Vancouver Police Department: Police Officers' Assessment of the Effectiveness of the Crisis Intervention Training Program and Its Impact on Their Attitudes towards Their Interactions with Persons Living with Serious Mental Illness

by

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Abstract

The purpose of this research was to examine the effectiveness of the Vancouver Police Department's (VPD) Crisis Intervention Training (CIT) course in equipping police personnel with the knowledge and skills to effectively intervene with mental health consumers by encouraging non-violent, non-lethal crisis intervention and the minimal use of force. This study examined 83 (n=83) course evaluation questionnaires completed by the recipients of the CIT course at the VPD, statistical data from the Office of the Police Complaint Commissioner (OPPC), and coroner's and media reports of deaths involving the mentally ill that resulted from police encounters. The analysis of the feedback from the CIT course participants revealed their enhanced awareness and knowledge about mental illness as well as an increased confidence in the disposition of skills and techniques learned during the training. The OPCC statistical data indicated a reduced number of complaints filed against the VPD; however no definite conclusions could have been drawn from this data. The analysis of deaths of the mentally ill killed by VPD officers did not reveal a specific trend after the enactment of the CIT course. Results of the study highlighted the necessity for the adoption of the VPD's CIT course model by all of the police departments in the province. Further recommendations for collaboration between law enforcement agencies in the province, mental health resources, and the implementation of various policies related to the CIT course were addressed.

Keywords: Mental health consumers; Vancouver Police Department; Crisis Intervention Training; deaths of mentally ill; police use of force

To Paulina, Russell, and my parents

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Chapter 1.

Introduction

In Canada, police officers by default are the first responders to 911 emergency calls; a significant number of these calls involve individuals who suffer from mental illness (Adelman, 2003; Wilson-Bates, 2008). On many occasions the encounters of the police officers with individuals who suffer from a mental disorder are resolved without any tragic incidents. In some instances, however, the encounters of police officers with the mentally ill result in injury to, or the death of one of the involved parties and/or other individuals (Adelman, 2003). After a tragic incident in October of 2000 in which the police killed a man who suffered from a mental illness and who had acted violently in one of British Columbia hospital's emergency departments, the Chief Coroner of the province made several recommendations to the Ministry of Public Safety and Solicitor General (Adelman, 2003). A recommendation of the Coroner was to provide training in non-confrontational conflict resolution between police and the mentally ill. Further to that, actions of the Royal Canadian Mounted Police (RCMP) officers at the Vancouver International Airport resulted in the death of a Polish immigrant in 2007. This incident called for a public inquiry on conducted energy weapon usage (Braidwood Inquiry, 2009). Some of the Braidwood Inquiry (2009) recommendations included the introduction of a curriculum for crisis intervention in officers 'training for new recruits and specific training for interactions with mentally ill individuals: in particular, the Inquiry emphasized the use of de-escalation methods before deploying a conducted energy weapon.

This thesis will examine the police officers' assessment of the effectiveness of the Vancouver Police Department Crisis Intervention Training (CIT) course in equipping the police, as well as their operational staff with the knowledge and skills to effectively

intervene with the mentally ill by encouraging non-violent, non-lethal crisis intervention and the minimal use of force.

This will be achieved through a comprehensive and systemic review of the key components of the training curriculum as well as attendance at a 4-day CIT course, and by evaluating the post-training questionnaires completed by the recipients of the Vancouver Police Department (VPD) CIT course. In addition, on the basis of data collection from the Office of the Police Complaint Commissioner (OPPC) and the systemic review of media reports and coroner's reports, the research will attempt to answer the question as to whether the CIT course for the VPD has been successful in reducing the number of formal complaints, injuries and/or deaths to police officers and the mentally ill and whether it has delivered an enhanced police service since its enactment in the past decade.

In the United States, extensive empirical work has attempted to assess the effectiveness of this specialized training by examining the preferred use of force by law enforcement agencies during their encounters with the mentally ill, scrutinizing the number of arrests and hospital referrals of the mentally ill, police officers' knowledge, attitudes and stigma associated with mental illness (i.e., Lester and Pickett, 1978; Godschalx, 1984; DuPont and Cochran 2000; Compton, Esterberg, McGee, Kotwicki and Oliva 2006; Wells and Schafer 2006; Skeem and Bibeau, 2008; Demir, Broussard, Goulding and Compton, 2009; Compton et al., 2011). To date, no research has been conducted in Canada aimed at evaluating the effects of the CIT programs for the police departments across the country in relation to mentally ill individuals. Thus, this first Canadian research will attempt to answer two questions: a) are the VPD officers better equipped after the training in responding to critical calls involving mentally ill persons by using de-escalation techniques and the minimal force required? and b) has the number of deaths/injuries of the mentally ill and the officers involved in the encounters diminish after the endorsement of the CIT course at the VPD? In addition, this research will assess the CIT participants' feedback related to the course curriculum components, course delivery, and its overall usefulness in addressing the issues that are relevant in day-to-day duties of police officers when responding to critical calls.

Prior to examining the effects on the VPD's CIT course participants and on the mentally ill, this thesis will first explore the legal framework of policing in Canada, the current legislation as well as provincial regulations, specifically: The *Mental Health Act.* The review of the organizational standards related to Crisis Intervention Training across the country and in British Columbia will also be outlined. Furthermore, this research will look at the obstacles to effective police encounters with the mentally ill in Canada, British Columbia and Metro Vancouver. Further chapters of the thesis will provide an analysis of the Crisis Intervention Training offered to police officers in Canada, with the emphasis on mental health training. This portion of the chapter will review the curriculum provided by police academies and other institutions as well as website based training. The emphasis of the analysis will focus mainly on the VPD's CIT course. In addition, an overview of a joint Crisis-Intervention-Team venture in Memphis, Tennessee, will be covered, followed by a summary of the occurrence of police deadly encounters involving mentally ill individuals in the United States and Canada. The questionnaires completed by the VPD's CIT course participants, the OPCC statistical data, the media reports and coroner's reports will serve as a source of examination in answering the research questions. The findings with respect to the outcome of the CIT course, the interpretation of the OPPC's statistical data of police incidents/complaints involving the mentally ill, and deaths resulting from these encounters will be provided. Finally, the thesis will conclude with the recommendations for the improvement of VPD's CIT course, the OPPC's annual reporting system, and recommendations for the stakeholders related to police encounters with the mentally ill.

Chapter 2.

Legislative History and Current Legislation

The *Constitution Act* of 1867 gave the Parliament of Canada power to enact criminal law. Section 92 (27) of the Act delegated the administration of criminal justice to the provinces and the majority of the urban areas have been given the authority by the provinces to maintain their own police force (Griffiths, 2008). However, only three Canadian provinces, Ontario, Quebec, and Newfoundland, maintain their own provincial force: the rest of the Canadian provinces and territories contract out their policing to the Royal Canadian Mounted Police (RCMP) known as the "Mounties" (Rigakos and Leung, 2006, p. 126). As a result, there are four levels of police forces in Canada: municipal, provincial, First Nations, and federal, but the RCMP is the only police force that services all levels (Rigakos and Leung, 2006). Based on the plurality of policing, there is no homogeneous training for recruits and in-service police officers: thus it varies across Canada. For example, most police training is delivered by federal or provincial police training institutions; however, some specialty training (i.e., crisis intervention, mental illness training) is delivered through contracting the services of private consultants who are experts in the field (Cotton and Coleman, 2010a).

The division of powers between the federal and provincial governments in Canada in relation to health care was set up by the Constitution Act (Taylor, 1987). Subsequently, all Canadian provinces and territories have legislation to treat and protect people with severe mental disorders as well as to protect the public. In 1965, the British Columbia government introduced the *BC Mental Health Act,* amended later in 1998 (Adelman, 2003). The Act has tremendous implications for individuals requiring involuntary treatment or receiving voluntary treatment, families of the mentally ill patients, and the front-line service providers who primarily are police and hospital personnel.

The recipients of police interventions who are in mental crisis can be dangerous, addicted to illicit substances, and may be characterized by irrational thinking and behaviour, making it difficult for police to intervene in such situations. Therefore, the *Mental Health Act* of B.C. contains provisions for the police about their conduct when they come into contact with a mentally ill person. Section 28 of the *Act* outlines:

> 1. A police officer or constable may apprehend and immediately take a person to a physician for examination if satisfied from personal observations, or information received, that the person
>
> (a) is acting in a manner likely to endanger that person's own safety or the safety of others, and
>
> (b) is apparently a person with a mental disorder
>
> 2. A person apprehended under section (1) must be released if a physician does not complete a medical certificate in accordance with section 22(3) and (4) [involuntary admission criteria].

The Act authorizes police to intervene if it is not possible for a person who has a psychiatric disorder to see a physician. A person in crisis does not have to commit a criminal offence before the police can intervene and apprehend (Sinclair and Turner, 2004). The word "apprehend" is not defined by the *Act*, but does not mean arrest. Under the *Act*, police must immediately take an individual to a designated medical facility for examination. When a patient is brought to a hospital (or community physician) by police under Section 28(1) of the Act, it is important that a brief written report be provided to hospital staff by the police. This report should include relevant observations of the patient's behaviour noted by the police. Once a person is taken to the hospital's emergency ward, the acting physician applies the involuntary admission in accordance with the Act, and completes a Medical Certificate (Sinclair and Turner 2004). Within the next 48 hours, a second physician must sign a committal certificate. The Act does not specify however, when the police can leave the patient. The reasonable interpretation of section 28(1) of the Act is that the police must retain custody until examination of the patient is completed by a physician, and a Medical Certificate is issued. However, before that happens, the hospital does not assume legal responsibility for the person who has been apprehended by the police and brought to the hospital in accordance with the Act (Sinclair and Turner 2004). Owing to a number of factors included in section 28

(1) and (2) of the *Mental Health Act*, in reality the voluntary admission as opposed to involuntary admission of the mentally ill patient is in most cases very problematic.

Furthermore, the *Criminal Code* of Canada allows police officers to arrest a person under s. 31 for breaching the peace (*Criminal Code,* R.S.C. 1985, C-34). However, there is no specific offence defined in the *Code* unless there are law violations involved. In most cases, the police use *Breach of the Peace Violation* to transport and release a person in a different area of town or keep a person in custody for a short period. Section 31 of the *Code* provides that:

> **Arrest for breach of peace**
>
> **31.** (1) Every peace officer who witnesses a breach of the peace and everyone who lawfully assists the peace officer is justified in arresting any person whom he finds committing the breach of the peace or who, on reasonable grounds, he believes is about to join in or renew the breach of the peace.
>
> **Giving person in charge**
>
> (2) Every peace officer is justified in receiving into custody any person who is given into his charge as having been a party to a breach of the peace by one who has, or who on reasonable grounds the peace officer believes has, witnessed the breach of the peace.

Section 495 of the *Criminal Code* allows police officers to arrest a person without warrant (*Criminal Code*, R.S.C. 1985, C-34). Section 495 of the *Code* is as follows:

> **Arrest without warrant by peace officer**
>
> **495.** (1) A peace officer may arrest without warrant
>
> (a) a person who has committed an indictable offence or who, on reasonable grounds, he believes has committed or is about to commit an indictable offence;
>
> (b) a person whom he finds committing a criminal offence; or
>
> (c) a person in respect of whom he has reasonable grounds to believe that a warrant of arrest or committal, in any form set out in Part XXVIII in relation thereto, is in force within the territorial jurisdiction in which the person is found

In summary, police officers have several options and factors to consider in resolving situations with the mentally ill: take no action, resolve the situation on-site, transport a person to a nearby hospital under the *Mental Health Act*, and/or take a person into custody depending on the circumstances of the encounter.

Current Situation: Obstacles to Effective Police Encounters with the Mentally Ill: An Overview

Owing to a number of factors, such as deinstitutionalization in the 1980s that resulted in the influx of mentally ill persons into the community, extensive emergency room (ER) wait times, shortage of hospital beds, and scarcity of the proper mental health training for medical personnel, the rate of recurrence of police encounters with the mentally ill had increased significantly over the past three decades (Adelman, 2003; Wilson-Bates, 2008). In the 1980s, a national trend to deinstitutionalize or not to institutionalize psychiatric patients resulted in the permanent closing of several hospital wards, and by the early 1990s there were approximately only 1000 beds remaining (BCMHA, 2009; MacFarlane, Fortin, Fox, Gundry, Oshry and Warren, 1997). During this time the British Columbia government planned for the development of several mental health services in the province, with the focus being on smaller more specialized facilities. However, these plans never materialized which resulted in the deinstitutionalization and placement of all mentally ill individuals within the community. For some individuals who were former patients of the Riverview hospital the news was received with contentment since they could become members of the community. However, for others, the results of deinstitutionalization were excruciating. According to the Lookout Emergency Aid Society (2007), the seriously mentally ill were incapable of finding or carrying on independently with life in society. The lack of Community support systems, the reduction in the number of hospital beds and the insufficient funding from the government have all contributed to the existence of a high concentration of seriously mentally ill individuals living in the community in a state of crisis. Furthermore, emergency wait times for mentally ill patients in distress who are brought by the police to the hospital are the same as for any other patients awaiting medical treatment. Although

not specified by the *Act*, a police officer's unwritten duty is to remain with the patient in the emergency room prior to the patient's admission to the Psychiatric Assessment Unit (PAU) (Adelman, 2003). According to Vancouver Police and RCMP reports, emergency room waits for police officers varied from between seven to twelve hours (British Columbia Schizophrenia Society, 2006). Consequently, the shortage of hospital beds for individuals with serious mental illness undoubtedly leads to a failure to provide treatment and increases the likelihood that they will become involved in encounters with the police (British Columbia Schizophrenia Society, 2006).

One of the other barriers that preclude effective police interactions with mentally ill individuals is the fact that physicians lack adequate information and knowledge in the mental health area and familiarity with provincial legislation. For example, many physicians and hospital personnel do not receive substantial training in mental health, mental illness**,** and suicide prevention; in fact, interns may receive a maximum of two-hours training during their residency (McMartin, 2007).

Chapter 3.

Mental Health Training for Police Officers

As stated earlier, all of these factors act as catalysts to the prevalence of police encounters with the mentally ill population. However, it is important to point out that police officers' role to act as gatekeepers in resolving incidents involving the mentally ill make them informal respondents whose knowledge and training about mental illness is crucial. According to a large body of research (see Alderman, 2003; Cotton and Coleman, 2010a), police officers' knowledge with respect to crisis situations involving mentally ill players is not sufficient to provide them with appropriate intervention and responses. In fact it is categorized as "comparable to the general population" (Alderman, 2003, p. 6).

What kind of mental health training is provided for police officers in Canada? Of particular significance for the purposes of this research is the study conducted by Cotton and Coleman (2010b) which related to the police officers' training with regard to mental illness. Based on this recent study, currently, thirteen police academies provide basic training to new police recruits. In light of the plurality of policing in Canada stated earlier, Cotton and Coleman (2010b, p. 13), reported that many police departments provide advanced educational training about mental illness in national academies (RCMP), provincial or regional colleges or academies (Ontario Police College, Atlantic Police Academy, Saskatchewan Police College and the Justice Institute of British Columbia), or under the patronage of a specific police department (i.e., Lethbridge, Edmonton). The province of Quebec requires police applicants to receive a CEGEP[1] diploma before joining the police force (Cotton and Coleman 2010b). It is important to note however,

[1] CEGEP stands for Collège d'enseignement général et professionnel, meaning "College of General and Vocational Education", an equivalent to the Vancouver Community College (VCC).

that not all the police departments in the country provide this basic training since there are no standardized regulations in place and mental-health training is not mandatory.

The variety of mental-health training offered to police officers varies in duration and intensity. For example, the basic training in Lethbridge (Alberta) takes only one hour, while in Edmonton it is 24 hours. It averages ten hours across the country (Cotton and Coleman, 2008; Cotton and Coleman, 2010b). Newly hired police recruits receive an assorted form of learning in this area whether it relates to the curriculum in relation to use of force training or just solely focuses on the educational aspect of mental illness (Cotton and Coleman, 2010a). Some police agencies oblige police officers to take the e-training instead of the academy training. The Canadian Police Knowledge Network (CPKN), created in 2004, caters to the Canadian police community (Cotton and Coleman, 2008). This non-profit organization offers a variety of e-learning courses which were developed in collaboration with police and specialized experts in the diverse areas of training. For example, CPKN offers an online course: *Recognition of Emotionally Disturbed Persons*, which provides an overview of the various categories of mental illness and focuses on the police officer's response strategies in crisis situations. The curriculum of this course is provided by forensic clinical psychiatrists, psychologists, and clinicians in partnership with police training instructors (Cotton and Coleman, 2008).

Crisis Intervention Teams: A Joint Effort of Police and Mental Health Professionals

Most of the available research related to police training and preparedness related to dealing with the mentally ill has not been as prevalent and ample as the reviews of police collaboration with mental health professionals to aid the mentally ill. Perhaps the most notable joint initiative of assisting the mentally ill in crisis is the Crisis Intervention Team (Adelman, 2003). The Crisis Intervention Team is based on the Memphis (Tennessee) Model developed in 1988 for individuals suffering from mental illness who come into contact with the police.

Prior to that, the Memphis Police Department (MPD) as well as other law enforcement agencies in the United States had been faced with several incidents involving the mentally ill that resulted in a person's or an officer's death (Moore, 2008; Munetz, Morrison, Krake, Young and Woody, 2006). In 1987 a mentally disturbed individual armed with a very large knife was cutting himself and threatened to injure his family members and neighbours; he was shot and killed by police officers in Memphis. This incident sparked a public outcry and a demand for intrinsic police training in defusing crisis involving the mentally ill (Moore, 2008). Not surprisingly, prior to this incident, similar cases have occurred across the country. During the same year, a man living with bipolar disorder and who was wielding a knife was shot by a police officer in California and another similar case took place in Texas. Also, two police officers lost their lives during encounters with the mentally ill. A California Special Weapons and Tactics (SWAT) officer was shot by a mentally ill individual and in North Carolina; an officer had his throat slit in an encounter with a mentally ill person (Moore, 2008). In both cases, the officers lost their lives. Yet, before 1988 in the United States, officers from various police departments received only a few hours of crisis intervention training in the police academy and no further advanced specialized training was in place despite the frequency of these fatal police encounters with the mentally ill.

