets the criteria for apprehension under Section 28 MHA, members shall apprehend the person and ensure that the person is taken to a physician for examination.
2. When a person attempts suicide or is about to attempt suicide, such person shall be apprehended under Section 28 of the MHA and taken to a physician for examination. The member shall accompany the patient to the hospital and provide the hospital staff with a full and detailed report as outlined in subsection 4.
3. Members shall maintain control of the apprehended person until the hospital has assumed responsibility of the person and admitted the person into care.
4. The British Columbia Ambulance Service (BCAS) will normally transport persons apprehended under Section 28 of the MHA. The apprehending member shall:
 - a. Consult with the Ambulance Attendant to determine the most appropriate hospital emergency ward for the person;
 - b. Immediately prepare a G.O. report after the person has been admitted into hospital. Obtain the hospital's fax number and the name of the appropriate contact person (e.g. Mental Health nurse);
 - c. After completing the G.O. report, contact the Information Management Section. Provide the Reviewer with the incident number, the fax number of the hospital, and the name of the hospital contact person. The Reviewer will process the electronic report, make a hard copy and fax the required report to the hospital; and
 - d. Notify the hospital staff when further police action is contemplated.

Persons on Unauthorized Leave from Hospital

5. In the case of patients who have eloped from provincial mental health facilities (Vancouver General Hospital, St. Paul's, UBC, Riverview are the main ones) the following applies:
 - a. If a patient is suspected of having eloped, a query will be made through CPIC. If there is nothing on file, further inquiries may be made directly to the hospital where the person is believed to be a patient on unauthorized leave. If no authority to apprehend can be located, consideration should be given to proceeding under Section 28 MHA;
 - b. If information is received from a provincial mental health facility authority (nurse, doctor, etc.), that a patient detained under the MHA has eloped, then members may:
 - i. if a form 21 Director's warrant has been issued, apprehend and return the patient to the facility (Refer to RPM Section [1.6.24\(ii\): Transportation to Hospital](#)); or
 - ii. where no warrant exists, the patient may be apprehended under Section 41(6) of the MHA, providing the apprehension takes place within 48 hours of the time the patient eloped.
 - c. When members assist in the transport of a patient on unauthorized leave to hospital, they shall advise staff at the hospital of the circumstances so that the hospital is aware that a Medical Certificate is in effect for the patient. A Medical Certificate provides the hospital with authority to prevent the patient from leaving the facility. The hospital then assumes responsibility for the patient.
 - d. Members are reminded that when hospital authorities require assistance of police to keep the peace, members shall provide assistance as appropriate, RPM Section [1.6.19: Hospital Emergency Calls](#).

Section 1.6.24(ii) - Transportation of Persons Apprehended under the *Mental Health Act*

(Effective: 2015.12.29)

POLICY

The police have the authority to apprehend and convey patients to hospital in certain circumstances under the British Columbia *Mental Health Act* (MHA). It is preferable to have the BC Ambulance Service (BCAS) transport the patient when available as mental health is foremost a medical issue; however, there are instances where it is appropriate for members to apply their discretion and convey the patient to a hospital or designated mental health facility in a police vehicle to eliminate waiting time for BCAS.

The decision to transport a person apprehended under the MHA in a police vehicle is a discretionary one for the apprehending members.

Before choosing the option to transport a person apprehended under the MHA in a police vehicle, members must weigh the convenience of doing so with both officer safety considerations and the needs of the apprehended individual. Members should consider that the person, no matter how cooperative at roadside, may become uncooperative after being placed in a police vehicle.

In making an assessment whether to transport an apprehended person in a police vehicle, members should establish that the following criteria exist:

- i. The person is not suffering from any physical, non-mental-health-related medical condition and/or distress that would require that they be seen by BCAS prior to hospital admission;
- ii. There are no significant hygiene or biohazard concerns; and
- iii. There are no apparent officer safety concerns.

All decisions to transport a person apprehended under the MHA in a police vehicle must be documented (including how the person met the above criteria) in the accompanying General Occurrence (GO) report.

The following procedure outlines the options that members have for transporting persons apprehended under the MHA.

PROCEDURE

BC Emergency Health Services

1. When a person has been apprehended under the MHA, it may be in the best interest of the patient to be transported by BCAS, for medical or other reasons. If BCAS requests that a police officer accompany them, a member shall do so.
2. If BCAS refuses to transport a person who has been apprehended under the MHA, members shall call a Supervisor.
3. The Supervisor shall:
 - a. Contact a BCAS Supervisor;
 - b. Advise the BCAS Supervisor that the patient is a person apprehended under the MHA and therefore transportation by the BCAS is more appropriate and is in the best medical interests of the patient; and
 - c. In the event BCAS continues to refuse to transport, the patrol supervisor may consider the transportation alternatives below, and follow up with the Youth Services Section Mental Health Unit for further assistance in resolving the matter.

Transport by Police Car

4. If members determine that it would be appropriate to transport a person whom they have apprehended under the MHA in a police car (not equipped with a partition), the following will apply:
 - a. Members shall notify their supervisor of the intended transport;
 - b. The apprehended person must be handcuffed and searched prior to being placed in the police car, and the police car must be searched by members before and after the transport;
 - c. The person must be placed in the rear passenger-side seat of the police car, with the seatbelt securely fastened;
 - d. The apprehended person must be accompanied by at least one member of the same gender;
 - e. Mileage, and start- and end-times must be provided by the transporting members to dispatch over the radio and the details logged in CAD remarks;
 - f. The destination hospital or designated facility must be contacted via phone by the assigned members to advise that the apprehended person is en route; and
 - g. Police vehicles with firearms stored in the interior vehicle gun rack shall not be used to transport patients. Members deploying with carbine or beanbag shall have apprehended patients transported by ambulance, or in a different police vehicle that is not carrying firearms such as carbine or beanbag.
5. If, at any time during the transport, the members' original assessment changes, whereby the transport in the police car is no longer appropriate (e.g. emergent medical issues, a significant change in the apprehended person's behaviour), they may discontinue the transport and call for BCAS.

Transport by Police Wagon

6. Children and youth under 19 years of age shall not be transported in a police wagon.
7. Police wagons should only be used for transporting persons apprehended under the *Mental Health Act* in exceptional circumstances (e.g., where the patient presents a biohazard concern, or is combative and the wait time for BCAS can make the situation more volatile or be detrimental to the patient).
8. Supervisory approval must be granted prior to transporting via wagon.

9. The assigned members must contact the destination hospital or facility by phone prior to transport, accompany the wagon while en route, and assume custody of the apprehended person upon arrival.
10. The apprehended person shall be placed alone in a compartment and must be transported directly to the destination hospital or facility.

Transport Destinations

11. Members transporting persons apprehended under the MHA should convey them to the nearest Metro Vancouver hospital or to BC Children's Hospital if the person is 16 years of age or under.
12. If feasible, members transporting individuals for whom a Form 21 Director's Warrant or a Form 4 Medical Certificate has been issued should convey them to the originating facility from where the document was issued. If the facility lies outside of the above mentioned geographical area, members should instead transport the apprehended person to the nearest hospital or designated facility, from where further transport will be arranged internally.