Partnering with Police to Effectively De-escalate People in Mental Health Crisis

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How Big is 'Big'

- Generally accepted that about 20% of population is deemed to have a mental health 'problem' at any point in time
- Health Canada (2003) -2.6 M Canadians (10%) reported MI
- Incidence & prevalence studies have shown that ~ 2% of the population has a 'serious' mental disorder

What Else Has an Influence?

- Overall movement of de-institutionalization
  - Transferring governance of Provincial Psychiatric Hospitals to local Boards
  - Reducing overall inpatient bed capacity
  - Strategy to increase community resource capacity – e.g. crisis services; case mgmt
- Family as consistent informal care provider & advocate - expectations & limits
- Consumer movement → preserve right to make decisions and to increase autonomy
- But... most people with a mental illness never come into contact with the criminal justice system

What are the Implications?

- Police are seen to be playing an expanding role as first-line responders for people with mental illness
- More police time spent at the scene on what is viewed as a health resource problem
- Significant time spent waiting in hospital ED
- No consistent reporting framework for police when dealing with mental health
- No national standards for data collection across police forces → difficult to measure magnitude

Points of Intersection

- Public & Police:
  - 911 – general public & Hospital-generated calls
  - Police communications centre calls
  - Patrol occurrence (happen upon a scene)
  - MHA Forms process (Forms 1, 2, 9, 13 & 47)
- Public & Mental Health (for crisis intervention)
  - Crisis lines
  - Hospital ED / urgent care centres
- Police & Mental Health
  - Forms issued (physician or Hospital)
  - Mobile Crisis Teams
  - CIT Response Team
  - Hospital ED / PES

Differing Roles

- Police Mission:
  - The Ottawa Police Service is dedicated to the safety and security of our community…
- Health Provider Mission:
  - The Ottawa Hospital is a compassionate provider of patient-centred health services ..
- Opposite poles directed towards a common individual / issue
  - Containment vs. support
- Important to recognize & respect the different roles

A View From ‘Here’

- Defining mental illness vs. ‘Emotionally Disturbed Person’ (EDP)
  - Behaviour vs. a finding of mental illness
- Clinical view (DSM-IV-R) vs. police officer’s perception
  - Behaviours related to Axis I vs. Axis II Dx
  - Substance intoxication → SI; psychosis
  - Patrol officer vs. MHU Officer or trained CIT
  - Reports of behaviour by relatives / neighbours

Factors Influencing How Mental Health Providers Respond

- Mental Health Reform
  - Least intrusive
  - As close to home as possible
  - Accessible (crisis lines / mobile response)
- Response standards → Crisis Line, MCT, ED wait time
- Individual deemed to be competent to make treatment decisions
- Face-to-face enhances assessment components
- No authority for use of force or entry onto private property

Expanding Role of Police…

- Prior to 1960s – *Who did you call when someone had a mental disorder?*
- Change to the MHA "dangerousness"
- Advent of 911 service - Emergency response units
- Only agency authorized to use force
- "First point of contact" with mentally disordered in the community

Number of MHA Reports
(Patrol & MHU)

Ottawa Police Services	2005	2006	2007	2008
Sec 17 Apprehension	1001	973	1082	1132
MHA Form 1 & Form 2	480	526	514	524
Hosp Voluntary	1,048	1,015	993	985
MHA Other	1,635	1,808	1,879	1,969
MHA Elopement	93	97	95	60
MHA Hospital Voluntary	1,048	1,015	993	985
Total	**4,257**	**4,419**	**4,590**	**4,670***

* 9.7% increase over 2005

Factors Influencing How Police Respond

- Use of Force Standards - 1992
- Johathan Yeo Inquest – 1992
- Adequacy & Effectiveness Standards 1999
- Policing Standards Manual 2000
- MHA Amendments - 2000
- Coroner's Inquests – ongoing

Criminal Charge *vs.* MHA Apprehension

Jonathan Yeo Inquest - 1992

- 11 year history of attacks on women prior to killing Nina de Villiers
- After being charged with sexual assault and using a firearm, Yeo released on $3000 bail, with no weapons restrictions
- Abducted Nina in Burlington and killed her using the same rifle he had used in the previous assault for which he was out on bail. Also murdered Karen Marquis in New Brunswick before shooting & killing self
- 137 recommendations aimed at preventing such a tragedy from happening again.

Yeo Inquest *(con't)*

"…in some instances, the women [of previous attacks] were afraid to come forward, in other instances, their complaints were either not treated seriously enough by police or the courts, or Mr. Yeo had managed to convince authorities that he needed psychiatric treatment not criminal charges to be laid."

