Police Interactions with Persons with a Mental Illness: Police Learning in the Environment of Contemporary Policing

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Mental Health and the Law Advisory Committee

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PREFACE

Starting in 2007, the Mental Health Commission of Canada (MHCC), through its Mental Health and the Law Advisory Committee (MHLAC), undertook a series of projects related to police interactions with people with mental illnesses (PMI).[1] There has been a significant increase in the number of such interactions over recent years and, concomitantly, increased concerns about some of the outcomes. While most interactions between police and PMI are uneventful, a few have resulted in negative outcomes, including the death of the person with the mental illness. The overall goal of the MHCC projects is to identify ways to increase the likelihood of these interactions having positive outcomes – that is, better outcomes for all involved.

When an incident does end badly, there has typically been a coronial inquest/fatality inquiry, which results in recommendations intended to improve the outcome of similar situations in the future. The most common recommendation is to increase the 'training' of police officers in order that they are better prepared. Indeed, it is inarguable that good education and training – learning, knowledge acquisition – in this regard is necessary. The primary purpose of this study has, therefore, been to delineate a model for the in-service education and training of police personnel, including police officers, concerning their work with people who appear to be experiencing mental health problems.

However, even though learning is essential, it is not a panacea. While it is tempting to be content with a paper that provides an outline or curricula for police learning, the authors feel that such a document can easily be taken out of context. If that is so, it will not contribute to the desired endpoint of improved outcomes for people with mental illnesses. Thus, we encourage the reader to consider this paper in a broader context. Part of that will come from outside of this paper.

For instance, an overview of the general situation concerning police interactions with PMI, written by the authors of this paper, is in press for *Police Practice and Research: An International Journal* (scheduled for publication in summer 2010). In addition, a previous MHCC study about basic police training delivered by Canadian police colleges and academies (Cotton & Coleman, 2008) will be summarized in this paper. The Mental Health Commission of Canada has also funded a study of police interactions with PMI from the point of view of the consumer – the PMI. This study is underway and will be completed in 2011. It is anticipated the findings will be instructive to police education and training.

[1] There are a variety of different terms used by researchers, police, consumers and others to describe people who are living with mental illnesses or people with lived experience of mental illness. In this paper, the term "person with a mental illness" or PMI has been employed as it is familiar to the target audience, and most accurately describes the situation in which police interact with this population—that is, at times when signs and symptoms of mental illness are readily apparent—as opposed to people who may have a history or past experience of mental illness but whose symptoms are not evident at the moment.

Again, no matter how well designed and complete a curriculum is, it will only result in improved outcomes if the learning engages the right people and in the right context. Thus, in this paper, attention is also paid to contextual factors — not only what should we teach, but also to whom should we teach and in conjunction with what other organizational structures and social systems. Thus, Section III of this paper addresses these additional factors. While not always reflected specifically in the recommended curriculum, they inform both its design and its delivery.

EXECUTIVE SUMMARY

In recent decades, the number of interactions between people with mental illnesses and police has increased significantly. While most of these interactions are minor in nature and are resolved uneventfully, there are unfortunately a few which result in significant negative outcomes. Whenever this is the case, one of the most frequent recommendations which has emerged from reviews is that police officers should be provided with education and training – learning – in order to give them the skills and knowledge necessary to interact adaptively with people with mental illnesses (PMI). This paper is Part II of a two-part review of that learning; Part I was a review of police education and training at the police academy basic training level. The purpose of the current investigation, Part II, was to review the state of police in-service education and training related to police/PMI interactions.

A review of current practice in a variety of jurisdictions across Canada as well as in the United States, the United Kingdom and Australia, suggests that there is considerable variability in existing programs. While many police agencies provide little or no learning in this area, others provide more comprehensive education varying in length from a few hours to several days. The content of the training varies from an overview considered appropriate for a wide variety of police officers up to and including highly focused training intended for specialist officers. While some police services provide 'one-size-fits-all' training, others deliver a variety of levels and degrees of learning. Unfortunately, in spite of the widespread acceptance of programs such as the Crisis Intervention Team (CIT) model, which originated in Memphis, Tennessee, there is little outcome research or data-based evidence to inform the exact nature of an effective program, and the research that does exist does not provide guidance as to which components of a learning program are most effective. Nevertheless, the existing research tends to support the contention that education and training is effective in improving outcomes overall.

Even though, the primary purpose of the paper is to provide an overview of what is delivered and what should be delivered in terms of curricula related to mental illness, it would be inappropriate to discuss curriculum without considering the greater context. While education and training is of course essential to ensuring that interactions between police and PMI are constructive and adaptive, education in and of itself is not a panacea and will not create the kind of change that is desirable if it occurs in isolation. Thus, before identifying 'desired practices' in terms of curriculum, it is necessary to comment on the circumstance within which this learning should occur.

First, every police officer operates within the context of his/her own organization. Therefore, it is essential that each police organization have in place policies and procedures that support the application of the skills and knowledge that police acquire through education and training. For example, the Canadian Association of Chiefs of Police has promulgated the *Contemporary Policing Guidelines for Working with the Mental Health System.* The Guidelines outline a series of processes and policies that should ideally be in place in any police agency in order to inform and support the work of not only individual police officers but of all police personnel who

encounter PMI. In addition to these policies and procedures, each police organization must also be guided by knowledge about the police academy training that their officers bring to the workplace.

As has been noted in a previous survey (Part I), police academies vary significantly in terms of the type and extent of learning at the basic-training level. In many cases, such academy level training has only been in place in recent years; thus, police officers who have been employed longer will not have had the benefit of that training.

Second, while the specific content of a mental-illness related curriculum is of course crucial, it is not the only determinant of successful learning. It is necessary that police agencies attend to a variety of other factors that will have a direct impact on the learning outcome. These include:

- selection of appropriate 'trainers,' including those who are both subject matter experts and who are operationally credible;
- inclusion of local mental health professionals, for the purposes of providing reliable information as well as to assist in forming local connections with mental health agencies;
- integration of PMI and their families into the training in order to provide direct first-hand experience with this population;
- use of a variety of forms of learning media including participatory strategies;
- focus on cognitive determinants of behaviour including attitudes, exercise of discretion and stigma; and
- adaptability of the curriculum to reflect the population receiving training (e.g. new officers versus specialized teams versus dispatch personnel) as well as local community needs.

By extracting components from a variety of education and training regimes already in place in Canada and other countries, and then combining them with what can be gleaned from outcome research, a comprehensive education and training regime based on an identified learning spectrum emerges; one that can be adapted to a variety of police agencies and police personnel. The proposed learning model has been entitled **TEMPO** — an acronym for **T**raining and **E**ducation about **M**ental Illness for **P**olice **O**fficers.

SECTION I

1.0: Introduction:

This study is Part II of a two-part series. Part I was a study by Cotton and Coleman (2008) of the curricula related to mental illness that are taught in Canadian police colleges and police academies.[2] In particular, the goal was to learn about the context and manner in which Canadian police officers were being educated and trained at the 'basic-training' level[3] to prepare them for their inevitable interactions with persons with a mental illness (PMI). The purpose of this study, Part II, was to first determine what types of 'in-service' Police/PMI training programs exist and then, in the context of the relevant literature, to identify and recommend a contemporary model of 'in-service'[4] police/mental health education and training for police personnel to Canadian police leaders and police oversight authorities. It was important that the recommended model not only be appropriate to the Canadian criminal justice and mental health environments as well as to the social environment in general, but also that it reflects the findings to date of scholars in this field.

The interest for this study was, as with Part I, based on the premise that appropriate education and training about people with mental illnesses would result in a greater likelihood of positive outcomes of interactions between police and PMI. Such outcomes to include a) more client-focused intervention, b) decreased use of force, c) more effective and efficient linkages with the mental health system when appropriate or desired and d) a reduction of stigma. Put more simply, appropriate education and training of police officers with regard to PMI is the 'right thing' to do. The question thus posed for this study was: how can police organizations ensure police personnel are adequately prepared for interactions with people with a mental illness?

While most police officers do not usually think of policing as a social service, it is in fact a social service – albeit one with unique authorities that distinguish it from other types of social agencies. Consequently, this study was positioned in the contemporary policing environment that encourages the generation of collaborative community-based solutions to problems for the furtherance of a focus on client/customer service, continuous evaluation and continuous improvement. To situate Part II with regard to in-service learning, it is first necessary to review the findings of Part I.

2.0: Background:

The findings of Part I (Cotton & Coleman, 2008) were informative to this study in that Part I concluded all the surveyed Canadian police colleges/academies included learning about working with PMI as part of 'basic-training.' They did this by using a wide range of programs.

[2] This Study uses 'colleges' and 'academies' interchangeably.
[3] In police jargon, this is often called 'recruit training' or 'cadet training.'
[4] Sometimes called 'advanced training' or 'block training.'

For instance:

> *virtually all programs address verbal strategies, dealing with aggression and suicide. Most also cover the basics of symptomology such as excited delirium, mental health law, dangerousness and use-of-force options. However, the data also indicate that in some cases, there is limited coverage and thus understanding of the issues because it is simply not possible to cover these topics in the times reported* (Cotton & Coleman, 2008, p. 15).

Even though many of the programs included learning about verbal strategies, suicide ideation and issues related to signs and symptoms of mental illness, some programs failed to teach police officers about symptoms of mental illness, did not provide an introduction to the major diagnostic categories or the skills to communicate appropriately and effectively with a person experiencing psychotic symptoms. This was a concern.

Overall, the programs varied substantially in terms of content, the backgrounds and skills of the presenters/facilitators as well as the overall depth and breadth of the education/training and the total time dedicated to each subject. For example, while some academies dedicated minimal time to the issue (less than five hours in some cases), others provided more than 20 hours of training. While this is problematic, this information is useful in that it informs the design of 'in-service' learning subject of this study.

For instance, Cotton and Coleman (2008) determined that on average most police officers received only approximately ten hours of education/training during 'basic' training. While that could be sufficient to begin to sensitize new police officers to the fact that some people they interact with might have a mental illness, it is likely inadequate to impart the necessary knowledge and skills to be effective. It is also unlikely to be sufficient to change personal attitudes in terms of stigma and bias.

It was apparent from the findings of Part I that even though substantial progress appears to have been made, in that Canadian police academies provided at least a minimal introduction to issues related to working with PMI during basic training, there is still much work to do. Furthermore, Part I raised the issue that, in general, mental illness and related matters have only been included in Canadian police academy curricula since about 2000. Therefore, many of those who began their police careers before 2000 might not have benefited from even the minimal basic training. This influences the shape of desired 'in-service' learning. Overall, Part I provided useful move-forward information and established a baseline not only for future studies of basic training but also for studies of in-service learning.

3.0: Methodology:

The goals of this study were achieved in four steps. First, in order to determine existing Canadian 'in-service' learning programs, in early 2009 by means of the Police/Mental Health and Liaison (PMHL) *Listserv*,[5] approximately 500 Canadian police agencies, Canadian police colleges and police academies as well as mental health agencies providing service to police with respect to police response to PMI were asked to describe the police/mental health education and training in their respective jurisdictions. Twenty-six responses were received from across Canada. These were predominantly from police agencies but some were from police/mental health partnerships as well as mental health agencies.

Second, a comprehensive literature review related to police education and training about police contact with PMI was conducted. This was targeted primarily at Canada, the US, the UK and Australia. The review sought a) to learn about research and evaluation that had been completed including recommendations about content, design and duration of effective 'in-service' learning programs and b) to identify and broadly assess current in-service learning programs used by police agencies outside of Canada, including in the UK, the US and Australia.

Third, the factors and influences that might have a specific effect on the nature of police contact with PMI but which have not been traditionally addressed in 'in-service' learning programs were explored. These included such factors as police discretion and ethical decision-making, police attitudes about mental illness, stigma related to mental illness, concepts of procedural justice and police use-of-force.

Finally, based on analysis of all of the above information, a contemporary model of police/mental health learning for Canadian police personnel, congruent with the fundamental principles of contemporary policing,[6] was developed to prepare them for appropriate responses to interactions with PMI. The recommended model takes into account the education and training needs of not only police officers but also that of call-takers, dispatchers, victim services personnel and 'front desk' personnel.

[5] Managed through www.pmhl.ca

[6] Several of the fundamental principles of contemporary policing apply directly to police interactions with PMI. They are: a conscious focus on delivering quality and valued customer/client service; consultation and collaboration internally and with the community; continuous evaluation and improvement; decentralization of authority and decision-making; teamwork; increased communication by actively sharing information internally and externally with the community; due process, fairness and equity; and an outcome focus (Coleman, 2008).

SECTION II: CURRENT POLICE LEARNING

4.0: In-Service Police Education and Training (Learning) - Canada

Prior to this study, little had been documented at the national level about what Canadian police personnel receive as 'in-service' Police/PMI[7] education/training. Similar to the findings of Part I, this study found a wide variety of Canadian police/mental health in-service learning programs. Not surprisingly, the variations in quality or availability of education/training programs are somewhat related to the size of a police organization. They ranged from no in-service learning in many small and even some medium-sized police agencies up to relatively comprehensive programs such as those developed by the Ontario Provincial Police, the Canadian Mental Health Association (CMHA)-BC in collaboration with the B.C. Provincial Police, the Halton Regional Police and the Halifax Regional Police. Of the smaller police organizations that provided 'in-service' training, it was often only an occasional short seminar from a representative of a mental health organization such as the Canadian Mental Health Association and/or the two-hour CPKN on-line course — *Recognition of Emotionally Disturbed Persons.*[8] Conversely, some large police organizations had well developed programs — but, overall, only a small fraction of their personnel received such training. Following are some examples that demonstrate the range of available 'in-service' learning:

ALBERTA

Alberta Government

The Office of the Alberta Solicitor General has developed an exceptional online course.[9] The course — *Policing and Persons with Mental Illness* — which was designed by a psychologist, two curriculum designers, a police officer and a representative from provincial corrections, is intended for all municipal police services and provincial corrections. It is suitable for both basic level police officer training as well as 'in-service' training. The course is described as:

> *not [being] a standalone segment, but an integral component of ongoing training. The broader curriculum structure in which this course is utilized draws upon adult learning techniques, ongoing cohort participation and the layering of foundational skills and knowledge (legal, operational and tactical). In a similar fashion, course modules are connected through ongoing application of Skills*

[7] In this paper, 'Police/PMI' denotes contact and interactions of police personnel with persons with a mental illness as well as categorizing the learning to prepare police personnel for their contacts with persons with a mental illness.

[8] Described later in this paper. Available at http://www.cpkn.ca/course_detail/emotionally_disturbed_e.html

[9] Public access to this site is not available. The authors were given access for the purpose of this study. The details of the course that follow in this paper are from that review.

and Knowledge achieved via completion of the previous modules and associated evaluation.

The course objectives are to:

- provide general information on mental health issues to police officers;
- develop police officer's awareness of the impact of mental illness on police officer-citizen encounters;
- recognize the dynamic relationship between police officers and citizens and the role of preconceived notions which may have an impact on the encounter;
- increase police officers knowledge of syndromes, diagnosis and symptoms of the most frequent mental conditions;
- increase officer awareness of the impact and extent of mental illness, and associated costs;
- enhance general knowledge about mental illness factors that could aid an officer;
- support the development of ten baseline behavioral competencies;
- aid officers to act more cautiously in approaching the citizen, so as to avoid harm to both the individual and themselves;
- assist officers in diverting mentally ill persons to a more appropriate system, such as the mental health system;
- assist officers in developing effective assessment techniques of police-officer citizen encounters; and
- develop behavior-centered skills.

The six-module course includes:

- Placing Policing and Mental Illness into Context;
- Officer's Perceptions and Stigma;
- Mental Disorders;
- Communication, De-Escalation and Responses;
- Procedures, Reporting, Authority and Process; and
- Suicide Intervention.

Of note is that this course is one of the few encountered during the literature review and direct enquiries of police agencies that includes a specific module with regard to "officers' perceptions and stigma."

Calgary Police

Further to a seven-hour course[10] during basic training, in-service education and training for the Calgary Police has three levels. At the first level, the Calgary Police use a 24/7 online course

[10] Although there are differences between a 'course,' a 'seminar' and a 'workshop,' police organizations tend to use the terms interchangeably and or call all formal learning 'a course.' Hence, references in this study to a 'course' might be referring to a 'seminar' or a 'workshop.'

constructed in-house and based on the handbook *The Calgary Police Service Officer's Guide to Dealing with Emotionally Disturbed Behavior* (2008).[11] At the second level, the Mental Health Interdiction Program extends classroom learning to hands-on community mental health practice. Police officers, trained by mental health professionals, together with psychiatric and forensic nurses and a psychiatrist have delivered the course. Ongoing semi-structured learning in the workplace follows the two-hour classroom training on mental health and mental illness. The foundation of the course is, *Calgary Police Service Officer's Guide to Dealing with Emotionally Disturbed Behavior*(2008).

At the third level, the Homeless Unit of the Police and Crisis Team (PACT) is a strategic community partnership between Calgary Police and Alberta Health Services. The pilot project, which began in late 2009, addresses persons in crisis who are presenting with public safety concerns, mental health and addictions issues and who, as a result, might be at risk of being homeless. The five-week orientation and training schedule has included:

- orientation and tours of mental health and homeless services and facilities in Calgary;
- various mental health assessment forms and checklists;
- review of the *Mental Health Act* and the *Diagnostic and Statistical Manual of Mental Disorders* (DSM);
- job shadowing by the mental health clinicians with police officers; and
- team discussions on the philosophy of PACT.

Community specialists provide information on homelessness, medications and their side effects, crisis intervention models, addiction, suicide and aboriginal mental health. Resources include the *Calgary Police Service Officer's Guide to Dealing with Emotionally Disturbed Behavior* (2008) as well as *Suicide by Cop* and *Pathways to Housing*.

