Improving Interactions between the Police and People Living with Mental Illness

by

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B.A. (Political Science), University of British Columbia, 2009

RESEARCH PROJECT SUBMITTED IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF PUBLIC POLICY

in the
School of Public Policy
Faculty of Arts and Social Sciences

SIMON FRASER UNIVERSITY

Semester 2012

Approval

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Degree: **M.P.P.**

Title of Capstone: ***Improving Interactions between the Police and People Living with Mental Illness***

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Abstract

Evidence suggests that interactions between people with mental illness (PMI) and police officers in British Columbia are strained. While programs exist to improve these interactions, they vary by police detachment, and consequently are inconsistent throughout the province. To determine how these interactions could best be ameliorated, I conducted 17 semi-structured interviews with mental health providers, lawyers, and police officers. All participants worked in the Lower Mainland; however, participants with experience in Surrey or the Royal Canadian Mounted Police were favoured. This information was then used to conduct a policy analysis of three options. Due to resource considerations, the policy options I analyzed are relevant for police detachments in cities with more than 20,000 people. The final results of my analysis indicated that police detachments should prioritize training 25 percent of a detachment's general patrol officers in the Crisis Intervention Team Training program.

Keywords: Police; Crisis intervention; Mental illness; British Columbia

For my mother, Hope. Without your continued love, unwavering curiosity, and optimism, I would not be half the person that I am now.

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Acknowledgements

First and foremost, my thanks go to Max – your support, laughter and hugs were instrumental in turning this project from a dream into reality. I would also like to thank my mum, Betty-Ann and Ron for their understanding and encouragement. I would not have embarked on this journey without their guidance, and the belief that the world can be changed for the better.

Many thanks to Royce Koop, my supervisor, who encouraged me to continue, even when I felt lost and overwhelmed. I would also like to thank my capstone group and classmates for the numerous hours they listened to me toss ideas around in the student room. Your insights, comments, and comforting will always be remembered.

Lastly, I would like to express my gratitude to all of my study participants. I greatly appreciated the time, thoughts, and concerns you shared with me. In particular, I'd like to thank all of the police officers who are so passionate about helping people living with mental illness. Your compassion and dedication are inspirational.

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List of Acronyms

ACT	Assertive Community Treatment
BC	British Columbia
CID	Crisis Intervention and De-escalation
CIT	Crisis Intervention Team
ECOMM	Emergency Communications for Southwest British Columbia Incorporated
FOI	Freedom of Information
IMIM	Incident Management/Intervention Model
JSTOR	Journal Storage
PMI	People with Mental Illness
RCMP	Royal Canadian Mounted Police
VPD	Vancouver Police Department

Executive Summary

Some police interactions involving people living with mental illness (PMI) can be particularly challenging, as police officers may encounter an individual actively experiencing a mental health crisis, or symptoms of their illness. While there are day-to-day programs to assist police officers in these interactions, a recent study prepared for the Mental Health Commission of Canada shows that many PMI are dissatisfied with these encounters. Specifically, 30 percent of British Columbian participants with mental illness believed their interactions with police could be improved, while 50 percent believed that similar situations with police should be handled differently in the future.

As mentioned, day-to-day programs to improve these interactions do exist, but these programs are inconsistently implemented throughout British Columbia and Canada. This is because police services vary by detachment. The three most popular programs reviewed by scholars researching this area are: (1) enhancing basic training (2) operating the co-responder model and (3) implementing Crisis Intervention Team training for general patrol officers. Since the RCMP detachment in Surrey, BC, has experience with each of these programs, I chose to focus my research on this municipality.

To examine which programs best improve these interactions in urban centres, I conducted a total of 17 semi-structured interviews. My participants consisted of police officers (n= 10), mental health service providers (n= 4), lawyers (n= 2), and a city councillor (n=1). To recruit participants, I relied on snowball sampling techniques. I also required that each of my participants had previous work experience within the Lower Mainland of BC. Additionally, I made a particular effort to ensure that some of my participants worked in the City of Surrey, and that police had experience within the RCMP.

After conducting these interviews, I engaged in a thematic analysis of the transcripts. Through this, I identified four global themes, or patterns, relevant to improving police interactions with PMI. The first theme, the “Learning Curve”, examines the importance of police training, and ways in which officers absorb information. The

second theme, entitled “Building Rapport,” focuses on the importance of building positive relationships between police officers, mental health service providers, and PMI. The third theme I derived was the “Information Bank,” which discusses the advantages and disadvantages of sharing information between the health care system and police departments. Lastly, the fourth global theme I constructed was “Mindsets.” This theme explores the resistance some officers feel towards mental health programs, necessitating the need for mental health champions to be present in the RCMP if a program is to succeed.