The MPD was the first police department in the United States that took an initiative in the creation of further, more specialized crisis intervention training. Preceding the creation of the specialized training, MPD officers received only eight-and-a-half hours training in defusing critical situations and the MPD publicly acknowledged that it was not enough (Moore, 2008). Consequently, a task force that comprised the National Alliance of Mental Illness (NAMI), specialists from Tennessee and Memphis universities, as well as families of mentally ill individuals was created. The task force recommended that the best solution for saving the lives of police officers and mentally ill individuals would be a creation of a specialized mobile team of police officers who are solely trained on mental-illness-crisis resolution (Moore, 2008). The MPD has decided to train officers in their department partnering with other mental-health community resources and to ensure that the officers are available 24 hours, seven days a week. The officers who showed interest in the 40-hour program became selected as members of the mobile crisis team. Further to that, they also had to demonstrate good judgment skills and a unique insight

about mental illness (Moore, 2008). After the completion of their training these officers perform mental health crisis intervention in addition to their regular police duties (Adelman, 2003). As a result of Crisis Intervention Team work, when the police refer a mentally ill individual to the hospital, the emergency department is bound by a non-refusal policy to assist and attend to the patient. Currently, the MPD has approximately 225 CIT trained officers and CIT trained dispatchers who actively cooperate with each other and the community's mental health resources (Vaughn, 2011).

According to the MPD, throughout the years, the crisis intervention training and the creation of a mobile team comprised of specially trained officers have successfully saved many lives of mentally ill individuals, resulted in lesser injuries to police officers, allowed for a diminished number of arrests of the mentally ill, and resulted in an enhanced use of police de-escalation techniques with a minimal use of force required. It also led to an immediate police crisis response and saved taxpayer's money (Moore, 2008; Vaughn, 2011). In the early 1990s, several police departments in the United States have adopted the Memphis Crisis Intervention Program, as it has been recognized and promoted by the NAMI, as the best police practice during encounters with the mentally ill, and its benefits have been discussed in the Council of State Governments Mental Health Criminal Justice Consensus Project (Munetz et al., 2006). Although the Memphis CIT has not been immensely disseminated across the country, it has been estimated that, in 2006, 100 to 300 crisis intervention programs in over 39 States and 500 U. S. cities based on the Memphis Model have become the training curriculum for a number of police departments in the United States (Munetz et al., 2006; RCMP, 2009; Watson, 2011). Although some police departments employ a different system response to the calls involving the mentally ill with some modification for the local needs, there is strong evidence that the Memphis Model has been most wildly adopted in the country and the most successful in saving lives of the mentally ill and police officers involved (Borum et al., 1998; Watson, 2011). Indisputably, the success of the CIT could not be attributed to the police alone without the collaboration of the multiple community stakeholders such as: NAMI, mental health providers, mentally ill individuals and their families.

It is important to note that the Memphis Model has been adopted in Canada by the Surrey RMCP in the fall of 2006: Car 67 is a similar joint venture of a mobile team, while Car 87 has been fully operational in the city of Vancouver since 1987 (Adelman,

2003; RCMP, 2009). The Crisis Intervention Team in Surrey is a community-based program that incorporates integrated community-based training and inter-agency liaisons with community committees. The Crisis Intervention Team program is an intensive 5-day course for RCMP officers. This program fosters a strong working collaboration between the police, its agencies, and the Provincial Health Authorities in relation to incidents involving individuals with mental-health problems. In addition, officers familiarize themselves with the *Mental Health Act*; they receive training about mental-health disorders which involves the recondition of the illness, assessment, and training on how to create a plan of action for an individual in a mental health crisis (RCMP, 2009). The final two days of the training are simulations of real life scenarios and involve actors so the members can practice effective integrative crisis response for emotionally disturbed persons. Another component of the program is the involvement of the crisis intervention team liaisons and community committees within each jurisdiction (RCMP, 2009). These trained liaisons oversee programs and initiatives at the local level concerning mental illness, while the committees maintain inter-agency collaborations, review, and assess community issues and concerns, and promote resolutions to benefit all involved stakeholders, such as police, Emergency Room (ER) hospital personnel, local health authorities, the general public, and individuals with mental illness and their families. As of February 1, 2009 there are more than 45 liaisons that represent 18 communities in the Lower Mainland (RCMP, 2009).

As mentioned earlier, the city of Vancouver also provides for the crisis response unit, Car 87. The mobile team is composed of a psychiatric nurse and a VPD officer who work closely with the Vancouver Coastal Health Authority (VCHA) - Mental Health Emergency Services (MHES) have been assisting individuals in mental crisis since 1984 initially on a trial basis (Adelman, 2003). The Surrey RCMP department has been utilizing the same police/mental health collaboration model using their Car 67 for the past eight years (Adelman, 2003).

Despite its successful operation, this collaborative teamwork is not without its shortcomings. The incidents involving mobile teams are unlikely to be resolved on-site. In the majority of cases people who suffer from a mental disorder and jeopardize their own safety or the safety of others, are more likely to be transported to the hospital or apprehended under the *Mental Health Act* (Adelman, 2003).

Chapter 4.

Vancouver Police Department Training

New recruits to the Vancouver Police Department receive three hours of mental health training as their mandatory component for the three month training at the Justice Institute of British Columbia (Wilson-Bates, 2008). This specialized component of the training course was prepared by the British Columbia Schizophrenia Society (BCSS) in collaboration with the Institute and the police members from Car 87 (Wilson-Bates, 2008; Cotton and Coleman, 2010a).

In addition to this basic training, the Vancouver Police Department offers a mandatory 32- hour program (Crisis Intervention Course), 8-hour sessions over a course of four days in a traditional classroom setting and averages 15 to 20 participants. The course prerequisites require a completion of the Justice Institute of British Columbia (JIBC) academy training or the VPD jail guard training (VPD, personal communication, November 22, 2010). It is offered for front line officers, members and Emergency Response Service (ERS) officers as well as Sergeants. It is also being delivered to the VPD's jail guards, community-based police officers, youth squad officers, school liaison officers, and human resources staff (Cotton and Coleman, 2010a; VPD, personal communication, November 22, 2010).

Brief History of the CIT Course

Prior to the commencement of the course, there had been a noticeable increase in the high number of profile police shootings with mentally ill individuals, and in particular, the case of Jose Augusto Ribeiro had received extensive media coverage (Hall, 2001; VPD, personal communication, October 20, 2010). Ribeiro, a Vancouver carpenter who suffered from schizophrenia, was shot by police twice on two different occasions and

almost died. During the first incident in 1978, Ribeiro wielded an axe at police officers during an episode of paranoia. Twenty years later, in 1998 Ribeiro was wounded during a police encounter when he emerged from the bathroom of his home, again equipped with an axe. At this time an emergency response team member wounded Ribeiro by shooting him three times (Hall, 2001). Ironically, two years earlier, the same officer who wounded Ribeiro fatally shot another individual who was mentally ill (Hall, 2001). After these encounters, the VPD started to use less lethal weapons such as stun and bean-bag guns during their encounters with mentally ill individuals who were violent. Consequently after these encounters, the VPD had publicly admitted and acknowledged that there is an urgent necessity for the creation of a police crisis intervention training (Hall, 2001). Sergeant John McKay, who was assigned to the VPD's Training Section in 2000, and Constable Heidi Schoenberger, who worked as an officer in the Mental Health Car 87, proposed that the VPD implement the CIT course for police officers (VPD, personal communication, October 20, 2010). In 2001, Schoenberger was sent to Albuquerque, New Mexico to attend the Crisis Intervention Program based on the Memphis Model. After the completion of the course, Schoenberger along with the co-worker of Mental Health Emergency Services Sheila Scotten, from Car 87, developed a training curriculum for the VPD's Crisis Intervention Program. The training curriculum was presented to the Training and Education Department of the VPD and was approved for implementation (VPD, personal communication, October 20, 2010).

CIT Program Design and Curriculum

The VPD training course is based on the Memphis Crisis Intervention Model and it was developed in 2002 to familiarize Vancouver police officers in identifying mental health disorders, providing appropriate intervention, and responding to encounters with mentally ill individuals (Cotton and Coleman, 2010a). The main goals of the course focus on enhancing awareness of mental illness, developing proper communication skills and providing police officers with available tools and resources to use in these encounters in the least non-violent manner (VPD, personal communication, November 22, 2010).

The course also covers all aspects facing front-line police officers and is designed to focus on day-to-day interactions of the VPD members relating to escalated calls of extreme crisis (VPD, personal communication, November 22, 2010). The VPD's training is provided by a collaboration of external mental health experts such as: B.C. Ambulance Service (BCAS), the Canadian Mental Health Association (CMHA) British Columbia Division, B.C. Schizophrenia Society (BCSS), as well as individuals who suffer from mental illness and the families affected by it (Cotton and Coleman, 2010a; VPD, personal communication, November 25, 2010).

The 4-day CIT program is made up of 11 sessions, practice activities throughout the course, as well as the active role-playing exercises. Session 1 covers the expectations, the intent of the course and the CIT history within the VPD (VPD, personal communication, November 25, 2010). Session 2, *Early Intervention and Schizophrenia,* focuses on signs and symptoms of mental disorders and on an early intervention. Session 3 explains *Geriatric Mental Health*. It provides an overview of the common psychiatric illnesses affecting the elderly, the risks involved and the cognitive assessment of the aged population. Upon completion of these sessions, it is expected that police officers will be able to discuss the signs of early psychosis, recognize common psychiatric illness of the elderly, disseminate appropriate resources available to the officers, and know how to assist people in mental crisis (VPD, personal communication, November 22, 2010). Session 4 is geared toward *Critical Incidents and Stress* related to police and jail guards' work environment. During this session, police officers learn about early manifestations of stress, how it affects them and how it projects on other people with whom police officers interact. Officers also become familiarized with the techniques for coping with day-to-day stressful situations at work. By the end of this session, police officers should be able to differentiate between cumulative and critical incident stress, state four possible symptoms that trigger it, and come up with strategic solutions for combating it (VPD, personal communication, November 23, 2010). *Fetal Alcohol Spectrum Disorder (FASD),* the fifth component of the course exposes police officers to the developmental and behavioural effects of the continuum of permanent defects associated with maternal alcohol consumption during pregnancy. Since the VPD officers interact with FASD individuals on a daily basis, the *Youth Criminal Justice Act* (YCJA) is reviewed in relation to sentencing youth who are diagnosed with FASD. At the

end of the session, the officers should be able to characterize four criteria for FASD diagnosis, recognize several characteristics of the adult individuals who suffer from FASD, and recognize the signs of FASD (VPD, personal communication, November 23, 2010). Session 6 focuses on *Crisis Negotiation* and serves as a guideline for police officers covering verbal crisis-management techniques. This session is presented by one of the exceptionally skilled crisis negotiators. Course participants learn how the VPD's special team of highly trained negotiators responds to barricaded and armed situations, hostage holding individuals, and suicidal incidents. By the end of the session, police officers are expected to differentiate between emotional and cognitive levels of crisis, create three to four intervention strategies, and present the guidelines for their encounters with suicidal individuals (VPD, personal communication, November 23, 2010).

Police officers are often confronted with individuals who are in a state of inebriation and drug use. *Addiction and Mental Health* – Session 7 of the training covers and explains the affect of alcohol and drugs on the human body. During this session, police officers receive detailed information signs and symptoms of psychosis. Experts in the field provide an overview of different drugs and the risk factors related to drug dependency. At the end of this session, the officers should be able to identify some risk factors associated with drug and alcohol addiction, provide classification of drugs, explain their general effects, and identify the symptoms of mental illness (VPD, personal communication, November 23, 2010). Session 8, *The Lethal Force Encounter* addresses the issues related to 'suicide by cop', an act whereby an individual presents a threat in attempt to get oneself killed or injured by the police. This session explains the categories and factors surrounding 'suicide by cop' including de-escalation techniques with the emphasis on verbal communication with the individual. Upon completion of the session, the officers should be familiar with the *Sadpersons* scale's to determine suicide risk, provide motivations for suicide and generate two or three important questions to ask during the encounter (VPD, personal communication, November 23, 2010). *Suicide* is the ninth Session of the training. It is led by counsellors from the Suicide Attempt Follow-up, Education and Research (SAFER) service, a division of Vancouver Coastal Health that provides support to individuals with suicidal ideations, those who attempted suicide, individuals who are concerned about someone who is suicidal and families or friends

who lost someone as a result of suicide. This session examines risk factors associated with suicide and encompasses verbal communication techniques used with suicidal individuals. At the end of the session, officers should be able to establish two to three factors of suicide, ask pertinent questions in order to obtain answers from suicidal individual, and know the *'Is Path Warm'* (Ideation, Substance Abuse, Purposelessness, Anxiety, Trapped, Hopelessness, Withdrawal, Anger, Recklessness, Mood Changes), the acronym used for the mnemonic device for suicidal risk assessment (VPD, personal communication, November 23, 2010).

Since there is a substantial aging population in the city, police officers often encounter situations related to abuse of older people, mental illness, onset of dementia and other psychological disorders in the elderly. Session 10 of the training focuses on *Elder Abuse.* Family dynamics including spousal, parent and child relationships and the elderly are covered. After the completion of this segment of the training, officers should be familiar with at least two relationship dynamics when responding to calls involving the elderly, acknowledge three common misconceptions associated with the elderly, and recall strategies for intervening with the offenders who abuse the elderly (VPD, personal communication, November 23, 2010).

Session 11 of the training, presented at the end of the second day, *Crisis Intervention,* provides a summary of the previous sessions and integrates information acquired by the officers. Communication theory is presented which leads to discussions on conflict resolution and crisis intervention. By the end of this session, officers will be expected to recap on different levels of conflict, demonstrate and give examples of how to properly communicate with others in crisis, and to be able to identify obstacles related to proper communication (VPD, personal communication, November 23, 2010). Session Eleven serves as a prelude to two additional days of the training, which involves active role-playing activities.

Practical activities have been an ongoing component of the entire training and of the two remaining days of the course. These activities are intended to encourage officers to apply the knowledge gained during the training as well as from their professional and personal experiences, and to employ all the resources that are available to them. The goal of the practical activities is to generate group discussions

and to come up with all possible outcomes of crisis resolution during the various types of scenario (VPD, personal communication, November 22, 2010).

The practical-activities course component is divided into seven lessons. Lesson 1 is presented by the members of British Columbia Schizophrenia Society (BCSS), mental health consumers and family members affected by the mental illness. The officers take part in an active listening exercise where four individuals simultaneously read different stories out loud and the officers are asked to answer a few questions relating to every story. This exercise is intended to give officers an insight into the mind of persons who suffer from schizophrenia and the 'voices' (auditory hallucinations) they hear. This activity is followed by presentations of personal stories from a person who has been diagnosed with mental illness and families who have been affected by schizophrenia. The presenters also provide some tips and suggestions to officers on communication strategies with a person who suffers from mental illness (VPD, personal communication, November 22, 2010).

Lesson 2 focuses on the review of various case studies. During this section of the course, practical exercises are introduced and officers are presented with the opportunity to discuss how to investigate the file and how to proceed with persons involved in critical situations (VPD, personal communication, November 22, 2010). Similarly, Lesson 3 centers on group discussions and covers crisis situations that officers are involved in on a day-to-day basis. Officers and presenters share their own stories and experiences during critical incidents (VPD, personal communication, November 22, 2010). During Lesson 4, a presenter asks officers to provide examples of their encounters with individuals who are under the influence of drugs and/or alcohol. The presenter also discusses the relationship between intoxication and aggression as well as shares his/her own experiences during ride-alongs with the VPD (VPD, personal communication, November 23, 2010). Lesson 5 focuses on the discussion of two case studies; the first case relates to police stress at work and the second one to a suicidal officer. Participants of the training are divided into small groups and discuss the outcomes and possible solutions to presented cases (VPD, personal communication, November 23, 2010). During Lesson 6, more case studies are presented and discussed. The final, fourth day of the training is solely dedicated to role- playing activities. These activities involve active listening techniques and paraphrasing. Prior to

the role playing exercises, verbal and non-verbal-crisis-intervention-communication skills are discussed with the emphasis on non-threatening safe environments, the emblems (officer's use of hand gestures) and crisis-resolution techniques (VPD, personal communication, November 25, 2010).

There is no final exam after the completion of the course; however, officers are requested to complete a course-evaluation questionnaire which assists the VPD's training department to assess the contents of the course, make suggested improvements to the curriculum, the course materials, handouts, audio-visual aids, and, most importantly, to collect feedback for subsequent analysis of the efficacy and helpfulness of the crisis intervention training in relation to officers' work settings (VPD, personal communication, November 25, 2010).

According to the VPD, this type of training is a proactive measure to potentially save injuries and the lives of the mentally ill, police officers and the public. It also helps police officers to develop appropriate attitudes and alter their biases held towards mental illness (VPD, personal communication, November 22, 2010). It is important to note that, on top of the CIT course, the Vancouver Police Department's agenda requires active involvement in various mental-health committees with the main focus being on the improvement of mental-health training for the police officers and all services available to the mentally ill in crisis.

Chapter 5.

Study

Methodology

As stated earlier, the Crisis-Intervention Training course was endorsed by the VPD in 2002. This course was offered in April, October, September, November, and December every year at the training classroom facility of the Vancouver Police (VPD, personal communication, November 22, 2010). Initially, the goal the Vancouver Police Department Training and Education Unit was to ensure that 25% of all patrol members receive this specialized training, but later the VPD's mandate was modified in order to ensure that 100% of the VPD's operational patrol officers and newly hired jail guards would complete the course. By February 2011, 449 frontline officers had received this specialized training and the VPD put forward a proposal to Police Services for a provincial adoption of the VPD's CIT Model (VPD, personal communication, November 25, 2010; Vancouver Police Board, 2011).

