

*Contemporary Policing Guidelines for Working with
the Mental Health System*

2015

Mental Health Commission of Canada

March, 2015

Prepared by:
Dorothy Cotton, Ph.D., C.Psych.
Terry Coleman, MOM, Ph.D.

Table of Contents

Preface	3
Introduction.....	3
Mental Health Strategy for Canada	5
The Strategic Approach to Interactions with Persons with a Mental Health Problems.....	5
Leadership.....	7
Stigma Free Environment:	7
Education and Knowledge	8
Inclusion of People with Mental Illnesses	9
Categories of Response.....	9
Community linkages	10
Initial Contact	10
Mental Health Consultation	11
Hospital Emergency Department Agreements	11
Data-driven Planning and Evaluation	12
Employment and Utilization of Appropriate Personnel	12
Transportation.....	13
Services to all Age Groups	13
Summary.....	13
Appendix A.....	14

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. It was also about that time many police colleges/academies began to include education in this regard as a part of the basic education and training of police officers. By the early-2000s, it was apparent that many police organizations were looking for guidance about how to establish or improve programs and activities in this area.

To that end, these Guidelines were originally developed by a subcommittee of CACP (the Canadian Association of Chiefs of Police) in 2006 and later revised and adopted by the Mental Health Commission of Canada (MHCC) through the Mental Health and the Law Advisory Committee (2008). Subsequently, the MHCC has also developed and promulgated extensive guidelines for police education and training related to 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 represent an updated and expanded version of the 2006 Guidelines; 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 people living with mental health problems and illnesses (PMI).¹ New in these Guidelines is *A Checklist for Assessing a Police Organization's Conformity with the 2015 Guidelines* (**Appendix A**).

Introduction

In recent years, the subject of police interactions with people who appear to be experiencing mental problems (PMI) 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 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

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

- relevant published literature, policies and developments from Canadian and other jurisdictions (in particular, the UK, US and Australia);
- key police and mental health informants across Canada to reflect and include current practices;
- research findings that reflect the 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 members (500+) of the Police/Mental Health Systems Listserv which includes both police and mental health practitioners from across Canada who work in this area.

- 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 do other members of the community; furthermore, they are more likely to be subjected 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 an overall structure for police organizations to use as a framework to assist in conceptualizing and organizing a strategic approach, as opposed to a purely tactical approach, to interactions with PMI.

Optimal outcomes for PMI are achieved when:

- PMI perceive that they have been treated in accordance with the principles of procedural justice;
- co-operation 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.

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 engage persons with a mental health problem to provide advice for development of strategies and consequent 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 linkages to police organizations so that assistance can be requested and provided as needed;
- wait time spent by police personnel and PMI at the hospital emergency departments and other transfer points is minimized;
- police organizations are actively involved in cooperative, collaborative and system-based planning of strategies and programs for PMI; and
- police organizations generate appropriate and sufficient data to plan and evaluate their programs.

² The use of *Programs* in these Guidelines includes formal as well as informal programs.

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

Notably, 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.

The Strategic Approach to Interactions with Persons with a Mental Health Problems

Since the evolving recognition over past years by Canadian police leaders of the necessity to ensure that their police organisations are prepared to address the issue of interactions with PMI, police organisations have implemented what can be 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 take a strategic approach, as opposed to only the tactical/program approach of the

³ Refer to: <http://strategy.mentalhealthcommission.ca/>

past; this will help to ensure that outcomes of these interactions are in the best interest of the PMI and the community in general.

To achieve this, police organisations should, congruent with their respective organisational strategy, establish a mental health strategy for the police organisation.⁴ In much the same way as, for example, progressive police organisations establish an *Organised Crime Strategy* or a *Youth Strategy*, their *Mental Health Strategy* would make a clear declaration about the organisation'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 organisation 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 for a police organisation? 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 organisational culture in which people with mental illnesses are treated with respect, with the same attention paid to their rights as are other members of society and, furthermore, that procedural justice principles are adhered to and criminalization is minimized.