Edmonton Police

Although not common for Canadian police agencies, the policy and procedures of the Edmonton Police Service (EPS) with regard to Police/PMI contact include the necessary 'training' requirements and expectations:

> *In order to recognize and respond to incidents involving suspected mental illness, EPS members receive, during basic recruit training,*

[11] Calgary police officers and mental health professionals developed the handbook, which is an in-house publication of the Calgary Police service. It presents important facts about mental illness and emotional disturbance and helps identify behavioral symptoms as well as providing information about community resources and the *Mental Health Act*. It also discusses effective ways of documenting observations and conducting interventions.

principles for defining and dealing with mental disorder, instruction in powers of arrest, arrest and transport, and arrest with warrants under the Mental Health Act*. Refresher training will be conducted at least every three years, or more frequently as appropriate.*

Of note is that Edmonton police officers receive quite extensive basic police/mental health training at police college compared to most Canadian police agencies (See Cotton & Coleman (2008) for a more detailed review of the EPS police college-level training).

ATLANTIC CANADA

Provincial Policing - Atlantic Region (RCMP)

The Atlantic Region is comprised of Nova Scotia, PEI and New Brunswick as well as Newfoundland and Labrador. In terms of 'in-service' education/training with regard to preparation for Police/PMI interactions, the Atlantic Region advised that this varies between provinces. Although all of the Atlantic Region provides suicide prevention training[12] to police first responders, in Newfoundland and Labrador training has also been delivered with respect to that province's *Mental Health Act*.[13] In addition, the Alzheimer's Society has provided half-day sessions in the policing districts based on the availability of police personnel to attend.

There was no related training in PEI or Nova Scotia during 2008/2009. Since late 2009, the RCMP in New Brunswick has been using the CPKN module *Recognition of Emotionally Disturbed Persons.* This is available to all employees of the RCMP across Canada through their Intranet. As of yet, it is not mandatory across Canada, but is used at the discretion of each provincial Division.

Halifax Regional Police (HRP)

Halifax Regional Police has taken an interesting approach in that they have constructed an education and training matrix with four levels of education/training. This was developed collaboratively by HRP and the joint response Halifax Regional Mental Health Mobile Crisis Team (MHMCT).

MHMCT worked with the Dalhousie University Department of Psychiatry to develop integral pieces of the training program. That which was developed by the Department of Psychiatry - *Recognition of Emotionally Disturbed Persons* - is now also delivered online through the Canadian Police Knowledge Network.

[12] Developed by Living Works.

[13] A RCMP officer shot one of the two deceased persons subject of the Reid/Power Inquiry. The inquiry made strong recommendations about the necessity of education and training for police officers in Newfoundland and Labrador (Report of Inquiries, 2003).

100 level: Basic police training

- 3-day training with all 'recruit'[14] classes; and
- 1-day training for lateral hires (summary and review).

Learning Objectives are:

- to introduce new police officers to broad categories of mental illness and mental health difficulties specifically as it relates to EDPs[15];
- to provide education on appropriate strategies and guidelines for responding to EDPs;
- to increase confidence, comfort and awareness in responding and resolving EDP presentations; and
- to understand and gain familiarity with the HRP policy and procedure in relation to EDPs and the Involuntary Patient Treatment Act (IPTA)[16] to understand the role of MHMCT, the service it provides and the relationship with HRP to introduce the MHMCT HRP officer triage card for EDPs.

200 level: Continuing education for first responders

- three-hour training for police officers who have not received the basic training (Level 100);
- provided four days per year for eight separate three-hour sessions/year;
- includes the CPKN on-line course; and
- a more interactive presentation with the MHMCT is under consideration.

Learning Objectives are:

- to provide continuing education to police personnel on broad categories of signs and symptoms of mental illness;
- to provide education on guidelines for responding to and resolving EDP calls to increase familiarity with the IPTA;
- to explain the role of MHMCT, the service it provides and the relationship with HRP; and
- to introduce the MHMCT HRP officer triage card for EDPs.

300 level – CIT training

- 40 hours of education/training;
- delivered at least twice per calendar year.

[14] The term 'recruit' is police jargon for a new police officer. Although it is usually used while the new officer is completing basic training, it is often also used for at least the first year of the officer's service.

[15] Emotionally Distressed Person or Emotionally Disturbed Person. These terms are often used interchangeably with PMI.

[16] This is comparable to the Mental Health Acts of other provinces.

Learning Objectives are:

- to increase awareness and understanding of mental health issues and particularly better understand the perspective of mental health consumers and their families;
- to develop and enhance the participants' skills in interviewing and communicating with mentally ill persons referred to as EDPs;
- to increase the participants' knowledge of the most common mental illnesses and the most appropriate ways to approach and deal with these individuals;
- to increase skills in communicating observations when providing report in response to EDP calls;
- to increase the knowledge of community resources to assist the mentally ill in the community, their family members and the police officers dealing with them;
- to develop knowledge, skills and strategies for police officers to safely de-escalate a person in a mental health crisis;
- to increase understanding and knowledge of the MHMCT role, the IPTA and the relationship with HRP; and
- to increase understanding of the systemic relationship between the Emergency Department, Psych Assessment Services and HRP.

400 level – Advanced training for MHMCT police officers

- prerequisite is successful completion of the 300 level course;
- the one week Capital Health Mental Health Orientation which is delivered to all new mental health staff; and
- a minimum of four job-shadow shifts with MHMCT.

Learning Objectives are:

- to gain a more in depth working knowledge of mental illness: signs and symptoms, strategies for maximizing individual and public safety and appropriate strategies for responding to EDP;
- to increase communication skills and strategies to respond to EDP; and
- to increase skills in reporting observations both verbally and in reports.

Royal Newfoundland Constabulary (RNC)

Further to their comprehensive basic education/training program, which includes emphasis on the wise use of police discretion and police ethics (Cotton & Coleman, 2008), their in-service learning includes:[17]

- a three-hour session on Fetal Alcohol Spectrum Disorder (FASD) delivered by Choices for Youth during which a mother shares challenges with her son who is suffering from FASD;
- a three-hour information session on Autism delivered by the Autism Society; and

[17] The frequency and level of experience of the students is unclear from their response.

- a one-day Mental Health First Aid[18] seminar delivered by a mental health professional.

BRITISH COLUMBIA

Police Intervention in Mental Illness Crisis (PIIMIC),[19] which was prepared by the British Columbia Schizophrenia Society (BCSS) in conjunction with the Justice Institute of BC Police Academy (JIBC), is a comprehensive and easy to understand online source of information about mental illness, legislation and related matters. While not a course per se, PIIMIC is widely regarded as a useful resource for police in any jurisdiction.

British Columbia Government

Subsequent to the death in late 2007 of a man at the Vancouver Airport after police had used a Conducted Energy Weapon (CEW) and the resulting concern about the circumstances of the death, the Government of British Columbia (B.C.) convened an inquiry – referred to as the Braidwood Inquiry – to make recommendations to prevent similar future occurrences (Restoring Public Confidence, 2009). In anticipation of the final report, the B.C. Government established the Braidwood Recommendation Implementation Committee (BRIC) chaired by a senior person in the Ministry of Public Safety and Solicitor General. It is anticipated it will be comprised of representatives from CMHA, B.C. Alliance on Mental Health and Addiction, the Chiefs of Police, the RCMP, the Police Associations (Unions), B.C. Civil Liberties, First Nations, Sheriffs, Corrections, B.C. Office of Police Complaints Commissioner, the Justice Institute of British Columbia (JIBC), the Pacific Region Training Center (PRTC) and "possibly others." Two working groups have been established for the development of standards and training:

- Crisis Intervention and De-escalation training (CID); and
- CEW training.

Of relevance to this study is this incident was the impetus for a review by the Government of BC of changes necessary to police education and training that will positively affect Police/PMI interactions. The intent is that the education/training will be built systematically using experts in curricula design and adult learning. Moreover, it will be performance based, so it will be 'defensible,' and will include the ability to evaluate the program(s). Directly relevant to this study is that a significant part of the new curricula will include verbal engagement and de-escalation techniques to avoid, whenever possible, the use-of-force.

British Columbia Provincial Police

CMHA-BC in collaboration with the RCMP E Division, which provides police services to the province of B.C., has implemented a modified CIT training model – *BC-CIT*. The partners emphasize that "this is not just training, but a sustainable community program." It not only delivers community-based cross-training to a core group of first responders (police personnel,

[18] For more information about MHFA, refer to Page 28.

[19] Available at http://www.jibc.ca/police/main/PIIMIC/piimic_introduction.htm & http://www.piimic.com

hospital emergency room (ER) personnel, emergency services dispatchers, ambulance paramedics, psychiatric emergency nurses, cell block guards, probation officers, parole officers, outreach and community service providers, social workers, corrections officers, mental health and addictions practitioners) but, after completion of the 40-hour training, CIT-trained liaison persons are identified from participating agencies (in particular mental health agencies and police services) to collaborate with the community with regard to problem-solving, protocol development, case management planning and joint education presentations.[20] CMHA-BC envisages:

> *a provincial CIT coordinating centre and regional training/coordinating coordinators. The provincial centre would develop and maintain training standards, and a standardized training package which will maintain those standards, protocols, policies, and coordinate/support the regional coordinators. The regional coordinators would develop training within the region, and maintain/support a liaison network for knowledge exchange and support in problem-solving (community of practice model).*

The BC-CIT program is guided by a cross-sectoral committee of the Provincial Police, municipal police agencies, the B.C. Ambulance Service, Provincial Health Authorities, the Canadian Mental Health Association – B.C. Division, B.C. Schizophrenia Society, families and persons with direct experience of mental health services, the Commission for Public Complaints against the RCMP and Crown counsel. While initially established in the Lower Mainland of B.C., it is now a provincial program. The syllabus includes:

- B.C. Mental Health Act - *Role of Police, Physicians & BCAS;*
- Criminal Prosecution of the Mentally Ill;
- Developmental Delay & Fetal Alcohol Spectrum Disorder;
- Mental Health Disorders & Common Medications;
- Early Psychosis Intervention EPI;
- Risk Assessment for First Responders;
- Complexity of Addictions;
- Excited Delirium and Restraint;
- Post Traumatic Stress Disorder – Compassion Fatigue;
- B.C. Schizophrenia Society (BCSS) Interactive Client & Family Panel;
- Adult Guardianship Act & Community Resources;
- Victim Precipitated Homicide " *Suicide by Cop;"*
- Health Authorities and the Police: *Disclosure Issues;*
- Crisis Communications Skills;
- EDP Simulations with *Ralston Studio Actors;*
- Stand Up for Mental Health – an anti stigma through client comedy troop; and

[20] Presentations made to agencies such as mental health service agencies, persons with a mental illness and the community in general.

- Cultural Awareness and Implications.

Although this program currently relies on evaluation through participant feedback, the partnership has collaborated with the University of the Fraser Valley to conduct comprehensive multi-year, multi-community research.

Vancouver Police (VPD)

Even though Vancouver Police do not use the U.S. CIT deployment model, their training program for police 'first responders' is based on the 40-hour CIT training. The VPD course, which is intended for new constables as part of a five-year development plan, is a modification of the usual four days (40 hours) of training to a three-day (36 hour) model to fit their 12-hour shift rotations. Although CIT guidelines suggest 25% of police officers should be trained, this will vary depending on the size, the geographic location and the social environment of the police agency or detachment. The goal of Vancouver Police, given their apparent high percentage of Police/PMI contacts (Wilson-Bates, 2008), is to train 100% of their 'patrol' officers.

The goals of the VPD Crisis Intervention Training (CIT) are to:

- initiate proactive intervention to deter crises which might involve high levels of force;
- minimize the use of force by police officers dealing with the mentally ill or citizens in crisis;
- reduce in risk and injuries to police officers;
- reduce liability through improved crisis management;
- facilitate identification and tracking of persons through Mental Health Emergency Services who either exhibit chronic behaviors that pose a risk to themselves or others and/or place a significant drain on police resources;
- develop a stronger partnership between police, the mental health community, the community as a whole; and
- increase public confidence and support with police intervention.

The course/seminar includes:

- Mood Disorders
  - Overview of mental illness and its impact on society;
  - Living with mental illness – the person, their family, friends and community; and
  - Specific focus on bipolar disorder.

- Depression, suicide
  - Overview of depression and suicide risk;
  - Overview of suicide intervention strategies for police officers; and
  - Awareness of depression and suicide risk for yourself, family and friends.

- Early psychosis intervention and schizophrenia
  - Overview of signs and symptoms of early psychosis, and focus on early intervention;
  - Overview of community resources in Vancouver; and
  - Specific focus on schizophrenia, including a BCSS partnership presentation.

- Critical incidents, post-traumatic stress disorder (PTSD) and self-care of the officer
  - Overview of critical incidents and post-traumatic stress disorder (PTSD); and
  - Specific focus on the self-care of the officer.

- Geriatric mental health
  - Increase awareness of the most common psychiatric illnesses of the older person;
  - Overview of basic tools to assess cognitive function and risk in the elderly; and
  - Overview of services available in Vancouver for the older adult with psychiatric illness.

- Developmental disabilities
  - Overview of mental illness and developmental disabilities;
  - Specific focus on impact on behavior, learning, and presence of mental health illness; and
  - Management and treatment of offenders with developmental disabilities.

- Police tactical considerations
  - Assessing the situation and scene with a person in crisis; and
  - Review of tactical options for police officers.

- Drugs and psychosis
  - Overview of drug use, drug-induced psychosis, drug use and mental illness;
  - Impact of drug use on the body – duration, physiological effect; and
  - Specific focus on crystal methamphetamine, cocaine and cannabis.

- Victim-initiated homicide
  - Overview of 'suicide by cop' (SBC); and
  - Preparation for the officer before, during and after a SBC encounter.

- Crisis intervention with a psychologist
  - Focus on communication theory and strategies for first responders; and
  - Practical application through role-play(s).

The VPD has not evaluated this course. Their position is that because it is based on the standard U.S. CIT training model it is "following best practices."

Delta Police

The policy and procedures of the Delta Police with regard to Police/PMI contact include their commitment to 'training' of personnel:

> *To provide employees with the education and training to perform apprehensions under Sec 28(1) of the* Mental Health Act*, when persons meet the criteria, and then deliver those persons to a physician.*

ONTARIO

Ontario Police College (OPC)

The OPC has developed a comprehensive written guide for working with PMI - *Not just another call … police response to people with mental illnesses in Ontario – a practical guide for the frontline officer*.[21] This was developed in response to recommendations from various coronial inquests (looking into the deaths of persons with a mental illness) that identified the need for enhanced police training and resources. The guide, which is provided to new police officers as a resource during 'basic' training at OPC, also provides police personnel with a useful ongoing reference.[22] Hospitals, psychiatrists, mental health workers, first responders, corrections officers and mental health consumer organizations, apparently, also use the guide.

Peel Regional Police

Peel Regional Police, which uses a COAST[23] joint mobile response model, provides a four-day 'in-service' seminar, presented by police, mental health professionals and persons living with a mental illness that includes:

- a pre-test;
- presentation on/simulation of de-escalation and suicide intervention;
- presentation of the justice system;
- youth and mental health issues;
- autism and vulnerable people;
- dual diagnosis;
- a presentation by/engagement with a "survivor family;"
- introduction to mental health by a psychiatrist;
- mental health court;[24]

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[21] Available online at the Ontario Police College website http://www.opconline.ca/

[22] A pocket-sized version has been developed for the use of 'frontline' police officers.

[23] Sometimes called a Community Outreach and Stabilization Team or a Crisis Outreach and Support Team. This is a police/mental health joint response model that was initially established in Hamilton, ON approximately 15 years ago. Over the last few years, other jurisdictions of the greater Toronto area have adopted this model.

- a panel from three local hospitals; and
- a post-test.

Halton Regional Police Service (HRPS)

Training for new police officers

Although new police officers receive some education with regard to Police/PMI contact at the Ontario Police College, Halton Regional Police provides additional training upon their return from the Ontario Police College to ensure they understand the COAST program and how to access community services in Halton Region. A COAST police officer and a COAST mental health worker deliver the 1½-hour module three times per year.

Police/PMI "specialist" police officers

As part of their structured multi-level approach to Police/PMI education, Halton Regional Police uses a modified CIT training model for their Police/PMI specialist police officers. This training, like most CIT training, is 40 hours in duration. The course, which is funded by the Ministry of Health, is delivered once a year. Design and delivery is by:

- COAST mental health workers;
- COAST police officers;
- members of the community;
- Schizophrenia Society of Ontario;
- family member(s) of a PMI;
- a person(s) with a mental illness from TAMI (Talking About Mental Illness);
- local hospital staff; and
- Halton Geriatric Outreach Team.

The course includes a broad overview of mental health issues including psychosis, mood disorders, dementia and substance abuse disorders. Simulations of 'real' police scenarios are used for which actors are trained to simulate symptoms. Evaluation is based on participant feedback. The course construction is such that it enables the establishment of new community relationships and the maintenance of existing relationships.

In-Service/Block Training

All police officers are required to complete annual Block Training, which provides an overview of psychosis and the COAST program. The 90-minute module, delivered at least 16 times per year, is designed and delivered by COAST mental health workers, COAST police officers and police Youth Justice Service social workers.

Citizens Police Academy

Although not strictly police in-service learning, it is likely that this is the only police agency in Canada delivering this type of community learning. The target group for the one-hour seminar

[24] A mental health court operates in the Peel Regional Police jurisdiction.

is community members who volunteer to attend the Academy to learn about the police agency. The annual presentation by a COAST police officer and a COAST mental health worker provides an overview of the program and information on how to access their services.

Victim Services

The target group for this 90-minute seminar is the volunteers of the Police Service's Victim Services work unit. These volunteers frequently encounter PMI during their work to support police officers. A COAST police officer explains the program and how to access the services of COAST.

Auxiliary Police Training

The target group for this two-hour seminar is the Police Service's Auxiliary Officers who provide support and assistance to the Police Service. A COAST police officer and a COAST mental health worker explain the program and provide information about how to access their services.