Upon completion of the course police officers were invited to complete a questionnaire relating to the knowledge gained from the course and techniques taught during crisis resolution based on de-escalation techniques, effectiveness of the instructors, and the material presented by them in various areas of mental health, use of force, crisis negotiations, course structure and clarity, course usefulness in day- to-day application at work, and to make suggestions to the VPD's Training and Education Unit for course improvements (see Appendix). The participation in the completion of the questionnaire was voluntary and anonymous. Since the commencement of the course, the VPD constantly strove to improve the proficiency of the CIT course by making it more lucid, effective, enjoyable for all participants and at the same assuring that, in the

end, the knowledge gained from the training would benefit all: police officers and members of the public (VPD, personal communication, November 25, 2010).

Data Collection: Sample

For the purpose of this study, permission was obtained from the VPD's Educational and Training Unit to collect the post-CIT course evaluation questionnaires. The Office of Research Ethics at the Simon Fraser University in Burnaby, British Columbia approved all study procedures. The questions included in the questionnaire were prepared by the VPD Training and Education Unit and remained unchanged since the commencement of the training in 2002 (VPD, personal communication, November 22, 2010). A total of 83 (n=83) copies of the questionnaires from the past years, including January 2010 to April 2011, were included in the study. Data collection took place in December 2010 and May 2011. The questionnaires related to course participants' responses to the CIT evaluation and included six items, the current assignment/section of the member, and years of service. The questions were as follows:

1. Overall, how useful was the course for you?
2. Was this course helpful? Did it address issues that are relevant to your work setting?
3. Was there sufficient opportunity for individual or class participation?
4. How effective were the presenter(s) in delivering the material?
5. Were handouts or other types of media used to deliver the course? If yes, how useful were they?
6. Is there any further information which you would like to add or bring to the attention of the Training Section?

Participants were asked to elaborate and give exhaustive answers to the survey. Table 1 provides a summary of data collection.

As illustrated in the table, the highest numbers of responses were collected in December 2010 and the lowest numbers of responses were collected in January and November of 2010. The officers' current years of service provided on the questionnaires ranged from one to 30 years, averaging nine years. The majority of the respondents (76) were working as active patrol officers, followed by the officers who specialized in

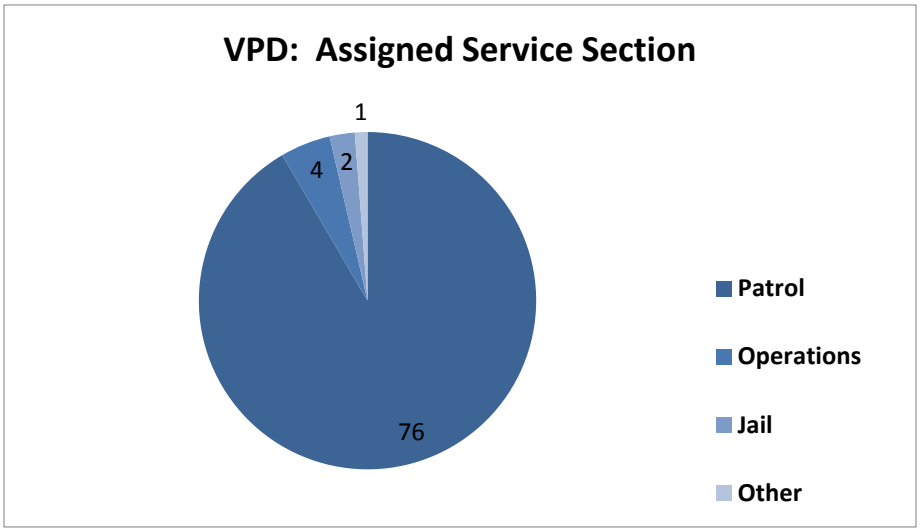
operational units (4) (i.e., Emergency Response Unit, Criminal Investigation Section), jail guards (2), and one school liaison officer.

Table 1. ***Post-CIT Course Questionnaires***

Training month and year	Number of questionnaires
January 2010	6
September 2010	12
October 2010	9
November 2010	6
December 2010	34
April 2011	15
Total	83

Note. VPD Training and Education Unit.

Figure 1. ***Assigned Service Section***



Note. VPD' Education and Training Department.

Procedure

The feedback provided by the respondents, to the question relating to usefulness and helpfulness of the CIT course and its relevance to police work setting, was largely positive. For example, 73 participants (88%) found the training to be very informative in learning communication techniques during crisis intervention and their application to

future police interventions. According to the respondents the course, not only provided better understanding of human behaviour during crisis situations but also offered new tools and ideas that officers could apply to work settings including the de-escalation techniques through active-listening communication and the minimal use of force required. The positive feedback relating to helpfulness and usefulness of the CIT is illustrated by the following comments:

> *Course was very effective, I learned a lot and wished it was introduced much earlier in the policing career.* Patrol officer, 9 years of service
>
> *I found this course very useful. I gained much more confidence after the course in relation to suicide calls and encounters with mentally ill people. I will apply all the strategies learned from the course at home and work.* Patrol officer, 7 years of service
>
> *It provided a good review of techniques, it reinforced same ideas that police officers formed through experience.* Patrol officer – 2 years of service
>
> *The most useful part of the course was guest speakers, regular people telling their stories. The course was very helpful.* Patrol officer – 5 years of service
>
> *Course was very useful, although not being a police officer but a jail guard, I found it very informative. It was very helpful; it provided good knowledge about critical incidents such as FASD which is relevant to jail settings. I was aware of the disorder but did not know the characteristics.* Jail guard – 1 year of service
>
> *On the whole, it was a useful course. It highlighted the importance of how active listening and rapport building are necessary tools to handle crisis, emotional and incidental.* Patrol officer –13 years of service
>
> *Course was good, some information was new, some was a good refresher. It was helpful mostly in retrospect looking at incidents and understanding more about what was going on at the time.* Operations– 11 years of service
>
> *The crisis intervention active listening skills techniques were very useful. It was a good concept to learn and also learning more about EDP [emotionally disturbed persons], especially how real hallucinations are to people who are experiencing them.* Patrol officer – 15 years of service
>
> *Great course, despite of my 20 plus years of policing experience I learned some valuable tools when speaking to people in crisis. I will most definitely network how to approach situations in the future. It was very helpful, very specific to frontline officers. Testimonials from mentally ill persons and family members affected by mental illness were very effective. Well run, well organized, very good exceptional content.* Patrol officer – 22 years of service

The course was very useful and long overdue. It drives home to all members that they will be first respondents to incidents such as mental health issues. Patrol officer – 30 years of service

This course was very useful. It gave police officers more cognitive tools for dealing with crisis situations. Most definitely helpful, about 95% of police job is communication so if the officers can defuse a situation softly it would make their job easier and more effective. Patrol officer – 25 years of service

Crisis Intervention Training course provided a good balance of new information on relevant issues such as mental health and addictions which also allowed for practice and application to work like scenarios. Operations – 7 years of service

The course offered very useful and relevant material, skills that can be used on a daily basis in every aspect of the world of policing. It helped to learn great techniques on how to de-escalate people in crisis. Operations – 10 years of service

The course presented more in depth perspective on how to deal with everyday issues. Crisis intervention was especially useful when it comes to objectifying the facts and reacting in purposeful way. The course was helpful in a way that psychosis, addictions, and mental health now offer more understanding. Operations – 20 years of service

This course was good. I wish that it was introduced in day one in the academy. It was very helpful, the more I know about crisis situations, the more I find myself involved understanding the laws related to people in mental health crisis. Operations– 22 years of service

The point of the course was to remind police officers how to communicate, think, and use common sense. Anything that encourages these things is good. The course was helpful; any forms of the concepts introduced during the course can be used by us every day. We need more training in all things. Frequent, relevant training is crucial to keeping us alive, useful and improving. The VPD could save money and improve public image and increase performance. We should train more, encourage safety and not be afraid to lead, guide, and direct our members. Patrol officer – 6 years of service

Seven (8%) out of the 10 remaining course participants found the CIT course moderately useful and three (4%) respondents did not find it useful at all. Here are some of their responses:

The course was rather elementary for my level of service, some good refresher items and resources given were useful. I would rather learn what happens to people who suffer from psychosis after they are dropped off at Detox and how can someone get into rehab. Patrol officer – 5 years of service

The course was not very useful with a few exceptions. Day three was useful in a way of learning about critical incidents and it was interesting. Some new learned vocabulary was useful. I would like to learn how crisis affects victim's family, attending officers and paramedics. Patrol officer – 2.5 years of service

The course was not very useful. If I have never been involved in an incident where conflict existed, this would have been a very informative course. The theories on conflict resolution, active listening are drilled in police officers on other courses taken previously. I would restructure the order of the presenters and make them present on different days. Patrol officer – 8 years of service

This course was moderately useful. I think that police naturally use tools presented during the course. A little less should be covered on police negative actions. Patrol officer – 6 years of service

"The course would have been more useful 9 years ago, in my first day of policing. The last two days were mostly effective and relevant to police work setting. Patrol officer – 9 years of service

Somewhat lots of useless info. More info needed to police related work. More concepts, scenarios, even recordings from live calls on how to deal with emotionally disturbed persons which is the most common occurrence on patrol. Patrol officer – 5 years of service

This course was ok. It reinforced some ideas that police officers form through experience. Patrol officer – 2 years of service

With respect to participants' rating of the curriculum of the training, including the effectiveness of the experts in the field and the delivery of the material presented by them, as well as the course structure and the opportunity to ask questions and participate in discussions, the respondents showed overwhelmingly positive responses. Also, the last two days of the training involving role-playing and active-listening exercises were met with course participants' positive feedback.

According to the questionnaire responses, course presenters demonstrated exceptional knowledge and understanding in the field of their study. For example, during the first day of training, a psychiatrist from the University of British Columbia very clearly outlined different types of bizarre behaviours and problems associated with a person's

mood, thinking process and cognition. He talked about depression, emphasizing that depressed persons are often suicidal, and individuals presenting with mania who suffer from judgement distortions and are usually too happy, too elated. He also described psychotic disorders characterized by losing connection with reality and perception – perceiving things that are not real (i.e., screaming), and delirium – being in a state of an acute confusion. The psychiatrist presented real-life examples and emphasized that intoxication, drug abuse and insulin deprivation (in diabetics) can mimic all of the psychotic disorders. He also acknowledged that doctors have the luxury to test individuals who act in an erratic way while police officers have to make their "diagnosis" very rapidly and for that reason, critical hints for a quick diagnosis of mental illness were presented. A great deal of appreciation was expressed by the participants' responses relating to the doctor's presentation which not only gave a better understanding of mental illness but also provided helpful tips for the quick recognition of the presence of mental illness during critical situations.

Other highly rated presentations by the course participants were related to geriatric mental health and elder abuse. Another physician from the Vancouver Coastal Health Authority covered the aspects of medical and psychiatric issues related to old age. He outlined four psychotic disorders associated with geriatric psychiatry and emphasized that some elders may present a chronic risk of harming themselves or others, as well as being resistant towards a support system, such as hospital or police.

On the other hand, another presenter, a VPD detective who talked about elder abuse emphasized the awareness of the calls for service from the elderly who are abused and/or neglected physically, emotionally, and sexually by their families and/or friends. The presenter stressed the seriousness of these calls first relates to a person's competence, and second to the firearms owned by the elderly or their family members. In addition, participants were given the address of the only existing safe location, the Seniors Services Society in New Westminster, British Columbia, where the elderly could be kept safely from being harmed. These presentations that took place in day one and day two of the course allowed the participants to have a deeper understanding of geriatric mental illness and elder abuse with which some stated they were not very familiar: these presentations made the respondents feel more confident when responding to calls from the elderly who are in crisis. However, the highest-rated

evaluation of the presentations was related to an *Early Psychosis and Schizophrenia* topic covered during the second day of the training. The presenters consisted of an expert in the field from the Schizophrenia Society as well as other guest speakers. Early signs of schizophrenia were defined and explained thoroughly. The participants appreciated the fact that the guest speakers were real people who were diagnosed with mental illness and the family members of those who have been impacted by the illness. The guest speakers shared their life stories with the audience, describing how the illness affected them on a daily basis; they described their experiences related to police encounters. Presenters offered useful advice and hints for talking to the mentally ill who are in crisis with the emphasis on non-verbal and verbal communication. They stressed that the distorted feelings and the perception of reality by the mentally ill are real. To illustrate it better, the presenters conducted an active-listening exercise where four separate unrelated stories were read out loud in ten second intervals and the course participants had to answer questions related to every story (VPD, personal communication, November 23, 2010). It was evident that it was an impossible task to achieve since the speakers' voices were heard simultaneously and overlapped. One of the presenters said: "*Do not argue with a schizophrenic person, don't yell, because as a police officer your voice could be one of the many voices they may hear"* (VPD, personal communication, November 23, 2010). Furthermore, the presenters emphasized that many cases of mental illness are related to suicide attempts and thus police should exercise a considerable degree of caution when encountering suicidal people. One of the participants stated in the questionnaire:

> *I feel more confident about my job after hearing the stories from people affected by mental illness; I feel that I am more prepared on how to deal with a situation involving a jumper, which is very common in police work*.
> Patrol officer – 11 years of service

At the end of the presentation, the course participants were given a list of expectations with respect to police and were requested that the list would be shared with other members of the department.

The *Suicide* topic was also covered in detail by a presenter from *SAFER,* outlining the spectrum of facts about suicide, signs of suicide risk and how police can help a person who is experiencing suicidal ideation*. SAFER* is an organization that tries to

liaise with hospitals to prevent people from committing suicide when they are discharged. Many participants of the course have appreciated the fact that they have gained more knowledge from the presentation, especially when it comes to helping a suicidal person and families of those who lost a loved one through suicide. As one of the course participants commented in the questionnaire:

> *I was not aware that SAFER is the only agency that supports suicide bereavement program, I feel that this information is very valuable because suicides and suicide attempts occur quite frequently in my line of work.* Patrol officer – 5 years of service

There were several positive comments from the course participants about the presentation relaying to Fetal Alcohol Spectrum Disorder (FASD). A police FASD expert and a FASD trainer explained how to identify it and how to increase the effectiveness of police interactions involving FASD calls. The presenters stressed that a high number of police encounters involve youth who have FASD and also suffer from mental illness (i.e., depression, schizophrenia, bi-polar disorder) and frequently end up in the criminal justice system. Presenters also discussed the tactics that police should use on how to communicate with violent youth who suffer from FASD. They also talked about several programs and services available for FASD youth. For example, two participants stated:

> *It was a good course. I truly enjoyed the FASD presentation. I didn't know that FASD is a police issue and because of that many youth end up in prison. It was also nice to find out that the VPD is the only department that identified FASD as an issue*. Patrol officer – 1.5 years of service

> *It was a very helpful course; presenters demonstrated good knowledge about their areas of expertise. FASD incidents are relevant to jail settings. I was aware of the disorder but did not know the characteristics.* Jail guard – 1 year of service

> *Course was useful. Some of the material was pretty basic, things that officers already know or should know, although a refresher was very good. It was helpful by providing a contact or resources in certain circumstances i.e., FASD or elderly abuse.* Patrol officer – 16 years of service

The respondents also appreciated the section of the course that covered lethal encounters, fatal police shootings and crisis negotiation. Experts in the respective fields discussed influencing factors (i.e., mental illness; substance abuse) and motivations of the individuals who endanger both: the officers' and their own safety, as well as that of the public. Examples of non-verbal and verbal communication were given including the questions that should be addressed by police to individuals who act in an aggressive or erratic ways and who are in a possession of weapons. Presenters put emphasis on police non-lethal conflict resolution through talking and bonding with individuals and only exercising the use of lethal force as a last resort. Strategies and techniques were outlined to the participants on how to defuse various critical situations of police encounters involving life-threatening situations. Two officers commented on this section of the course:

> *The course was very useful, it gave members a base knowledge on how to negotiate in critical situations and communicate properly. It was very helpful and relevant to police work settings because it helped the members to understand mental illness better and expect certain things.*
> Patrol officer – 1 year of service

> *Each topic of the course was beneficial and helpful. I enjoyed the crisis negotiation part because my interest lies in negotiations. The last two days of the course were by far most effective, beneficial and engaging. We could apply and practice negotiation techniques covered previously.*
> Patrol officer – 1 year of service

Furthermore, the *Police Stress* topic was presented by one of the VPD's Sergeants. Since there are many "stressors" (i.e., shift work, organizational stress, and critical-incident stress) that police face at work, the presenter discussed different types of stress that officers face, with the emphasis on the cumulative stress and its consequences. The presenter gave examples on how to cope and combat stress and discussed how the Critical Stress Management Team (CSMT), a peer support group comprised of the officers who have been involved in critical accidents, can help other

members to overcome cope with the fallout of critical situations. Some of the comments on the questionnaire related to this portion of the training were:

> *The course was very useful, it was helpful and relevant, it covered issues of police stressors – an integral part which is so often least addressed. Patrol officer* – 4 years of service

> *This course provided an opportunity to learn different crisis intervention skills in diffusing situations. The content is very good for policing. I am glad that police stress was discussed because people need to recognize stress and know how to manage it. Although suicides among police are a rare occurrence, they do happen.* Patrol officer – 8 years of service

> *The course was useful in managing stress techniques and active listening tactics stood out. It addressed the issues when dealing with mental health consumers, suicidal people, and also managing stress at work and at home. I really enjoyed the course because time slot was excellent for those who attended to course and live outside of Vancouver.* Patrol officer – 1.5 years of service

The last two days of the training were met with the participants' overwhelming positive feedback. This portion of the course was devoted to role-playing and active-listening exercises that followed a presentation mentored by a police psychologist who specializes in crisis management, hostage situations, and kidnappings (VPD, personal communication, November 24, 2010). The presenter first explained conflict theory and defined crisis on cognitive, emotional and behavioural levels, as well as the principle of integration, emphasizing that in critical and non-critical situations, individuals comply and obey those they trust. The presenter explained the importance of non- threatening, safe environments as being crucial in resolving critical encounters involving police and public such as emblems – gestures the officers should use while communicating non-verbally. Reiteration of the previously presented course material was applied to different case scenarios in which the participants could exercise the knowledge gained from the training. This involved group and class discussions.