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 organisation'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. to maximize the likelihood of positive outcomes of interactions with people with mental health problems;
2. to ensure that the intended nature of police interactions with PMI reflects sensitivity to local issues including demographics and cultural factors;
3. to ensure that 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 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.

4. to focus on the outcomes of proactive and reactive police activities related to interactions with PMI; and
5. to facilitate a change of organisational attitudes and culture with regard to mental health problems.

Leadership

As indicated in the *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 pro-actively. In particular, police leaders must work to change organisational culture such that negative stereotypes and stigma about mental illness are eliminated. According to the Consensus Project⁵

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 of the Chief of Police 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 activities supportive of mental health causes; and
- knowledge of the Mental Health Strategy for Canada and in particular, those strategic directions related to involvement of PMI in the criminal justice system.

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.

⁵ Refer to: www.consensusproject.org

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 rates of arrest;
- impatience with the amount of time spent with PMI, thus decreasing the likelihood of utilizing sometimes time-consuming de-escalation techniques;
- failure to adhere to principles of procedural justice in interactions with PMI;
- use of demeaning language or manner 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;
- the tolerance of the use of derogatory language when interacting with or talking about PMI;
- the reference to MHA apprehensions as arrests rather than apprehensions;
- the viewing or assessing of interactions with PMI as less important or of lower status than other types of police work;
- the embodiment of stereotypes and/or discriminatory language in internal documents such as policies and procedures;
- within the police organizational structure, the location of programs or personnel related to PMI under “Criminal Investigations” or “the Morality Unit” or “the Vice Squad;”
- the low prioritization of police service delivery related to PMI;
- the direct or indirect release of mental health apprehensions in police records checks;
- the 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 issues such as these 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 Mental Health Commission of Canada’s *TEMPO* framework.⁶

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>

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

- anti-stigma education to challenge the attitudinal barriers that lead to discriminatory action;
- the 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—such as books, pamphlets, internet links and other resource materials—are available for employees to consult on an as-needed basis.

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 that their personnel have the opportunity to meet with and talk to people with mental illnesses and other mental health 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 different types of situations, a police organization should have systems or programs in place that allow for a range of different types of responses including (but not limited to):

- primary and crisis response;
 - usually police first responders 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 that have had repeated or frequent interactions with police;
- support to witnesses and victims who are PMI.

While a single specific program—such as a joint mobile response team or a CIT 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 might be useful for determining which type of response and, thus, which response model is merited in an individual situation. Even in police organizations that have a team or individual that provides specialized response to PMI, it remains the case that the majority of interactions with PMI, at least initially, will 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 people with mental illnesses;
- 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 to the mental health system for PMI other than the hospital emergency department;
- 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

Given that a significant number of police interactions with PMI are initiated through a call-for-service or assistance, such as by 911, and are managed by dispatchers, call takers, or crisis line personnel as well as often by direct contact with police front counter staff, there needs to be mechanisms in place to maximize the likelihood that the first contact and response are appropriate; for example, responding

police personnel must have sufficient information to respond quickly and effectively. First contacts might be improved by:

- education and training for those who are likely to receive and direct such calls so that they are able to accurately identify PMI and relay helpful information to police responders;
- clear procedures including decision-tree-type models for allocating and assigning responses to calls for service;
- a template or procedure for obtaining information about the PMI from the caller (whether it is the PMI or someone else) including the nature of the apparent mental health problem, the name of community supports, families and previously involved agencies;
- the availability of consultation, for example, for call takers with mental health professionals;
- 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 which 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 that will provide prompt case-by-case advice as required by telephone or in person.

It is particularly important to have consultation available at the level of primary response since this is most often the juncture at which serious injury and other high profile and undesirable outcomes occur. While there is a tendency to refrain from including mental health practitioners at the point of first response for fear of harm to the mental health 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, in for example hospitals, typically interact with this clientele in a variety of environments on a full time basis in their daily work and are, thus, well prepared to do so with without incurring physical harm. Furthermore, they have often developed skills to defuse potentially volatile situations; skills that are from time to time essential in some interactions with PMI.