Yeo Inquest *(con't)*

Recommendation 48

a) Where a suspect has committed a violent crime, the officer shall not consider voluntary or involuntary hospitalization of the suspect as a substitute for criminal charges;

**Teaching position at OPC since & integrated into Adequacy Regulations (1999) & Policing Standard Manual (2000)

Mental Health Act
- *Revised 2000*

S. 17 Police Apprehension Authorities

- Reasonable grounds to believe the person has a mental disorder
  (acting or has acted in a '*disorderly manner*')
- Danger to self or others
- Danger to wait

Dangerous Medicine: Police Response to Persons with Mental Illness

- Be careful of what you ask for….
- Duty to protect life and property
- When talking doesn't work….use of force options
- Relinquish control of the situation

Challenges….for Police

- Lack of information → "cold calling"
- Long waits at hospital
- Police officer opinion vs. ED physician
- Confusion over roles "if there is a weapon"
- Called to attend at hospitals to assist with patients
- Never enough beds for assessment purposes/large remand population
- Insufficient community resources for referral
- Lack of resources "just give me a 1-800 #"
- Police unaware of HSJCC

General Guidelines: the *Do's*

- Collect as much information as possible from all possible sources *prior* to intervening
- Take your time & eliminate noise and distractions
- Ask permission first
- Treat with dignity and respect as you would want a family member treated
- Keep your distance and respect personal space
- Talk slowly and quietly -identify yourself and others and explain your intentions/actions - your actions should be slow and prior warning should be given if you intend on moving about the room

Do's…… (con't)

- Explain in a firm but gentle voice that you want to help. Ask how you can be of assistance
- Develop a sense of working together "help me to understand what is happening to you"
- If they are fearful of your equipment, take the time to explain that you carry the equipment to enable you to perform your job which is to protect the public and them
- Give choices whenever possible to allow some level of control

Don’ts

- Do not deceive - be honest and open in all situations - you are reality
- Do not challenge
- Do not tease or belittle
- Do not forget the emotions can be painful
- Do not violate personal space
- Do not forget to ask about medication