Following the presentation, the respondents took part in role-playing exercises. According to the presenter, role-playing encourages active participation in confronting situations and, since communication is the key component of police work, the CIT course participants were divided into pairs and had to come up with a hypothetical or a

real story they were going to tell to their partner. During the active role-playing, one person was telling a story and the other one was involved in active listening and then the roles switched. The role-playing exercise was followed by an evaluation of the interaction and the statements made by the active listener and were opened to a discussion by the other course participants as well as the expert presenter. The role-playing exercises allowed the course participants to practice good listening skills, empathize and understand concerns, and see values and views held by others from another perspective. These exercises also encouraged a facilitation and implementation of a non- threatening environment by engaging a mutual trust between the role-play partners. As mentioned earlier, a class discussion took place following each role-playing exercise not only to evaluate the outcome but also to address the issues and concerns raised by other course participants who questioned why various decisions were made while the expert presenter offered the most appropriate responses and what the best decisions should be made in a given scenario. For the majority of the course participants, the last two days of training were very effective. Firstly, the reiteration of the previous days' course material allowed them to better familiarize themselves and retain the course content and, secondly, the application of the course material during the active-listening exercises and the discussion that followed, enabled the participants to apply the skills and utilize the tools necessary in resolving conflict and/or critical situations in a non-lethal, non-threatening way. This is what the course participants had to say:

> *Overall, the course was helpful, especially last two days, a good reminder on little tips for talking and opening people up*. Patrol officer – 7 years of service

> *On the whole, it was a useful course. Highlighted the importance of how active listening and rapport building are necessary tools to handle crisis, emotional and incidental.* Patrol officer – 11 years of service

> *Day one and two of the course were not as useful as the last two days of the course with a few exceptions. Day three was useful in a way of learning about critical incidents and it was interesting. Some vocabulary was learned it was very useful*. Patrol officer – 3 years of service

The course was useful, applicable to patrol duties as well as personal. The course was helpful in a way how to deal with drug addicts, mentally ill and unstable, FASD people because police officers deal with them every day. Role playing exercises were very helpful. Patrol officer – 8 years of service

This course was valuable in learning communication techniques. It was very helpful. It would influence how I will communicate with people on a daily basis as well as during critical situations. Last two days of the training were very useful. Patrol officer – 1.5 years of service

The course was useful in gaining more insight on how to be a better listener. It helped to better understand on how to de-escalate situations better during hands on. Patrol officer – 1 year of service

The course provided a good balance of new information on relevant issues such as mental health and addictions which also allowed for practice during the last two days and application to work like scenarios. Patrol officer – 2 years of service

The course presented more in-depth perspectives on how to deal with everyday issues. Crisis intervention especially was useful when it comes to objectifying the facts and reacting in purposeful way. The course was helpful in a way that psychosis, addictions and mental health offer more understanding, elder abuse – a good reminder/refresher, good role playing exercises, very helpful. Crisis intervention course is always very useful. Patrol officer – 22 years of service

Overall, the feedback provided by the course participants relating to the helpfulness and usefulness of the training in relation to police work was very positive. Regardless of the years of service, the officers found the CIT course to be very efficient and, as some put it in their questionnaires: it was long overdue. Based on the responses provided, the course not only reinforced the skills gained during their work experience, but, most importantly, it provided new knowledge applicable to police work and opened new avenues by providing tools and techniques that are effective in every day police work when dealing with critical incidents. For example, as stated earlier, for some participants, the training changed their perspectives on how to deal with mentally ill persons and allowed them to improve with respect to communicating more effectively after having an enhanced understanding of the illness and hearing the stories from real people affected by it. To summarize, the usefulness of the course was met with a

positive evaluation, including all the areas of critical confrontation involving police response as well as managing and coping with work-related stress.

Since the goal of the VPD is to constantly improve and assist participants in the training process, the participants were also asked to evaluate the effectiveness of the presenters in delivering the material as well as elaborate to whether the course had allowed for enough individual and class participation and whether it had provided sufficient and adequate audio and visual aids. All of the course participants (n=83) have stated in their course evaluation questionnaire that, during the four days of training, there was sufficient opportunity given to them to ask questions and participate in group discussions: typical comments are as follows:

> *There was sufficient opportunity for individual participation; the practical portion of the course was very useful.* Patrol officer – 6 years of service
>
> *There was sufficient opportunity for individual participation and great role play exercises* Patrol officer – 1.5 years of service
>
> *There was sufficient opportunity for individual participation, especially on the last day of class.* Patrol officer – 16 years of service
>
> *There was enough opportunity for individual and class participation, I enjoyed the role play exercises.* Patrol officer – 20 years of service
>
> *There was always an opportunity to speak and asks questions during the training.* Patrol officer – 20 years of service
>
> *There was enough opportunity for individual and class participation, especially during the last two days of classes because it was a good application of theory in practice.* Patrol officer – 25 years of service
>
> *During the four days of training, there was enough opportunity for individual and class participation, we could asks questions during the role playing. This course was great because it provided a good balance of new information on relevant issues such as mental health and addictions and allowed for practice and application to work like scenarios.* Patrol officer – 2 years of service
>
> *There was enough opportunity for individual and class participation and all presenters welcomed questions and comments.* Patrol officer – 15 years of service

Results

In general, the participants have been very appreciative of the opportunity given to them during the CIT training to ask questions, probe, and participate in discussions as well as during their active role play exercises. The respondents felt that the course was well- structured and organized by allowing them to constantly enquire about all the topics covered and that, in turn, it provided them with more knowledge and confidence in relation to critical incident calls. Moreover, most participants regarded highly the efficiency, knowledge and helpfulness of the presenters in delivering the material during the CIT training. For example, 88% of the respondents rated the quality of presentations and the knowledge presented by the experts as good or very good, 8% thought that presentations and presenters were fairly good, 2% made negative comments about presentations and the material delivery by presenters, and one participant did not answer the question. Table 2 provides the numbers of the participants' responses related to the evaluation of the presentations and the presenters' knowledge, efficiency and the delivery of the course material. Most positive comments were related to presenter's expertise in their field of practice, real-life examples shared with the audience, and primarily, testimonials from mentally ill individuals and families subjected to mental illness were regarded as being the best and most powerful learning tool for the participants.

Table 2. Effectiveness of the CIT course.

Effectiveness of the CIT presenters/ Quality of Presentations	
Very good, good	73
Moderate	7
Poor	2
No answer	1

Note. VPD Training and Education Section; *N* = 83.

Some comments evaluating presenters were as follows:

> *Very effective course. Exceptional content, great presentations especially testimonials from a mentally ill consumer and a family member were very effective.* Patrol officer – 22 years of service

Presenters and presentations were great; in particular presentations about illicit drug use and aggression, harm caused by drugs, and during the last two days of the training related to communication involving de-escalation techniques. Patrol officer – 7 years of service

Presentations were fairly effective to varying degrees. At times there was information overload. Patrol officer – 25 years of service

Presenters and presentations were very effective, good examples and good demonstrations of the material. Patrol officer – 1 year of service

Very good presentations, sharing personal stories and experiences were excellent. Patrol officer – 22 years of service

During the two last days of training, the presenter had a way of keeping us interested and I enjoyed class interaction. Some of the other speakers were more lecture type making it more difficult for us to concentrate. Patrol officer – 1 year of service

Presentations and presenters were good. Patrol officer – 12 years of service

Presentations were all surprisingly effective, even the ones who I thought weren't going to be good, but they were. Patrol officer – 20 years of service

FASD presentation was very informative and presenters were excellent. Other presentations were very informative too, except some suicide topics that overlapped. Patrol officer – 14 years of service

All presentations were good. It helped to have presenters who had firsthand experience of the issues like mental health. All presenters were knowledgeable about the info they presented. Patrol officer – 1 year of service

Presenters were very effective and easy to relate to police work involving critical calls. Patrol officer – 3 years of service

One presenter was borderline insulting in how he spoke to us as we were almost grade 9 students. Patrol officer – 5 years of service

> *Presenters knew their material and were able to give work related examples.* Patrol officer – 4 years of service
>
> *Presenters were very easy to follow and listen to, knew the material very well and provided real life examples*. Patrol officer – 1.5 years of service
>
> *Presentations varied, the guest speakers with CMHA Schizophrenia stories and guest stories were very useful and interesting and other presenters were good too. One presenter covering suicide topic was not as engaging though.* Patrol officer – 3 years of service

With respect to usefulness and delivery of audio and visual aids provided by the VPD's training department and the presenters during the course, the respondents were not unanimous. For example, some participants believed that power point slides were not necessary – preferring more videos on crisis negotiations, while for others, power point presentations were very helpful in outlining and following each presentation. Most of the participants appreciated receiving handouts in the beginning of the training and found them useful as a resource and making succinct notes including all the contact information given by the presenters. In addition, many respondents would prefer to listen to 911 calls or watch videos related to critical incidents and discuss the appropriate course of action.

The last item on the questionnaire was related to participants' feedback on overall course experience including comments and suggestions addressed to the VPD's Training and Education Unit that could aid the enhancement of the training (VPD, personal communication, November 22, 2010). As noted earlier, the VPD's goal was to deliver exceptional course content and to assist participants in a training program by constantly making necessary changes and/or adjustments to the course curriculum and its delivery. Of the 83 participants who submitted the course evaluation questionnaires, 38 of them (46%) provided comments addressed to the VPD's Training Department. The comments were related to requesting more scenarios, videos from real police negotiations and recorded live calls that could accompany the training. Many participants were thankful for the opportunity to take the training, and a few believed that the course should have been compressed to two days of instead of four: interestingly enough of those who served more years in the police force did not express this view.

The following feedback illustrates additional information addressed by the participants to the VPD's Training Department:

> *Basically, videos were great, presenters were great but I would suggest having more group scenarios*. Jail guard – 1 year of service

> *I am a former school teacher. In education we use the same techniques to elicit information from students and push them to expand on their feelings and ideas such as mirroring, restating, summarizing, minimal encouragement. It was good to be reminded to use them again in our line of work.* Patrol officer – 3 years of service

> *Good time spent. Excellent instructors.* Patrol officer – 9 years of service

> *Very well run and organized course. Good job.* Patrol officer – 22 years of service

> *Considering it was a mandatory course, I am glad I had the opportunity to learn from this material.* Jail guard – 3 years of service

> *The course is dry and hard to follow if your interest is not in the material. The content is very good for policing and dealing with critical situations. I feel this course should have been shorter.* Operations – 6 years of service

> *Limit the use of power point slides. They should be used as guides, only stressing out major points. Many times, I found myself reading from them and not paying attention to presenters.* Patrol officer – 10 years of service

> *More case studies would benefit learning. More videos of actual incidents, even audio, like 911 calls, audio clips from psychiatrists during interaction with the patients would be good, drug presentations were good but more visuals to accompany them would be useful*. Patrol officer – 22 years of service

> *Helpful course, good format, time schedule, lots of breaks. Drug talk was very good and in a language that is very clear and understandable*. Patrol – 13 years of service

I personally appreciate the last two days of classes with negotiation techniques introduced. I work in D1 [district one] and jumpers are quite prevalent. What we were thought during the course was extremely beneficial and fuelled the interest I already have for negotiations. Patrol officer – 1.5 years of service

More examples on how to deal with emotionally disturbed persons would be beneficial; they are the most common in patrol. Patrol officer – 5 years of service

It was informative and interesting listening to presenters who have mental health issues. Operations – 7 years of service

I loved stories told by guest speakers affected by mental health. Patrol officer – 25 years of service

In policing we deal with MHA [Mental Health Act] all the time and with my previous career I worked with mentally ill, so for me this was a bit of review. Patrol officer – 1 year of service

I would like to learn even more on dealing with people who have mental disorder and addiction, intoxicated and violent people on how to better communicate with them. Patrol officer – 5 years of training

I would like to see more real videos on negotiations and see real scenarios. Patrol officer – 1 year of service

It would be nice to have a guest speaker who has been negotiated against. Patrol officer – 2.5 years of service

More videos on police negotiations rather than power point. Patrol officer – 1.5 years of service

More videos on successful negotiations. Patrol officer – 4 years of service

Some presentation topics overlapped. Patrol officer – 3 years of service

I think that addictions, mental health and FASD presentations should be longer while SAFER, Geriatric Mental Health and Elder Abuse should be part of the team training material. Patrol officer – 8 years of service

Summary

Based on the answers provided by the CIT participants related to the six items on the evaluation questionnaire, the training provided by the VPD has received very positive feedback. For the majority of the respondents, the course has proved to be a very successful tool in learning how to interact with individuals in crisis and how to de-escalate potentially violent situations. As stated earlier, the most powerful and beneficial elements in the participants' learning were presentations delivered by the CMHA and their guest speakers who were affected by mental illness, followed by the presentations related to substance abuse, aggression and FASD. For most of the participants, listening to stories from the mentally ill individuals and the family members, who are faced with mental illness, have altered their perspectives on mental illness and allowed them to gain the insight necessary to understand mental illness.

Overall, the participants appreciated all the components of the course, for the majority, various topics covered during the four days of training were beneficial and relevant to their work settings. As many respondents stated, especially the last two days of training related to active role-playing, listening skills and de-escalation techniques used in critical situations proved to be very successful and helped the participants gain more knowledge and confidence during crisis resolution. Only a small number of negative comments were related to course presentation topics that covered similar content (i.e., crisis negotiations involving suicide incidents and SAFER presentation).

Furthermore, the course respondents not only highlighted the importance of active listening and role-play exercises during the last two days of classes, but they gained more confidence and understanding on how to use minimal use of force during encounters with the mentally ill and people in crisis (i.e., individuals living with schizophrenia, suicidal individuals, individuals diagnosed with dementia, etc.). The *Addictions* part of the training also allowed the participants to gain a better knowledge of how the intoxication and the abuse of illicit substances affect the human body from a

physiological point of view and at the same time increasing their awareness with respect to assessing individual's behaviour in critical situations they encounter on a daily basis at work. The course participants believed that the tools and skills provided during the training enabled them to enhance their interpersonal skills, understand mental illness better, and increase the quality of their performance in handling critical calls.

Efficiency of the CIT: What do we know so far?

Does the CIT course help police officers in the de-escalation of critical encounters involving mentally ill consumers? Can this specialized training be seen as an efficient countermeasure in reducing the number of deaths and/or injuries to mentally ill individuals and police officers involved in the encounters as well as in reducing the number of formal complaints with the OPCC? Is the training effective to adequately prepare officers to employ minimal use of force in handling these calls? Do officers develop better skills and knowledge on how to best handle critical encounters after the completion of the training?

As mentioned earlier, to date no examination has been undertaken in Canada concerning crisis intervention training for police officers and its effects on critical calls involving the mentally ill. In the neighbouring country of the United States, however, a handful of studies have examined the effectiveness of crisis intervention training on police response to individuals with mental illness. These studies, although notably imperfect, and having some limitations, scrutinized officers' attitudes, perceptions, use of force, police discretion, and transport to hospitals' emergency rooms during police encounters with the mentally ill.

The first study to assess the relationship of police responses to encounters involving violence to self and others was conducted in Las Vegas, Nevada. The researchers examined 655 reports between March 2003 and May to 2005 to determine whether the officers who received a 40-hour crisis intervention training responded to dangerous violent situations with minimal use of force, at the same time promoting public safety and jail diversions (Skeem and Bibeau, 2008). Most of the recorded calls related to psychiatric emergencies involving suicide and self-harm. The researchers found that

the responding officers used low level force (physical and/ or tasers)[2] in 28 of out of 189 events (15%) when the individual's level of violence was perceived as high but did not seriously injure anyone. Of all the events, 74 % were resolved through involuntary hospitalization and only 4% resulted in a person's arrest. These study findings suggest that the officers who had received crisis intervention training rely on less-lethal use of force in extreme encounters involving violence by promoting public safety and jail diversion.

Similarly, in an earlier study, DuPont and Cochran (2000) found that a crisis intervention program has influenced police officers' perception in a positive way while responding to calls involving individuals with a history of mental illness by encouraging the use of de-escalation techniques and the exercise of less force during these encounters while at the same time decreasing officers' injuries. In the most recent study, Compton, Demir Neubert, Broussard, McGriff, Morgan, and Oliva (2011), found strong evidence of a reduction in the use of force by police officers who had received 40 hours of crisis intervention training. Those police officers who received crisis intervention training used less force during the encounters with individuals who suffered from mental illness in comparison to their counterparts who had not been so trained. The study was conducted in Atlanta, Georgia and included 135 police officers of whom 48 received crisis-intervention training and 87 did not. All of the police officers completed a survey involving three different hypothetical scenarios related to police use of force and a mentally ill person. Compton et al. (2011) found that officers who had received the training considered using non-lethal force as a more effective measure in circumstances involving a mentally ill individual in each of the three scenarios. An earlier study, measuring officers' attitudes toward mentally ill individuals revealed that, owing to a lack of specialized crisis-intervention training, police officers hold negative attitudes toward mental illness (Lester and Pickett, 1978; Godschalx, 1984). In fact, the crisis intervention training has been proved to be effective in changing officers' perceptions and attitudes towards the mentally ill. These studies revealed that the officers who completed the training became more knowledgeable about psychotic disorders as well

[2] Skeem and Bibeau (2008) classified use of tasers as a low-level force.

as the mental health resources available in the community to assist persons who suffer from the illness.

An early study conducted in the United States measured how crisis intervention training impacts the officers' attitudes towards persons who suffer from mental illness**.** Compton, Esterberg, McGee, Kotwicki, and Oliva (2006) examined officers' knowledge and attitudes toward mentally ill individuals. 159 participants were requested to complete a survey immediately before and after the training; the survey measured their attitudes, perceptions, experience, and biases towards mentally ill persons. Compton et al. (2006) found that the officers who completed the training were more supportive of treatment programs available to individuals who suffer from schizophrenia, became more aware of the illness, reduced their stigmatization of - and improved their attitudes towards mentally ill persons.