Based on the best practices and insights provided by my participants and other researchers, I developed three detailed policy options to improve interactions between police officers and PMI. Due to resource constraints, these options are appropriate for cities of 20,000 people or more. After detailing these options, I conducted a policy analysis, by examining the extent to which each option satisfied four criteria. These criteria were effectiveness, police acceptance, cost, and equity. The final results of my analysis suggest that police detachments should prioritize training 25 percent of their general patrol officers in Crisis Intervention Team training. In the long term, enhancing basic training and implementing a 24-hour co-responder model may be appropriate for some police detachments.

1. Interactions Between People Living with Mental Illness and the Police

1.1. The Problem

> Never did I imagine that my most dangerous moments as a cop would be not with gangsters and bank robbers, but with people who are frightened and delusional due to mental illness and psychosis...It's even worse when you know the man you might have to shoot, and you know that he is not a criminal so much as someone who has slipped through the cracks. (Cst. Steve Addison, Vancouver Police Department Officer)

Throughout the last five decades in British Columbia (BC), people with mental illness (PMI)[1] have been moved from large institutions to underfunded community-based resources (Romanow, 2002, 178). This underfunding has led to inadequate supports for PMI, and has resulted in an increased number of police interactions with PMI in crisis (Adelman, 2003, 5; Borum, 2000, 332; Goodman, Hinton, Stanyon, & Tashiro, 2009, 4; Ruiz & Miller, 2004, 260). The Vancouver Police Department (VPD) reported that approximately one-third of their calls in 2008 involved PMI, directly costing the VPD $9 billion per annum (Wilson-Bates, 2008, 11). Other studies in Canada place the average number of police calls involving PMI between 7%-30% (Canadian Mental Health Association, 2008, 1). These calls involve a variety of interactions, such as apprehending PMI under the BC *Mental Health Act*, responding to calls in which the public is concerned by the behaviour of a person, and situations in which PMI are victims of crimes (Wilson-Bates, 2008,6).

[1] For the purposes of this study, I have used a broad definition of PMI. When using this term, I am referring to people exhibiting apparent signs of mental illness, whether they have been medically diagnosed or not. It is important to note that despite this broad term I am not referring to people with mental illness coupled with substance abuse problems. Since people with concurrent disorders have unique experiences with police officers, it is inappropriate to assume that programs aimed at improving interactions with PMI will be effective for people living with concurrent disorders.

Interactions involving PMI can be particularly challenging for the police to respond to, as officers may need to deal with someone actively experiencing a mental health crisis or symptoms of his or her mental illness (Adelman, 2003, 6-7). Contributing to these difficulties, many traditional policing strategies can be ineffective, and in fact may escalate a situation rather than defuse it (Fyfe, 2000, 346). This is because traditional policing techniques advise officers to control a situation by establishing authority without the use of weapons, through standing in an authoritative stance, and approaching suspects assertively (Fyfe, 2000). Such actions can elicit fear, confusion, and possibly aggression for a person experiencing a mental health crisis, intensifying the situation (Commission for Public Complains Against the RCMP, 2010).

While the number of PMI who have died during police encounters is relatively low in BC,[2] a recent study highlights that the majority of PMI believe their interactions with police could be improved. One-third of PMI believe these interactions should be handled differently in the future (Brink et al., 2011). As one participant in the Brink study stated:

> I have [had] a lot of positive and negative interactions with the police. I often feel very uncomfortable and/or threatened when I am near or in contact with the police. I fear that I am always in trouble with them and they're hunting me down like an animal. (S274, Brink et. al, 2011, 48)

In this quotation, the participant illustrates his or her feelings of anxiety and mistrust towards police officers as a result of his or her previous interactions with law enforcement. The existence of these feelings among PMI is particularly concerning, as such negative encounters limit the police's ability to fulfil their mandate "to serve and protect. Furthermore, these negative interactions contravene the principles of community policing, which emphasize working collaboratively with people in a community as well as increasing a community's satisfaction and trust in police officers. Consequently, when a substantial portion of PMI feel "threatened" by officers using

[2] From 2000 to 2009, 8 PMI have died as a result of a police officer discharging his or her firearm. During this ten-year period, a total of 30 people lost their lives due to an officer discharging his or her firearm during a police incident (Parent, 2011, 57).

assertive tactics, such as an authoritative stance, police are unable to meet these objectives. In light of this information, the policy problem of this capstone is:

PMI have strained interactions with police officers in BC.

