VANCOUVER POLICE DEPARTMENT

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

Beyond Lost in Transition

Inspector Scott Thompson
Youth Services Section
Drug and Mental Health Policy

For

The Vancouver Police Board and
Chief Constable Jim Chu
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EXECUTIVE SUMMARY [1]

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

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

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

[1] The Executive Summary is taken from the original as well as the abridged "Policing Vancouver's Mentally Ill: The Disturbing Truth. Beyond Lost in Transition" reports and was intended for the December 8, 2010 Police Board meeting as well as Vancouver Coastal Health.

The 2010 “report card” notes that some two weeks after the report’s release, the provincial government announced a new provincial facility, the Burnaby Center for Mental Health and Addictions **(**BCMHA) which opened July 1, 2008. The BCMHA offers a voluntary model of care for concurrent disorder/dual diagnosis patients with an average stay projected at 9-12 months and is currently full (100 beds) with a waiting list of some 300-plus people. In 2010 an additional 40 pre- and 40 post-transitional treatment beds were added to the BCMHA model of care. The URC was identified as one of three priorities relative to housing and treatment and health needs; however, funding and a physical site for a URC have not been allocated. The City of Vancouver and provincial government have made significant progress with respect to housing with some 2855 new, and to be built, housing units coming on line. The three-year Federal Mental Health Commission of Canada “At Home/Chez Soi" project will also bring 300 new housing units on stream. This project will examine selected population cohorts of the concurrent disorder or complex client population and compare the outcomes of different housing and treatment models. It is unknown what progress has been made to establish a more effective mental health records system to assist mental health workers in accessing information about patients both within and between health authorities as well as provincially, whereas the VPD, RCMP and other municipal police have adopted a PRIME template to better capture mental health related data and track benchmarks across BC. Extended wait times for police who have apprehended people under the MHA continues to be an issue with the average wait time being one hour 11 minutes with there still being outliers of some four to five hours at both hospitals. Other progress includes the transformation of the existing VPD/Mental Health Emergency Services (MHES) Car 87 into a unit that can address concurrent disorder or dual diagnosis clients.

One finding in Part Two of the report is that there is a high level of daily contact requiring information exchange and cooperation between police and health services in Vancouver with some 16,500 citywide such calls for service in 2009. Data from a 2007 Severe Addiction and Mental Illness (SAMI) chart also reveals the scope of the mental

illness and substance abuse in BC with some 260,069 severe cases including substance use disorder, major depression, bipolar disorder, and schizophrenia.

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

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

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

A February 11, 2010 Ministry of Health news release states that 441 mental health beds have been opened across BC as part of the devolution of Riverview Hospital with further plans to develop and de-centralization the remaining 412 beds within regional facilities. The VPD submits that, given its findings, the need is great and it remains to be seen whether this plan will provide sufficient capacity needed to address the long term institutional mental health and addiction treatment needs of the many “Bills” and “Karls” police deal with daily.

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

Between February 1, 2009 and February 1, 2010 the VPD identified seven suicides committed by subjects who were previously dealt with by police for issues relating to MHA or “Disturbed Person” incidents. Further analysis indicated that these individuals also had a history of having been assessed psychiatrically in a hospital or having been committed at some point during the previous two-year period for mental health issues. There were also 487 suicide attempts where the subjects had previous contact with VPD for mental health/EDP issues and had a history of having been committed, received medical or psychiatric assessment or had been previously listed as missing from an institution. Of these suicide attempts, 18 occurred on bridges. In one case study an individual committed suicide by jumping off a bridge the same day he was released from hospital. In a second incident a patient committed suicide by jumping off a bridge while out on a two-hour pass from a hospital psychiatric unit. The VPD submits that these incidents reflect in part the challenges and uncertainty medical practitioners face

in determining whether an individual will take their own life or not, and the police do not have the appropriate expertise to determine whether the mental health system's response was adequate or not. However, a more public and transparent review process regarding medical practice in this area is lacking and a formal process does not exist to advise attending physicians either in a psychiatric unit or emergency room of a patient's suicide and the circumstances surrounding the death, so that practices may be informed by any lessons learned.

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

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

The VPD's key finding is that from a "street cop's" point of view little has changed since the 2008 LIT report. There has been progress and positive outcomes in the areas of supported housing, police record management and analysis, and moderate to long term treatment services for dual diagnosed patients in a quasi-institutional environment (BCMHA). The police, however, are still responding day after day to "difficult to

manage” and “treat” chronically mentally ill and addicted individuals on the streets of Vancouver. Other issues relating to suicide, suicide attempts and missing persons consume police resources, frustrate police, and in some cases endanger the lives and safety of patients, front-line police officers, other first responders and the public. From a “Problem Oriented Policing” perspective the attempts of the police to solve these “problems” are still being hindered by the barriers of information sharing, a lack of system capacity and a lack of apparent will on the part of health system in Vancouver to adapt and change in order to work effectively with the VPD to truly solve these issues in a constructive and sustainable way. The key finding of the first Lost in Transition report was that a lack of capacity in the mental health system is failing Vancouver’s mentally ill and draining police resources; unfortunately, that tragically remains true.

RECOMMENDATIONS[2]

1. **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 along with additional resources to support the facility. (Lost in Transition 2008)**

2. **That the Ministry of Health and Vancouver Coastal Health establish an "Assertive Community Treatment" (ACT) team model with sufficient capacity to address community based treatment needs in Vancouver and implement a model similar to the one that exists in Victoria, BC where the Victoria Police Department are part of an integrated team. (Beyond Lost in Transition 2010)**

3. **That Vancouver Coastal Health, St. Paul's Hospital, Vancouver General Hospital and the police establish formalized standing bodies with appropriate terms of reference that includes police, emergency room, and psychiatric unit as well as psychiatric ward medical staff and management with a mandate to monitor, identify, de-brief and resolve critical incidents and other police/health related incidents as well as systemic issues. (Beyond Lost in Transition 2010)**

4. **That Vancouver Coastal Health, St. Paul's Hospital, Vancouver General Hospital establish an information sharing and feedback mechanism so attending Emergency Room and psychiatric unit and ward physicians are advised in a timely manner of suicides, suicide attempts and other critical incidents involving their patients. (Beyond Lost in Transition 2010)**

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[2] These six prioritized recommendations are from both the 2008 Lost in Transition and the 2010 original as well as the abridged "Policing Vancouver's Mentally Ill: The Disturbing Truth. Beyond Lost in Transition" reports. The recommendations are a "short list" intended for the December 8, 2010 Police Board meeting.

5. **That St. Paul's Hospital and Vancouver General Hospital pursue changes in hospital practice to speed up the admission process for police who have arrested an individual under the provisions of the Mental Health Act. (By negating the need for the emergency physician to initially examine the patient- Lost in Transition 2008)**

6. **That the Ministry of Health make legislative changes in the Mental Health Act to facilitate a speedier health system response and reduce police wait times at the hospitals. (Beyond Lost in Transition 2010)**