Another study that utilized the same sample of 159 officers surveyed the officers' beliefs and knowledge about causes of schizophrenia before and after completion of the training (Demir, Broussard, Goulding, and Compton, 2009). The researchers found that there was a significant increase in the officers' knowledge about the causes of schizophrenia after they had completed the training. In particular, the officers who were exposed to personal and family histories of mental illness have changed their causal beliefs, improved their attitudes toward mental illness and gained better insight about causes of the illness. Congruent with previous studies measuring officers' attitudes and knowledge after the completion of the training, Wells and Schafer (2006) found that the officers who completed crisis intervention training reported improved knowledge, communication skills, and confidence in responding to the needs of mentally ill individuals in crisis situations and felt better prepared to handle these calls. 126 police officers from five police departments in Lafayette, Indiana were surveyed about important and critical aspects of their work experiences with mentally ill individuals. The officers were asked about how these encounters were resolved, their satisfaction with the outcome, the barriers that prevented them from effective intervention, and the challenges the officers faced that inhibited them from improving their work performance. Although all of the respondents felt more informed and educated after the training, almost 93% of them believed that the improvement of their interactions with mentally ill persons depends on collaboration with mental-health providers.

In a qualitative focus-group study in Georgia, Hanafi, Bahora, Demir and Compton (2008) examined the effects of a Crisis-Intervention Team training course for police officers. 25 officers from Atlanta, who had completed the specialized training in the past year, participated in the study. The researchers reported increased officers' awareness and knowledge related to mental illness after the completion of the training, an improved ability to recognize a mentally ill person. Hanafi et al. (2008) also reported improved officers' attitudes and decreased stigma associated with mental illness, reduction of injury to mentally ill consumers and the officers involved in the encounters by using de-escalation techniques learned during the training, as well as, fewer arrests and more frequent diversion to treatment centres.

In another study, related to the effectiveness of crisis-intervention training, Strauss and his colleagues (2005) found that officers in Louisville, Kentucky who had received a 40-hour specialized training course were capable of accurately identifying individuals with schizophrenia and transporting them to the emergency services in critical situations. It is important to note that the officers' recognition of the mental illness matched physicians' diagnosis. While Teller, Munetz, Gil and Ritter (2006) analyzed police-dispatch logs in Akron, Ohio, two years prior to - and four years after - crisis-intervention training in order to determine monthly calls related to mentally ill consumers, they also discovered the effectiveness of the training. Teller et al. (2006) found that since the implementation of the training, the number of these type of calls have been on the rise and most of the police encounters with the mentally ill resulted in an increased rate of hospital transports on a voluntary basis suggests that the CIT officers became more specialized and knowledgeable in assisting mentally ill persons in crisis.

When it comes to police arrests involving the mentally ill and the association of the outcome of the crisis intervention, the efficacy of training also yielded positive results. Earlier studies that examined the prevalence of the police encounters with mentally ill individuals pointed out that these persons are more likely to be arrested and charged for the same type of offence than individuals who do not have mental illness – even though the mentally ill represent a small proportion of all people who come in contact with police (Schellenberg, Wasylenki, Webster, Goering, 1992; Robertson, Pearson, and Gibb, 1996; Crocker, Hartford, and Heslop, 2009). Crocker et al. (2009) also found that women with serious mental illness were less likely to be charged with an offence in

comparison with men, and both women and men who suffered from a mental illness were more likely to commit another offence and to do so sooner than those who did not suffer from a mental illness. However, as mentioned earlier, the most recent studies demonstrated that persons with mental illness are potentially less violent and that crisis-intervention training has indeed prompted police officers to divert individuals with mental illness to treatment facilities as an alternative to being arrested (Skeem and Bibeau, 2008; Hanafi et al., 2008).

In contrast to previous findings, a Chicago study that examined the impact of crisis- intervention training on police responses to individuals with mental illness found that the specialized training did not reduce the number of arrests: however, the CIT-trained officers diverted greater proportion of individuals with mental illness to mental health services in comparison with their non-CIT trained counterparts (Watson, Ottati, Morabito, Draine, Kerr, and Angell, 2010). The researchers interviewed 112 police officers, CIT-trained and non-CIT- trained, and asked them about their encounters with the mentally ill in the past month, the amount of force that was used, their own skills in responding to this type of calls, their perception of the CIT training and mental health services in their community, and how these calls were resolved. Watson et al. (2010) found that crisis intervention training had the greatest impact on these officers who held positive attitudes towards mental illness and mental health services, and that those officers who knew a mentally ill person were more likely to divert mentally ill individuals to mental health facilities. Nevertheless, the effects of the crisis-intervention training have shown that these officers who received training were more familiar and confident in resolving critical situations involving the mentally ill by assisting and directing them to appropriate community resources.

Borum and his colleagues (1998) examined police officers' perspectives on responding to mentally ill persons in crisis. In this study, data was collected from 452 officers in three different police departments that varied in their system response to these calls; these police departments where located in Birmingham, Alabama; Knoxville Tennessee; and Memphis, Tennessee. One department employed specialized officers who had crisis-intervention training, the second one relied on a mobile team of qualified respondents to mental-health calls, and the third one employed an in-house social workers team who assist officers in responding to these calls. Police officers from these

three different departments were surveyed about their perceptions and the effectiveness of their department in responding to calls involving individuals with mental illness, and the cooperation of the mental health system with police departments. The researchers found that over 50% of the surveyed officers from all three departments felt they were well prepared to respond to critical calls involving mentally ill individuals. However, the highest preparedness and efficiency of these programs in responding to calls was reported by the officers in Memphis. Since the Memphis Police Department (MPD) officers volunteer to have specialized crisis intervention training, this finding is not surprising. Further to that, the officers from the same department who did not receive specialized training did not feel as confident and equally prepared in responding to mental health calls as their counterparts who had received the training. Also the officers from the MPD reported the strongest cooperation of psychiatric emergency services in the disposition of the mentally ill. It is important to note, that the MPD has an arrangement with the ER department at the Tennessee University Hospital that results in an open-door policy. This means that individuals who are brought in by the CIT trained officers are being admitted within 15 minutes, making the Memphis Crisis Intervention model very effective (Vickers, 2000).

As highlighted, unequivocally, there is strong evidence that crisis-intervention training programs have a positive impact on police response to critical calls. The training not only minimizes officers' stigmatization of those individuals living with mental disorders but also improves officers' attitude, knowledge, confidence, and their approaches with respect to reduce the use of force towards mentally ill consumers by using more efficient verbal communication techniques.

Discussion: Present Study

How does the present study relate to research conducted in the U.S. concerning the effectiveness of the CIT on police officers and their interactions with mentally ill individuals? This study addressed two questions: a) are the VPD officers better equipped after the training in responding to critical calls involving mentally ill persons by using de-escalation techniques and a minimal force required? b) has the number of

deaths/injuries of the mentally ill and the officers involved in the encounters diminished after the endorsement of the CIT course at the VPD?

In addition to the collected 83 questionnaires from the Crisis-Intervention Course participants after the completion of the training at the Vancouver Police Department, the data also included statistics from the Office of the Complaint Commissioner of British Columbia and an overview of police shooting incidents in the second section and third section of the study.

Findings and Analysis: Crisis Intervention Training

The participants were surveyed on the usefulness and effectiveness of the training in relation to their police work, performance of the presenters, the ability to actively learn and participate in the discussions as well as the helpfulness of the training aids. After examination of the responses several patterns emerged. A general consensus (88%) emerged that the 32 hours CIT course prepared participants for, and increased their confidence in, their use of de-escalation techniques in crisis situations. According to the responses from the CIT course participants, the training has heightened their awareness and understanding in identifying mental illness, enhanced their knowledge related to substance abuse and mental illness, made them more confident to respond to emergency calls involving the mentally ill, and increased their preparedness in defusing violent situations by employing improved verbal communication skills, rehearsed during the active role-playing portion of the CIT course. In their responses to the questionnaires, the majority of the participants stated that de-escalation techniques rehearsed during the training encouraged them to improve their skills that are critical in saving people's and officers' lives and promoting public safety by deploying non-lethal, non-threatening practices with a minimal use of force being required.

Perhaps the most powerful component of the training in bringing awareness to mental illness and understanding it from a different perspective was delivered by the presenters who were guest speakers from British Columbia Schizophrenia Society (BCSS). The overwhelming majority of the course participants, (81%) have reported that hearing the stories from real people who suffer from schizophrenia and these who have

family members that constantly struggle with the illness, had a remarkable impact on altering their views and reducing the stigmatization of those living with mental illness, the stories also fostered increased patience and improved future communication in de-escalating encounters with the mentally ill in crisis. Also, from the perspective of the CIT participants, listening to guest speaker's advice and suggestions on how to best communicate with mentally ill individuals and how to act during these encounters, had prepared them to become more confident in taking a less-rushed approach in de-escalating critical situations.

This finding is congruent with an earlier study, conducted by Watson, Agnell, Schaefer Morabito and Robinson (2008), who examined the experiences of mentally ill individuals with respect to their interactions with the police: this study found that positive attitudes, professionalism, non-threatening communication, and a commitment to de-escalation on part of the police during these encounters affects the experiences of the involved parties in defusing critical situations. Watson et al. (2008) interviewed 20 mentally ill individuals in Chicago, Illinois about their 67 encounters with the police in order to discover how police interactions are experienced by individuals with mental illness. The majority of the encounters (73.13%) took place in a public place, followed by participants' homes (16.42%), and the remainder (10.45%) occurred in a shelter or an agency. Watson et al. (2008) found that mental-health consumers feared police; however, officers' positive attitudes and an understanding of mental illness prevented many encounters from escalating and changed the behaviour of the respondents. What the study participants desired from law enforcement in less intense encounters was to be fair, kind, respectful, and to allow them to be listened to - and responded to – in a calm manner. Watson et al. (2008) have emphasized the importance of perceived procedural justice.

In their questionnaires, the majority of the CIT course participants expressed the view that the knowledge and skills gained during the training would allow them to apply more effectively the newly-learned techniques in critical encounters involving mentally ill individuals. As demonstrated earlier, based on the participants' responses, the training was extremely useful and long overdue because it is critical in saving lives and/or injuries to the mentally ill and police officers involved. It highlighted the importance of how active listening and rapport building are necessary in de-escalating emotional and

incidental crisis when dealing with the mentally ill. Some participants have stated that the training was also beneficial in providing them with the necessary contact information on accessing mental health resources. Others have stated that they will not only employ strategies and skills learned from the course at work but also will apply them in their personal lives.

A recent Canadian study that examined the municipal police recruits' satisfaction with the training at the Justice Institute in B.C., revealed that 86% of the officers were satisfied with the training (Feenan, 2011). A self-administered survey was sent to the newly hired police officers six months after their completion of the academy training. 51 officers, who responded to the survey, believed that the training provided them with the sufficient knowledge, skills, and confidence to perform their police duties by applying learned skills during the training. Feenan (2011, p. 48), found that the JIBC graduates who were satisfied with the training felt prepared "to tackle the challenges that they will face in today's complex world". In other words, positive feedback provided by the police officers suggests that their satisfaction with the training is important; if the police training is deemed successful, its effect will be carried out in practice.

Consistent with previous U.S. studies evaluating crisis-intervention-training for police officers and Feenan's (2011) findings, the results of this research, support the proposition that the CIT has met its goals in better preparing them to handle critical calls in general as well as the calls specifically involving mentally ill individuals more effectively and efficiently. This was based on the participants' assessment of the effectiveness of the specialized training. It could be argued that the officers who completed the CIT course and expressed positive attitudes about the knowledge derived from it and its application to future police encounters that are related to mentally ill consumers, will more likely embrace the training, follow through with the concepts, techniques, and skills they have acquired. However, the question still remains: in practice, how successful are the effects of the training in diminishing the injuries and/or deaths of mentally ill individuals and police officers? Is the number of complaints filed with the OPCC against police diminishing after the introduction of the VPD's crisis intervention training in 2002?

Many police departments lack internal record keeping in determining the effectiveness and the impact of the CIT on crime rates (Watson, Schaefer Morabito, Draine, and Ottati, 2008). However, the VPD's Training and Education Unit not only strives to constantly enhance the training, based on the course evaluation feedback provided by the participants, but also scrutinizes whether the training has met its goals in equipping police officers to strive for best practices in minimizing use of force, and improving knowledge and confidence in responding to any type of critical incidents. As outlined earlier, research to date has assessed, in a variety of ways, the positive outcomes and the effectiveness of the CIT measuring officers' attitudes, knowledge and stigma associated with mental illness, use of force, police discretion, and the drop off of mentally ill individuals to designated facilities. Consequently, this research includes additional outcomes and data sources relevant in determining the effectiveness of the CIT offered by the VPD.

As stated earlier, a 2007 study conducted in Vancouver, British Columbia, that measured the frequency of calls made to the Vancouver Police Department in a period of 16 days, revealed that almost 50% of these calls were related to mental illness (Wilson-Bates, 2008). Based on this report, it is unknown, however, how these calls were resolved. Thus one of the measures of the effectiveness of the CIT at the VPD may possibly be substantiated by the analysis of the OPCC statistical data and data sources related to police fatal shootings from one year to the next one.

Chapter 6.

The Office of Police Complaint Commissioner (OPCC)

One of the measures of the effectiveness of the CIT course for the VPD is the examination of statistical data provided by the OPCC. The analysis of the number of formal public complaints filed against police with the OPPC could provide the answer to whether the CIT course has been successful in reducing the number of formal complaints, injuries and/or deaths to the mentally ill and other individuals, and whether it has delivered an enhanced police service since its introduction in 2002. It is important to emphasize that these OPPC statistics are not exhaustive of registered complaints against police since not all individuals who are dissatisfied with police actions file a complaint ("OPCC", n.d.).

The OPCC in British Columbia was established on July 1st, 1998 and it is an independent civilian organization that reports to the British Columbia Legislature. It provides an oversight of lodged complaints against municipal police officers and/or certain tribal police officers or departments (OPCC, Annual Report 2003; OPCC Annual Report 2005, "OPCC", n.d.). There are 15 police agencies falling within the jurisdiction of the OPCC, pursuant to the *Police Act:*

- Abbotsford
- Central Saanich Police Service
- British Columbia Combined Force Special Enforcement Unit (BCCFSEU)
- Delta Police Department
- Nelson City Police Department
- New Westminster Police Service
- Oak Bay Police Department
- Port Moody Police Department

- Greater Vancouver Transportation Authority Police Service (GVTAPS) (effective as of December 5th 2005)
- Stl'atl'imx Tribal Police
- Kitasoo Xaixais Police Service
- Victoria Police Department
- Vancouver Police Department
- West Vancouver Police Department

It is important to note that the OPCC has no authority to respond to complaints launched against the RCMP. The Commission for Public Complaints (CPC) against the RCMP is mandated to receive complains across Canada and provides similar service to that of the OPCC (OPCC, Annual Report 2006).[3]

The goal of the OPPC is to ensure that the complaint process remains impartial and fair for an individual as well as a police officer and it seeks to resolve complaints successfully. The OPCC's headquarters are located in Victoria, British Columbia; however, an individual can lodge a complaint by mail, by e-mail, by fax, by phone or in person at any municipal police department. There are also 19 support groups that can aid an individual in filing a complaint ("OPCC", n.d., para. 4). It is important to note that an individual may file a "Non-Registered Complaint" if he or she only would like to inform the OPCC or the police department about individual concerns with the police ("OPCC", n.d., para. 2). Also if a complaint is not serious in nature and/or is less complicated and does not involve bodily harm and/or injury, it could be resolved independently from the OPPC or the police department during mediation rather than a disciplinary process ("OPCC", n.d.).

All the complaints against police must contain at least one allegation of police misconduct under s. 77 the *Police Act* and must be filed with the OPCC within one year of the incident date ("OPCC", n.d., para. 1). There are three different types of complaints: *Police service or policy, Internal discipline,* and *Public Trust* (OPCC, *Police*

[3] As of December 7th, 2011 a new civilian body to investigate serious police incidents was introduced by the BC government. The OPCC will have the authority to override complaints launched against the new civilian body's conduct on a municipal and federal level (Bailey, 2011).

Act 2010 s. 52.1(1)). The latter allegations are filed with the OPCC while police service or policy and internal discipline complaints are resolved within the local police board, unless they affect the relationships between the public and police ("OPPC", n.d.). Not all public complaints are admissible; the Police Complaint Commissioner (PCC) must first review their admissibility ("OPPC", n.d.). Once the admissibility of the complaint is granted, a *Public Trust* complaint can be resolved by summary dismissal, informal resolution (mediation), an investigation or a public hearing ("OPPC", n.d; OPCC, Annual Report 2003). The recommended disciplinary measures by the OPCC for an officer's misconduct are recorded on the officer's Service Record of Discipline and may result in an officer's dismissal, verbal or written reprimand, reduction of rank, and/or mandatory training to enhance professional qualifications. If the OPCC's decision does not provide a resolution that is satisfactory to the complainants, they make apply to the OPCC requesting a public hearing. The OPCC may also make this decision without having received a formal complaint application (OPPC, Annual Reports 2003-2009).

Annual Reports of Complaint Files with the OPCC

Since its existence, the OPPC has received 4985 complaints (2413 or 48% of the complaints were related to the VPD's misconduct), averaging 415 complaints a year in total and 201 for the VPD, respectively (OPCC, Annual Reports 2003-2009*)*. Tables listed below characterize the number of complaints including open and closed files since 1998 to 2009. The data provides the total number of complaints launched for the VPD explicitly. There is no annual report yet available from the OPCC for the year 2010.