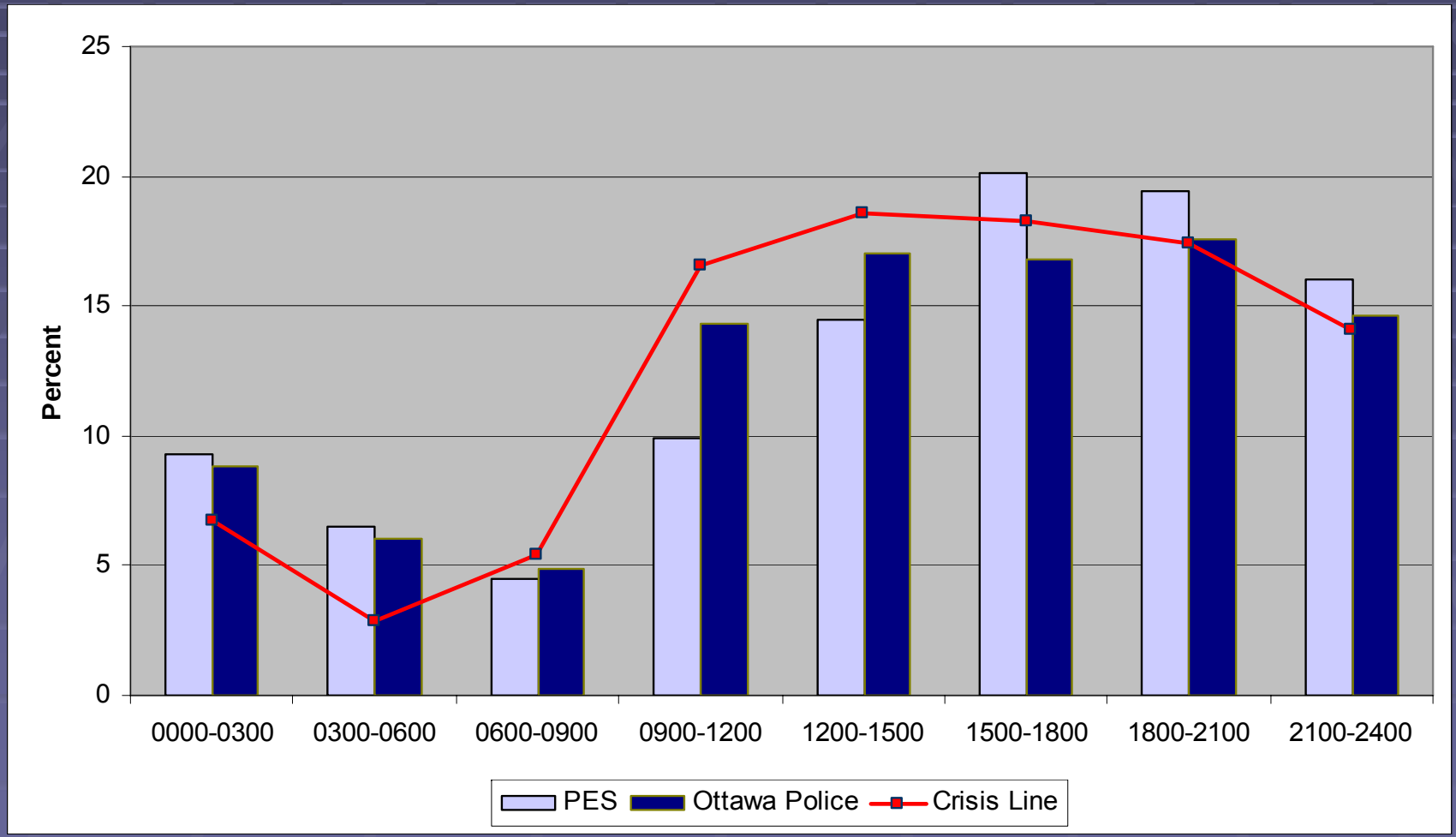
Models of Police Response…

- Enhanced generalist training
  ("Not Just Another Call…")
- Mobile Crisis Response (e.g. COAST, LEAD, HELP (mental health worker + police officer teams)
- Crisis Intervention Training (CIT)
- Direct consultation line to psychiatrist
- "*Psychiatrists in Blue*" CACP subcommittee

When to Join Forces

- Police response will always be 24/7
- Crisis lines *should* be in operation 24/7
- Evidence in literature that MCT response can be less than 24/7 → based on pattern of calls and resources available
- Generally, MCT response can be most effective from 0800 – 0100 hrs

Time of Day Analysis
Arrival Time in ED / Crisis Call



Crisis Line data from Champlain District

Pros & Cons of Different Models

- CIT:
  - CIT trained officer responds to all MH calls
  - Police only response → rapid deployment
  - Better suited to urban area
  - Must have significant proportion of officers trained to provide coverage
  - Requires large investment in training
  - More standard police response since large proportion of officers trained with same training material

Pros & Cons of Different Models

- LEAD
  - Based on CIT, but includes ED, EMS & diversion
  - Contingent of officers trained, but difficult to cover 24/7
  - Better suited to rural areas
  - Protocol development provides common understanding of roles & expectations of first responders (police, EMS) and health services (crisis teams, hospital ED) → divert from CJ

Pros & Cons of Different Models

- COAST / MCT
  - Joint police / MH response, so have advantage of both perspectives at scene → evaluation of mental status more fulsome
  - Can provide both safety & comprehensive evaluation → more effective hospital & criminal justice diversion
  - Link person to community services for f/u
  - Police service must be willing to designate contingent of officers to this function
  - Flexibility for nature of response

COAST / MCT - Issues

- Important to develop written MOU
  - Define scope of joint service, roles & expectations
  - Sets out all parameters, incl. resources dedicated
  - Establish dispute resolution mechanism
- Information sharing
  - Need to establish mechanism to share relevant information from police data or health record → can use 'agent of HIC' status in PHIPA
  - Police 'referral' to MCT mechanism to establish health record → consultation back to police is not deemed health information

Barriers / Pitfalls

- Mobile response
  - Police more action oriented; MH worker often wanting extensive consultation before acting
  - Define if response is a 'live' response or within 24 hours
- Entering a residence
  - Police have common law authority to enter a residence; MH worker's common law authority less clear → need policy to help guide actions
- Role blurring
  - Need to ensure that each team member respects expertise of other, but maintains own mandate → e.g. apprehension
  - Team-based partners vs. individual-based partners

Police in Emergency Dept.

- Issue of medical ‘clearance’ common in many hospitals → apprehended person will need to be registered, triaged & assessed
  - ED wait time strategy may have some influence → most apprehended individuals in CTAS 3 & 4
  - Should apprehended persons have priority within CTAS level?
  - Mechanism to fast-track known individuals with no indications of medical issue

Police in Emergency Dept.

