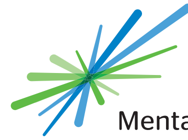

Contemporary Policing Guidelines for working with the Mental Health System 2015

Mental Health Commission of Canada

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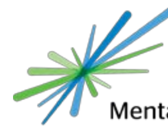

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PREFACE

While joint initiatives between police organizations and the mental health system have existed in Canada since about the mid-1960s, there has been a dramatic increase in the number of such programs since the mid-1990s. Around the same time, many police colleges/academies began to include mental health education as part of basic education and training. By the early-2000s, it was apparent that many police organizations were looking for guidance about how to establish or improve such programs and activities.

To that end, these guidelines were originally developed by a subcommittee of the Canadian Association of Chiefs of Police (CACP) in 2006 and later revised and adopted in 2008 by the Mental Health Commission of Canada (MHCC) through the Mental Health and the Law Advisory Committee. Subsequently, the MHCC has also developed and promulgated extensive guidelines for police education and training related to persons with mental illness (PMI) in its 2014 report, *TEMPO: Police Interactions — A report towards improving interactions between police and people living with mental health problems.*

These revised guidelines are an update and expansion of the 2008 version. They reflect changes in knowledge and practice over the past decade gleaned from formal research, as well as the experience of police, mental health practitioners and PMI.[1] New in these guidelines is *A Checklist for Assessing a Police Organization's Conformity with the 2015 Guidelines* **(Appendix A)**.

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[1] In order to ensure that all available and current information was considered in the development of the revised guidelines, sources consulted included:

- relevant published literature, policies and developments from Canadian and other jurisdictions, particularly the United Kingdom, United States and Australia;
- key police and mental health informants across Canada to reflect and include current practices;
- research findings that reflect firsthand experience and recommendations of people living with mental health problems and illnesses;
- *Changing Directions, Changing Lives: The Mental Health Strategy for Canada;* and
- all 500+ members of the Police/Mental Health Systems Listserv from across Canada working in this area.

INTRODUCTION

In recent years, the subject of police interactions with people who appear to be experiencing mental problems has continued to be an area of concern for police organizations. These police interactions occur in many forms, the most common of which include:

- apprehensions under provincial/territorial mental health acts, including community treatment orders (where applicable);
- requests for assistance (often from families and the public) in regard to people who appear to be experiencing mental health problems;
- arrests of people for an offence who appear to be experiencing mental problems;
- services to victims of crime who appear to be experiencing mental problems; and
- informal supports for people who appear to be experiencing mental health problems who are known to police.

Research is clear that PMI interact with police more often than other members of the community; furthermore, they are more likely to be subject to higher levels of police use of force than other people. Given this state of affairs, in recent decades, there has been a proliferation of programs and activities, usually originating with police services, with the intent that such interactions will result in optimal outcomes for all involved parties; for example, that police services are better prepared from an organizational standpoint to address issues related to these interactions.

The purpose of these guidelines is to provide police organizations with a framework for moving beyond a purely tactical approach to conceptualizing and organizing a strategic approach for PMI interactions.

Optimal outcomes for PMI are achieved when:

- PMI perceive they have been treated in accordance with the principles of procedural justice;
- cooperation and collaboration between police and PMI and, when appropriate, their families is encouraged and facilitated;
- linkages are improved with mental health agencies and systems;
- police personnel are knowledgeable and skilled in their interactions with PMI;
- programs, whether formal or informal, are appropriate to the age and situation of the PMI;[2]
- use of force, if necessary at all, is minimized;
- repeat encounters of PMI with the criminal justice system are minimized; and
- informed decisions to arrest/charge or not arrest/charge are made appropriately.

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[2] The use of *programs* in these guidelines includes formal and informal programs.

Effective and cooperative efforts toward working with the mental health system occur when:

- police have direct access to advice and input from mental health professionals;
- police organizations are actively involved in cooperative, collaborative and system-based planning of strategies and programs for PMI;
- police engage persons with a mental health problem for advice in the development of strategies and programs;
- police are able to readily divert or redirect calls involving PMI to mental health resources when police involvement is not required;
- mental health professionals and agencies have direct links to police organizations so that assistance can be requested and provided as needed;
- wait times at hospital emergency departments (EDs) and other transfer points is minimized for police personnel and PMI; and
- police organizations generate appropriate and sufficient data to plan and evaluate their programs.

For police organizations that do not yet have a mental health strategy, or are in the early stages of development, the guidelines provide a structure for developing such a strategy and necessary programs.