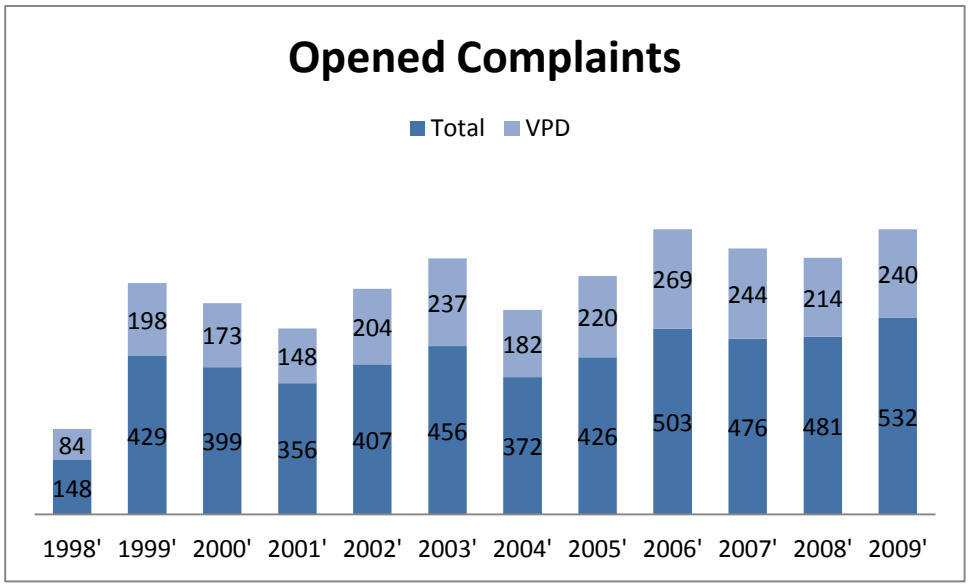
Complaint Files Opened

Table 3. OPCC, Annual Reports 2003-2009

Year	Total	VPD
1998[a]	148	84
1999	429	198
2000	399	173
2001	356	148
2002	407	204
2003	456	237
2004	372	182
2005	426	220
2006	503	269
2007	476	244
2008	481	214
2009	532	240

[a] Since the OPCC came into existence on July 1st, 1998, data presented covers complaint files opened from July 1st to December 31st, 1998.

Figure 2. OPCC: Complaints launched from 1998-2009



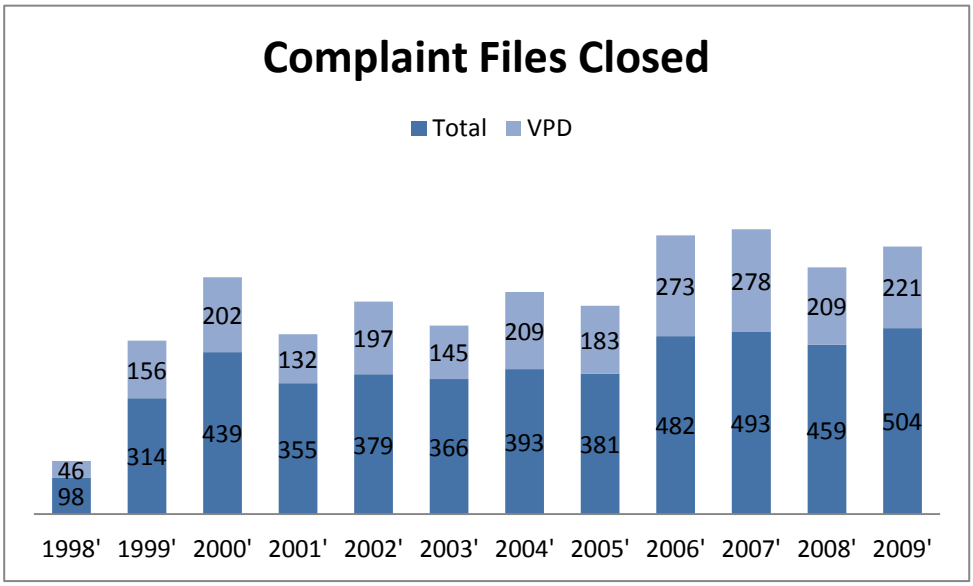
Complaint Files Closed

Table 4. OPCC, Annual Reports 2003-2009

Year	Total	VPD
1998[a]	98	46
1999	314	156
2000	439	202
2001	355	132
2002	379	197
2003	366	145
2004	393	209
2005	381	183
2006	482	273
2007	493	278
2008	459	209
2009	504	221

[a] Complaints files closed from July 1st to December 31st, 1998.

Figure 3. OPCC: Closed complaints from 1998-2009



Over a period from 1998 to 2009, the OPCC had resolved and closed 4663 complaint files, including 2251 VPD files. Throughout the years, most of the launched complaints were related to public trust, followed by internal discipline, service and policy breach (OPCC, Annual Reports 2003-2009). The complaints were substantiated following an investigation and disciplinary action against police, the remaining number of files were either closed though informal resolution (mediation) or were withdrawn due to its inadmissibility (OPCC, Annual Reports 2003-2009). 2009 was the busiest year for launched and closed complaints.

Annual reports, including the characteristic of the complaint, were published from 2003 to 2009 (OPCC, Annual Report 2003 – 2009). The complaints against an officer are defined by the *Code of Professional Conduct Regulations*, enacted in 1998, and may contain one or more allegations (compounded complaints) as defined in the *Code* as follows:

> Discreditable conduct
>
> Neglect of duty
>
> Deceit
>
> Improper disclosure of information
>
> Corrupt practice
>
> Abuse of authority
>
> Improper use and care of firearms
>
> Damage to police property
>
> Misuse of intoxicating liquor or drugs in a manner prejudicial to duty
>
> Conduct constitution an offence
>
> Being a party to a disciplinary default
>
> Improper off-duty conduct. (OPPC, 2003, p. 46)

During the years 2003 to 2004, 2007, and 2008 the most common allegation launched against an officer or a department with the OPCC was the *Abuse of Authority*,

followed by *Discreditable conduct* and *Neglect of duty.* In 2005, 2006, and 2009, Abuse *of Authority, Neglect of Duty,* and *Discreditable Conduct* were the most common launched complaints (OPPC, Annual Report 2003 – 2009). Finally, the most common complaint against an officer from 2002 to 2009 was the *Abuse of Authority* characterized by a *Public Trust* complaint.

Complaints Related to Mentally Ill Consumers

It is important to note that the OPCC data outlined in the Annual Reports only provides samples of the variety of complaints and specific information regarding complaints involving the mentally ill is scarcely made available to the public. These case summaries in the OPPC's Annual Reports do not specify the municipality of the occurred incidents nor do they relate to officer's excessive use of force or the *Abuse of* A*uthority* during encounters with the mentally ill. Rather these summaries are characterized as an officer's *Neglect of Duty* (OPCC, Annual Reports 2003-2009). For example, in 2003, the OPCC reported one case related to a mentally ill individual. A complainant's sister called police worrying about her brother's wellbeing. When police arrived the complainant refused to open the door to his residence. Consequently, *Car 87* was dispatched and the complainant again refused police access to his home. Officers, concerned about the complainant's behaviour, forced their entry into the residence. The complainant was detained under *s. 28* of the *Mental Health Act* and transported to a nearby hospital. During the complainant's two-week stay at the hospital, no efforts were made by officers to secure the complainant's residence door, which was damaged during the encounter and as a result, the complainant's personal effects were stolen from his home (OPPC, Annual Report 2003*).* Since various officers were involved in the case, the supervisor, who was at the scene and took control of the situation, was found to have committed the offence of *Neglect of Duty*; however, no corrective or disciplinary measures were imposed.

In the 2004 OPPC's Annual Report, there were no complaints related to mental illness (OPCC, Annual Report 2004*)*. In 2005, police received a call from a mother regarding her son's erratic and aggressive behaviour. The complainant's son was arrested and placed in jail. During her son's stay, the complainant contacted mental-

health officials who were familiar with her son's illness and suggested that it would be in her son's best interest to be admitted to a hospital under *s. 28 of* the *Mental Health Act.* While the transfer papers were being prepared, the complainant's mother received a call from an officer, who was unaware of the prior arrangements being made for her son, and was told to pick up her son from jail. When the complainant attempted to explain the situation that was taking place, the officer spoke with her in a very unprofessional manner and was rude. The complaint was resolved informally, through mediation where the complainant and the involved officer signed a consent letter (OPCC, Annual Report 2005).

In the following two years, 2006 and 2007, the OPCC did not report any cases involving mentally ill individuals (OPPC, Annual Report, 2006; 2007*).* The following two cases related to the mentally ill are outlined in the 2008 OPPC report. The first case occurred in 2006 and involved the suicide death of a mentally ill man. Police received two 911 calls related to the suicide attempt. The first one was from the man's aunt informing police about her nephew's suicide threat and, 40 minutes later, the man called the police advising that he had slashed his wrist. The police arrived nearly 90 minutes after the aunt's call. Consequently, the man had already died. Since officers did not respond to these calls in a timely manner, the 911 respondent neglected their duty to respond or direct police officers immediately to the man, the OPCC's final Investigation Report substantiated *Neglect of Duty* and a disciplinary hearing was scheduled. Before the hearing took place, the second final investigation was launched, during which the *Neglect of Duty* allegation was removed and replaced by the *Discreditable conduct* relating to the Sergeant who made inappropriate comments during the incident. Initially, the Sergeant was suspended from work for three days without pay. The OPCC's *Commissioner* made a revision of the charges and requested a comprehensive review. Subsequently, the *Neglect of Duty* charge was re-instated; the officer in charge received a six-month rank reduction, and a written reprimand relating to *Discreditable Conduct (*OPCC, Annual Report 2006)*.*

The second case involving a mentally ill individual was not lodged (no formal complaint was filed) with the OPCC. A man reported to the police that his female friend, who suffers from mental illness, was assaulted by her landlady. When the female attended a police station to report an assault, she changed her mind and reported that

the assault never took place. The man who contacted the OPCC believed that his friend became intimidated by the police and thus changed her statement. Further to that incident, the man was told by the investigator that he was not a credible witness. Police contacted several other witnesses and found out that the landlady runs a foster care service. Based on the statements from other witnesses the allegations of assault against the landlady were found to be fabricated. The OPCC reviewed the police investigation and decided to close the file (OPCC, Annual Report 2008).

Another case launched with the OPPC in the following year was a case in which a mentally ill man alleged that his neighbour, who lived upstairs, was able to touch him through the walls with his electromechanical-device. When the man called to complain about his neighbour, he alleged the police would not treat him seriously. During his previous calls to police regarding the same matter, the man alleged that an officer had threatened him and ordered him to leave his neighbour alone. Before the investigation could be launched, the man passed away and the OPCC dismissed the file. However, the police department had been requested to investigate what had happened during the encounters involving the complainant (OPPC, Annual Report 2009).

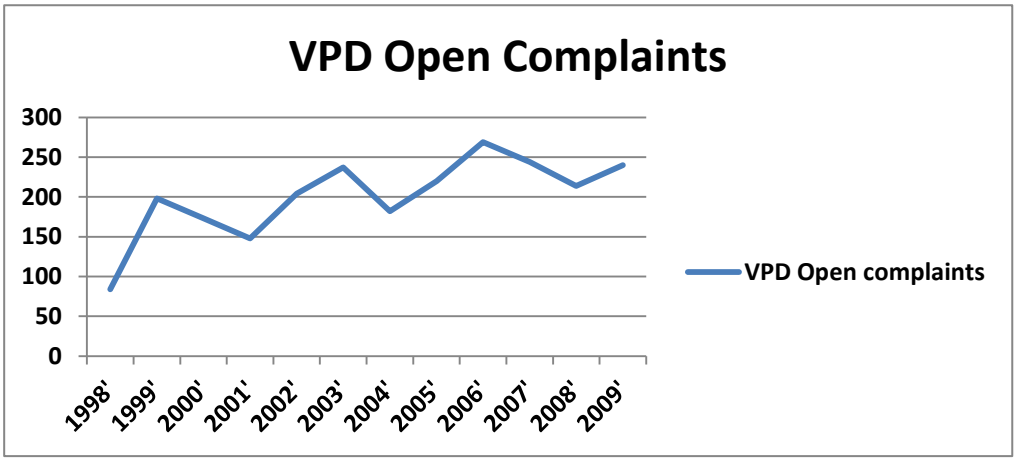
Clearly, the OPPC Annual Reports lack very important information in providing statistical data of the filed complaints relating to police involvement in critical incidents. These reports do not indicate whether the complaint files are related to mental-health issues as the RCMP's CPC reports do (CPC, Annual Reports 2003-2004). The OPCC does not categorize their statistical data based on the vulnerable population outlined in the *Police Complaint Commissioner`s Mandate and Powers.* The annual reports also fail to provide statistical data for the launched complaints related to police excessive use of force. However, the Commissioner may order a *Public Hearing,* if he believes that the hearing is in the public interest. The dates of the past and scheduled *Public Hearings* are posted on the OPPC's website ("OPCC", n.d.).

Complaints against the Vancouver Police Department

Based on the statistics, provided by the OPCC with respect to VPD's complaint files launched in the years 1998-2009, the highest number of complaints was registered

in 2006, while the lowest was filed in 1998. Since the enactment of the CIT course by the VPD in 2002, except for the year 2006, in every year there was a noticeable, slight decline of complaints filed with the OPCC against the VPD's department and its members. As illustrated in a Figure 2 the years that followed 2006 were characterized by a slight fall, except for 2009 in which there was a small rise in filed complaints; however, the number of complaints filed never surpassed the number filed in 2006.

Figure 4. VPD's open complaints trend (OPCC, Annual Reports 2003-2009)



The Effectiveness of the CIT Course Based on the OPCC statistics: Findings

The VPD's CIT course has been in effect since 2002, which is almost a decade. During this time, the overall number of filed complaints did not follow an upward trend; quite to the contrary, it remained fairly steady with the exception of a slight increase in the year 2009. Between 2007 and 2009, the number of complaints did not surpass the peak number reached in 2006. These promising findings suggest that the VPD's CIT course (among other factors not examined by this review), may positively contribute to the reduction in complaints; and in preparing officers to safely and effectively perform their duties in a professional manner.

In addition, the population growth in Metro Vancouver (City of Vancouver) has been on a constant rise every year. According to Statistics Canada (2011), the estimated population growth in Metro Vancouver rose from 574,614 in 2002 to 642,843

in 2010 therefore suggesting that with an increase of population in the city more complaints should have been launched with the OPCC, thereby confounding statistical outcomes. Understandably then, definite conclusions cannot be drawn from the statistical analysis of the OPCC. There is not enough evidence to substantiate the claim that the CIT solely diminished the number of the launched complaints. A more detailed statistical analysis of the yearly complaints to- population-ratio (i.e., 100,000) would need to be employed in order to provide more reliable results in finding out the answers. Furthermore, the frequency of official complaints filed with the OPCC that are related to mental health consumers and the police use of excessive force remains unknown since it is not delineated in the OPPC's Annual Reports.

Chapter 7.

Police Shootings

Although the number of police shootings of the mentally ill in Canada may not be the best indicator to measure the effectiveness of the crisis-intervention-training since there is no standardized obligatory training across the various police forces in the country: nevertheless, it is important to examine the trend of police deadly shootings. It is a complex task to report the frequency of police encounters with mentally disordered individuals. The informational resources are scarce and incidents of police encounters with the mentally ill are often unreported (Cotton and Coleman, 2010a). The most thorough investigation of the incidents conducted by Hartford, Heslop, Stitt and Hoch (2005) in London, Ontario discovered that individuals with mental illness were three times more likely to interact with police in comparison to the general population, and twice as likely to be charged and/or arrested. The other study from Belleville, Ontario revealed that 6% of the police cases in 2005 involved the mentally ill (Cotton and Coleman, 2010a). A recent study involving 1,154 calls made to the Vancouver Police department over a period of 16 days, in September of 2007, reported that between 31% to 49% of these calls were associated with police encounters with the mentally ill (Wilson-Bates, 2008). Research on police encounters with the mentally ill has not been comprehensive or widespread making all the available statistical data questionable. Yet, the existing data suggests that police officers do indeed experience more encounters and are more likely to interact with the mentally ill population in comparison to members of the general population; but how these incidents are resolved raises yet another question.

Police Use of Force Involving Mentally Ill

Some research proposed that police training could be an effective countermeasure against injuries and/or deadly encounters to police officers, citizens and the mentally ill (Hontz, 1999). Is the CIT effective in reducing the deaths of mentally ill individuals and/or police officers involved in these encounters? Has the number of deadly police shootings diminished over the years?

Police use of force resulting in the death of an individual has always drawn much attention from policy makers, researchers, and the media. In past decades, media reports on police shootings of the mentally ill in Canada have been increasingly prevalent (Adelman, 2003). These media reports frequently provide a biased story, often sensationalized and unfounded. However, when injury to or death of an individual results from excessive use of force by police, it meets with a community's resistance and lack of a public trust in the police (Ross, 2000).

How often do police kill an individual in a critical encounter? For example, in the United States, the highest number of police killings including firearms, knives, and tasers reported by the FBI (2010) from January 01, 2000 to December 31, 2009 totalled 3753 deaths. The most police shootings occurred in 2004, resulting in 437 incidents, while the averaging number of deaths per year was 375. The FBI's *Uniform Crime Statistics* do not specify how many of these killings involved mentally ill people. In Canada, deadly shootings by the police resulted in 139 deaths between January 01, 1999 to December 31, 2009; averaging 12 deaths per year which is a rare occurrence in comparison to the United States' statistics (Parent, 2011).

Recent Police Shootings in Canada

According to media reports from January 01, 2010 to July 31, 2011, Surrey RCMP had fatally shot two men, in March of 2011. The first case involved a male known to police, who had been convicted and had served time in 2004, for firearms possession without a licence, pointing a gun at his former girlfriend and her boyfriend, and assaulting a police officer. Prior to his death, the man was driving in his vehicle and sped away

from a routine police traffic stop. Consequently, police began a pursuit and deliberately rammed the man's vehicle after the man hit a third party car. During the incident, the man pointed a gun at an officer who fired shots killing the man. The gun used by the suspect was loaded and police also recovered another replica of a handgun from the man's vehicle (Bolan, 2011).

A few days later, Surrey RCMP responded to a call from a female in relation to domestic-violence dispute. As police arrived a few minutes after the call, a suspect pointed a gun at one of the officers. Police then killed the man outside his house (Bolan, 2011). During the following month, Vancouver Police Department officers were involved in another shooting. A man wielded a knife at officers and was shot. He was taken to a hospital in critical condition to undergo a surgery. Further details of the incident were not released by the media (Krishna, 2011).

Two men lost their lives, in Montreal in June 2011, when police used excessive force. One of these men was an innocent bystander. Montreal police responded to a call involving a mentally ill homeless individual who had been ripping open garbage bags, wielding a knife and threatening individuals in his proximity. When the police arrived at the scene three officers fired approximately ten shots from across the street killing the suspect. This tragic incident took the life of an innocent man who happened to be walking along the street during police shootings. He was struck by the stray police bullet and died few hours later at a hospital. This most current incident sparked public outrage and created community resistance against police fatal shootings. An investigation will be launched to determine whether the police involved acted appropriately with respect to the use of force and it will be determined whether the police actions were justified (Hamilton, 2011).