- Design characteristics → is there an area to allow police to hold apprehended individual away from main waiting room
  - Long wait time may increase stress level and result in need for code white response
  - Issue of privacy and dignity
- Under s. 33 of MHA, police officer must remain and retain custody of person until hospital takes custody and releases police

Establishing effective communication with mental health staff and crisis team

Give the ED Physician Grounds to Form

- Thorough documentation including verbatim comments and changes in pattern of behaviours – anything that might reveal that the person may be preparing to act out on their beliefs/delusions, etc.
- Bring in all records including previous convictions, charges, calls to residence, and any other statements
- Bring suicide notes if found (electronic notes present extra challenge)
- Bring witnesses including family/neighbours etc.
- Use EDP template if available → consistent content & format for relevant information

Documentation / Records

Reports should include:

- ✓ Description of the behaviour or conversation, i.e. “talking to self”, “plans to take overdose of (specific) pills” – “receiving a message directing him/her to…” – refrain from using psychiatric terms;
- ✓ Note changes in the *pattern* of behaviour, e.g. escalating aggression (i.e. physically assaulting others, self abuse; other subtle indicators might include giving valued possessions away, attempting to obtain a weapon, etc.)

Appendix 5 – Emotionally Disturbed Person (E.D.P.) Form

Example

OFFICER:		OCCURRENCE #:		DATE: (yy/mm/dd)	/ /

GENERAL

Name of Subject:		DOB: (yy/mm/dd)	/ /
Type of Dispatched Call:			
Who Contacted Police:			
Location:			

APPEARANCE/BEHAVIOUR

Check ALL Boxes that Apply

GENERAL		HYGIENE		ACTIVITY	
Co-operative w/Police	☐	Dirty	☐	Slow	☐
Rude	☐	Clean	☐	Agitated	☐
Maintain Eye Contact	☐	Body Odour	☐	Restless / Fidgety	☐
Proper Clothing	☐	Malnourished	☐	Abnormal Movements	☐

THINKING

DISORGANIZED THINKING		ABNORMAL SPEECH		ODD BELIEFS		HALLUCINATIONS	
None	☐	Rapid	☐	Paranoid	☐	Voices	☐
Mild	☐	Loud/Swearing	☐	Grandiose	☐	Visions	☐
Moderate	☐	Few Words	☐	Bizarre	☐	Abnormal Sensations	☐
Severe	☐	Other	☐	Other	☐	Other	☐
Describe Other:							

MOOD

Sad	☐	Anxious	☐	Rapid Change of Mood	☐
Happy	☐	Flat	☐	Mood Not Appropriate for Situation	☐
Angry	☐				

ORIENTATION

Ask & Record Responses

Day:	Month:	Year:	Location

DWELLING

Food in Fridge	☐	Clean	☐	Disorganized	☐
Rotten Food	☐	Dirty	☐	Fire Hazard	☐
Comment:					

Emotionally Disturbed Person (E.D.P.)

ALCOHOL / DRUG USE

ALCOHOL		DRUG USE					
		ADMITTED			SUSPECTED		
Admitted	☐						
Suspected	☐	Drug Type			Drug Type		
Quantity:		Cocaine	☐	Marijuana ☐	Cocaine	☐	Marijuana ☐
Comment:		Other:			Other:		

DANGER ISSUES

ACTIVE TO SELF		ACTIVE TO OTHERS		PASSIVE TO SELF	
Suicidal Thoughts	☐	Homicidal	☐	Poor Self Care	☐
Self Mutilation	☐	Aggressive	☐	Poor Judgment	☐
Suicidal Act	☐	Weapon(s) Present	☐	Clothing Inappropriate for Weather	☐

MEDICAL INFORMATION

Family Doctor:		
Previous Apprehension MHA:		
Hospital Associated With:		
Psychiatrist:		
Other Professional Agency		
Is Subject on Medication:	Yes ☐	No ☐
Name of Medication:		
Pharmacy Name & Phone:		

ACTION

Follow Up with Professional – Name:		Arrested/Charge	☐
Voluntary – Hospital name		MHA Section 17	☐
Form			

HOSPITAL INFORMATION

Take to Hospital Known to Subject – if Unknown, Take Subject to Closest Hospital

SUBJECT DOES NOT CHOOSE THE HOSPITAL

Hospital Name		Admitted	☐	Arrested/Charge ☐
Doctor Seen:		Discharged	☐	Left Before Decision Was Made ☐
Total Time at the Hospital				

OVERALL COMMENTS