The guidelines do not recommend or endorse any single model of intervention, nor do they advocate for any particular type of program. Although designed as a framework, the guidelines might also be useful as a *gap analysis* tool **(refer to Appendix A)**.

A police organization might meet all the recommendations in the guidelines without any formal program or dedicated personnel or it might have a comprehensive mental health strategy with more than one formal program and many dedicated staff. The strategy and the program details should necessarily reflect the local needs, demographics, available mental health services and other local jurisdictional considerations.

MENTAL HEALTH STRATEGY FOR CANADA

Consistent with *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*,[3] police organizations, in collaboration with partners, should include activities related to the strategic directions found in *Changing Directions, Changing Lives*. For instance:

Strategic Direction 2.4

Reduce the over-representation of people living with mental health problems and illnesses in the criminal justice system and provide appropriate services, treatment and supports to those who are in the system.

Strategic Direction 2.4.5

Provide police, court and corrections workers with knowledge about mental health problems and illnesses, training in how to respond, and information about services available in their area.

[3] Refer to: http://strategy.mentalhealthcommission.ca/

THE STRATEGIC APPROACH TO INTERACTIONS WITH PERSONS WITH A MENTAL HEALTH PROBLEM

Since the evolving recognition over past years by Canadian police leaders of the necessity to ensure that their police organizations are prepared to address the issue of interactions with PMI, police organizations have implemented what is best described as standalone programs. That is, they have not been anchored in a strategy. However, most of these programs appear to have been successful in improving outcomes for all parties to these interactions.

Nevertheless, to advance, enhance and embed this important area of policing, it is appropriate for police leaders to employ a strategic approach, as opposed to the solely tactical/program approach of the past. A strategic approach will help ensure that outcomes of these interactions are in the best interest of the PMI and the community in general.

To achieve this, police organizations should, congruent with their respective organizational strategy, establish a mental health strategy for the police organization.[4] In much the same way as, for example, progressive police organizations establish an organized crime or youth strategy, their mental health strategy would make a clear declaration about the organization's position and intent, including the commitment of related resources, concerning all aspects of interactions, including proactive as well as reactive, with PMI.

A well-crafted mental health strategy, established in consultation and collaboration with the community and mental health stakeholders, will make the position and goal(s) of a police organization and its activities regarding interactions with PMI clear both externally (to the public) as well as internally (to fellow employees). That is, such a strategy is an important means of communicating commitment.

So what should be included in a mental health strategy? The foundation of a mental health and policing strategy should likely include a guiding principle such as the following:

> *That each police organization should foster an organizational culture in which people with mental illnesses are treated with respect, with the same attention paid to their rights as other members of society and, furthermore, that procedural justice principles are adhered to and criminalization is minimized.*

[4] Such a mental health strategy in the context of these guidelines should be focused on the interactions of police personnel with PMI they encounter while working with the public. Although outside the scope of these guidelines, a police mental health strategy could also include a second part — the important issue of mental wellness in the police workplace.

The strategy and its implementation must of course provide for clear outcome goals that are measurable. Far too often in the past, the goals of police programs related to mental health matters have been unclear. The measurement and determination of success has, thus, been challenging, if not in many cases impossible.

Without being prescriptive or limiting the scope of a police organization's mental health strategy regarding interactions with PMI, arguably, there are five fundamental measurable goals that should in some manner be reflected in a strategic approach:

1. Maximize the likelihood of positive outcomes of interactions with people with mental health problems;
2. Ensure the intended nature of police interactions with PMI reflects sensitivity to local issues, including demographics and cultural factors;
3. Ensure police personnel work effectively with the mental health system and other government and non-government agencies that might be involved with people affected by mental health problems;
4. Focus on the outcomes of proactive and reactive police activities related to interactions with PMI; and
5. Facilitate a change of organizational attitudes and culture with regard to mental health problems.

LEADERSHIP

As indicated in the sample guiding principle above, there is a key role to be played by police leaders to ensure that people with mental illnesses are treated respectfully and that the issue is addressed proactively. In particular, police leaders must work to change organizational culture in order to eliminate negative stereotypes and stigma about mental illness. According to the Consensus Project:[5]

> *The single most significant common denominator shared among communities that have successfully improved the criminal justice and mental health system's response to people with mental illness is that each started with some degree of cooperation between at least two key stakeholders — one from the criminal justice system and the other from the mental health system (Consensus Project report p. 14).*

Essential components of robust and positive leadership in this area should include:

- a strong and visible presence and support from a police chief and other senior management personnel that indicates the importance of this aspect of police work;
- through consultation and collaboration externally, as well as internally, the establishment of a mental health strategy for the police agency;
- strategic and operational leadership by personnel with a high level of operational credibility;
- adequate and secure funding for relevant programs/initiatives;
- no tolerance of stigmatizing language and attitudes within the organization, including in policies and procedures;
- organizational participation in public and high-profile activities such as Mental Health Awareness Week and those supporting mental health causes; and
- knowledge of the *Mental Health Strategy for Canada*, particularly those strategic directions related to involvement of PMI in the criminal justice system.