Lanark County LEAD[25] Team

This group, which is a joint police/mental health model, successfully provides services to several smaller municipal police agencies in southeastern Ontario including Smith Falls, Perth, and Cornwall as well as the Leeds-Grenville, Lennox and Addington, Renfrew County and Lanark County Ontario Provincial Police (OPP) detachments.[26] All partner agencies have signed off on a protocol, which includes the required police 'training:'

> *Training will be an important component of our ability to better serve the emotionally distressed person. Our partners are committed to assist each other in their training needs. Training will be constantly modified to enhance our ability to serve the emotionally distressed person.*
>
> *LEAD Team members will attend an initial 16 hours of training under instructional supervision of trained professionals. LEAD members will then take their training back to the rest of the team to further develop and renew our program.*

Consequently, LEAD in conjunction with their member agencies, which include EMS and the hospital district as well as police, deliver annual in-service training to police first responders, hospital staff, Mental Health Crisis Team (MHCT) members and Emergency Medical Services (EMS). Their 16-hour in-service module provides an overview of serious mental illness, including symptoms, behaviors, risk assessments, de-escalation strategies and improved recognition of persons at risk of mental health crisis through exposure to the basic dynamics of

[25] The acronym "LEAD' refers to the counties served by this program.

[26] The protocol document, which includes training, is available at http://www.pmhl.ca/webpages/reports/LEAD%20Team%20Protocol.doc

common types of mental illness and to the viewpoints and feelings of mental health consumers first hand. The training, which is designed and delivered to assist team members to better understand that mental illness is a disability/disorder and not a crime, includes skill development for de-escalating potentially volatile situations, gathering relevant history, assessing medical information and evaluating the individual's social support system.

Ontario Provincial Police (OPP)

The OPP has several levels of education and training for their personnel relative to persons with a mental illness:

New Police Officers – In addition to 'basic' training with regard to police/mental health at the Ontario Police College (OPC), new police officers complete additional police/mental health training at the OPP Academy. This includes scenario-based sessions dealing with persons who apparently have a mental illness.

In-Service Training – all uniform police officers must complete annual two-day 'block training,' which includes:

- mental illness and the *Mental Health Act*;
    - history of mental illness;
    - Forensic Services;
    - Court Support Services;
- psychosis and schizophrenia;
- de-escalation techniques;
- dementia;
- mood disorders;
- personality disorders;
- anxiety disorders; and
- scenario-based training involving aspects of mental illness and *Mental Health Act*.

Evaluation is by means of a pre-test/post-test questionnaire.

Crisis Negotiator Training –police crisis negotiators[27] must complete the Ministry accredited Crisis Negotiator's Course, which includes sessions on mental disorders and disturbed persons. A psychiatrist usually delivers this.

Emergency Response **–** police personnel responsible for Search and Rescue (SAR) functions must complete the Search Management Course, which includes modules that address the psychology of lost persons, including those with a possible mental illness.

[27] Sometimes, although inaccurately, called 'hostage negotiators.'

Communication Centre Operators/Supervisors – In the OPP, these positions are not staffed by police officers. These personnel must complete required training at the Ontario Police College that is regulated by Ministry Adequacy Standards. O. Reg. 3/99. This training includes modules on mental illness and disturbed persons.

Offender Transport Personnel – All Offender Transport Officers receive a two-hour presentation during their three-week basic training on mental illnesses and the *Mental Health Act*.

Security Officers – All security officers receive annual training, which includes *Mental Health Act* scenarios and regulations.

Prisoner Care – All personnel responsible for guarding prisoners must annually complete the Prisoner Care Workbook, which addresses aspects of suicide prevention and how it relates to mental illness.

Operational Field Briefings – These scenario-based training documents are distributed to front-line police officers and support staff on a monthly basis. Some Briefings address the *Mental Health Act* and mental illness.

Belleville Police

Belleville Police provides suicide prevention training (ASIST) to all police officers as well as police dispatchers. This is delivered by a combination of police officers and community partners. Belleville Police expand on this by way of a two-day in-service interactive workshop for community partners as well as for police officers and dispatchers. This workshop, which is also delivered by a combination of police officers and community partners, also focuses on suicide intervention. Evaluation consists of participant feedback. Given its interagency nature, the workshop is considered beneficial from the perspectives of building relationships.

Cornwall Police

The policy and procedures of the Cornwall Police with regard to Police/PMI contact include their commitment to 'training:'

> *To ensure that members of the Cornwall Community Police Service are given direction and training in order to assist them (2006/09/28) in providing a safe and professional response to complaints involving persons with mental illness, who are emotionally disturbed, or have a developmental disability. This Order is made pursuant to the Police Service Act Regulation 3/99 (Adequacy Regulation Guideline LE-013).*
>
> *All new agency personnel who may come into contact with members of the public shall receive comprehensive training to assist in identifying persons with mental illness.*

All agency personnel who may come into contact with the public shall receive yearly refresher training.

SASKATCHEWAN

Saskatchewan Police College

In addition to education and training relative to Police/PMI contact during basic training of new police officers at the Saskatchewan Police, during which they receive instruction on the meaning of mental illness as well as strategies and procedures for dealing with people with mental illness, 'in-service' learning is limited to that for new and soon-to-be municipal police supervisors (corporals and sergeants). This consists of a half-day presented by a mental health professional, a person with a mental illness and a police officer.

ORGANIZATIONS OTHER THAN POLICE SERVICES

CALEA (The Commission on Accreditation for Law Enforcement Agencies)

Although not a learning program, CALEA's standards are relevant and informative to the design and delivery of police/mental health learning. Even though CALEA[28] was established as a U.S. credentialing authority for police and "law enforcement" agencies, several Canadian police agencies[29] have now also been accredited and joined the CALEA network. As a result, these police agencies have police/mental health policies and practices that are deemed to meet the standards for CALEA accreditation.

The purpose of CALEA's Accreditation Programs is to improve the delivery of public safety services primarily by:

- maintaining a body of standards, developed by public safety practitioners, covering a wide range of up-to-date public safety initiatives;
- establishing and administering an accreditation process; and
- recognizing professional excellence.

Of relevance to this study is CALEA's standard for accreditation - Section 41.2.7 - which in part reads:

41.2.7 Mental Illness

The agency [must have] a written directive regarding the interaction of agency personnel with persons suspected of suffering from mental illness that addresses:

[28] Available at http://www.calea.org/Online/AboutCALEA/Commission.htm

[29] Brantford Police, ON (200 police officers); Camrose Police, AB (43 police officers); Edmonton Police, AB (1700 police officers); Lethbridge Police, AB (180 police officers); and Winnipeg Police, MB (1700 police officers).

a. guidelines for the recognition of persons suffering from mental illness;
b. procedures for accessing available community mental health resources;
c. specific guidelines for sworn officers to follow in dealing with persons they suspect are mentally ill during contacts on the street, as well as during interviews and interrogations;
d. documented entry level training of agency personnel; and
e. documented refresher training at least every three years.

Of particular interest is that CALEA suggests:

> *Agency directives should be developed in collaboration with mental health professionals, who can train or assist the agency with training. Training should include access to the court system and applicable case law. The training should be reviewed and/or updated at least every three years. This training may be addressed for officers in the required use of force training (standard 1.3.11) or annual training (standard 33.5.1) and for all personnel during shift training (standard 33.5.2), or other in-service program*.

In the absence of Canadian policing standards for what is appropriate to include in learning for Police/PMI interactions and the lack of evidence-based[30] curricula, CALEA's standard might be a useful starting place for Canadian police agencies that are not CALEA accredited.

Mental Health First Aid (MHFA)

MHFA was developed in 2001 by the Australian Centre for Mental Health Research. The purpose was to provide initial support for persons who might be developing a mental health problem or are experiencing a mental health crisis; its goal was to improve mental health literacy. Since then, the program has been developed, evaluated, disseminated and implemented internationally, including in England, Scotland and Canada. Australia and Scotland have incorporated MHFA into their national mental health strategies. In 2010, the Mental Health Commission of Canada (MHCC) assumed the responsibility for MHFA in Canada.[31] They advise, "anyone can benefit from Mental Health First Aid (MHFA)," including "families affected by mental health problems, teachers, health service providers, emergency workers, frontline workers who deal with the public, volunteers, human resources professionals, employers and community groups."

[30] In this document, 'evidence-based' refers to the implementation of programs and practices that are based on findings of scientifically conducted research.

[31] Available at http://www.mentalhealthfirstaid.ca

While currently, in Canada it seems that only the Royal Newfoundland Constabulary (RNC) and a few Alberta RCMP detachments use MHFA as a learning tool, MHFA has the potential to be useful for police personnel at all levels of experience as part of a comprehensive learning scheme. MHFA-Canada provides a 12-hour course delivered in four three-hour modules. According to their website, "participants will learn how to provide initial help to people who are showing signs of a mental health problem or experiencing a mental health crisis." MHFA also provides a course focused on youth with a mental illness that "is designed to be sensitive to the unique aspects of mental health problems in young people."[32] Although the intent of MHFA is not to teach people to be therapists, it does teach how to recognize the symptoms of mental health problems, how to provide initial help and how to guide a person to appropriate professional help (Bather, Fitzpatrick & Rutherford, 2008, p. 13).

Bather, Fitzpatrick and Rutherford (2008), in *36: The Police and Mental Health,* a publication of the Sainsbury Center for Mental Health in the U.K, pointed out:

> *the development of community and neighborhood policing creates an opportunity for the police to take a more active role in identifying people at risk of more serious offending who may benefit from mental health care and other services. Police officers need more and better training in mental health issues. Mental Health First Aid is a potentially useful approach to training that would fit the role of the police in dealing with mental health-related crises* (p.1).

They further succinctly explained,

> *However well [police] relate to mental health services, the police will always need some of the skills of a social worker, a parent and a communicator at the point of contact with an individual, before other services arrive to take over. These skills are not necessarily accrued through formal training targeted just at the police. They can best be acquired through joint agency training, for example training delivered to a group that spans the criminal justice care pathway – from police to probation and from court staff to prison officers, etc. It is also essential that service user[33] input is incorporated and that voluntary groups are engaged* (p.12).
>
> *Mental health awareness training for police officers is important, in order to promote non-stigmatizing front-line practice and an appropriate/proportionate response when engaging with members of*

[32] This is particularly relevant in Canada to Section 6 of the Youth Criminal Justice Act.

[33] In Canadian parlance, this refers to 'consumers' and 'consumer groups.' That is, persons living with a mental illness.

> *the public who have mental health problems. In this context, 'dangerousness' should not be viewed by the police as the default and should not be confused with 'vulnerability'* (p.13).

Bather, Fitzpatrick and Rutherford (2008) suggested that the training is also useful for other police personnel including "front desk workers [and] call centre workers" (p.13).

MHFA training has been comprehensively evaluated in Australia[34] using randomized controlled trials and a qualitative study. According to MHFA-Australia, it has been found to be effective at:

- improving the course participants' knowledge of mental disorders;
- reducing stigma; and
- increasing the amount of help provided to others.

Canadian Police Knowledge Network (CPKN)

CPKN currently offers three online learning programs related to mental illness. In collaboration with the Halifax Regional Mental Health Mobile Crisis Team (MHMCT)[35] and the Dalhousie University Department of Psychiatry, CPKN provides a two-hour online module – *Recognition of Emotionally Disturbed Persons*[36] It was designed to build confidence of first responders, including police officers as well as those from other disciplines such as emergency medical services, when dealing with EDPs. The module is used by several Canadian police agencies. Most of these are smaller police agencies that use it as stand-alone training, while some others use it as part of a blended program,[37] e.g. Halifax Regional Police. It is also used by some Canadian police agencies to satisfy the CALEA mental health training standard for their officers.

This module reviews the broad categories of Emotionally Disturbed Persons (EDPs) and provides recommended response strategies and approaches to deal with persons in crisis.

The learning objectives are to:

- be able to define mental illness;
- understand the percentage of population affected by mental illness;
- become aware of some provincial rules and regulations regarding the treatment of the mentally ill;
- define 'emotionally disturbed person' and describe the category system that can be used to help first responders identify the types of emotionally disturbed persons;

[34] Available at http://www.mhfa.com.au/evaluation.shtml.

[35] A joint response program of the Halifax Regional Police and local mental health services.

[36] Available at http://www.cpkn.ca/course_detail/emotionally_disturbed_e.html

[37] Blended learning, in this situation, is when a tool such as online learning is used in conjunction with other methods such as the conventional classroom and/or role-playing.

- describe the Head - Heart - Hands strategy and other tools useful to first responders in performing focused assessments and initiating response strategies for emotionally disturbed persons;
- recall the signs and symptoms of a Category R emotionally disturbed person and the recommended general response strategies for first responders;
- recall the signs and symptoms of a Category A emotionally disturbed person and the recommended general response strategies for first responders;
- recall the signs and symptoms of a Category ED emotionally disturbed person and the recommended general response strategies for first responders; and
- recall the signs and symptoms of a Category S emotionally disturbed person and the recommended general response strategies for first responders.

The Ontario Police Video Training Alliance[38] also recently produced a DVD – *Psychosis* – as a resource for training police personnel. This is available online through CPKN. Furthermore, CPKN has also launched a new program – *Excited Delirium Syndrome.* Given that some police interactions with PMI have been fatal and that in some cases 'excited delirium' has been cited as a factor, increased knowledge for police personnel of this phenomenon will be useful in the larger context of PMI interactions.

5.0: In-Service Police Education and Training (Learning) - International

Because the issue subject of this study is not unique to Canada, this study also included the U.S., Europe, in particular the U.K., and Australia.

UNITED STATES

Although it is apparent from the literature that either the CIT training and education model, or a modified CIT curriculum, are increasingly preferred in the U.S. and Canada, these are not the only models used. For instance, as Keram (2005) pointed out, in 2000 the California State Legislature required the Commission on Police Officer Standards and Training (POST)[39] to establish a training curriculum based on the premise that outcomes of Police/PMI contacts would improve with appropriate education/training of police officers. The legislation required:

- education/training to be long enough to be substantive but short enough so that police officers could attend without jeopardizing operational deployment; and
- that it should be suitable for officers in large urban areas as well as remote rural areas.

The result was an eight-hour program delivered by a police officer and a "mental health clinician" that embraced:

- concepts that emphasize de-stigmatization;
- the biological basis of mental illness;
- developmental disabilities;

[38] Available at www.opvta.com.
[39] Available at http://www.post.ca.gov/

- major mental illness;
- verbal intervention strategies;
- alternatives to lethal force;
- community and state resources suitable for referrals;
- state mental health legislation;
- the training inadequacies that had arisen in litigation against police agencies; and
- the inclusion of advocates of persons with a mental illness in program design (Keram, 2005, p. 48).

ENGLAND AND WALES

The IPCC (Independent Police Complaints Commission) conducted extensive research with regard to policing and persons with a mental illness and found that mental health is a factor in many of their investigations such as deaths in police custody, police shootings of vulnerable people, the management of 'missing persons' enquiries and the investigation of crime. They recommended police officers be adequately trained to recognize the symptoms of mental disorders and understand their powers under the *Mental Health Act* (Mind, 2007; IPCC, 2008). Subsequently several national organizations including the Association of Chief Police Officers (ACPO)[40] and the National Police Improvement Agency (NPIA)[41] responded. ACPO, for example, established a *Mental Health and Disability Committee.*

Despite what has debatably been a late start compared to the U.S. and Canada with regard to changing the way Police/PMI interactions are handled, the police and related authorities in England and Wales[42] are now making substantial progress. NPIA advised of two recent developments that are of particular interest to a Canadian audience. The first, and worthy of emulation in Canada, is the Association of Chief Police Officers (ACPO) Mental Health Strategy for England and Wales which was approved and released to the public in early March 2010. This strategy was developed in collaboration with several agencies including the U.K. Government's Department of Health as a means of demonstrating ACPO's commitment to the improvement of service provided by the police to PMI and people with a developmental disability.[43]

The Mental Health Strategy will help police to:

- reduce crime and victimization involving people with mental ill health or learning disabilities;[44]

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[40] The equivalent of the Canadian Association of Chiefs of Police (CACP). Available at http://www.acpo.police.uk/ . - http://www.cacp.ca/intro/

[41] Available at http://www.npia.police.uk/

[42] Police in Scotland and Northern Ireland operate somewhat independently, but similarly, to those in England and Wales.

[43] Available at http://www.acpo.police.uk/pressrelease.asp?PR_GUID={3F40855B-2EA1-4B10-8225-648D90FB08F5}

[44] The UK term 'learning disabilities' refers to what in Canada is known as 'developmental disabilities' or 'mental retardation.'

- reduce the use of police custody suites for Section 136 *Mental Health Act* detentions - in accordance with MHA Codes of Practice;
- increase the use of diversion and liaison schemes for people with mental ill health or learning disabilities so as to reduce offending, manage health needs and avoid future problems;
- make people experiencing mental ill health or learning disabilities feel more confident in reporting offences to the police and giving evidence;
- support and inform the development of force policies and procedures and bespoke Service Level Agreements;
- achieve better partnership working through improved relationships with statutory and voluntary social and healthcare agencies and a better understanding of each other's skills, knowledge and responsibilities; and
- reduce the number of public enquiries, IPCC investigations, and Coroners Inquests, and subsequent costly litigation, arising from poor responses by the police service to people with mental ill health or learning disabilities.

The Mental Health Strategy provides a framework for improved services to people with a mental illness that will result in:

- improved health-related response people with mental ill health or learning disabilities;
- improved criminal justice response to people with mental ill health or learning disabilities;
- more efficient use of police resources;
- improved partnership working; and
- improved information sharing.

The education and retraining necessary to operationalize the Strategy is under advanced development. However, it will include an e-learning module to be completed by "police officers." As explained by NPIA:

> *Mental health awareness training for police officers is crucial in order to promote non-stigmatizing frontline practice and an appropriate and proportionate response when engaging with members of the public who have mental ill health or learning disabilities. To this end, the NPIA is producing a number of national learning and development products to assist forces in delivering the National Mental Health Strategy. Through training, police officers will become more confident in responding to people experiencing mental ill health or who have a learning disability, and more adept at providing access to the appropriate services for this group of people*.