In March 2011, police in Terrebone, Quebec, fatally shot a man at a gas station. The deceased was a suspect in a robbery that happened a few days earlier and police tried to prevent him from another heist when he was apprehended. The suspect tried to flee from police in a vehicle driving it toward an officer standing outside. As a result, police shot the suspect who later died at a hospital. One of the involved officers was injured. It was the third police shooting that happened during the same week in Quebec; however, there were no deaths reported in previous instances (Cherry, 2011).

In the neighbouring province of Alberta, in June 2011, Calgary police received a call from a woman who was in distress resulting from a domestic dispute. A 911 dispatcher heard threats being uttered in the background directed at the caller. A few minutes later, when police arrived, a man brandishing a knife was shouting threats at the officers. Police fired four shots killing the man. The suspect was known to police from previous calls related to alcohol-induced loud parties and mayhem (Moharib, 2011).

According to media reports, an Edmonton police fatal shooting that occurred in March 2011, was the second one that happened during this year. Police responded to a call of a distraught man who was alleging to be suicidal. The man was shot by police outside of his vehicle. He was taken to a hospital but died a few hours later. In an earlier shooting that happened in February, police killed a 17-year old man who had a criminal record. Prior to his death, the 17-year old along with two other teenage companions kept approaching various people demanding money, personal items and jewelry. He would wield a knife and a baseball bat. When police responded to the call from the victims, the perpetrators were still at the scene and began to flee from police. Two were successfully apprehended but the third was fatally shot by an officer. Police confirmed that alcohol was a factor in the youth's criminality (McLean, 2011).

Police Shootings in British Columbia

An earlier study by Parent (2003) revealed that, from January 01, 1980 to December 31, 2002, there were 47 police shootings in British Columbia that resulted in the death of an individual, and over 100 non-fatal shootings resulting in injury. 28 out of the 47 fatal shootings took place in the RCMP's jurisdiction and most of them occurred in the remote, rural areas of the province. The only exceptions were a shooting in Burnaby involving the RCMP's Drug Section within the City of Vancouver, and single fatal shootings that took place in Coquitlam, Surrey, Langley, New Westminster, Maple Ridge and West Vancouver. According to Parent (2003), approximately 50% of the 28 police shootings constituted "suicide-by-cop" or "victim- precipitated suicide" where victims deliberately provoked a lethal response from officers.

In the most recent study, covering the period from January 01, 2000 to December 31, 2009, the police shot 30 individuals (29 males) in British Columbia (Parent, 2011). In half of the fatal shootings, a criminal offence was committed and a victim of police shootings was found to be under the influence of illegal substance. In four cases, a victim used a motor vehicle as a weapon in attempt to kill an officer, and three other individuals were shot in a violent physical confrontation in which an officer feared for his/her life. Eight cases of police shootings involved a person with a documented history of mental illness. In four of these cases, officers were confronted by aggressive and irrational behaviour on the part of the victims who were armed with a potentially lethal weapon. On two occasions, the officers involved in the lethal shootings were injured and were subsequently hospitalized. In three of these fatal shootings, the officers initially deployed a taser in an unsuccessful attempt to incapacitate an individual and subsequently were forced to shoot and kill.

Police Shootings in Metro Vancouver

Parent and Verdun-Jones (1998) has reported that over a 15-year period from 1980 to 1995, 15 individuals (14 in Metro Vancouver) were killed by members of a municipal police department and three officers lost their lives during these use-of-force encounters. Five of these individuals had documented histories of mental illness and eight of them displayed suicidal behaviour prior to threatening the police. Almost all of the individuals (14 out of 15) were in possession of a weapon, either a gun or a knife, and displayed irrational and aggressive behaviour toward officers. In all of these encounters with the police, the officers were exonerated. In fact, in the majority of cases involving police use of force, the officers are justified, the only exception is: criminal and civil liability when the officers would have not been justified (Parent and Verdun-Jones, 1998). A recent Canadian study indicated that between the years of 1992 and 2002, there were eleven deaths of mentally ill people as a consequence of police encounters (Coleman and Cotton, 2010b).

In the years from 2003 to 2010, according to the media reports, seven more individuals, who suffered from mental illness, lost their lives in police encounters. On three occasions, the police shot and killed individuals and in four cases these deaths

were taser related. Two individuals died in 2003 in taser-related police shootings. In 2004, a man was tasered by police in his downtown hotel apartment and died. The same year, another individual died as a consequence of police using a taser and was pronounced dead at the scene. A coroner's toxicology report revealed lethal levels of substance abuse in his body (Lee, 2004).

There were no media reports of police shootings of the mentally ill in 2005 or 2006. In 2007, police shot and killed a Vancouver man with history of bipolar disorder who swung a bicycle chain, hitting an officer in a head (Woo and Hal, 2010). Three years later, in 2010, two more individuals were fatally shot by police. One of them was a homeless man who acted in an irrational way wielding a utility knife at the officers. Another case involved an individual who was killed by the RCMP in Deep Cove (North Vancouver) after allegedly striking several vehicles in a police chase. The individual refused to comply with police and provoked officers to shoot him. After being shot, he was transported to a hospital where he died 30 hours later. 18 months prior to his death, he had been diagnosed with bipolar disorder swinging from elation to depression (Warnica, 2011).

It is important to note that not all police shootings result in the death of an individual. These cases however are often not reported by the media since they are resolved without the discharge of a firearm but by the officer‘s using less-lethal tactics. For example, in May 2011, Transit Police received a call about a man who was acting erratically, dangerously waving a sword-like object at one of the Skytrain stations in Burnaby. The man continued on the Skytrain toward Vancouver city centre. The Vancouver Police responded to this call, made contact with the man observing that he continued to wield a sword. The police followed the man onto the streets and began their negotiations asking the man to drop the sword. The man acted irrationally and did not comply with police orders. Concerned about the man's and bystanders' safety police ineffectively fired an Arwen (a riot control pistol) gun and a taser. The man started to flee and was apprehended in police pursuit without additional weapon use. No one was injured during the incident. The man was taken to police custody where he is facing possible weapon charges, and awaiting a scheduled psychological evaluation (Woo, 2011).

The latest police shooting reported by the media occurred in July 2011. A man was shot dead by a Vancouver Police officer near the downtown area. The man was allegedly wielding a machete at the officers. During the initial encounter with the man, police officers fired a few rounds from a beanbag shotgun; however, the man did not drop his weapon. The officers resorted to using a firearm, subsequently killing the man. It is not known if the man suffered from mental illness (CTVBC, 2011).

Tasers

Tasers, commonly described as Conducted Energy Weapons (CEW), were introduced to law enforcement agencies in 2001; and since that date, there have been over 330 taser related deaths in the United States and over 26 in Canada (Amnesty International, 2008). While in the United States coroners have listed taser shock as a cause of death or a contributory factor in more than 24 cases, in Canada, there was no substantiated evidence in coroners' reports attributing these deaths to police taser use with the exception of one of the RCMP case in 2007 (Amnesty International, 2008; Braidwood, 2009). While the FBI's (2010) statistics do not report how many of these taser-related deaths involved individuals with mental illness, in Canada, according to media reports, five of these deaths involved mentally ill individuals (CBC, 2011). For example, from 2003 to 2008, eight of 26 men who lost their lives in a taser- related deaths at the hands of police, have died in British Columbia. In 2003, a man died in Burnaby (RCMP's jurisdiction) while pulling a knife and a hammer on police officers. A toxicology report revealed high levels of substance in man's bloodstream (CBC, 2011).

A similar case occurred during the same year in Prince George, British Columbia. The RCMP responded to call about a man acting aggressively. He was tasered by police and died 16 hours later at a hospital. In this case as well, the coroner's report revealed high levels of an illegal substance in his system (CBC, 2004). As mentioned earlier, in 2003, two men have lost their lives in taser-related police incidents, and, in 2004 two individuals lost their lives during taser related incidents. In May 2004, a Vancouver man who suffered from psychosis was tasered by the Vancouver police in his residence and died. The autopsy report revealed high levels of an illegal substance in his bloodstream (CBC, 2011).

Almost two months later, another individual was stunned with two separate taser guns by the same police force. He had locked himself in the common bathroom of his residence, began smashing objects and refused to leave when police arrived. In the meantime, a fire started on the first floor of the building and police were forced to take control of the situation. In this case as well, high levels of a substance were found in the man's bloodstream and an enlarged heart related to a prolonged substance use were listed as contributing factors to the man's death (CBC, 2011). In 2005, Surrey RCMP responded to a domestic-dispute call. A man who was punching his wife was subdued by a police taser and died at a hospital the same evening. The coroner's report was consistent with previous cases ruling high levels of substance abuse in the deceased's bloodstream. The victim also suffered from a coronary disease (CBC, 2011).

The landmark case of a police related fatality occurred with the death of a Polish immigrant Robert Dziekanski at the Vancouver International Airport in 2007. RCMP officers deployed to the incident fired the CEW five times, resulting in Dziekanski's death. In this particular case, the actions of the RCMP officers were not excused and were categorized as an excessive use of force (Braidwood Inquiry, 2009). The coroner's report revealed that Dziekanski died as result of the stress from the CEW and the police struggle while being handcuffed and pinned to the ground (Braidwood Inquiry, 2009). The RCMP speculated that the death was attributed to the 'Excited delirium', a condition where a person experiences irregular heartbeats and suddenly dies. This incident alone called for a public inquiry and resulted in several recommendations on the police use of force regarding deploying CEWs and bringing about more strict regulations; *Recommendation 5* relates to taser deployment on mentally ill individuals:

> 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. (Braidwood Inquiry, Phase One, 2009, p. 310)

After the Dziekanski incident, in June 2008 Paul Kennedy, the Public Complaints Commissioner for the RCMP, outlined in his recommendations related to the use of tasers; the main recommendation being, that the RCMP officers who taser individuals

and are unaware of their medical conditions are required to provide immediate medical attention in order to save their lives. Also, Kennedy has recommended that the use of tasers be restricted to officers with five or more years of experience in police force (CBC, 2008).

One month later after Dziekanski's death, another man was shocked by a police taser, pepper-sprayed and hit with a baton; he died five days later at a hospital. The Chilliwack RCMP reported that prior to his arrest, the man drove erratically endangering public safety and was later subdued at a rental store where he was belligerent toward the police (CBC, 2011). In 2008, a man who was a suspect in a bank robbery was tasered twice by the Langley RCMP at his home. After the robbery when police arrived at his residence, the man asked police to shoot him. A self-inflicted wound, causing a massive bleeding, contributed to the man's death. The man died in a hospital the same day (Spencer, 2011). Even though the incidents of police taser use and general shootings resulting in the deaths of individuals who are suffering from a mental illness are rare, they nevertheless create a loss of public confidence in law enforcement and call for more specialized police training when it comes to the use of force.

It is also important to acknowledge, however, that there were several cases in which mentally ill individual's actions resulted in a death or injury to a police officer and/or innocent civilians (Parent, 2004). From 1980 to 1994, 15 individuals were killed by police officers; three police officers had also lost their lives (Adelman, 2003). There are reported cases of police officers being injured by sharp objects during their encounters with the mentally ill ("Vancouver Police", 2008). In other instances the police saved innocent civilians whose lives where jeopardized and threatened by the mentally ill.

Overall, the number of individuals who were killed by police and who were suffering from mental illness is not substantial and/or the number of police officers' deaths in the line of duty are small; nonetheless, every death is one too many. The analysis of media and coroner's reports have revealed that police shootings of mentally ill are not on the rise; yet, it is difficult to determine a specific trend related to these incidents. As demonstrated earlier, in the past three decades, there is no specific pattern of police deadly shootings of the mentally ill across the country. There are some

years when no individuals were killed by police officers, while in some years the number of deaths exceeded five. Therefore it is almost impossible to determine whether the VPD's CIT course in fact diminished the number of deaths resulting from police shootings. However, coroners' investigations and reports have acknowledged a systemic lack of proper training of police officers' in identifying disorders, providing appropriate intervention, appropriate responses, and subsequently the use of lethal force in crisis situations when dealing with the mentally ill population (Adelman, 2003).

It may certainly be argued that crisis-intervention training for police officers will remedy this situation by encouraging a reduced use of excessive force and, thereby, play an important role in saving individuals' lives. It is, therefore, strongly recommended that every police department across the country implement this specialized training and make it mandatory. The nature of CIT programs varies across Canada (Cotton and Coleman, 2010a) and, to date, some police departments still have not taken the initiative to implement them, despite the existing evidence that the crisis-intervention program contributes to the fostering of a better-prepared law enforcement response to persons in crisis, including those with mental illness. Today, VPD's crisis-intervention course, based on the Memphis Model, holds out the promise of being the program that should be adopted by all the police departments across the country.

Chapter 8.

Limitations

Several limitations of the study should be noted. First, the data obtained from the Vancouver Police Department consisted of 83 questionnaires from January 2010 to April 2011 training sessions, which makes it a small sample. Further examination of the effectiveness of the VPD's CIT course based on the collection of all available course evaluation feedback from the participants could provide a deeper insight into the significance of the training. Also, follow-up research conducted six months after the training would provide more validity and reliability in assessing the officer's skills acquired during the CIT course in handling critical calls related to mentally ill persons. Second, although the majority of the respondents provided positive feedback about the training and found it very applicable to police work, it cannot be predicted with any degree of certainty that all the course participants will equally apply the skills and techniques learned during the training while responding to calls involving mentally ill individuals. It is not possible to make definitive statements about the effects of crisis-intervention-training on each individual officer's disposition. The existing evidence suggests that CIT-trained officers who are police force veterans and have encountered mental illness in their family are more prone to respond to critical calls involving mentally ill persons by using non-physical, non-lethal force as a more effective course of action (i.e., Compton et al., 2009; Demir, 2009; Watson, 2010). Also, those police officers who are satisfied with the training, are more likely to embrace it, and execute the techniques and skills learned in their day-to-day police duties (Feenan, 2011). Third, further research examining a comparative study of the effects of the crisis-intervention-training on the VPD's course recipients vs. non-CIT trained officers in relation to encounters with mentally ill individuals, arrest rates, jail diversion, and use of force should be conducted before reliable conclusions can be formulated concerning the long term effect of the CIT

course. [4] Fourth, although the OPPC statistics provide the number of complaints filed against the Vancouver Police Department since 1998, the OPCC annual reports fail to indicate how many of these complaints pertain specifically to mental-health incidents making it impossible to determine the ramifications of the CIT on the outcome of the cases. Finally, the statistical data provided in the study based on the coroner's and media reports involving the deaths of mentally ill people in Vancouver do not outline whether the officers involved in the lethal encounters had been the recipients of the crisis intervention course. Yet, the coroner's reports had identified the need for specialized, non-confrontational police training for dealing with mental-health crises (Adelman, 2003). Future research should use knowledge derived from this review and acknowledge the effect of the CIT course offered by the VPD as a means to measure the effects of this specialized training. The explicit conclusions related to police use of deadly force in the encounters with the mentally ill cannot be drawn. There is insufficient data available from fatal police shootings in Canada, B.C., and specifically in Metro Vancouver. Data from the past decade are characterized by extremes; there have been years when no deadly shootings of the mentally ill occurred, but there have also been years when several individuals have lost their lives in these encounters. Therefore, it cannot be claimed with certainty that the CIT has diminished the number of police deadly shootings.

[4] As of November 2011, the VPD no longer provides the 32-hour training. The CIT course is being developed as a three and a half hour format. This training will be available on-line for the remaining VPD officers who have not been CIT trained and it is mandatory for all patrol officers in British Columbia (VPD, personal communication, October 2011; CPKN, 2011).

Chapter 9.

Conclusions and Recommendations

The effects of deinstitutionalization of the mentally ill, lack of suitable resources, and lack of mental-health training for physicians in British Columbia will still continue to create a challenge for law-enforcement officers in responding to calls involving mentally ill persons (Adelman, 2003; Sealy and Whitehead, 2004; Wilson-Bates, 2008). However, the CIT course offered by the VPD aims at becoming an exemplary program that prepares police officers to utilize their skills and techniques learned during the training to provide more effective and humane responses to critical incident calls. Based on the feedback provided by the course participants, two main themes emerged: an increased awareness about mental illness and substance abuse and confidence gained by course participants in responding to critical calls related to mental health consumers by application of the learned skills during the training. Upon the completion of the course, the general consensus was that the participants felt that the CIT course was overdue because this type of training is critical in saving lives and protecting public safety. The findings presented here suggest the CIT course is perceived by police officers as being beneficial to the Vancouver Police Department and the community. As noted earlier, the Crisis Intervention program is not mandated in Canada at municipal, tribal, provincial, or federal levels. However, in November 2011, the VPD terminated the 32-hour course owing to budgetary cuts (VPD, personal communication, October, 2011). This specialized training has been replaced by the three and a half hour e-training offered through the CPKN. This new, pilot program will commence in 2012. The completion of the training will become mandatory for all front-line patrol officers in the province of British Columbia (CKPN, 2011). Although, changes to the course curriculum and its delivery have been made, the remaining police officers who are not CIT- trained will be trained on-line. A further study will be required to ascertain the validity of the on-line training relative to the classroom component. However, the current consensus

among the officers who received the CIT four-day classroom training suggests that the 32-hour specialized training already delivered by the VPD, deserves high recognition. Propelling the need for the continued CIT is the fact that mentally ill individuals and substance abuse addicts constitute a not insignificant part of the population of city of Vancouver, particularly in the Downtown East Side (Wilson-Bates, 2008). Therefore, the training of a better equipped and specialized police force should be continued and enhanced to reduce the likelihood of injury and/or death to all parties involved; officers an officer's and the mentally ill. In addition, the family and friends of individuals with a mental illness are more likely to feel more secure and safe knowing that specialized CIT officers can apply enhanced skill sets in de-escalating critical situations involving mentally ill (VPD, personal communication, November 23, 2010).