Hospital Emergency Department Agreements

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

- how police and ED personnel will exchange information, including use of 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 which will help to minimize waiting times for PMI and the police who are accompanying them; these might include a prioritization of PMI when they come to the ED, or a method for giving the ED advance notification that they will be arriving with a PMI; or other methods; and
- a pre-screening mechanism and an alternative mental health destination to minimize the likelihood that police will bring PMI to the ED 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 otherwise have access to appropriate data to allow them to:

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

In a systems approach, it is inherent to the improvement of interactions between police and PMI that each community will have unique needs and issues, in terms of the nature of the population, the available mental health services and supports, the local geographics, and the history of interactions between police and PMI; this will inevitably 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 present program outcomes compared to the desired outcomes;
- the knowledge and skills of the organization's employees;
- the attitudes and expectations of the local community such as might be determined by surveying the community; and
- the overall effectiveness of existing programs or dedicated activities.

Employment and Utilization of Appropriate Personnel

Given that working with PMI is an essential aspect of police work, police organizations should strive to ensure that they hire and promote personnel who have positive attitudes toward PMI, who might

⁷ **Coding:** It is important that personnel responsible for coding calls-for-service and their eventual disposition do so accurately. The initial call is usually recorded and coded based on often incomplete information. It is, therefore, important that post 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.

have 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 might 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 as part of 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 including, in particular, coach officers, members of emergency response teams, crisis negotiators and use-of-force instructors.

Transportation

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

Services to all Age Groups

Police organizations should ensure that they are able to provide appropriate services and supports to PMI in all age groups including not only adults but also youth and seniors. For these latter groups, specialized mental health services might be subsumed under broader services for these age groups (e.g. 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 recognise 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 problems* (often referred to as the TEMPO 2014 report).

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

Dr. Dorothy Cotton, Ph.D, C.Psych at dcotton@nintu.net

Dr. Terry Coleman, MOM, Ph.D at ColemanTG@Shaw.Ca

Appendix A

At A Glance:
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....	Which includes...	And which is reflected in (where, for example, in policy or practice)
An organizational mental health strategy	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Visibility of senior management support • Secure and ongoing funding of initiatives • Public and visible support 	
Stigma free environment	<ul style="list-style-type: none"> • Attention to language and terminology issues • Appropriate prioritization of programs and services related to PMI • Unbiased police record checks policy 	
Education and knowledge	<p>Comprehensive approach overall consistent with TEMPO recommendations including:</p> <ul style="list-style-type: none"> • Comprehensive curriculum • Ongoing education • Focus on de-escalation strategies • Education for officers and support staff 	
Inclusion of PMI	<ul style="list-style-type: none"> • Representation of PMI in education, program development and advisory capacities 	

Comprehensive response programs/tactics	<ul style="list-style-type: none"> • Primary and crisis response • Secondary response • Case management • Support for victims and witnesses who are PMI 	
Community linkages	<ul style="list-style-type: none"> • Visible community partnerships • Advisory committees • Local contacts and consultants 	
Initial contact	<ul style="list-style-type: none"> • Education and processes for dispatchers and call takers 	
Mental Health consultation	<ul style="list-style-type: none"> • Availability of case by case advice and consultation by MHPs 	
Emergency department Protocols	<ul style="list-style-type: none"> • MOUs with local hospital EDs • Methods for exchange of information 	
Data and evaluation	<ul style="list-style-type: none"> • Methods of data collection consistent with overall goals • Analysis and planning tools utilizing data 	
Personnel	<ul style="list-style-type: none"> • Ensuring the approach people are employed and selected for special assignments 	
Transportation	<ul style="list-style-type: none"> • Ensuring the safe transport of PMI who are involved in police interactions 	
All ages groups	<ul style="list-style-type: none"> • Addressing the needs of youth • Addressing the needs of seniors 	