To enhance both police officer and PMI safety, and to ensure as many amicable and respectful encounters as possible, this study seeks to determine policy options that will improve police responses and interactions with PMI in BC.

In particular, the policing practices and programs of the Royal Canadian Mounted Police (RCMP) E Division are examined within the context of the City of Surrey (Public Works & Service of Canada, 2011). As one of the fastest growing municipalities in British Columbia (City of Surrey, Undated) , Surrey is likely to experience an increase in absolute interactions between the police and people living with mental illness in the coming years. Assuming that percent of all reported incidents involve a person with mental illness (Wilson Bates 2008, 11), almost 14,000 incidents occur between police and PMI per year in the city (Research & Planning Surrey RCMP, 2011). This is, in fact, an underestimation, as it does not account for any apprehensions under the BC *Mental Health Act*, due to the limited publicly available data. Using Brinks et al.'s (2011) findings, one can assume that of these interactions, 7,000 PMI believe their encounters with the police could be improved, while over 4,500 people believe similar situations should be handled differently in the future.[3]

Given the growing number of encounters between PMI and police officers, the Surrey RCMP detachment has implemented a variety of programs to ensure these interactions are resolved as safely and respectfully as possible. This makes Surrey an

[3] These numbers are general estimatations. In 2011, there was a total of 46,041 actual offenses committed in Surrey (Public Works & Service of Canada, 2011). Assuming 30% of these offenses invovled PMI, it is estimated that 13,800 interactions occurred between police and PMI in 2011 (46,041 * 30% = ~ 14,000). Brink's study suggests 50% of PMI believed their interactions with police could be improved, while 33% of PMI believed similar situations should be handled differently, thus 14,000 * 50% = ~7,000 people; 14,000 * 33% - ~4,500 people.

ideal municipality to study, as the RCMP officers have practical experience working within these programs, and may offer valuable insight into the expectations and limitations of these models.

I begin this study with a discussion of the structure of the police in Canada, with an emphasis on British Columbia, and I then review the current situation in BC as of April 2012, when this study is completed. The second section of my paper describes my methodology, while the third details key themes I identified throughout my discussions with a variety of participants from the mental health and policing professions. The fourth section provides an overview of programs aimed at improving interactions between PMI and police officers. Policy options are then explained in my fifth section, with an outline of the criteria and measures I used to assess the policy options contained in the sixth. The seventh section contains an analysis of my policy options, and my eighth section explores my final recommendation. Finally, I conclude my paper in section nine, and offer insights as to where future policy analysts should focus their research.

1.2. Structure of the Police

The structure of the police in Canada is both a federal and provincial matter (Ministry of Justice, Undated). The federal government has exclusive jurisdiction over criminal matters, and is responsible for federal policing (Parent, 2011, 61-62). On the other hand, the provinces are allowed to establish their own provincial policing agency, and can pass policies and regulations related to the provincial police; however, these regulations must be within the limits of federal regulations (Parent, 2011, 61-62). Seven Canadian provinces, namely BC, Alberta, Saskatchewan, Manitoba, Prince Edward Island, New Brunswick, and Nova Scotia, all contract the function of provincial policing to the RCMP (Coleman & Cotton, 2010c, 46).

In BC, the *Police Act* sets out the responsibilities of provincial and municipal police, and allows the province to regulate or restrict the use of force guidelines for provincial officers (Ministry of Public Safety and Solicitor General, 2012). The *Act* also regulates the types of weapons officers can carry, such as pepper spray and batons (Parent; 2011, Ministry of Public Safety and Solicitor General, 2012).

Additionally, the Police Act requires a municipality to take responsibility over its police services once the municipality has reached a population of 5,000 people (Parent, 2011, 61-62). Currently, 58 municipalities contract the RCMP for services, while 11 municipalities in BC have their own independent municipal police force (Ministry of Public Safety and Solicitor General, 2011; UBCM Executive, 2009, p. 4). In municipalities that contract an independent police force, the municipal government is responsible for 100 percent of the policing costs.