Recommendations

Prior to 2002, the VPD had no program in place, with the exception of a four-hour brief academy training, to teach police recruits the skills and techniques to safely and effectively prevent or de-escalate volatile mental health encounters that often threatened civilian and officer's safety. Based on the reviewed literature related to the effectiveness of the crisis intervention program and the research presented, it is crucial that the VPD continues to train all patrol officers, dispatchers, jail guards and human resources employees. This type of training is not only a proactive and fundamental step in protecting public safety but serves a dual purpose: it potentially reduces injuries and saves the lives of the mentally ill and police officers. With that principle in mind, presented in the following sections of this research are recommendations divided into four categories: a) recommendations for the enhancement of the VPD's CIT course based on the feedback provided by course participants;[5] b) recommendations for the improvement of the OPPC's Annual Reports and record keeping; c) strategy and policy proposals that address cooperation of police with mental health resources in the community; and finally, d) recommendations to further improve police enhanced responses to critical calls.

[5] Recommendations provided by the recipients of the CIT were effective before the demise of the 32-hour course.

Crisis Intervention Training Recommendations

Although the majority of the course participants stated in their training-evaluation questionnaires that the CIT course at the VPD increased their knowledge, awareness, reduced their perception of stigma associated with mental illness, and also prepared them to more effectively employ de-escalation techniques with minimal use of force in resolving critical calls; several participants suggested changes to improve and thus benefit more from the CIT course. These suggestions related to specific sections of the training. For example, the most common one (21%) was to provide a more extensive coverage on crisis negotiations (*Crisis Negotiation* session) with the main focus on verbal communication, choice of phrases and wording to be used.

In addition, course recipients recommended having presenters who are negotiators to share real-life stories and advise how the crisis was resolved. Others (15%) have recommended that listening and analyzing actual recordings from a 911-call centre could provide an excellent tool to develop strategies: they further believed that it would be helpful to obtain responses that could be discussed in a group discussion with the assistance of an expert facilitator. For other participants (7%), inviting guest speakers who have attempted to commit suicide *(Suicide session)* and were rescued by police. Listening to their stories could make the training more valuable in understanding the perception of a critic, viewed from a perspective other than a police perspective.

Several participants (18%) recommended changes to the role-play exercises during the last day of the training. Course participants have suggested that, during role-play activities, an expert presenter could act as a person in distress and the course participants as the responding officer; thereafter, a class discussion could follow to evaluate the exercise, addressing questions and answers to the presenter, (i.e., what the officer did right or wrong in the situation and what could have been done differently).

A few participants (3%) suggested amendments to the *Addiction and Mental Health* section of the course stating that a brief summary and a list of illicit substances and the corresponding behavioural and psychological effects on the human body could aid significantly in fostering more precise and quicker assessments by an officer responding to a distress call. Finally, the most common suggestions (26%) related to

the improvement of the presentations by having less power point presentations, more hands- on training, engaging in more discussions during each section of the course and providing more videos. As stated earlier, all the responses evaluating the CIT course have been very valuable to the VPD's Training and Education Unit and the responses were examined closely while changes to improve the course curriculum were made. These responses were also taken into account by the Training and Education Unit while plans were made to incorporate some of these recommendations during future CIT sessions; these improvements to the curriculum were made on an ongoing basis.

Recommendations to the OPCC's Annual Reports

As previously stated, the OPCC is a body that is independent of the legislature and that investigates complaints filed against police departments or police officers (OPCC, 2010). The OPCC retains all of the complaints filed since its existence. These records are reported to the public in annual and statistical reports. In addition, the OPCC is empowered by the *Police Act* and can order a court hearing to preserve or restore public confidence in the investigation of police misconduct; either a complainant or a police officer who is dissatisfied with the outcome of the investigation could also request a public hearing (OPCC, 2010). All dates are of the scheduled hearings are available to the public and are listed on the OPCC's website. The public can attend all the hearings with the exception pursuant to section 143(8) of the *Police Act:*

> A public hearing must be open to the public unless, on application of the complainant or respondent, the adjudicator orders that some or all of the hearing be held in private to protect a substantial and compelling privacy interest of one or more of the persons attending the hearing.
>
> (OPCC, 2010, para. 7)

Since its establishment in 1998, the OPCC's mandate has been to remain impartial and ensure that police departments and officers are held accountable for their actions. While, the OPCC's statistical and annual reports provide the data for the analysis of the filed complaints against the police department and individual officers, these reports do not identify specific complaints filed by the members of a vulnerable population or provide a comprehensive assessment of these types of complaints (i.e., the mentally ill

and/or their families) (OPCC, Annual Reports 2003-2009). Given that the OPCC annual reports are available to the public, it would be beneficial for the public to become informed about the number of complaints filed which relate specifically to mental illness and an officer's or a department's misconduct in this context. Thus, it is recommended that the OPCC include these detailed statistics in their future reports. This initiative could provide an insight to the public and especially to the families of the mentally ill with respect to how officers handled critical calls and in turn could possibly act as a catalyst for further policy and practice developments designed to enhance the quality of police training and to expand access to community health-care resources.

It is important to note that on December 7th 2011, the B.C. government appointed the first civilian director to be in charge of a new civilian Independent Investigations Office (IIO) (Bailey, 2011). The IIO will investigate serious incidents that result in severe injury or death within municipal and federal police departments in B.C. Although the IIO is an independent civilian body, it will report to the Attorney General of BC, but its conduct and decisions will be separate from the government. However, the OPCC will have the authority to investigate complaints related to the IIO conduct and incidents (Bailey, 2011). This milestone decision by the B.C. government in the creation of the IIO will allow for enhanced police accountability and transparency during future investigations. Having a "Police Watchdog" such as the IIO will allow for improved examination of police use of force concurrently protecting the vulnerable population (i.e., mentally ill consumers, drug addicts). The establishment of the IIO was a necessary step to restore and maintain public trust in the police (Bailey, 2011).

Recommendations for the Stakeholders

Hospital Personnel

The CIT course is the only one of the necessary components that warrants police officers to utilize skills and techniques learned during the training when responding to critical calls involving the mentally ill. In order to be successful, police cannot manage the mental health crisis in the community alone. In order to enhance public faith in policing, cooperation between police departments, community mental-health resources,

and family members of the mentally ill is essential (CMHA, 2003). Today, lack of proper resources (i.e., shortage of hospital beds for the mentally ill, the results of the deinstitutionalization of psychiatric services) is perhaps the most significant barrier to effectively aid mental-health consumers in distress. Therefore, as police officers by default are the first respondents in the mental-health system, they must remember that their role is to effectively de-escalate critical situations, provide security that reduces the harm and threat to mentally ill individuals, involved officers and the public, and also to take the most appropriate course of action. Depending on the event, this may encompass no-action, an arrest or transport of an individual to a healthcare facility under s. 28 of the *Mental Health Act.* The latter course of police action requires cooperation on the part of medical personnel. However, according to McMartin (2007), many physicians lack adequate information and education about mental illness, especially suicide prevention, and the *Mental Health Act.* This lack of training and the subsequent shortage of beds, results in many mentally ill patients not being admitted to hospitals due to misdiagnosis, or being admitted and released after a short period. Many physicians and hospital personnel are not well trained with respect to mental illness; interns may get a maximum of two hours training during their residency (McMartin, 2007). Consequently, a program designed to provide extensive mental health training for doctors in Metro Vancouver and in the province, with the emphasis on mental health and local resources available to improve the services for the mentally ill, is indispensable. This avenue will benefit not only the mentally ill but also the physicians and the police who are their partners under s.28 of the *Mental Health Act.* The police and mental healthcare facilities should continue to grow in a reciprocal relationship and engage in improvement of the knowledge, practices and accountability required in their daily tasks to fight mental illness and save lives.

Mental Health Consumers and Their Families

There are several community initiatives in Metro Vancouver that provide a variety of support programs for family members and individuals who are mentally ill. Such initiatives have been undertaken by the Canadian Mental Health Association (CMHA), Coast Mental Health (CMH), Vancouver Coastal Health (VCH), British Columbia Schizophrenia Society (BCSS), Mental Health and Addiction Services (MHAS), and many counseling services for suicidal crisis like S.A.F.E.R. (Suicide Attempt Follow-up

Education and Research Program) to name a few (VPD, personal communication, November 25, 2010). These organizations not only empower and educate mental-health consumers and their families by providing services, treatment and support in the community but also offer their services to train and instruct CIT course attendees at the VPD.

As mentioned earlier, based on the analysis of the questionnaires completed by the course participants, the knowledge conveyed by these field experts/presenters at the training sessions, has enabled police officers to gain a deeper insight with respect to understanding mental illness and addictions which in turn allows them to execute their duties more effectively during encounters with the mentally ill. However, there are policy obstacles that need to be overcome to allow for a better partnership between police and mental-health services. For example, the *Personal Information Protection Act (PIPA)* (SBC 2003, c. 63) in British Columbia does not allow for disclosure of personal mental-health information without a person's consent. In some circumstances, however, when the personal safety of individuals in the community is paramount, the consent is not necessary (PIPA, 2003). Section 58(2) b of the *PIPA* states:

> authorizing the disclosure of personal information relating to the mental or physical health of individuals to medical or other experts to determine, for the purposes of section 23, if disclosure of that information could reasonably be expected to result in grave and immediate harm to the safety of or the mental or physical health of those individuals

As many recipients of the mental-health system are involved in police encounters, personal information sharing between mental-health services and police departments could potentially save lives. For example, if the name of an individual who is mentally ill existed in the police data base before any encounters occurred, the officers could become more informed when dispatched to a critical call, knowing that an individual had been a client of the mental-health system and handle the situation more effectively. Thus, mental-health service providers should address this issue based on their judgment as the circumstances of individual cases may vary in terms of the appropriateness of encouraging their clients to consent to release their personal information to police.

Further to that, as guest speakers from the BCSS suggested during the CIT course, the families who struggle with mental illness would feel much more confident in police work if they knew that the police are equipped with relevant and necessary information about a mental-health recipient when responding to a crisis call. Also, when circumstances permit, it would be highly recommended that police officers follow up with individuals, their families and mental-health services to establish whether any more assistance is necessary. In addition, as suggested by one of the guest speakers during the VPD's crisis intervention training, before all of the front line VPD patrol officers complete their training, families of the mentally ill should be allowed to ask for CIT trained officers to attend when requesting police assistance in crisis situations. This option would put the families of the mentally ill at ease knowing that a qualified, knowledgeable group of the CIT- trained officers have been dispatched to respond to - and defuse - a critical call by providing support and reassurance.

Police

With regard to recommendations stemmed from the CIT course to improve police response to critical calls; several issues need to be addressed. First, there should be a personal-information-sharing database related to a person's mental illness between various police departments in the Vancouver region, the creation of a mobile team of CIT-trained police officers in addition to Car-87, and a decision by the provincial government to make the CIT course mandatory for all police departments throughout the province of British Columbia by adopting the VPD's training program as a model. As stated earlier, the plurality of policing services in Canada, (among other factors not covered in this review) has not allowed for homogenized policies and procedures or police training across the various departments in the country.

While, prior to 1950, the B.C. Provincial Police (BCPP) was the only policing body in British Columbia, later that year, the RCMP had been contracted out to police many municipalities in the province and continues to police the same areas (Gordon and Stewart, 2009). What this implies is that municipalities such as Burnaby, Surrey or Langley, are still under the jurisdiction of the RCMP. This means, that police responses to critical calls by the Vancouver Police Department, other municipal police departments, and the RCMP are governed by different protocols and training. For instance, if an

individual who experiences a mental crisis lives in a different municipality than Vancouver, he or she is under the authority of a different policing force in the area. The RCMP, other municipal police departments or the VPD do not share their information regarding the clients of the mental-health system (VPD, personal communication, November 24, 2010). Thus, the creation of personal database records that identify a mentally ill individual (i.e., the name, mental health history, history of arrests, contact information) for the use of each level of policing and the implementation of a system of information exchange potentially allow police officers to respond to calls more effectively by eliminating the unpredictability factor. As many participants of the CIT course pointed out in their questionnaires, implementing a system of information exchange would be beneficial in terms of saving the lives of clients of the mental-health systems, police officers, and members of the public, and would also improve police practices during high-stress police encounters with the mentally ill.

In addition, the RCMP contract currently expires in 2012, but as of November 2011, the B.C. government is negotiating a renewal (CBC, 2011). This would mean that the RCMP detachments will continue to provide the same policing services in the Metro Vancouver Region (Gordon and Stewart, 2009). The diversity of different police forces, described by Gordon and Steward (2009, p. 2) as "a patchwork of municipal departments and the RCMP, creates several challenges and a somewhat problematic scenario since these various police forces operate under different policies and procedures. Thus, an amalgamation of the various police departments in the Metro Vancouver Region or the creation of a regional police would be desired. It would provide a better, unified security force that operates according to the same standards and policies in the various jurisdictions and provides an enhanced response to critical calls that could potentially alleviate human suffering or death.

Secondly, the creation of a CIT team would be a particularly effective means for enhancing officers' and community's safety and resolving crisis more effectively. For example, many of the CIT course attendees, especially police veterans, have found the training very informative and essential. They have expressed a high degree of interest in defusing crisis situations involving the mentally ill. Thus, in addition to the VPD's Car 87, a partnership between the department and the Vancouver Coastal Health Authority, who have been assisting individuals in mental crisis for almost 30 years in Vancouver,

the creation of an additional CIT specialized mobile team of police officers who would be available to respond to mental-health emergency calls on a 24-hour basis would be essential. As noted earlier, in many U.S. cities, police departments have created mobile-crisis-intervention teams in which officers who volunteer to be CIT-trained demonstrate interest and insight with respect to mental illness. These mobile teams that become first respondents are credited with a high rate of success in defusing mental-health disturbance calls (Munetz, et al., 2006; Moore, 2008; Vaughn, 2011). Consequently, the VPD's adoption of the Memphis Crisis Intervention Program could spur the creation of a Crisis Intervention Mobile Team that mirrors the Memphis Model. This mobile team would encompass patrol officers who volunteer to be on the team, have backgrounds in psychology or demonstrate interest in the mental health area. They could provide extensive coverage for individuals experiencing a psychiatric crisis in lieu of the emergency response teams that are often dispatched to disturbance calls involving an element of mental illness.

Thirdly, the impacts and the benefits of the specialized crisis-intervention training for police officers have been scrutinized by this review. As noted earlier, this type of training is currently not mandatory for police departments across the country and, while responding to mental disturbance calls, officers often operate with different procedures and policies. Therefore, a mandatory in-class crisis intervention training for all the levels of policing should be instituted. Mental illness exists in every town of the Metro Vancouver Region, and across the country and, therefore, the police response to mental-health emergency calls should be consistent. Aboriginal communities, especially, have been vastly affected by high rates of mental illness, resulting in suicides where mental-health services are scarce (MacNeil, 2008). Specialized CIT officers who are entrusted with ensuring a community's safety would immensely benefit from this specialized training, should the CIT course become reinstated to its original 32-hour in-class training format.

Finally, upon completion of the CIT course by all VPD patrol officers, the VPD's Training Department should create a mandatory CIT re-training, refresher on-line or in-class course for patrol officers, jail guards and VPD's dispatchers. To date, the available research has examined the importance of continuing education for medical emergency-response professionals, physicians and firefighters (Clark, 1993; Latman, Wooley, 1980;

Roter, Rosenbaum, de Negri, Renaud, DiPrete-Brown, and Hernandez, 1998). Compton and Chien (2008) conducted the first study in Atlanta, Georgia to examine the scope of police officers' knowledge retention related to mental illness after the completion of the crisis-intervention-training program. In their study, 88 officers who received the specialized training in the past three years completed a survey related to their familiarity with the training material. Not surprisingly, Compton and Chien (2008) found that knowledge retention decreased months after the training, regardless of the officer's gender or age, or completed education. Also, a greater number of years of police service predicted better knowledge retention among the officers, suggesting that more experienced officers became more familiarized with mental illness owing to more frequent encounters. These study's findings indicate that police officers would benefit from continuing crisis-intervention-training education and more experienced officers tended to be more likely to retain the course material.

Hence, the VPD should continue to re-train the recipients of the CIT with the goal of maintaining an adequate level of current knowledge and proficiency in responding to mental disturbance calls. If there are enough funds for re-training, ideally, this advanced training could be implemented a year after the original completion of the CIT course. These CIT re-training sessions could include a role-playing exercises and de-briefing sessions where the officers could exchange their experiences and share success stories during critical situations that they have encountered. The refresher CIT course could maintain the VPD's proactive approach in reducing the risk of injury and/or death to the mentally ill and police officers who are involved in critical encounters and protect public safety.

One has to keep in mind that the more dehumanized mental illness is, the more difficult it is to implement the intervention(s) to help individuals who are affected by it. The VPD's CIT course combined with an increased public awareness and better mental health system support is the critical step to aid the vulnerable population and save lives. Therefore, indisputably, the *Status Quo* of the VPD's CIT course needs to be re-addressed in the immediate future, and an emphasis should be placed on restoring the 32-hour in-class training. Further, that change should be adapted as a provincial model for all municipal and federal police forces. It is improbable that three and a half hours of e-training will impact equally well on CIT-recipients' attitudes and disposition toward their

interaction with persons living with serious mental illness as the 32-hour in-class training had originally achieved. Finally, whatever form future crisis-intervention-training may take, in-class, or on-line, that all participants should be required to undergo periodic refresher courses of CIT in consecutive phases. Such follow-up training will improve officers' recall and enhance officers' skill sets which, in turn, will only improve safety for all concerned when managing challenging interactions with mentally ill individuals.

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Appendix.

Crisis Intervention Training Course Evaluation

Vancouver Police Department Crisis Intervention Training

VPD – CRISIS INTERVENTION TRAININIG

COURSE EVALUATION

1. Overall, how useful was this course for you? Please elaborate:

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2. Was this course helpful? Did it address issues that are relevant to your work setting? Please elaborate:

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3. Was there sufficient opportunity for individual or class participation? Please elaborate:

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4. How effective were the presenter(s) in delivering the material? Please elaborate:

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5. Were handouts or other types of media used to deliver the course? If yes, how useful were they? Please elaborate:

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6. Is there any further information which you would like to add or bring to the attention of the Training Section?

Please state your current years of service----------

What section are you currently working with?----------

Please return the completed forms to the Education and Training Unit staff. THANK YOU for your input.

August 2009(RF &CH)