Learning outcomes will be the ability to:

- recognize signs/behaviors which may be indicative of mental ill health or learning disability;
- demonstrate an understanding of a range of learning disabilities to be able to effectively communicate with and support the individual;
- provide initial support to a person who may be experiencing one or more of a range of mental health issues;
- describe the role of the health and social care agencies in the context of police responses to people experiencing mental ill health or who have learning disabilities;
- define appropriate police responses and powers to intervene in situations involving mental ill health;
- identify police responses to victims and witnesses who may be experiencing a mental ill health issue or have a learning disability;
- identify appropriate police responses to suspects and offenders with mental ill health or have a learning disability; and
- manage information relating to people with mental ill health or learning disabilities in accordance with national guidance.

Dyfed Powys Police

Notwithstanding the more recent substantial progress of the NPIA and ACPO, in 2004 the Dyfed Powys Police in collaboration with a local mental health agency implemented a Community Police Development (CPD) program relative to Police/PMI interactions. The objectives were:

- to enhance the skills and knowledge of new (student) police officers about mental health issues through a better understanding of mental illness and treatments, relevant legal aspects and practical skills in communicating with people experiencing mental distress; and
- to ensure the most appropriate use of mental health resources in a way that best meets the needs of service users.

The six-day training program, intended for each intake of new police officers, operates four times a year. The program starts with a two-day course on Mental Health First Aid[45] followed by a four-day placement in the mental health service of their respective home policing jurisdiction. The program can be summarized as:

> *Service users are involved in the program planning and delivery and discuss their experiences of mental illness with the officers. There are opportunities to meet other members of the multidisciplinary team, and to spend time on the unit. The police engage in learning sessions about the prevalence of mental health problems, how these may*

[45] This program is now available in Canada through the Mental Health Commission of Canada. Refer to Page 28 for more information.

> *present and the most appropriate skills to use with people experiencing mental health distress.*
>
> *Other learning experiences include a short ward placement, role-playing essential communication skills, observing various treatment techniques and participating in a simulated voice hearing exercises. Officers also attend ward rounds, spend time with patients, visitors, staff, and patients` advocates; and have attended Mental Health Act Tribunals. They have also accompanied Crisis Resolution Teams (CRT) on home visits and the daily organization of Community Mental Health Teams (CMHTs) in Adult Mental Health, in areas that they would eventually police.*

Evaluation is essentially limited to student feedback at the conclusion of the six-day training. Some additional ongoing feedback is received and recorded from partners and the community. Over 300 police officers have completed the CPD over the past six years. Evidence to date has shown a reduction in the use of Section 136 of the *Mental Health Act* (Department of Health, 2008) and improved relationships between the police and mental health services.

Since the program was first established for new police officers, CPD training is now also delivered to custody sergeants, Community Support Officers, firearms officers, incident commanders in the Firearms Division and police crisis negotiators.[46]

AUSTRALIA

As described by Clifford (2010), the situation in Australia with respect to Police/PMI interactions is similar to that found in Canada, the U.S. and the U.K. As a consequence of the frequency of interactions overall and due to numerous situations during which a PMI was shot and killed by police as well as the resultant coronial inquests and public clamour, it was deemed necessary for police to be better prepared to resolve these situations with sensitivity and a reduction of the use of force, in particular, the use of lethal force.

Consequently, initiatives have been developed in Australia "to improve the capacity of police officers to respond effectively to mentally ill individuals, using less coercive methods of event resolution and interaction during mental health crisis interventions" (Clifford, 2010, p. 1). This is achieved across Australia through the introduction of specialist mental health training for police officers such as modified CIT models as well as other mental health/policing response models. These include the Queensland Police Service's Mental Health Intervention Project (a tri-agency partnership with Queensland Ambulance Service and Queensland Health) and the

[46] Sometimes referred to in common parlance as "hostage negotiators."

New South Wales (NSW) Police Force's Mental Health Intervention Team (MHIT) pilot program.[47]

The goals of the NSW project include:

- reduction of the risk of injury to police and mental health consumers when dealing with mental health related incidents;
- increased awareness of 'front-line' police of the risks involved in the interaction between police and mental health consumers;
- improved collaboration with other government and non-government agencies in the response to, and management of, mental health crisis incidents; and
- reduction of the time taken by police in the handover of mental health consumers into the health care system (NSW Police Force, 2008).

The New South Wales Police use a four-day course/seminar, similar to the CIT training model, to address frontline issues involving mental health and an understanding of the relevant mental health legislation. It is designed to develop the skills, knowledge and abilities of first responder police officers such as communication strategies, risk assessment and crisis intervention techniques so that they are able to effectively and efficiently manage incidents in which mental illness is an issue. Similar to the U.S. CIT model, police officers that successfully complete the training are awarded a distinctive MHIT badge to be worn on their uniforms.

Although there has been relatively little in the way of collaborative research between academe and police in Canada, there are a number of examples in Australia which have investigated police practices with regard to Police/PMI contact. One such evaluation project is currently underway at Charles Sturt University at the behest of the NSW Police (Clifford, 2010; NSW Police Force, 2008). Another is a research partnership between the Victoria State Police and Monash University – Project PrimeD (**P**olice **R**esponses to the **I**nterface with **Me**ntal **D**isorder). It is anticipated this will identify 'best practice' models of engagement that will inform necessary education and training (Monash University, 2008).

Starting in 2005, the Australian Federal Police contracted with O^2C Solutions, a private sector provider, to deliver two days of mental health in-service training to police first responders. This training, which includes a presentation by a person with a mental illness, addresses:

- prevalence of common mental disorders;
- suicide;
- depression;
- substance use disorders;
- anxiety disorders;
- schizophrenia;

[47] Additional information at http://www.mhca.org.au/MediaReleases/2007/NSW%20police%20trial%20welcome.pdf

- personality disorders; and
- mental health resources.

Based on evaluation by way of a pre-test/post-test questionnaire of participants in the training, O^2C concludes the training to be successful.

SECTION III: Important Factors Affecting the Design of Education/Training

6.0: Evidence-Based Design and Delivery of Learning

Ideally the design and delivery of learning will be more effective, as well as efficient, if it is based on the findings of rigorous evaluation and research. However, it is apparent from the literature that the evaluation of, and research relative to, Police/PMI education and training has not been comprehensive or widespread. An evaluative review by Tucker, Van Hasselt and Russell (2008) revealed methodological shortcomings in the extant research which

- prevent definitive conclusions regarding efficacy of police interventions (e.g., Memphis Crisis Model);
- have significant implications for the development of policy, standard operating procedures, and training of police personnel; and
- are potentially relevant to the safety of mentally ill persons who, as subjects or suspects, also become potential victims (p. 236).

Watson, Angell, Vidalon and Davis (2010) suggested that deficiencies are likely because the internal record keeping capabilities of police organizations are such that the empirical data required for evaluation are often not available (p. 362). Of the research that does exist, the majority has been focused on CIT education/training; yet, even that is arguably less than robust with respect to the general quality of studies, making its basis for designing 'evidence-based' learning programs questionable. In order to interpret the evaluation and research relative to CIT learning, as presented in the literature, it is first necessary to understand CIT.

Crisis Intervention Teams, which originated in 1988 when the Memphis Police developed CIT in collaboration with the National Alliance on Mental Illness (NAMI), are a police-based pre-booking approach.[48] This approach uses specially trained police officers to provide police first response to calls-for-service involving a person with mental illness and then to liaise, as necessary, with the mental health system (Borum, Williams, Deans, Steadman & Morrisey, 1998). Consistent with contemporary policing principles, CIT is entrenched in a problem-solving approach that aims to address the issues underlying the reason for the call-for-service rather than "simply incapacitating the individual or removing him or her from the community" (Thompson & Borum, 2006, p. 27). Although CIT guidelines suggest 25% of police personnel should be educated and trained, this might vary depending on local circumstances.

Although, when first established, the primary objective was to reduce police officer and citizen injuries, it has since evolved such that the diversion of PMI, when appropriate, from the criminal justice system is equally important. Watson, Morabito, Draine and Ottati (2008) opined that

[48] 'Pre-booking' in this context refers to an appropriate alternate resolution of the situation before an arrest is made and/or a charge laid for a breach of a statute. For example, referral of the PMI to a mental health agency rather than arresting that person.

> *the basic assumptions underlying CIT, are that training coupled with new policies for dispatch and patrol along with partnerships with mental health providers will increase linkage to mental health services for people with mental illness, reduce the use of force during encounters, and decrease arrests and injuries to both citizens and officers, remain untested against a rival hypothesis that the availability and ease of linkage to mental health treatment is the principal mechanism for effecting these outcomes* (p. 362).

The essential elements of CIT are:

- the forging of police partnerships with mental health community resources; and
- shifting the role of police and organizational priorities from the traditional policing model that dealt reluctantly with PMI to a service-oriented model (Watson et al., 2008, p. 361).

They also pointed out that the literature has failed to be specific about "which components of CIT are most important to which outcomes, or under what conditions CIT is likely to be most effective" (p. 362). This, of course, affects the sought-after evaluation.

Critical to the successful operationalization of CIT, and important to this study, is the 40-hour education/training program that has increasingly become the defacto 'industry standard' in the U.S. and is increasingly prevalent, although usually in a modified form, in Canada and the U.K. It is mental health professionals, police officers, mental health advocates and 'consumers' from the respective community who typically facilitate the learning, development and mastery of effective crisis intervention skills. Content usually includes education about the causes, signs, symptoms and treatment of mental illness; substance abuse; psychotropic medication; information on commitment criteria and procedures; consumer rights; personal stories from 'consumers' and family members; visits to mental health treatment providers and information about treatment modalities as well as training in communication and de-escalation skills. Notwithstanding scholars such as Vermette et al. (2005) found police officers did not value role-plays, Reuland (2004) found that CIT training often includes role-play exercises. Moreover, although not always popular with police personnel, Reuland and Schwarzfeld (2008) suggested that experiential learning techniques[49] such as:

- role-plays;
- site visits;
- consumer and family member testimonials; and
- simulation exercises (p. 18)

should be included in learning.

[49] Experiential learning refers to structured activities designed to enable students to learn through experience (Reuland & Schwarzfeld, 2008, p. 18).

While much literature is available that explains what constitutes a CIT program, there is little published research on its effectiveness (A. Watson, personal communication, January, 2010; Compton, Bahora, Watson & Oliva, 2008). Some examples of this are:

a. As the result of a wide literature review, Compton et al. (2008) found only twelve reports that described empirical CIT research (p. 49). They concluded that "the CIT model may be an effective component in connecting individuals with mental illness who came to the attention of police officers with appropriate psychiatric resources" (p. 52). Furthermore, "early research indicates that the training component of the CIT model may have a positive effect on officer's attitudes, beliefs and knowledge relevant to interactions with [persons with a mental illness]" (p. 52). They reported that, at a systems level, "CIT in comparison to other pre and post-diversion programs may have a lower arrest rate and lower associated criminal justice costs" (p. 52). They acknowledged, though, that considerably more research is necessary.

b. Compounding the dearth of research is the issue of the quality of studies as well as the nature and value of the research to the establishment of 'evidence-based' education and training. Even though, intuitively, it might seem that police education/training is necessary for improving interactions with people with mental illness, Watson et al. (2008) were clear that "the existing research does not focus on whether training and how much is sufficient for improving outcomes" (p. 363). They cautioned that while the CIT model might seem to be attractive, there is an absence of a "solid evidence base for CIT or other interventions to improve police intervention with mental illness" (p. 366).

c. With respect to the quality of studies to date, the literature includes several examples of pre-test/post test evaluation of CIT training. For instance, research by Compton, Esterberg, McGee, Kotwicki and Oliva (2006) based on a pre-test/post-test evaluation of 159 police officers,[50] indicated that

> *CIT programs may effectively correct myths, enhance understanding and support, and reduce reports consistent with holding stigmatizing attitudes in the context of officers' responding to calls involving individuals with schizophrenia. This may lead to improved rapport-building skills, de-escalation abilities, and communication between officers and family members; improved patient and officer safety; better outcomes for patients in terms of referrals to mental health services; and fewer incarcerations for minor*

[50] A control group was not used.

> *infractions related to externalizing behaviors of serious mental illnesses* (p. 1201).

d. Bahora, Hanafi, Chien and Compton (2008) came to a similar conclusion by means of a pre-test/post-test evaluation of 40 hours of CIT training. Their study involved 92 police officers.[51]

e. Steadman, Deane, Borum and Morrisey (2000) concluded that the deployment of CIT in Memphis was successful in that it had reduced the "arrest rate" resulting from Police/PMI contact as well as increasing referrals to mental health resources.

f. Hanafi, Bahora, Demir and Compton (2008) used thematic analysis of focus group discussions post-CIT training to evaluate its effectiveness. Their findings suggested officers experienced an increased knowledge of mental illness, increased patience when dealing with PMI, an increase in referrals and a decrease in criminal charges/arrests as well as improved application of learned skills. They determined that CIT training reduced the unpredictability of crisis interventions and reduced the risk of injury (p. 427). However, given the methodology, they cautioned about the generalisability of their findings. Their sample size was small and represented only one perspective of the interactions between police and PMI.

g. Evaluations of CIT, and thus the training and education to prepare police officers for CIT assignment, are impeded by the absence in many police agencies of the necessary "internal record keeping capabilities to determine if CIT has met its goals" (Watson et al., 2008, p. 362). Consequently, the available empirical data necessary to evaluate the effectiveness of CIT are limited. Overall, Watson et al. (2008) lamented, "the existing conceptualizations and research on CIT effectiveness have been narrow in scope and have lacked attention to broader contextual forces that may shape implementation and outcomes" (p. 362). Furthermore, they pointed out,

> *given the various methodological and resource constraints inherent in evaluating applied interventions, studies to date have not included control groups or modeled important organizational and contextual factors likely to influence CIT implementation and the outcomes of interest* (p. 362).

[51] This included a control group of 34 police officers.

Nevertheless, CIT is presumed to have wide-ranging effects and thus outcomes. From the perspective of Watson et al. (2008) CIT training

> *should enhance the skills of officers in encounters with those who have mental illness and their families, reduce the need for force by officers, reduce the incidence of violence in these encounters by persons with mental illness, reduce the incidence of arrest, reduce the incidence of injury to all parties involved, and increase access to crisis and other psychiatric treatment. These concepts can be readily measured. A more challenging question is how to study change in these concepts in a way that can assess the effectiveness of police interventions such as CIT. This challenge is apparent in outcomes such as reduced shootings. In a police agency, what does a change of one or two shootings over a year mean in terms of effectiveness of CIT? By more thoroughly conceptualizing these outcomes, we may find opportunities to develop evidence for components of the logic of CIT effectiveness, refine the model, and move toward testable outcome models* (p. 362).

Despite some reservations about evaluations to date, Watson et al. (2008) agreed "the current research supports CIT as a promising approach to improving police response to persons with mental illness" (p. 366). They suggested, that although research about the effectiveness of the CIT model is imperfect, there is growing evidence that it might reduce officer injuries, minimize the use-of-force, improve officer knowledge, improve the identification of mental illness, improve attitudes of police personnel and their confidence in responding to persons with mental illness, at least in the short term, as well as increase transports to emergency treatment facilities and referrals to mental health services. However, there was not, they cautioned, any "evidence to suggest that the other [desired] outcomes of CIT have been realized." In particular, it is not clear that the "implementation of CIT has decreased arrests of persons with mental illness" (p. 362).

Although CIT and the respective training are widespread in the US, this is not the only learning model used by police to work with PMI. Some other examples of research relative to police/mental health learning other than CIT training were:

a. McAfee and Musso (1995) found that Police/PMI education and training across 50 U.S. states had four common themes:
    - crisis intervention;

- interpersonal communication/human relations;
- mental illness/mental retardation;[52] and
- mental health referral agencies (p. 57).

They further found that dedicated Police/PMI 'training' time ranged from two hours to 55 hours. This is similar to the range identified across Canada (Cotton & Coleman, 2008). McAfee and Musso (1995) concluded, "the majority of states provide[d] training in the area of mental illness and in generic skills (e.g. crisis intervention) …. to avoid inappropriate confrontations" (pp. 61-62). They added,

> *new police officers must be sensitized to a recognition that many citizens have special needs, may not easily understand police commands, cannot understand the concepts of a police caution and may have difficulties communicating information about a crime* (p. 62).

b. A study by Vermette, Pinals and Applebaum (2005) of 150 U.S. police officers found that police officers identified dangerousness, suicide by cop, decreasing suicide risks, mental health law and the "potential liability for bad outcomes" as being the most important to police officers (p. 42). Vermette et al. (2005) acknowledged that given the limitations of their study, such as a small sample and potentially a bias of the study population, the findings should be treated with caution.

c. Janus, Bess, Cadden and Greenwald (1980) conducted a study of an "experimental" group of U.S. police officers. The police officers were first given 16 hours of instruction covering abnormal psychology as well as psychiatric description and syndromes. Janus et al. (1980) found positive attitudinal changes of police officers in the experimental group (compared with the control group who received no instruction) and concluded that they were brought about by intensive instruction (p. 228). They claimed this has "important implications for police work" (p. 229). Interestingly, though, despite the observed attitudinal changes of the experimental group, they still found evidence of police bias toward persons with a mental illness. However, although they were unable to determine whether it was due to fear or to ignorance, they were confident that "it could be minimized by education" (p. 229). While somewhat informative, the methodology of their study makes it difficult to evaluate whether education such as they delivered can lead to lasting positive changes of police behavior.

d. Research in the U.S. by Godschalx (1984) concluded that whereas a brief education seminar was effective in increasing knowledge of police officers, it was

[52] This is the language used in their paper.

ineffective in changing attitudes (p. 116). Their research was based on a small sample, however, and thus caution is necessary when applying these findings.

e. Based on a U.K. evaluation using pre and post questionnaires, Pinfold, Huxley, Thornicroft, Farmer, Toulmin and Graham (2003) concluded "short educational interventions can produce changes in participant's reported attitudes, and can leave police officers feeling more informed and more confident to support people in mental distress" (p. 337). This study also had limitations due to the absence of a control group and only a four-hour learning intervention. Thus, they concluded, the effect of the intervention was not strong (p. 339).