[5] Refer to: www.consensusproject.org

STIGMA-FREE ENVIRONMENT

Police organizations should identify and eliminate, with the assistance of external expertise if necessary, the sources of stigma and negative stereotypes within the organization in order to maximize the likelihood of positive outcomes with PMI.

Stigma can be defined as a devaluation of a person on the basis of a characteristic they possess, in this case, mental illness. One of the outcomes of this devaluation is discrimination. In policing, the outcomes of stigma about mental illness can include:

- undue assumptions about the relationship between violence and mental illness, resulting in increased use of force and higher arrest rates;
- impatience with the amount of time spent with PMI, thus decreasing the likelihood of using potentially time-consuming de-escalation techniques;
- failure to adhere to principles of procedural justice in interactions with PMI;
- use of demeaning language or manners in interactions with PMI;
- failure to take seriously complaints of victimization by PMI; and
- difficulty providing support to victims and witnesses who are PMI.

Stigma manifests in police organizations in a variety of ways, including:

- the absence of a formal mental health strategy;
- tolerance for the use of derogatory language when interacting with or talking about PMI;
- referring to Mental Health Act apprehensions as arrests rather than apprehensions;
- viewing or assessing interactions with PMI as less important, of lower status than other types of police work;
- embedding stereotypes and/or discriminatory language in internal documents, policies and procedures;
- the categorization within the police organizational structure of programs or personnel related to PMI under “Criminal Investigations” or “ Morality Unit” or “Vice Squad;”
- low prioritization of police service delivery related to PMI;
- direct or indirect release of mental health apprehensions in police records checks;
- assignment of low value or status to specialized mental health related positions, such as arbitrarily using them for employees who need accommodation rather than employees who possess the necessary competencies.

The elimination of stigma requires that these issues are promptly redressed.

EDUCATION AND KNOWLEDGE

Education is the foundation of any interaction between police personnel and a person with a mental illness. Education occurs at a variety of junctures, including the police academy, other learning for new employees and ongoing in-service education. A police organization should ensure that each employee receives an appropriate level of education and training, consistent with the provisions of the MHCC's *TEMPO* framework.[6]

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

- anti-stigma education to challenge the attitudinal barriers that lead to discriminatory action;
- de-escalation/defusing interactions with PMI by means of effective verbal and non-verbal communications; and
- ethical decision-making, human rights protection and social responsibility.

Such education should also include;

- factual knowledge about symptoms of mental illness;
- specific behavioural skills, including an emphasis on verbal communication and de-escalation strategies and tactics;
- a variety of levels and degrees of education specific to the individual employee's particular job assignment; and
- direct interactions with people with mental illnesses.

Education is not a single experience but occurs on an ongoing basis, both formally and through self-directed learning. In addition to formal courses, lectures and scenario training, police organizations should ensure that information sources (e.g. books, pamphlets, internet links and other resource materials) are available and accessible for employees to consult as-needed.

[6] These guidelines should be read in conjunction with the MHCC's TEMPO 2014 framework found at: http://www.mentalhealthcommission.ca/English/document/36596/tempo-police-interactions-report-towards-improving-interactions-between-police-and-pe

INCLUSION OF PEOPLE WITH MENTAL ILLNESSES

Research reports that one of the most powerful tools in changing attitudes and behaviours in regard to mental illness is direct experience with people with mental illnesses. Police organizations should ensure their personnel have the opportunity to meet with and talk to people with mental illnesses and problems in a variety of contexts. These might include:

- their inclusion in the design and delivery of all levels of mental health education and training;
- the creation of an advisory committee or task force comprised of PMI; and
- the creation of opportunities for police employees to visit mental health agencies and/or shadow mental health professionals.

CATEGORIES OF RESPONSE

Since police might interact with PMI in a variety of situations, a police organization should have systems in place that allow for a range of different types of responses, including but not limited to:

- primary and crisis response;
    - usually first-responders police alone, although sometimes in company with a mental health professional;
- secondary response;
    - often a joint police and mental health professional response to support first responders and/or subsequent follow up with a PMI;
- case management;
    - usually a multi-agency follow-up response to situations that involve PMI who have had repeated or frequent interactions with police; and
- support to witnesses and victims who are PMI.