If a municipality contracts the RCMP, though, the cost is shared with the federal government. The cost-sharing divide is dependent on the population of a city. For a city over 15,000 people, the municipal government pays 90 percent of the costs, while the federal government pays 10 percent. For cities with a population between 5,000 and 15,000 people, the municipality pays for 70 percent of the services, while the federal government pays for 30 percent (UBCM Executive, 2009, p. 4). In communities with less than 5,000 people, the BC provincial government pays for 70 percent of the services, leaving the federal government to pay 30 percent (UBCM Executive, 2009, p. 4).

While each municipality pays the principal amount of the RCMP's budget, the city itself has very little control over the RCMP's services. A study by the Union of British Columbian Municipalities demonstrated that in BC, a majority of local government officials felt the police services were not fully accountable to local government (2009, p. 28). As Diane Watts, Mayor of Surrey noted,

> The operational needs and the operation of the RCMP solely sits with the RCMP or any other police agency. We don't determine how they operate. We will joint plan with them. We will make sure that...issues that we have are addressed, issues that they have are addressed (Personal Communication, January 12, 2012).

Ultimately, while municipalities may communicate with the RCMP through the municipal policing board[4], the RCMP detachment has full control over its operational duties, budgeting and priority planning (UBCM Executive, 2009, p.18).

1.3. The Current Situation

As a result of a police detachment's power to allocate resources where it wishes, the programs and services offered to police officers relating to PMI in crisis are inconsistent throughout BC. New Westminster Police Department, for example, does not appear to have any advanced training courses related to mental health crises, nor does it appear to have a particular position or program devoted to following up with mental health calls. On the other hand, Surrey's RCMP detachment has both a Mental Health Officer, a police car which responds to mental health emergencies with a psychiatric nurse, and has offered Crisis Intervention training (CIT) for their officers (RCMP, 2009a; Anonymous Personal Communication). While such a discrepancy between two fairly geographically close municipalities may be concerning, it is important to note that the services each detachment provides should suit its community, and New Westminster may not have the need for such extensive supports. The point here is that the current resources offered to police officers are inconsistent across the province.

Currently, all RCMP officers receive training at a facility called Depot, located in Regina, Saskatchewan. Cadets are required to complete an intensive 24-week course, before they are assigned to a particular policing detachment. Once a Constable has been assigned to a detachment, the officer receives any additional training necessary to meet provincial requirements.

Previously, RCMP officers assigned to BC proceeded directly to their detachment, but in response to Robert Dziekanski's death in 2007 at Vancouver's

[4] The mayor and one other city councillor are allowed to sit on the municipal police board (Ministry of Public Safety and Solicitor General, 2011).

International Airport, the Braidwood Commission recommended the province introduce training guidelines for all police in BC. The BC government has complied with this recommendation, and as of January 30, 2015, all frontline police officers will have be required to complete BC's Crisis Intervention and De-escalation (CID) course, which is still in the process of being developed (Ministry of Public Safety and Solicitor General, 2012). This makes BC the only province to mandate mental health training for all police officers (Cotton & Coleman, 2010c, 14).

This CID training is speculated to contain both an online training component as well as a face-to-face component. In total, it is expected to take approximately two days to complete (Anonymous, personal communication). Such training will provide more consistency across the province and hopefully assist all BC officers to recognize a client presenting signs of a mental illness, and thus to de-escalate a crisis situation. Given that the specifics of this program are unknown, it has been suggested that some detachments suspend more extensive Crisis Intervention Team training for their members, in case there is overlap between these two courses (Anonymous, personal communication).

As it stands, there are a few legal complaints that are particular to encounters between PMI and the police. For one, some PMI believe they are being unlawfully surveilled by the police, which in some cases is a symptom of a person's mental illness. Second, there are a myriad of issues regarding an officer's legal right to take an individual for examination by a doctor, under Section 28 of BC's *Mental Health Act* (1996, c. 288). Section 28 of the *Mental Health Act* gives the police the ability to apprehend an individual if the person "is acting in a manner likely to endanger that person's own safety or the safety of others, and is apparently a person with a mental disorder" (1996). This issue can become of particular importance if a person living with mental illness is experiencing a crisis in his or her home, and the police must break into the person's residence. Without a warrant, or adequate grounds to apprehend a person to the hospital, such an entry by the police would be considered illegal. Consequently, this matter of apprehension has become of particular importance to people living with mental illness, as well as to the police who are often questioned about their reasoning to apprehend an individual (D. King, personal communication, November 18, 2011; Anonymous personal communication).