It is apparent that even though some literature is available with regard to education and training for Police/PMI interactions in general and for CIT in particular,[53] scholars, overall, have concerns about the methodology of the research (e.g. study quality), including the often-small sample sizes and the frequent use of pre-test/post-test methodology.[54]

7.0: Police Discretion and Ethical Decision-Making

Police are accorded substantial discretion in how they resolve calls-for-service to which they are dispatched as well as encounters they make directly during their course of business. However, the literature explains, the application of discretion is enhanced when a police officer has the appropriate knowledge, understanding and experience with which to make the best decisions from all available options. For instance, discretion is required when decisions such as whether to apprehend involuntarily or whether or not to make referrals to mental health agencies rather than arrest/charge for an offence. It also applies to situations that present an ethical dilemma.

The nature of incidents involving PMI often requires police officers to assess the situation quickly in order to apply the necessary considerable informed judgment. Menzies (1987, p. 430), cited by LaGrange (2003), concluded a police officer must

> *assess situationally the mental condition of their subjects and … develop sufficient linguistic skills for communicating such 'diagnoses' to superiors and other officials" – including mental health professionals, for whom they must provide a capsule summary of the incident and behavior that will support and justify the police response* (p. 94).

[53] On both counts, most of this is U.S. based.

[54] Pre and post-test evaluations identified in the literature review were conducted immediately before the learning event and soon after completion of the event. Thus, they are unable to account for the necessary mid to long-term behaviour change of police personnel. The value of the findings was compounded by the often-small sample sizes used for these evaluations.

In police encounters with PMI, discretion must be based on sound reasoning and unbiased good judgment in order to determine which of several options is most appropriate in resolving the situation. Police also must use discretion in making decisions and taking action that sometimes arise from ethical dilemmas. This has implications for police education and training, and even hiring, with regard to being prepared for such encounters. When police exercise discretion in interactions with PMI, arguably they have historically done so in order to:

- protect members of the public, and
- act in a paternalistic role to safeguard disabled individuals (Bloom & Schneider, 2006).

However, herein lies potential for an ethical dilemma.[55] If one reviews ethical guidelines and value statements of police agencies on the one hand, and those of mental health professionals on the other, some clear differences become evident. In a broad sense, the responsibility of police is to the collective community – society. For instance, many police agency mission statements from services across Canada include common phrases such as:[56]

- "…ensuring that police are accountable to the public;"
- "the fundamental duties of a police officer include serving the community;"
- "law enforcement official shall at all times … serve the community and protect all persons;" and
- "in partnership with the community … to secure a safe and secure environment."

Conversely, the duty of mental health professionals is to the 'individual.' Ethical priorities for mental health professionals[57] include such statements as (taken from various Codes of Ethics for physicians):

- "a physician shall act only in the patient's interest…;"
- "a physician owes his patients complete loyalty…;"
- "the health of my patient will be my first consideration…;" and
- "a physician shall regard responsibility to the patient as paramount."

These distinctions, which speak to the occupational cultures as well as the legal obligations of each group, not only have ramifications at the operational level but also for the design and delivery of learning to police/mental health groups. Each group has to understand the culture and occupational constraints of the other.

[55] For the purpose of this study, an ethical dilemma is a situation wherein moral precepts or ethical obligations conflict in such a way as to make any possible resolution to the dilemma morally intolerable. In other words, an ethical dilemma is a situation in which guiding moral principles cannot determine which course of action is right or wrong.

[56] Although these have been paraphrased, they reflect the messages found in many mission statements.

[57] In this instance, this refers to physicians and psychiatrists.

One situation that sometimes challenges decision-makers and can raise an ethical dilemma is the exercise of authority further to provincial mental health legislation. Canadian provinces and territories, pursuant to their respective mental health legislation, empower police by virtue of an order authorized by a judge or physician to apprehend a person who appears to be mentally disordered and has displayed indication of actual or potential harm to themselves or to others. In this situation, discretion is usually limited to transporting the person involuntarily to a facility for psychiatric assessment or persuading the person to accompany them voluntarily. In the absence of a pre-authorized order when police have reasonable and probable grounds that a person is a threat to others or to themselves due to a mental disorder, one of their options is to apprehend without an order when it is not practical to obtain one from a physician or a judge (Gray, Shone & Liddle, 2008). If that is their decision, they can then take the subject involuntarily to a "facility" for psychiatric examination or refer the person to a mental health professional.

The situation is similar when an offense has been committed by a PMI. Police have discretion about whether or not to arrest for the offence(s) in question. This is particularly so when the offence is minor. A police officer might decide to arrest and charge, to take no further action, to conclude the contact with a warning, or divert/refer that person to the mental health system. Lamb et al. (2002), albeit in a U.S. context, concluded that when police officers are not aware of appropriate referral alternatives they will likely arrest or charge the PMI. This is compounded in communities that have few psychiatric inpatient beds or have limited community mental health services. In such cases, it will seem to a police officer that psychiatric attention might be better accessed through the criminal justice system. The above issues have the sometimes problematic and unintentional effect of influencing police discretion whereby some PMI who commit minor crimes are inappropriately charged and thus enter the criminal justice system. Citing Patch and Arrigo (1999), Lamb et al. (2002) pointed out "some police officers are [found to be] more prone to arrest persons with mental illness, some make a more vigorous attempt to have these persons hospitalized, and a few tend simply to release them with no further disposition" (p. 1267).

While police officers have substantial discretion when resolving a police/PMI contact, Lamb et al. (2002) found that "there is considerable potential for the disposition to be influenced by police officers' personal attitudes or beliefs" (p. 1267). Furthermore, "in these instances," they shared, "the officers act freely and solve the problem in whichever way they deem appropriate on the basis of their particular attitudes toward, perceptions of, and assumptions about persons with a mental illness" (p. 1267).

Another ethical dilemma often encountered by both police and mental health professionals in the context of police/PMI encounters relates to decisions about what information to share between agencies. For example, at what point does the broader issue of public safety override consideration of individual privacy rights? When do exigent circumstances override the rights of a PMI with regard to self-determination? Yet another dilemma presents when a police officer encounters a person with an apparent mental illness who, in the police officer's

assessment, is in serious need of treatment/hospitalization. However, the person does not want to attend voluntarily and the circumstance does not meet involuntary apprehension criteria. The ethical dilemma is: what is the right thing to do?

The appropriate exercise of police discretion is a complex but critical issue. There is not always a clear disposition, in particular, resulting from a police/PMI interaction. However, and of relevance to this study, even though not all ethical dilemmas require police discretion in the traditional sense, they do, as with police discretion in general, require appropriate knowledge in order to make well-informed decisions. It is reasonable to conclude, and supported for example by Borum (2000), that the exercise of discretion will be improved with the necessary knowledge and competency level.

The resolution of police/PMI situations will be improved if the police personnel involved have been educated with regard to the options and consequences of the various options. With regard to the discretion required to resolve ethical dilemmas, significant time is required during formal learning to discuss the situations likely to be encountered, including both the practical options available and the rights of the PMI, and then work through them with experienced police and mental health personnel. The point is that the issue of discretion (decision-making) as well as the resolution of ethical dilemmas must be included in formal learning *and* be reinforced at the operational level. Based on this study, it does not appear this subject is adequately covered in current police/PMI learning.

8.0: The Target Group(s) for Police/Mental Health Learning

Determining the composition of the target audience – the participants – of the learning is of course a critical consideration. Traditionally, police/mental health training has only included police officers. However, it is clear from the literature that education and training relative to police/PMI interactions should not be limited to police officers. At a minimum, it should include all of those police personnel who have, or are likely to have, contact with PMI. Schwarzfeld, Reuland and Plotkin (2008),[58] were emphatic that:

> *all law enforcement personnel who respond to incidents in which an individual's mental illness appears to be a factor receive training to prepare for these encounters; those in specialized assignments receive more comprehensive training. Dispatchers, call takers, and other individuals in a support role receive training tailored to their needs* (p. 3).

[58] This is a useful and recommended source relative to the necessary learning for Police/PMI response and interactions.

Moreover, Reuland and Schwarzfeld (2008) were specific that supervisory and support personnel, such as midlevel managers and field-training officers[59] should also be trained so that they can assist police first responders and facilitate successful resolutions. To this can be added 'front desk' personnel as well as victim services workers and volunteers. The literature is also clear that the target group should include local mental health personnel who are, or will be, working in conjunction with police officers.

Although some Canadian in-service learning included police personnel other than police officers as participants, it appeared that many did not. Nevertheless, a few Canadian models are emerging that target a wider group of police personnel than only police first responders. In Canada, the best example is the Ontario Provincial Police (OPP). Police in England and Wales include police crisis negotiators, incident commanders and designated police firearms officers such as those assigned to Emergency Response Team (ERT) or Special Weapons and Tactics (SWAT).[60] These examples are wise and should be encouraged (Coleman & Cotton, 2010b).

9.0: Design and Delivery of Learning

Reuland and Schwarzfeld (2008)[61] pointed out that although learning is an essential element of police interactions with PMI, it "must do more than *inform* its participants—it must also *transform* them" (p. 2). Reuland and Schwarzfeld (2008) cautioned that mental health trainers/facilitators should be careful not to over-focus on specific diagnoses and thus lose the attention of police personnel. The intent of the learning should be such that police personnel understand and recognize symptoms so that they can better problem-solve and, when appropriate, make suitable referrals to community resources. Lamb et al. (2002) further warned that education and training alone are insufficient without changes to police academy curricula for the instruction of the use of lethal force as well as, at an operational level, the establishment of mobile crisis teams (p. 1269). That is, the resolution to improve police/PMI interactions goes beyond just education; a systems approach is necessary to achieve desired sustainable shifts of attitudes and thus shifts of occupational and organizational culture.

It is important to construct a learning program or a learning continuum to maximize knowledge exchange such that it not only imparts factual knowledge but also examines the process and outcomes of police/PMI interactions. As we have seen, the extant evaluation and research is only moderately helpful. Nevertheless, in the absence of comprehensive and conclusive evidence, it is reasonable to use such programs as CIT curricula as a foundation.

[59] Field Training Officers (FTOs) are experienced police officers who are assigned to coach new police officers and familiarize them with the variety of situations that police encounter. The coaching period varies between police agencies from a few days or weeks up to approximately six months.

[60] Police emergency response teams with the responsibility of resolving 'high risk' incidents involving potential violence have various names. Two of the more common are *Emergency Response Team* or *Special Weapons and Tactics.*

[61] Notwithstanding *Improving Responses to People with a Mental Illness: Strategies for Effective Law Enforcement Training* (Reuland & Schwarzfeld, 2008) is prepared for the U.S. environment, it also provides a good base for structuring Canadian learning for Police/PMI interactions.

Indeed, Watson et al. (2008) suggested that based on research to date, CIT is "a promising approach to improving police response to persons with a mental illness" (p. 366). Complementary to what is included in CIT curricula, Lamb et al. (2002) found, in a U.S. context, police officers wanted to know:

- how to recognize mental illness;
- how to deal with psychotic behavior;
- how to handle violence and potential violence;
- what to do when a person is suicidal;
- what community resources were available as well as how to gain access to them; and
- when to call a specialized mobile crisis team (p. 1269).

Lamb et al. (2002) concluded from their work that the education/training of police officers should, at a minimum, include:

- familiarization with the classification of mental disorders;
- learning and demonstrating how to manage persons with mental illness, including crisis intervention;
- how to gain access to meaningful resources less restrictive than hospitalization; and
- the laws pertaining to persons with mental illness, in particular the criteria specified for involuntary psychiatric evaluation and treatment (pp. 1269-1270).

In addition, they added, "considerable emphasis should be placed on de-escalating situations that might otherwise lead to the use of deadly force on persons with mental illness" (p. 1269). Based on their extensive experience in the police and mental health universe, Cotton and Coleman (2008) suggested that police officers should at least:

- know the signs and symptoms of mental illness to enable recognition of a person with a mental illness;
- know about mental illness to make an assessment about how much control the subject is likely to have of their behavior;
- know whether it is likely that the PMI is capable of understanding and responding to the directions given by police;
- know that the standard police procedures that would typically disarm a non-mentally ill person, stabilize the situation or lead to co-operation might have the opposite effect on a person who is experiencing a mental health crisis;
- know how to appropriately adjust decision-making regarding when to apprehend, when to arrest, when to divert, when to seek additional input;
- be comfortable with techniques for defusing and calming situations involving PMI;
- be able to reasonably accurately assess suicide risk;
- be familiar enough with mental health legislation to take appropriate action;

- be aware of mental health agencies and options, and who to call for consultation and/or assistance; and
- be aware of the stigma and bias with which most people — including both the public and the police — approach people with mental illnesses so police can adjust their own behavior accordingly (pp. 4-5).

Of significant note is that the literature suggested the design of learning, with respect to content and delivery, for police personnel should be in conjunction with mental health personnel. For instance, Reuland and Schwarzfeld (2008) recommended a "multidisciplinary planning committee to discuss all issues related to program planning, including training" (p. 4) as well as for determining the composition of the training cadre. Lamb et al. (2002) posited that the most effective learning process to prepare police officers for police/PMI contact is led by, and includes, both police and mental health professionals.

Furthermore, with regard to delivery, the literature is clear that it is important to include a person with a mental illness and or a family member. For instance, Pinfold et al. (2003), citing the work of Penn, Guynan, Daily, Spaulding, Garbin and Sullivan (1994); Angermeyer and Matschinger (1996) and Corrigan, Green, Lundin, Kubiak and Penn (2001), determined that "a consistently effective strategy for improving public understanding is … personal contact with someone with a mental health problem, providing a believable and positive experience to dispel myths and stereotypes through direct experiences" (p. 337). The result, they concluded, was that police officers felt better informed and had increased confidence for their future contacts with PMI (p. 343).

10.0: Selection of the 'Training' Cadre

The careful selection of those who facilitate learning can greatly impact success in shifting police personnel behaviour. Reuland and Schwarzfeld (2008) pointed out the necessity to identify and utilize police and mental health 'trainers' who have the required competencies, experience and credibility to 'teach' their colleagues. Trainers, they said, should have an understanding and appreciation of the goals of the respective police/mental health response model and have experience with PMI in the criminal justice system. Although it is important to include mental health professionals as well as persons with a mental illness and their families as 'trainers,' those who are selected should have a positive attitude toward the police. That is, they should "have moved beyond any negative outcomes of [past] encounters [with police]" (Reuland & Schwarzfeld, 2008, p. 12). Overall Reuland and Schwarzfeld (2008) maintained, the trainers, including police personnel, should "be prepared to contribute in a constructive, positive manner" (p. 12).

The need for qualified and credible trainers is critical to the effectiveness of not only 'training' but also the success of the service delivery model and, thus, the practices used to interact with PMI. For instance, as Reuland and Schwarzfeld (2008) clearly pointed out, it is important for police personnel to understand the occupational culture of the mental health profession and for mental health professionals to understand the occupational culture of police organizations.

It is, thus, essential that the messaging during learning also speaks to the commitment of police and mental health professionals to work together for the achievement of better outcomes for all parties, notwithstanding their different occupational cultures and sometimes different legislative and regulatory regimes.

11.0: Procedural Justice and a Client/Customer Focus

Canadian communities not only expect public sector services to be delivered with a client/customer focus but they expect to be treated fairly and with respect in accordance with principles of procedural justice. In their daily work, police officers are faced with a myriad of situations, most of which do not require law enforcement in the narrow sense.[62] However, many situations require a police officer to be adept at the de-escalation of conflicts, conflict resolution and mediation. All of these require the application of superior interpersonal communication skills and a service-oriented focus. Moreover, police officers often find themselves, according to Worden (1989), in situations of "ambiguity and uncertainty" (671). Egon Bittner (1990), a highly regarded policing scholar cited by LaGrange (2003), concluded a police officer must have

> *the ability to analyze situations, to determine which of several (potentially conflicting) procedures or rulings to apply, and be able to arrive at such determinations quickly – these qualities may require considerable knowledge, intelligence, and judgment, and these are the qualities that are believed to be most directly relevant to higher education* (p. 92).

Some situations, such as those in which the subject appears to have a mental illness, require superior judgment, the judicious use of discretion and a significant degree of "insight into the dynamics of human problems" (Worden, 1990, p. 589). For instance, Watson et al. (2010) pointed out that the literature suggests PMI who come into contact with the police are likely to be less distressed if they feel they are treated "fairly and in good faith" (p. 2). This is informative when designing and delivering education/training to police personnel.

While the designs and delivery of police education and training relative to police/PMI contacts vary, there is an increasing tendency, including in Canada, to use the CIT training program at least as a base. As discussed earlier, the important elements of this program, according to Watson et al. (2010), are the building of police relationships with mental health resources and the

> *shifting [of] police roles and organizational priorities from an exclusively traditional law-enforcement model, which reluctantly dealt with persons with a mental illness to a more service-oriented*

[62] Studies conducted in the U.S. and Britain have found that, depending on the jurisdiction, only 15-25% of a police officer's work was crime related and it might be closer to 7-10% when calls-for-service are more closely analyzed (Bayley, 1996: 40).

> *model that responds to mental illness as a community safety and public health concern* (p. 3).

A client/customer service orientation is a fundamental of contemporary (community) policing (Coleman, 2008). Key to such an approach is the conduct of police personnel. Watson et al. (2010) stated the literature is clear about the outcome of positive and respectful behavior by police. That is, when police exercise their authority in a procedurally just manner, the result is community cooperation and respect; on the other hand, disrespectful behavior of police officers reduces the likelihood of public cooperation (pp. 3-4). For instance, Watson et al. (2010) citing McCluskey (2003), pointed out that "persons with mental illness [who perceive] their treatment at the hands of police as respectful and dignified rather than coercive may be more likely to comply with officer requests" (p. 5). Watson et al. (2010), citing Lind & Tyler (1988), Tyler (1990) and Tyler & Lind (1992), concluded that key to satisfying procedural justice are:

- voice/participation—including having the opportunity to present one's own side of the dispute and be heard by the decision maker – the police officer(s);
- dignity—being treated with respect, politeness, and dignity and having the decision maker acknowledge the subject's rights; and
- trust that the authority - the police officer(s) - is concerned with the subject's welfare (p. 3).