While a single specific program, such as a joint mobile response or crisis intervention team approach, might be useful, it is generally not sufficient to meet all the needs of the police organization and to address the many and varied situations in which police and PMI interact. A triage process can help identify the type of response, and therefore which response model is merited in an individual situation. Even in police organizations with a dedicated team or individual providing specialized response to PMI, the majority of interactions with PMI, at least initially, involve interactions with first-responder police personnel.

COMMUNITY LINKAGES

In keeping with the preferred systems approach for maximizing the likelihood of positive outcomes of interactions with PMI, police organizations should form working alliances and relationships with their community partners. This might include:

- police participation on regional planning and liaison committees related to PMI;
- police membership on boards of agencies and associations related to mental illness, such as the Canadian Mental Health Association, the Schizophrenia Society, the Alzheimer Society, the Mood Disorders Association, the Autism Society or the Association for Community Living;
- formal memoranda of understanding or similar agreements with local mental health agencies to facilitate information exchange, and to provide access points to the mental health system for PMI other than the hospital ED;
- the establishment of a police advisory committee that includes a range of mental health agencies and organizations comprised of and/or representing PMI;
- an in-house advisory committee involving a variety of mental health services and PMI to assist in issue identification and planning; and
- the identification of a readily-identifiable person or work unit within the police organization with whom mental health agencies and professionals can communicate and consult as needed.

INITIAL CONTACT

A significant number of police interactions with PMI are initiated through a call for service or assistance (i.e. 911) and are managed by dispatchers, call takers, or crisis line personnel, as well as by direct contact with police front counter staff. There must be mechanisms in place to effectively respond at first contact, such as ensuring police personnel are sufficiently informed to respond quickly and appropriately. First contacts can be improved by:

- education and training for those who are likely to receive and dispatch calls so they are able to accurately identify PMI and relay helpful information to police responders;
- clear procedures, including decision tree models, for allocating and assigning responses to calls for service;
- a template or procedure for obtaining information about the PMI from the caller (whether they or someone else is the PMI) including the nature of the apparent mental health problem, the name of community supports, family and previously involved agencies;
- availability of mental health professionals for consultation with call takers;
- a method for accurately flagging and providing information about PMI within the police organization's record management system; and
- the ready availability of resource materials and mental health agency contact information.

MENTAL HEALTH CONSULTATION

A police organization should have in place a means to obtain mental health advice and consultation as necessary on a case-by-case basis. This might be accomplished through a variety of means including:

- availability of a joint mobile response team that includes mental health personnel;
- employment by the police organization of one or more mental health professionals who are available to provide advice and consultation as needed; and
- agreements with local mental health agencies to provide prompt case-by-case advice as required by telephone or in person.

The primary response level is the most common juncture at which serious injury and other high-profile and undesirable outcomes occur. Therefore, it is particularly important to have consultation available at the primary response level. While there is a tendency to refrain from including mental health practitioners at the point of first response for fear of harm to the practitioner, it should be borne in mind that much of this fear is rooted in stigma and an inaccurate perception of dangerousness. It is important to note that mental health practitioners typically interact with this clientele in a variety of environments (e.g. hospitals) on a full-time basis in their daily work and are effectively prepared to do so without incurring physical harm. Furthermore, they often have skills to defuse potentially volatile situations — skills that can be essential in some interactions with PMI and valuable to police personnel.

HOSPITAL EMERGENCY DEPARTMENT AGREEMENTS

A police organization should have in place an agreement with their hospital ED that will identify issues and solutions such as:

- how police and ED personnel will exchange information, such as standardized rating scales and symptom measures for communication purposes;
- how and at what point the ED staff will assume custody of PMI who are brought to the ED by police;
- for the purposes of minimizing the negative effect of stigma, the availability of a private space for PMI who are waiting with police;
- a formal agreement about processes to help minimize waiting times for PMI and the police who are accompanying them, which could include a prioritization of PMI when they come to the ED, advance notice to the ED of a PMI arrival; and a pre-screening mechanism and alternative destination to divert PMI who are not likely to be admitted or treated at the ED.

DATA-DRIVEN PLANNING AND EVALUATION

It is strongly recommended that police organizations generate, collect, and can access appropriate data to enable them to:

- determine local needs and plan responses and services accordingly; and
- evaluate programs and services.