1.4. Research Objectives

In response to the concerns expressed by PMI, this study seeks to improve encounters between police officers and people living with mental illness.

Other objectives of this study are to:

1. Determine effective police practices in Commonwealth countries for responding to people with mental illness;
2. Recognize the challenges and opportunities faced by police officers when responding to calls involving people with mental illness;
3. Suggest practical recommendations to the RCMP or BC provincial government that will improve encounters between police and people living with mental illness, particularly within the City of Surrey.

2. Methodology

I utilized two methodologies in this study: (1) literature review (2) in-depth semi-structured interviews.

2.1. Literature Review

I reviewed police practices, training programs, and specialized response teams throughout Canada, Australia, the United Kingdom, New Zealand, and the United States. I examined these regions because they have similar political institutions, and levels of infrastructure to British Columbia, making them appropriate jurisdictions for comparison.[5] Moreover, these jurisdictions have implemented methods to improve police interactions with PMI for over 10 years, providing a significant amount of information about the successes and challenges of their endeavours.

Data about practices in other provinces and countries were obtained through online searches of academic journal databases, including Academic Search Premier, JSTOR, Canadian Public Policy Collection, Science Direct, and Google Scholar. Grey literature, or literature produced by service providers or police organizations, was also used to understand the practices within these jurisdictions. The vast majority of these documents are publicly available.

2.2. Semi-Structured Interviews

2.2.1. Why Interviews?

The second method I used was semi-structured interviews. I chose semi-structured interviews for three reasons. First, the literature available on police programs

[5] The focus on BC is justified since BC contracts policing facilities from a federal police force.

is largely quantitative, and inconclusive. Having conducted an initial literature scan, I realised that my understanding of police officers' experiences in these programs was limited, as was my understanding of the challenges surrounding the implementation of many of these programs. Since semi-structured interviews allow a researcher to explore the experiences of their participants, this method was the most appropriate data collection tool for the information I sought.

Second, a semi-structured interview allows a researcher to approach an interview with a loose arrangement of questions, from which the researcher may deviate to explore an idea in detail, or discuss an unexpected topic raised by the participant (Britten, 1995, 251). The flexibility of a semi-structured interview also permits a researcher to explore the meanings participants attach to specific terms, and offers an opportunity for the researcher to clarify her interpretations of the participant's responses (Britten, 1995, 252). While following unexpected responses and clarifying meanings can produce new and fascinating findings, this action can affect the participant in unanticipated ways, as the interviewee listens to his or her experiences and opinions being repeated back (DiCicco-Bloom, & Crabtree, 2006, 319). In some circumstances, such listening can result in unpredicted harm to the participants (DiCicco-Bloom, & Crabtree, 2006, 319). In case of this, I carried a list of mental health resources with me to each interview, although I never had the need to distribute them.

Third, the loose configuration of a semi-structured interview also lends itself to the iterative process of data collection, as data analysis can happen in conjunction with data collection (DiCicco-Bloom, & Crabtree, 2006, 316). The analysis of early interviews allows the researcher to consider new ideas, discard ineffective questions, and develop questions on the basis of previous interviews (DiCicco-Bloom, & Crabtree, 2006, 316). Due to this, a researcher's interview schedule is a living document. For a rough outline of the schedule used throughout the interviews, please see Appendix A.

2.2.2. What Happened?

In total, I conducted 17 interviews with police officers (n=10), mental health professionals (n=4), lawyers (n=2), and city councillors (n=1). Participants were required to have work experience in the Lower Mainland, preferably Surrey, and were chosen on

the basis of five criteria. The five criteria were: (1) experience as a police officer (2) experience mitigating security issues involving people with mental illness (3) experience training police officers (4) experience launching or hearing complaints against the police on behalf of a person with mental illness and (5) experience in municipal government working with the police.

To guarantee that officers were able to speak freely, I informed all police participants that they would remain anonymous at the beginning of the interview. Participants who were not police officers also had the option of remaining anonymous throughout the interview. To ensure the anonymity of each police officer, I have omitted the date of our interview from my citations, and withheld any identifying details, such as an officer's position and detachment. Each interview took place at a location mutually agreed upon by the participant and myself, and all interviews were audio-recorded and transcribed. For a list of participants who did not chose to be anonymous, please see Appendix B.