The work of scholars such as Watson et al. (2010), Lind and Tyler (1988), Tyler (1990), Tyler and Lind (1992), Bittner (1990), McCluskey (2003) and Worden (1990) make it clear that treating people fairly and leaving them with a perception of fairness is important to the establishment of relationships and a better understanding of the situation by all parties. This decreases the probability of escalating a potentially volatile situation. Moreover, it not only improves the situation in-hand but also contributes to improved interactions in the future with the same person(s) and/or those with whom these persons have shared their experience.

Procedural justice (due process, fairness and equity) and a client/customer focus fit together; they are both fundamental principles of contemporary policing (Coleman, 2008). They both require the application of appropriate verbal communication skills, the building of rapport, an understanding of mental illness and the establishment of relationships. Procedural justice and a client/customer focus also mean it is necessary to have knowledge of community resources for purpose of referrals and to have a good understanding of the legislation within which police personnel must work. The desired outcome is that service 'recipients' feel they were well treated. This influences the design and delivery of police/mental health learning in that attention is required not only to ensure understanding of available resources and processes, but also to (1) understand the skills that build rapport and equip police personnel to de-escalate sometimes-volatile situations and (2) an appreciation of the rights of the PMI.

It is not clear from the analysis of responses to this study whether procedural justice and a client/customer focus receive sufficient attention in Canadian police/mental health learning.

Police agencies and their mental health partners, where applicable, are urged to ensure both are included as the overarching framework for police/mental health learning and pPolice/PMI interactions.

12.0: Behaviour and Attitudes of Police Personnel

Even though knowledge transfer is the key to learning, the primary goal of police/mental health learning should also be to change police officer behavior and attitudes regarding persons with mental illness (Price, 2005). As we have already seen, Reuland and Schwarzfeld (2008)[63] pointed out learning in preparation for police/PMI interactions "must do more than *inform* its participants—it must also *transform* them" (p. 2). Transformation as a goal of learning is vital, especially in work environments a) where some police personnel still view police/PMI interactions to be less than 'real' police work and b) where stigma and bias is still evident to at least some degree. Although somewhat obvious, Lamb et al. (2002) concluded police officers "have assumed the role of 'street-corner psychiatrist' by default" (p. 1266). They added, while speaking from a U.S. perspective, that many officers have accepted this role. Nevertheless, according to Husted, Charter and Perrou (1995) and Borum (2000), albeit also in U.S. contexts, they apparently have done so reluctantly and sometimes even with resentment. The ambivalence of Canadian police officers was noted in a study conducted by Trovato (2000).[64] He noted, "on the one hand, officers feel a profound obligation toward EDPs [emotionally disturbed persons] …. while, on the other hand, they feel the public needs protection from them" (p. 81).

Also in a Canadian context, a study of police attitudes by Cotton (2004) indicated ambivalence. It showed approximately 50% of officers were concerned that PMI take up more than their fair share of police resources. A considerable minority (38%) of police officers felt they would not be in the position of having to deal with mental illness-related issues if it were not for inadequate mental health services (Cotton, 2004). This would appear to suggest that some police officers did not consider dealing with PMI to be 'real' police work. On the other hand, the study by Cotton (2004) also showed that many, if not most, police officers respond to PMI situations appropriately and with sensitivity. Her study showed most police officers (80%) agreed that dealing with PMI is part of their role and supported the notion that they should be appropriately trained (Cotton, 2004). This is similar to findings reported in a U.S. context by Vermette et al. (2005). They found that police officers were interested in learning more about interacting with persons with a mental illness and that they considered it to be an integral aspect of community-policing. These findings are encouraging and consistent with the philosophical shift of many police agencies from a traditional reactive enforcement model to the collaborative and problem solving community-policing model (Price, 2005, p. 50).

[63] Notwithstanding *Improving Responses to People with a Mental Illness: Strategies for Effective Law Enforcement Training* (Reuland & Schwarzfeld, 2008) is prepared for the U.S. environment, it also provides a good base for structuring Canadian learning for Police/PMI interactions.

[64] Inspector Frank Trovato of the Toronto Police.

Borum (2000) cited research from the 1960s and 1970s that suggested negative attitudes and bias of police personnel towards people with a mental illness "was largely due to a lack of information" (p. 333). It has also been suggested that the inadequate preparation of police officers for this role has unnecessarily resulted "in the criminalization of persons with mental illness" (Lamb et al., 2002, p. 1267). The literature suggests education can be, at least, a partial solution to negative attitudes.

Watson and colleagues (2004b) studied whether a police officer's knowledge that a person has a mental illness influenced their perceptions, attitudes, and responses (p. 49). They found that police officers with such knowledge viewed PMI as being less responsible for their personal situation, more deserving of pity and more worthy of help, but at the same time, more dangerous than persons for whom no mental illness information was available. Of specific note, and important to the design of education and training, they found that a police officer's perception of a person to be violent was significantly increased when a police officer 'knew' that a person had schizophrenia. This is of concern since "if this heightened sense of risk causes officers to approach persons with mental illness more aggressively, [police officers] can escalate the situation and may evoke unnecessary violence" (Watson, Corrigan & Ottati, 2004b, p. 52). Borum (2000) was clear that training in verbal skills is critical to de-escalate real or perceived conflicts. Such training can not only improve the confidence of officers but also can reduce fear and decrease the risk of harm to officers and persons with mental illness (Price, 2005).

13.0: Stigma

From research by scholars such as Trovato (2000), Cotton (2004) and Vermette et al. (2005) as well as personal experience of the authors of this study, it is apparent that some police personnel do not consider responding to calls-for-service for PMI to be 'real' police work. Why does this perception continue? Is it possible that stigma associated with mental illness is a factor – a manifestation of prejudice? The literature suggests that it is.

In most societies, including in Canada, there remains a deep-seated stigma associated with mental illness, and often an unwillingness to recognize or deal with the resulting discrimination. The experience of the authors of this study as well as various colleagues in policing, the community and mental health agencies as well as consumers and families of PMI is that stigma with regard to mental illness, and thus with regard to persons with a mental illness, is present in police agencies. While this likely does not apply to all police personnel, its presence is such that it is a concern and thus must be a focus of education integrated throughout police learning curricula.

The literature suggests police education should include anti-stigma initiatives to challenge the attitudinal barriers of police personnel that lead to discriminatory actions. For instance, curricula designed to prepare police personnel for interactions with persons with a mental illness should include more than fleeting attention to an explanation of why it is that police interactions are important and, indeed, are an integral element of contemporary policing.

Educational models, thus, should include clear linkages between working with persons with a mental illness and the fundamental principles of contemporary policing.

Police personnel who are selected to educate and train their colleagues must have the experience and the required attitude. However, educators should also have credibility with their peers as being a 'real' police officer; that is, a police officer who has acted or is acting as a respected operational police officer. This is important in the police occupational culture, but is also important generally since it is human nature to more readily accept and act upon information if the person delivering the message is judged as credible. Furthermore, if the education, regardless of duration or instructor, does not address the issue of stigma and prejudice then the desired cultural shift toward accepting this as 'real' police work will be incomplete. An explanation, supported by the literature, is that police officers who do not consider police/PMI interactions to be 'real' police work might not have been sufficiently educated and trained to understand their role and to understand mental illness and the tactics for resolving interactions with PMI (Borum, 2000).

14.0: Mental Illness, Violence and the Use-of-Force

Although many in our communities, including many police personnel, associate mental illness with violence, the link between mental illness and violence is not well supported by evidence. For that reason, it is important to share accurate knowledge about the relationship between mental illness and violence in order to correct the stereotypical relationship perceived by many. Factual knowledge about the real relationship between mental illness and dangerousness is, therefore, critical when weighing the presenting situation and then applying discretion avoid escalation of often-delicate situations. While the vast majority of police/PMI interactions do not include violence or the need to use force, those that do inevitably become very public and/or often end tragically. The likelihood of violence increases when a person with a mental illness "has a co-occurring substance abuse disorder and/or is not taking his or her medication" (Reuland, Schwarzfeld & Draper, 2009, p. 6). Again, this is important information for police personnel.

Dupont and Cochrane (2000), Nicoletti (1990) and Fyfe (1989) expressed concerns about the use of force by police officers. They identified the necessity to modify use-of-force training to include a greater emphasis on the lower end of the use-of-force continuum **(Appendix A)**. That is, an emphasis on initial approach and contact – 'officer presence' – and verbal as well as non-verbal communication by the officer. In the specific context of police/PMI contacts, Dupont and Cochrane (2000) suggested this can be achieved by a better understanding of the symptoms and behaviors of a person with a mental illness and by learning and applying verbal communication and de-escalation techniques. The literature suggests this will reduce the incidence of the use of physical force.

In part, the literature tells us, this will be because stigma and a police officer's fear is reduced and, in part, because the officer has increased confidence based on the knowledge gained through education and training. Sources contacted during this study, including the Canadian

Mental Health Association (CMHA) and the Schizophrenia Society of Canada (SSC), supported this view. Use-of-force training must be more than technical skills such as those necessary to use a weapon and to ensure containment. It must also include a client focus and an emphasis on procedural justice.

The work of Compton, Demir, Broussard, McGriff, Morgan and Oliva (2009) also supported this. Their study of police use of force on people with schizophrenia compared a group of 48 CIT-trained police officers with 87 officers who were not CIT-trained. CIT training, as mentioned previously, includes an emphasis on understanding mental illness and the symptoms of mental illness as well as an emphasis on de-escalation techniques. By using a series of scenario-based vignettes that represented an escalating situation with a person with psychosis, they found that the CIT trained officers tended to rely more on "non-physical action" (p. 1) than non-CIT officers to resolve an escalating situation of psychosis. As a result, Compton, Demir, Broussard et al. (2009) determined CIT training might be an effective means of reducing the use-of-force in police/PMI encounters. Moreover, they concluded, their findings demonstrated a role for clinicians, advocates, and schizophrenia researchers in promoting social justice through partnerships with diverse social sectors such as the criminal justice systems (p. 8).

The authority for police officers to use force, pursuant to the *Criminal Code of Canada*, is one that is intended to be used 'when all else fails.' When police officers are trained in the use-of-force, most Canadian police agencies employ a use-of-force continuum model **(Appendix A)**. This is usually demonstrated graphically by means of concentric circles that represent a recommended continuum of action for a police officer from initial contact up to, and including, the use of lethal force. While discussing the utility of the graphic is outside the scope of this study, what is relevant is that the continuum starts at 'officer presence.' That is, the initial attitude and actions of a police officer upon arrival can affect whether or not the situation escalates and, thus, whether a more direct intervention such as voice or physical restraint is necessary.

Anecdotally, it has been apparent that at least some police officers spend insufficient time at the 'lower' end of the continuum – 'presence' and verbal communication – before escalating to a "higher" level – the use of physical force. While each situation faced by a police officer is potentially different, there are often common denominators across situations that require attention. For instance, one common denominator is the difficulty a police officer might have when trying to communicate with a person behaving in a 'bizarre' manner. In these situations, improved comprehension of the total circumstance and a good understanding of the appropriate communication skills could avoid escalation of the situation. This is supported by the work of Compton, Demir, Broussard et al. (2009) and Compton, Demir, Oliva et al. (2009).

Dupont and Cochrane[65] (2000), who instituted the first CIT program, have been critical of how police officers are taught the use-of-force, at least, in the U.S. context. Cited by Tucker et al. (2008), they pointed out

> *that the survival model of training regarding self-defense and firearms not only exceeds the real-life frequency of such an occurrence (particularly when compared to the rate of incidents involving mentally ill individuals in crisis) but also seems to inappropriately mold an officers' perception of dangerousness* (p. 245).

Over time, a 'rule' has emerged in policing that a police officer should not permit an armed offender to get closer than 21 feet without the officer drawing their handgun.[66] Dupont and Cochrane (2000), cited by Tucker et al. (2008), not only questioned the '21-foot rule,' but in particular, they questioned the validity of this rule when dealing with a person who might have a mental illness.

A study conducted by John Nicoletti (1990) with respect to the use-of-force by police in Colorado, and cited by Borum (2000), found that

> *elevated stress levels, lack of training, lack of control over the situation and lack of self confidence were the most frequently cited causes for over reaction, while behaviors mentioned most frequently as being desirable for de-escalation of force were communication and mediation skills, attitude, self defense, physical condition and anger control* (p. 335).

This is informative and applicable for not only the design and delivery of use-of-force training but also for Police/PMI education and training in general. James Fyfe (1989), a leading scholar with regard to the use-of-force, maintained that the notion deadly force encounters result from 'split-second' decisions is not supportable (Borum, 2000, p. 335). He suggested that excessive force could be reduced by focusing learning on what a police officer should do and say when approaching a situation rather than focusing training primarily on what the officer does during the encounter. Similarly, Watson et al. (2008) posited that the "lack of knowledge and skills on behalf of police officers can cause them to respond with undue force" (p. 360).

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[65] Major Cochrane was a long time Memphis police officer.

[66] For more than 20 years, a concept called the '21-foot rule' has been a core component in training officers to defend themselves against edged weapons such as knives and axes. Originating from research by Salt Lake City trainer Dennis Tueller and popularized by the *Street Survival Seminar* as well as the seminal instructional video *Surviving Edged Weapons*, the 'rule' states that in the time it takes the average officer to recognize a threat, draw their sidearm and fire 2 rounds at center mass of a person, an average person charging at the officer with a knife or other cutting or stabbing weapon can cover a distance of 21 feet. (http://www.policeone.com/edged-weapons/articles/102828-Edged-Weapon-Defense-Is-or-was-the-21-foot-rule-valid-Part-1/)

While police have various options including the use of firearms when exercising force, one of the options – the Conducted Energy Weapon (CEW),[67] which was intended and marketed as a 'less-than-lethal' use-of-force – has been controversial. In large part, this has been because of what has been viewed as its inappropriate and insufficiently regulated use. On several well-documented occasions in Canada, the use of the CEW has resulted in the death of subjects including several who have been persons with a mental illness. One such incident was the death in 2007 of a man at Vancouver Airport after police subdued him with a CEW.[68] This incident resulted in the Braidwood Commission on Conducted Energy Weapon Use (CEW).

In June 2009, the Commissioner released the first of two reports – *Restoring Public Confidence: Restricting the use of conducted energy weapons in British Columbia* – resulting from the work of the Inquiry (Restoring Public Confidence, 2009). The Commissioner made several recommendations of direct significance to this study:[69]

Emotionally disturbed people:

4. *I recommend that the Ministry of Public Safety and Solicitor General approve a curriculum for crisis intervention training comparable to that recommended by presenters at our public forums, and require:*
   - *That it be incorporated without delay in recruit training for officers of provincially regulated law enforcement agencies; and*
   - *That all currently serving officers of provincially regulated law enforcement agencies satisfactorily complete the training within a time frame established by the Ministry.*
5. *I recommend that officers of provincially regulated law enforcement agencies, when dealing with emotionally disturbed people, be required to use de-escalation and/or crisis intervention techniques before deploying a conducted energy weapon, unless they are satisfied, on reasonable grounds, that such techniques will not be effective in eliminating the risk of bodily harm*.

Subject self-harm

6. *I recommend that officers of provincially regulated law enforcement agencies be prohibited from deploying a conducted energy weapon in the case of subject self-harm unless:*
   - *the subject is causing bodily harm to himself or herself;*

[67] Often referred to as the 'Taser.'

[68] While it is not clear whether this man had a mental illness per se, it is apparent that he was behaviorally disturbed and emotionally distraught.

[69] The B.C. Government has established the Braidwood Implementation Committee to address recommendations of the Commission (Refer to Page 19).

- *or the officer is satisfied, on reasonable grounds, that the subject's behavior will imminently cause bodily harm to himself or herself* (Restoring Public Confidence, 2009, pp. 19-20).

Because of what has been viewed as the overall inappropriate use of CEWs by Canadian police, but in particular in situations where the subject has been a PMI, several support and advocacy groups for persons with a mental illness have formulated positions. In 2009, the Saskatchewan Canadian Mental Health Association (CMHA-Sask) shared their concerns, which are typical of advocate/support groups, with the Saskatchewan Government via the Saskatchewan Police Commission. Their position can be summarized as:

> *we see [two key areas] are lacking in police use of Tasers or firearms when it comes to relating to first responder interaction with those with mental health issues, namely training in diffusing a situation, and the placement of Tasers higher up on the "use of force" models of all police [agencies]* (Brief to the Saskatchewan Police Commission, 2009, p. 4).

CMHA-Sask pointed out that evidence-based best practices for effective crisis response should include:

- *the development of a core of carefully selected "first call" crisis response officers available 24 hours a day 7 days a week;*
- *a specialized system of dispatch;*
- *a comprehensive 40 hour integrated training for designated officers, dispatch, psychiatric liaison nurses, and other first responders (e.g. ambulance paramedics) with ongoing annual training;*
- *good information and information sharing systems;*
- *protocols for achieving collaboration with mental health services;*
- *development and ongoing support of community crisis response collaboration teams once these professionals are trained; and*
- *a means of evaluation and measuring outcomes* (Brief to the Saskatchewan Police Commission, 2009, p. 5).

They emphasized that the most appropriate and effective response when dealing with persons with apparent mental illness is the use of de-escalation techniques. These techniques, they added,

> *must be clearly understood and practiced as they are very different from the communication techniques generally used in police interventions. There must be a recognition and acceptance that these techniques take time and patience, and require listening skills and ways of interacting that may be out of sync with police practices of "command and contain" [which are] applicable in other police interventions. These are, however, the methods most likely to effectively resolve an incident involving a*

> *person with mental illness safely and with the best outcome for all involved* (Brief to the Saskatchewan Police Commission, 2009, p. 6).