In a systems approach, it is inherent to the improvement of interactions between police and PMI that unique needs and issues of individual communities — nature of the population, available mental health services and supports, local geography, history of interactions between police and PMI — inform the development of local programs and services. Relevant data might, therefore, include accurate data that facilitate the determination of:

- the overall frequency and nature of interactions between police and PMI;[7]
- the number and nature of previous interactions between police and individual PMIs;
- the actual program outcomes compared to the desired outcomes;
- the knowledge and skills of the organization's employees;
- the attitudes and expectations of the local community (e.g. survey or poll information); and
- the overall effectiveness of existing programs or dedicated activities.

[7] **Coding:** It is important that personnel responsible for coding calls-for-service and their eventual dispatch do so accurately. The initial call is usually recorded and coded based on often incomplete information. It is therefore important that after attendance and investigation, the initial coding for the situation be verified or changed as necessary. For example, a call for service might indicate a mental health problem but is subsequently found not to be or vice versa. The recoding ensures data are accurate for future analysis and planning.

EMPLOYMENT AND UTILIZATION OF APPROPRIATE PERSONNEL

Working with PMI is an essential aspect of police work, therefore police organizations should strive to ensure they hire and promote personnel who have positive attitudes toward PMI, previous experience with this population, and who appear to be able to develop the appropriate skill sets to interact constructively in situations involving PMI. This could be accomplished through a variety of means including:

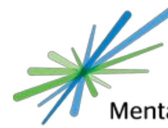
- active recruitment and hiring of new personnel who have prior experience working with PMI;
- assessment of attitudes and beliefs about PMI in the initial selection process;
- careful selection and assignment of personnel to specialized programs, such as a crisis intervention team or joint mobile response team; and
- consideration of attitudes related to PMI when selecting for other specialized positions, particularly coach officers, members of emergency response teams, crisis negotiators and use-of-force instructors.

TRANSPORTATION

Police organizations should ensure policies and procedures are in place to ensure that PMI who require transportation as the result of a police encounter (e.g. Mental Health Act apprehension) include provisions for returning them to their residence, point of origin or to another mental health agency when applicable.

SERVICES TO ALL AGE GROUPS

Police organizations should ensure they can provide appropriate services and supports to PMI of all ages, including adults, youth and seniors. For these latter groups, specialized mental health services might be subsumed under broader services for these age groups (i.e. within a youth strategy or within a vulnerable persons strategy) or they might be included in a broad-based mental health strategy and related response programs.



SUMMARY

The guidelines recognize that each jurisdiction has unique needs, challenges and resources. Thus, while mental health strategies might be similar across jurisdictions, their programs might vary to reflect local circumstances. These guidelines are not intended to be prescriptive. They have, however, been derived from the research literature and identified promising practices. As previously mentioned, the guidelines should be read in conjunction with *TEMPO: Police Interactions — A report towards improving interactions between police and people living with mental health*.

If you require advice or assistance in implementing all or part of the guidelines, please contact:

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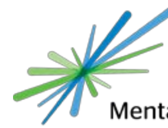
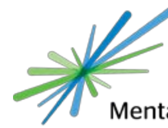


APPENDIX A

A Checklist for Assessing a Police Organization's Conformity with the 2015 Contemporary Policing Guidelines for Working with the Mental Health System

Do we have…	Does it include…	Does it reflect (i.e. policy or practice)
An organizational mental health strategy	• A strong statement of principle • Clear goals and objectives • An implementation plan • Suitable metrics for enabling evaluation of the strategy and programs	
Evidence of senior management leadership	• Visible senior management support • Secure and ongoing funding of initiatives	
Stigma-free environment	• Attention to language and terminology • Appropriate prioritization of programs and services related to PMI • Unbiased police record checks policy	
Education and knowledge	Comprehensive approach overall consistent with TEMPO recommendations including: • Comprehensive curriculum • Ongoing education • Focus on de-escalation strategies • Education for officers and support staff	
Inclusion of PMI	• Representation of PMI in education, program development and advisory capacities	

Comprehensive response programs/tactics	• Primary and crisis response • Secondary response • Case management • Support for victims and witnesses who are PMI	
Community connections	• Visible community partnerships • Advisory committees • Local contacts and consultants	
Initial contact	• Education and processes for dispatchers and call takers	
Mental health consultation	• Availability of case-by-case advice and consultation by mental health proesssionals	
Emergency department protocols	• MOUs with local hospital EDs • Methods for exchange of information	
Data and evaluation	• Methods of data collection consistent with overall goals • Analysis and planning tools utilizing data	
Personnel	• Ensuring the appropriate people are employed and selected for special assignments	
Transportation	• Ensuring the safe transport of PMI who are involved in police interactions	
All age groups	• Addressing the needs of youth • Addressing the needs of seniors	



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