Overall, they recommended that "best practices in crisis intervention training be incorporated in police recruit and ongoing training for all officers" (Brief to the Saskatchewan Police Commission, 2009, p. 9).

As was noted in the previous study (Part I) on academy-level training, six of the 13 police academies who provided basic-level training in Canada included some reference to issues related to mental illness in their basic use-of-force training. The questions posed to prospective respondents to the survey for this study did not include a direct question with respect to mental health interactions and the use of force. However, given the profile of such incidents and recommendations made by many Canadian coronial inquests, it is reasonable to assume that police agencies that had directly addressed this issue by amending use-of-force training would have responded accordingly. No responses were received. The exceptions, although only in part, were the OPP, the Vancouver Police and the Dyfed Powys Police in Wales. In the first instance, the OPP includes a module for police crisis negotiators. In the second instance, the Vancouver Police includes a module – *Police Tactical Considerations* – that includes a "review of tactical options for police officers."[70] In the third instance, Dyfed Powys Police includes modules for firearms officers and police crisis negotiators as well as incident commanders of the firearms division. Of note is that although none of these speak directly to inclusion of the police/PMI curricula in the use-of-force training, it is arguably progress compared to responses from other police agencies.

15.0: Post Secondary Education

While to some extent peripheral to the discussion of in-service learning, it is useful to look briefly at the literature with regard to post-secondary education of police personnel. Even though pre-hire post-secondary education is not, usually, a pre-requisite for hiring police officers in Canada, according to research a candidate with a higher level of education is likely, in many respects, to be better prepared to be a police officer. This includes how they will interact with persons with a mental illness.

LaGrange (2003) posited that contemporary policing in urban communities is "a demanding balancing act in a highly diverse and complex world, one in which officers must have a grasp of social forces, ethics" and the intricacies of applicable legislation (p. 91). Many scholars[71] cited by LaGrange (2003), found that university education results in an improved appreciation of the ethical issues inherent in policing and an improved understanding of the social and legal

[70] In police parlance, this usually includes situations up to and including the use of force.

[71] Such as Lynch, 1976; Tyre & Braunstein, 1992; Cascio & Real, 1976; Finckenauer, 1975; Gross, 1973; Reed, 1988; Roberg, 1978; Smith, Locke, & Fenster, 1970; Feldman & Newcomb, 1994; Carter & Sapp, 1989; Kappeler, Sapp, & Carter, 1992.

complexities. For example, studies have indicated that when police officers are less authoritarian due to greater sensitivity based upon increased knowledge and understanding, the result is that police agencies receive fewer citizen complaints about police conduct. Overall, she determined, the evidence shows that higher education results in "a more professional, less dogmatic approach to police-work" (p. 88). This is supported by a meta-analysis that concluded higher education "is a valid predictor" of superior police officer performance "except for commendations and injuries" (Aamondt, 2004, p. 51).

Notwithstanding some identified and important benefits, Rydberg and Terrill (2010) pointed out that "college education[72] will [not] provide amelioration of all intricacies of police discretion" (p. 114). However, of relevance to this study is a finding by Rydberg and Terrill (2010) that "college education … significantly reduced the likelihood of [the use-of-] force occurring" (p. 92). This is supported by findings of Aamondt (2004), McElvain and Kposowa (2008) as well as Terrill and Mastrofski (2002).

With regard to police/PMI interactions, LaGrange (2003) found in a U.S. police agency[73] that even though the encounters she studied were overall comparable in nature, the reported outcomes differed depending on the officers' level of education. More specifically, even when other factors were taken into consideration, university-educated officers were statistically more likely to make "psychiatric referrals" than their less educated colleagues (LaGrange, 2003, p. 106). Compared to the university-educated officers, those with lower levels of education were more likely to make an arrest as well as more likely to handle incidents informally.

While debate continues about the advantages of a university education to the work of a police officer, evidence overall seems to be positive. Police agencies or police academies that rely on mandatory education prior to hiring or admission to a police academy might want to ensure that the necessary behavioral and technical competencies related to working with PMI are included in the curricula of the mandatory or desired pre-hire post-secondary education. Considering the findings of research, pre-hire 'higher-level' education coupled with an appropriate behavioral competency profile would provide a good foundation on which to build the post-hire learning and development necessary for police/PMI encounters.

[72] Colleges in the US, unlike in Canada, are degree granting institutions.
[73] An agency with 156 patrol officers.

SECTION IV: RECOMMENDATIONS

Although some Canadian police agencies were found to be providing reasonably comprehensive Police/PMI education and training, many were not. Moreover, in some of the agencies that provided learning it was often only a relatively small proportion of personnel who received it. Furthermore, in many cases it was only police officers who received the learning instead of all personnel who encounter PMI. This is problematic. It is also problematic that several matters of arguably critical relevance such as ethical decision-making, police discretion, client-focused procedural justice and stigma with regard to mental illness in the police workplace were in most cases either not covered or did not appear to be adequately covered. Curiously, it is also appears to be the case that mental health issues in children and youth are largely missing in existing Police/PMI learning schemes. The present study did not specifically focus on this aspect of training, and it may well be that these issues are subsumed elsewhere in the education and training of police personnel. This is an area that merits further investigation. However, in the absence of evidence to the contrary, it would seem appropriate to consider including basic content regarding children and youth in general training related to mental illnesses, just as topics related to mental illnesses in the elderly population — such as the dementias — are generally included.

After considering the findings of the literature review and a review of learning programs in Canada, the United States, the United Kingdom and Australia, as well as directly communicating with a variety of police and mental health professionals, the following recommendations have been formulated to better prepare police personnel for contact with persons with a mental illness

Recommendation I: A Framework for Learning Design and Delivery

That notwithstanding the many important elements of police/mental health learning design and delivery, the overriding theme should be:

- a focus on anti-stigma education to challenge the attitudinal barriers that lead to discriminatory action; and
- ethical decision-making, human rights protection and social responsibility.

Recommendation II. The Learning Spectrum

That, at a minimum, the objectives of the ***Learning Spectrum***[74] necessary to prepare police personnel with regard to Police/PMI encounters are:

- *to understand:*
  - the importance of adherence to the fundamentals of contemporary policing, such as:
    - a client focus;

[74] The *Leaning Spectrum* is applicable to all Police/PMI learning including basic training and in-service training.

        - procedural justice;
        - relationship building;
        - an outcome focus; and
        - a multi-agency approach
    - the role of police personnel in encounters with PMI; and
    - the role of mental health professionals, family and community supports in police encounters with PMI, consistent with a systems approach.

- *to understand:*
    - the symptoms such as hallucinations, delusions, paranoia, thought disorder, mood disturbances, intellectual impairments, memory problems, dis-inhibition, behavioral disturbances and other signs and symptoms that may accompany major mental illnesses and related problems;
    - knowledge about mental illness sufficient to make an assessment about the influence that mental illness may be having on a person's behaviour and ability to comprehend and respond to a police officer's requests or instructions; and
    - the interplay between culture, race, gender and other person-specific characteristics that affect the experience of mental illness.

- *to understand:*
    - the importance of fostering of police/mental health agency relationships;
    - the importance of information sharing protocols between police and mental health agencies;
    - local mental health legislation sufficient to take appropriate action when necessary;
    - other relevant legislation including that which defines privacy rights and human rights;
    - the function of local mental health agencies and options and where/how to call for consultation and/or assistance and/or to make referral(s); and
    - organizational policies and procedures relevant to Police/PMI encounters.

- *to understand:*
    - how to use communication skills and de-escalation techniques for defusing and calming situations involving PMI;
    - how to determine whether it is likely that the PMI is capable of understanding and responding to the directions given by police; and
    - that the standard police procedures, which might typically disarm a non-mentally ill person, stabilize the situation or lead to co-operation, might have the opposite effect on a person experiencing a mental health crisis.

- *to understand:*
    - the relationship between mental illness and dangerousness; and

- be able to reasonably accurately assess suicide risk and how to contain the situation and/or when to intervene accordingly.

- *to understand:*
  - how to appropriately adjust decision-making regarding when to apprehend, when to arrest, when to divert/refer, when to seek additional input;
  - how to apply problem-solving in the police/mental health environment; and
  - how to apply ethical decision-making.

  Rationale:
  The above has been identified from the literature as well as from what are currently considered 'best practices.' The input of experienced police and mental health professionals who have worked extensively with PMI has also been incorporated. It is not intended as an exclusive list. It is worth noting that existing programs and research in this area are largely silent about issues of culture, race and gender as they relate to the experience of mental illness. However, we recommend inclusion of these issues in training as there are indeed cultural, racial and gender-related factors that are directly relevant to both the experience of mental illness, and to the manner in which mental health problems are best addressed. Furthermore, it is not suggested that all of the above learning objectives be given equal weight and, thus, time for each learning module. It is recommended, however, that all of the recommended ***Learning Spectrum*** *be covered across the modules of the delivery model outlined in Recommendation III.*

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Recommendation III: Learning Model - TEMPO

That Canadian police agencies be encouraged, in collaboration with their local mental health professionals, to adopt a multi-module learning delivery model - **T**raining and **E**ducation about **M**entalhealth for **P**olice **O**rganizations (**TEMPO**) - *to address the learning necessary to prepare police personnel for encounters with persons with a mental illness (PMI).*

TEMPO, in its entirety, is intended for all police personnel such as police officers, call-takers, dispatchers, front desk staff and victim services workers who have contact with persons with a mental illness. This model has built-in flexibility to take into account local circumstances and the target group(s). The recommended content of each module, which can be finalized by local subject matter experts, is based on the **Learning Spectrum.** The difference between each module is the target group and thus the emphasis placed on each subject area, the degree of detail and the amount of practical or experiential learning. Consequently, the duration of each module differs.

TEMPO 100:

The focus of learning at the **TEMPO 100** level is to ensure that police first responders have sufficient knowledge and skills to be able to manage the types of encounters that police personnel have on a regular basis and to know when to seek additional support or, when available, more skilled intervention.

TEMPO 101: Police Basic Training[75]

This four-day module for 'new police officers/police cadets' in police college/academy should cover the entire recommended ***Learning Spectrum***. Students will receive reinforcement of some of the subject matter during their recommended modified use-of-force training (Refer to **TEMPO 500**).

TEMPO 102: Lateral-Hire Police Officers

A two-day module for lateral-hire[76] police officers that might not have previously received the comprehensive police/mental health learning such as found in **TEMPO 101**. The purpose being that these officers will then be able to operate at the same level of understanding as those who received this education during standard basic training – **TEMPO 101**. This module should cover the entire recommended ***Learning Spectrum.***

TEMPO 103: Police Personnel/Support Staff

A one-day to two-day learning module for personnel such as Communication Centre operators/supervisors, 'front desk' personnel and victims services workers.

The module should cover the recommended ***Learning Spectrum***. The CPKN course *Recognition of Emotionally Disturbed Persons* or the Alberta Government course *Policing and Persons with Mental Illness* could also be useful as a learning tool within this module.

Given that the contact Communication Centre Operators/Supervisors usually have with PMI, their family and/or their friends as well as the public with respect to 'bizarre' behavior or identified mental illness is in large part by telephone, role-plays/simulations based on their work environments should be included in learning.

TEMPO 104: Offender Transport/Prisoner Care Personnel

A one-day module covering the learning objectives of the recommended ***Learning Spectrum*** for personnel responsible for prisoners. A particular emphasis should be placed on symptoms of mental illnesses and suicide awareness in the context of working with both young offenders and adult offenders.

[75] Also known as 'recruit' or 'cadet' training.

[76] Police officers who have already received acceptable basic training with another police agency and have experience as a police officer.

The CPKN course *Recognition of Emotionally Disturbed Persons* or the Alberta Government course *Policing and Persons with Mental Illness* could also be useful as a learning tool within this module.

TEMPO 200:

The **TEMPO 200** level learning assumes a pre-existing basic level of competence, and builds on it, but is still focused primarily on the first police responder. It includes both a refresher/review of previously taught information and an update on new developments.

TEMPO 201: Continuing Education (In-Service Training) for Police First Responders

A minimum one-day module for:

- police officers who did not receive the 'training' during their basic training;[77] and
- approximately every 3 years, each first responder police officer.

This module, which should cover the recommended ***Learning Spectrum***, could use a classroom format blended with an online resource such as the CPKN course *Recognition of Emotionally Disturbed Persons* or the Alberta Government course *Policing and Persons with Mental Illness*.

This module should also include a case study critique of recent Police/PMI encounters to enable discussion of the positives and the negatives of each situation. It might be appropriate to focus on specific subject matter that has not been well applied during past situations. Changes in legislation as well as changes in the operation of the local mental health system should also be reviewed.

Police agencies with specialist mental health response teams should include team members as facilitators.

TEMPO 202: Field Training Officers/Officer Coaches & newly promoted Supervisors

This two-day module is intended for two target groups:

- designated FTOs/Officer Coaches to enable them to re-enforce the learning their 'new' police officers experienced in basic training; and
- newly promoted supervisors (corporals/sergeants).[78]

With respect to FTOs/Officer Coaches, it is safe to assume in the early days of **TEMPO** implementation, that FTOs, who usually have approximately three years of service, will not have completed **TEMPO 101**. Thus, a minimum of two days is considered necessary for **TEMPO**

[77] These are the police officers, sometimes with many years of service, who completed basic police 'training' when the police college/academy provided either no 'training' with regard to police/mental health contacts or very little 'training' They will, however, have gained some 'on the job' learning. This module is intended to update them and bring them to the level of those who completed **TEMPO 101** in basic training.

[78] Many Canadian police agencies and police colleges currently do not provide 'training' with regard to Police/PMI encounters for newly promoted supervisors.

202. This could be reduced to a minimum of one day when the majority of new FTOs have completed **TEMPO 101** during their basic training.

Although this module ought to cover all of the recommended ***Learning Spectrum***, given the role of an FTO/Officer Coach/Supervisor, this module is intended to focus on what new police officers should experience as part of their workplace learning. Because this is an important phase in the socialization of new police officers, it is critical to emphasize subject matter such as understanding mental illness, police officer attitudes and stigma related to mental illness as well as de-escalation techniques.

TEMPO 300:

The 300 level learning is for police personnel in specialized assignments that require either a more in depth and higher level of skill and knowledge, or a more focused understanding compared to the first responder.

TEMPO 301: Specialized Assignments

A one-week (40 hour) learning module for personnel such as police crisis negotiators,[79] incident commanders, firearms/use-of-force instructors, ERT/SWAT commanders and search and rescue managers.

In addition to covering the recommended ***Learning Spectrum***, a case study(s) is recommended to enable learning from past situations. An emphasis should be placed on the value of working with mental health professionals to plan and implement tactics for a satisfactory resolution.

TEMPO 400:

The **TEMPO 400** level is learning for specialist officers who will be providing expert or consultative services with regard to Police/PMI contact.

TEMPO 401: Advanced learning for police personnel assigned to a joint police/mental health response team and/or for police specialists[80] with regard to mental health response.

This one-week (40 hour) intensive module should cover the entire recommended **Learning Spectrum.** The module should also include proficiency in reporting observations both verbally and in writing. It should also include, in addition to the 40-hour formal learning, workplace learning in the form of a minimum of four job-shadow shifts with their police/mental health response team, if their police agency has one, and a minimum of four job-shadow shifts with a mental health facility.

Personnel who successfully complete this module, as evidenced by an exam, will be awarded the **TEMPO** insignia to be worn on their uniform or, if working in 'plain clothes,' on their jacket.

[79] Sometimes, although inaccurately, called 'Hostage Negotiators.'

[80] This would be similar in concept to the CIT officers in the U.S.

TEMPO 500:

Learning Module to be inserted into Use-of-Force 'training'

It seems that police officers might be spending too little time and energy at the lower end of the use-of-force continuum before progressing to physical contact. This one-day module is intended to be integrated into what has traditionally been stand-alone use-of-force 'training.' It should complement and reinforce the learning of all other **TEMPO** modules. While it should cover the learning objectives of the recommended ***Learning Spectrum,*** particular emphasis, and thus reinforcement, should be placed on:

- an understanding of symptoms such as hallucinations, delusions, paranoia, thought disorder, mood disturbances, intellectual impairments, memory problems, dis-inhibition, behavioral disturbances and other signs and symptoms that may accompany major mental illnesses and related problems;
- knowing about mental illness sufficient to make an assessment about how much control the subject is likely to have of their behavior;
- communication skills and de-escalation techniques for defusing and calming situations involving PMI;
- whether it is likely that the PMI is capable of understanding and responding to the directions given by police;
- knowing that the standard police procedures, which might typically disarm a non-mentally ill person, stabilize the situation or lead to co-operation, might have the opposite effect on a person who experiencing a mental health crisis;
- having an understanding of the relationship between mental illness and dangerousness;
- being able to reasonably accurately assess suicide risk and know how to contain the situation and/or when to intervene accordingly;
- knowing how to apply problem-solving in the police/mental health environment; and
- knowing how to apply ethical decision-making and to exercise of police discretion.

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The following Recommendations IV to XV, although identified individually, are intended to apply to the design and delivery of all police/mental health learning including all modules of **TEMPO**. Although these recommendations are numbered for reference, they do not reflect an order of importance; they are all considered important in the context of a holistic learning regime.

Recommendation IV: Selection of Trainers/Facilitators

a. That trainers/facilitators have subject matter expertise and experience. Furthermore, for police personnel at least, they should have operational credibility with their peers.

Rationale:
While studies have shown that most police personnel accept contact with PMI as part of their role, there are still some who do not. Consequently, this cannot be overlooked during the education and training of police personnel. The police occupational culture is such that unless the trainer/facilitator is not only a subject matter expert but also has internal credibility with their peers the transfer of learning will be compromised. Credibility in the police culture is usually earned by operational achievements.

b. That police organizations with a structured police/PMI response model such as a joint response model or a model similar to CIT include members of those programs as trainers/facilitators of police/mental health learning.

Rationale:
Those police agencies with some form of specialized police/mental health response will likely have personnel with the necessary subject matter expertise and knowledge as well as likely have the important credibility. Using instructors from those work units will also help to build the important relationships required. This has good potential to increase the legitimacy of the response units from the perspective of the 'students.'

Recommendation V: Competency Based Human Resource Management

a. That police/mental health learning for police personnel in preparation for interactions with people with a mental illness is based on a competency profile congruent with bona fide occupational requirements (BFOR).

Rationale:
The behavioral competencies necessary to be effective during police/PMI interactions are not exclusive to those interactions. They are also critical to many aspects of policing and are usually included in other learning curricula whether as standalone subjects or integrated into learning such as that required for domestic dispute intervention and the interviewing of witnesses and victims. It is important that these behavioral competencies be reinforced and cross-referenced across learning programs.

b. That the development of technical and behavioral competencies with regard to verbal communication, interpersonal, conflict resolution/mediation and de-escalation techniques, ethical decision-making (all of which are required for successful Police/PMI contact) be integrated and reinforced across the police learning spectrum.

Rationale:
By using a competency-based human resource management model, the determination of relative competence and the identification of necessary learning will be facilitated. This will not only ensure consistency of learning and enable transformational learning but will also be defensible if challenged.

Recommendation VI: A Stigma-free Police Environment

a. That police leaders ensure they have contemporary and stigma-free policies in place to guide police/mental health education, training and operations.

   Rationale:
   The issue of stigma with regard to mental illness in police organizations is still a factor. This can be a difficult situation to rectify because it requires leadership from 'the top' of each police agency. Such leadership must ensure that language, policies, procedures, and practices as well as learning are revised to establish a stigma-free organizational environment. Engaging the respective chiefs of police associations and the Mental Health Commission of Canada (MHCC), which has pledged to address stigma relative to mental illness, is important to make progress. While including it in learning curricula is vital, it will make little difference until it is viewed as the organizational 'way to do business.'

b. That the provincial and national chiefs of police associations work with the Mental Health Commission of Canada as well as mental health organizations such as CMHA and SSC to develop a framework for an anti-stigma program for police personnel.

   Rationale:
   As the literature alludes to, and supported by anecdotal information and observations, a deep-seated stigma about metal illness is still prevalent in Canadian society as a whole. Not surprisingly, it is also prevalent, to at least some degree, in Canadian police agencies. This is a concern. The MHCC has identified the elimination of stigma as a primary goal of the Commission. It would be prudent for the various associations of chiefs of police, on behalf of their member police agencies, to work closely with the MHCC to develop an integrated program to address the important issue of stigma to be included in police education.

c. Further that the anti-stigma program must be a key component of police basic training and reinforced during subsequent in-service education and training.

   Rationale:
   Stigma and misunderstanding about mental illness, in particular with regard to potential violence, is present in our society as well as our police agencies.

Anecdotally that is apparent but also is supported by the literature. Such stigma and misunderstanding will continue to be a barrier to improving services provided for PMI and interactions with PMI until stigma is resolved or at least reduced. Thus, the inclusion of anti-stigma programs in ongoing learning is important to share the message, reinforce the message and to change attitudes and behaviors.

Recommendation VII: Attitudes of Police Personnel

a. That education for police personnel includes a focus on why and how interactions with people with a mental illness are 'real' police work.

Rationale:
The attitude of some police officers that responding to situations involving a PMI is not 'real' police work seems to at least partially be connected to stigma with regard to mental illness. However, it is also likely, as suggested by the literature, that it is linked to some police personnel not being fully aware of their roles in the contemporary policing world and/or do not fully understand mental illness.
It is important applicants for police employment view encounters with vulnerable persons such as PMI to be a legitimate function of contemporary policing. This should be a consideration when selecting suitable applicants for employment in a police agency. It is also important that this be made clear to police personnel during basic training and reinforced during the training of field training officers (FTO), supervisors, managers and soon to be supervisors/managers during in-service training. The attitude shift will require a cultural shift for some personnel and will take time to become noticeable. Hence, it will require frequent reinforcement in the workplace.

Recommendation VIII: Use-Of-Force Training

a. That the police use-of-force training be reviewed by police academies and police agencies to ensure that ample time is dedicated to understanding and learning how to resolve situations without the use-of-force; and further,

b. That, while recognizing the importance of technical competence with regard to use-of-force techniques, that all use-of-force training be modified to include and emphasize knowledge about mental illness and symptoms of mental illness, verbal communications, interpersonal skills and de-escalation techniques.

Rationale:
The literature suggests, and supported by anecdotal information and observations, that use-of-force training tends to focus primarily on technical aspects. Although current use-of-force training pays attention to officer safety, this safety can be enhanced by also paying attention to the lower end of the use-of-force continuum. This can be achieved by including a better understanding of

mental illness and by stressing the communications skills and de-escalation techniques necessary to defuse a potentially physical confrontation. The inclusion of such learning will likely avoid, in many situations, the need for physical force or at least reduce the level of force required.

Recommendation IX: The 'Right' Learning for the 'Right' Personnel

a. Notwithstanding the extant literature does not provide strong evidence with which to confidently implement 'evidence-based' learning, that police leaders, police policy analysts and police educators stay abreast of research and evaluation developments and modify policies and curricula accordingly.

   Rationale:
   The extant literature provides some indication of what will be effective learning. However, it is insufficient yet to identify effective learning models. It is important that as research and evaluation matures with regard to this subject that learning programs be modified by police agencies. Unfortunately, the literature tells us that police leaders, in general, have not embraced research relative to many aspects of policing and thus have made the necessary agencies.

b. That police organizations partner with universities and researchers to study the effect in the operational environment of the learning delivered with regard to police/PMI contact.

   Rationale:
   As the literature review clearly demonstrates, the research and evaluation of police/mental health learning as well as various police/mental health deployment models has not yet matured sufficiently to enable the identification of effective and transformational learning. Police agencies rarely have internal expertise and capacity to conduct the required research/evaluation but, in partnership with academic organizations, this could be achieved not only for the benefit of police and mental health service providers but also for the community in general.

Recommendation X: Design and Delivery of Police Learning

a. That police learning be designed and delivered by a combination of police and mental health professionals, mental health advocacy organizations and people living with a mental illness. Further, that those who participate in the design and delivery of learning are, whenever practical, from the local jurisdiction.

   Rationale:
   The purpose of formal learning in this context is two-fold. First, it is important to impart knowledge to the students, but second, it also, when properly structured, enhances the vital relationships between police, mental health agencies and PMI.

When local resources are involved, the learning is more likely to be up-to-date and relevant to that jurisdiction.

b. That all learning with regard to police policies, practices and police/PMI interactions be client focused and embrace the principles of procedural justice.
Rationale:
The contemporary literature is clear that police/PMI interactions should be client focused and adhere to the principles of procedural justice. Furthermore, a client focus and procedural justice are key fundamentals of contemporary policing.

c. That police agencies as well as police academies use a competency-based and problem-based learning (PBL) approach for police/PMI interactions similar to that used by the RCMP Academy.

Rationale:
Substantial literature exists to support a combined competency-based and a problem-based learning model. This not only ensures relevancy but also addresses the principles of adult learning. Competency based human resource management [CBHRM], and thus competency-based learning, is also non-discriminatory and defensible if challenged.

Recommendation XI: Provincial Policing Standards

a. That provincial police acts/regulations include provision for mandatory police/PMI 'training' for police personnel.

Rationale:
While not all provinces have regulations governing the standards required of policing, some such as Ontario do. Although police/PMI interactions are not the only sensitive issues that police encounter, it is significant from the perspective of public policy. It would thus be prudent for provinces to establish provincial policies and/or standards to ensure that each municipality and provincial police agency not only have an approved policy for police/PMI interactions but also meet a minimum standard for the relevant education and training both at police college and during in house in-service learning.

Recommendation XII: Policy and Standards

b. That police agencies develop the appropriate policies and procedures with regard to police/PMI contacts that in turn guide the required learning.

Rationale:
Strategic management and responsible business practices require appropriate policies and procedures to be in place to guide the implementation and management of operational as well as administrative/support programs.

Without such policies and procedures, it is not clear internally and externally how or if the education and training for a program is linked to the goals of the program. Learning that is not linked through policy and procedures to the program is at a risk of not delivering the correct education and learning to achieve the planned goals.

Recommendation XIII: Resource data-base/library

a. That, at a local level, police agencies maintain an up-to-date and readily accessible resource 'library.'

Rationale:
This can be either electronic or in hard copy but is intended to provide police personnel with 'quick' access to local community agencies that can provide direct assistance and advice if necessary such as referrals of PMI. Moreover, in addition to learning in a formal setting, such a library can be used for ongoing learning. It is important, therefore, to keep it up-to-date. The establishment of such a 'library' is also one of the recommendations of the Contemporary Policing Guidelines for Working with the Mental Health System (Cotton & Coleman, 2006).

Recommendation XIV: Integrated Learning

a. That police leaders as well as directors/managers of police colleges/academies integrate the development of behavioral competencies required for interactions with vulnerable persons, such as verbal communication, de-escalation techniques, patience and relationship building, across police learning programs.

Rationale:
The competencies required to manage, and if necessary de-escalate, police/PMI interactions are not unique to those interactions. Ensuring they are integrated across formal police learning enables reinforcement and development of these important competencies in all facets of policing and not only those directly related to Police/PMI interactions. This will improve overall proficiency and, thus, improve outcomes of interactions with PMI.

Recommendation XV: Consumer Driven Education

a. That as evidence becomes available about the experiences of PMI with police interactions and the advice that they might offer to police agencies, that this be integrated into learning curricula.

Rationale:
A research project sponsored by the Mental Health Commission of Canada is currently (Spring, 2010) underway in BC. An objective, amongst several, is to learn from PMI what they consider to be the necessary learning for police

personnel. Research such as this will bode well for all stakeholders involved in, or affected by, Police/PMI interactions.

b. That police agencies consult locally with consumer groups and advocates and integrate local issues, concerns and advice into the **TEMPO** model.

Rationale:
It is important that the model be appropriate to the Canadian criminal justice and mental health environments as well as the social environment in general. This is best achieved through local engagement. To do otherwise not only reduces the opportunity to build and reinforce relationships but also results in the loss of context-specific local knowledge about the prevailing social environment.

SECTION V: CONCLUSION

This study was occasioned by several factors. First, although police interactions with persons with a mental illness have long been a component of policing (Bittner, 1967), there is little doubt that police personnel now have more frequent contact with PMI than they did 20 or more years ago. Arguably, it has become an even more important function of policing than it used to be. Second, there is little doubt that the public now has much higher expectations than in the past about how police interact with PMI. Third, contemporary policing is a multifaceted and complex business. It is much more than simply enforcing the law. Contemporary policing requires problem-solving of social issues in consultation and collaboration with the parties involved and/or with other human service agencies. It is about quality of life issues. Included in this category are the calls-for-service with regard to people with a mental illness or people who appear to be emotionally disturbed.

The primary question posed by this study was: how can police organizations ensure police personnel are adequately prepared for interactions with people with a mental illness? The literature is unequivocal that education and training of police personnel in conjunction with mental health professionals and persons living with mental illness is critical to improved police/PMI interactions. Reuland and Schwarzfeld (2008) insisted that learning is not only necessary but must be transformational as opposed to only informational. While the literature reminds us the intent of education and training – learning – for police personnel is not to enable them to be diagnosticians, it is essential that they possess sufficient knowledge and skill to be able to resolve a police/PMI contact within a framework of procedural justice and a client/customer focus.

The literature is unequivocal that all police personnel whose work includes contact with PMI, and not just police officers, should be well prepared for their interactions with PMI. The reason proffered is simply that such preparation will lead to better outcomes all around, in particular, for PMI. The thrust of the literature is that preparation should include structured and focused learning. Even though the literature is not clear about what works and does not work with respect to improving outcomes, there are strong indications that de-escalation techniques based on understanding mental illnesses and their attendant symptoms as well as appropriate oral communication skills are just two of the key elements for success. Consequently, based on a) what is emerging in Canada as appropriate learning and b) the extant literature, which suggests preferred learning content and delivery, this study constructed a comprehensive and multilevel, yet flexible, model for police personnel based upon the identified *Learning Spectrum*—that is, the **TEMPO** model. The additional recommendations are complementary to that model. They are intended to encourage decision-makers to reflect the findings of this study in the design and delivery, and, thus, the outcomes of **TEMPO**.

The preparation for, and management of police/PMI interactions, and thus police/mental health learning, is an important and sensitive aspect of public policy. It is essential for all parties involved directly or indirectly to enable a resolution that is the optimum under the

prevailing circumstances. This is best achieved when police agencies establish client-focused policies and procedures and are proactive before a very public crisis 'forces' them to be reactive, often in response to an external review.

Although most police/PMI interactions are resolved without the use of force, some regrettably are not. In that regard, also based on the literature, the authors strongly recommend that the subject matter included in the *Learning Spectrum* be integrated into use-of-force training as well as other courses/seminars that address broader interpersonal and communication skills training. This will not only facilitate a better understanding, overall, of the issues but it will also reinforce learning and likely increase its successful application. By preparing police personnel as recommended in this study, police agencies and police oversight authorities can be proactive organizationally and better prepared operationally.

.Although this study has identified and proposed a structured, comprehensive and flexible formal learning model, it is important that police leaders and oversight authorities recognize that learning is not a one-time event. It is an ongoing process of renewal and reinforcement both through formal learning and through semi-structured workplace learning. Although the latter in many police organizations will require a shift of the corporate culture, this is possible when police agencies work collaboratively with each other, with mental health professionals, mental health advocates and persons with a mental illness as well as scholars. It is only through ongoing continuous evaluation and improvement that the outcomes of police/PMI interactions will be responsive to our dynamic environment. It is, thus, important that police leaders and social scientists ensure the learning provided to personnel is scientifically evaluated so that it can be validated or amended as necessary to maximize its effectiveness. All, of course, in the furtherance of optimizing police/PMI encounters.

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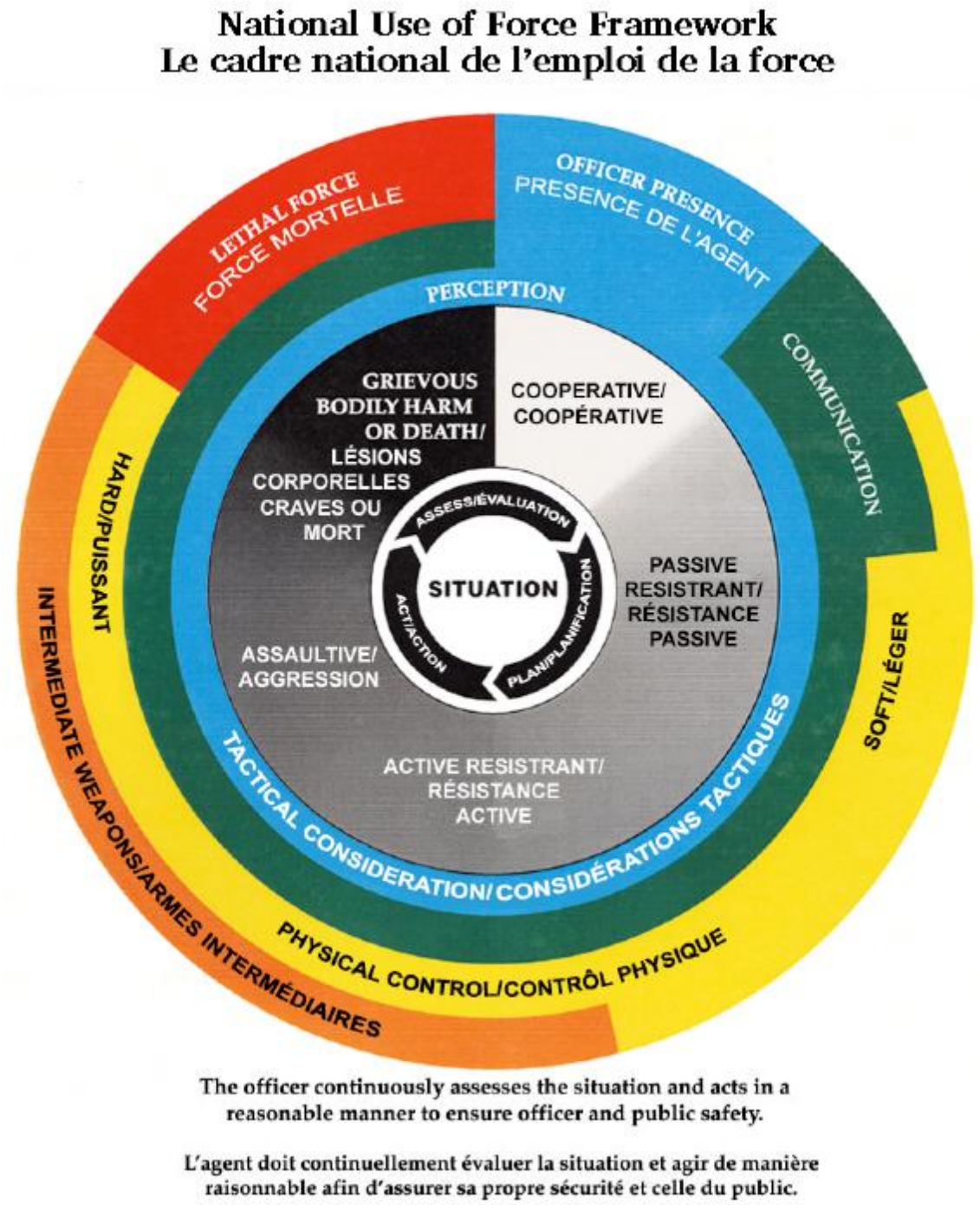
APPENDICES

Appendix A: Canadian National Use of Force Model



Source: Canadian Association of Chiefs of Police. (n.d.). Retrieved from http://www.cacp.ca/media/library/download/266/Useofforcemodel.pdf