2.2.3. Recruitment

Interview participants were recruited via email and telephone requests. Contact numbers and emails were taken from publicly available sources such as organizational websites, as was the case when I contacted Pivot Legal Society. Where email addresses were available, I sent potential interviewees an introductory email and I attached the written consent form to the email, so that the individual could decide if he or she wished to respond to my request (See Appendix C for the introductory email, and Appendix D for the consent form).

Interview participants were also recruited through snowball sampling techniques. I gave my personal contacts a copy of my written consent form, as well as my email address and telephone number. Then I asked my personal contacts to provide this information to people they believed would be relevant for me to interview, for example, RCMP officers and mental health service providers. The third party was then allowed to contact me, or request that I contact them through our mutual contact.

2.2.4. Purpose

The purpose of these interviews was to gather information on different methods to improve interactions between police and PMI, and the practical consequences of each method. For example, I inquired regarding details about the difficulties implementing or operating certain police models, as well the costs, and potential effectiveness of different methods. As a result, my interview schedule focused on the following topics:

- Police Organizational Factors – Barriers, Attitudes, Resources
- Legal Framework – Municipal, Provincial, & National
- Police Training Practices – Use of Force Guidelines and Withdrawal Tactics
- Specialized Police-based Response Units – Co-responder Models & Crisis Intervention

2.2.5. Analyzing Findings

Findings from semi-structured interviews were interpreted through thematic analysis. In essence, a theme is a pattern found within one material or across multiple materials (Braun & Clarke, 2006, 79). These materials may be things such as transcripts, articles, television shows, newspaper articles, and blogs. In the case of this study, the themes are derived from my interview transcripts.

To conduct a thematic analysis, I first transcribed each interview, and then read each transcript once to familiarize myself with the content. Having read the transcript without taking notes, I re-read the text, noting down basic themes, and thoughts in the margins. Afterwards, I arranged these basic themes into slightly larger groupings, or organizational themes. With these organizational themes in mind, I read the transcript once again, looking for specific examples of these organizational themes. I then checked the examples I had matched with each organizational theme. Once I had completed this process for each transcript, I reviewed all of the organizational themes, and created global themes. Following this, I checked that each organizational theme fit within the global themes. Each global theme was then reported in Section 3 (Attired-Stirling, 2001, 4-11; Braun & Clarke, 2006, 86-93; The process of Thematic Analysis).

2.2.6. Quality of Findings

Steinar Kvale offers some interesting suggestions for measuring the quality of qualitative findings (1996, 144-5). In total, he suggests that six criteria can be used to assess the quality of a semi-structured interview.

The first criterion Kvale suggests is that the shorter the interviewer's questions, and the longer the participant's answers, the better the interview process (1996, 144-5). This indicates that the interviewer is hearing more from the interviewee, eliciting more information than he or she is giving. While my transcripts show that participants were allowed to speak at length in many circumstances, there were instances in which I interrupted an interviewee, or communicated pieces of information, limiting my participant's response time. In most circumstances, my participants returned to previous discussion points in our conversation when they had not had the chance to elaborate on their perspective. Due to this, I believe my data satisfied this criterion. In the few instances where I should have withheld my question, and given my participant time to finish his or her thoughts, my interviewees returned to these topics, producing relevant information to my research questions.

The second criterion Kvale proposes is analyzing whether the interviewer asked clarifying questions of certain responses during the conversation (Kvale, 1996, 144-5). I did this often throughout my interviews, as police and mental health jargon can be confusing and difficult to remember. Further, there were many aspects of policing that I did not understand, necessitating clarification before I could respond to my participant during our conversation.

The third criterion Kvale mentions is the ability of the interviewer to verify meanings and her interpretations of the participant's responses throughout the interview (Kvale, 1996, 144-5). While I did repeat my interpretation of some participant's responses to them, there were times when I over-clarified my meanings. My transcripts indicate that in some circumstances, participants deemed my clarifications as rudimentary, arousing suspicion that I was less versed in the topic than I was. On the other hand, some interpretations that I related to my participants produced vital clarification, and deepened my insight into interactions between police and PMI.

Fourthly, Kvale believes “spontaneous, rich, specific and relevant answers from the interviewee” are indicative of a high quality interview (1996, 144-5). Many of my participants offered interesting, relevant, and surprising information during the course of our conversations, although my interruptions limited some of the spontaneity from my participants. As previously mentioned, when participants felt I had shifted too quickly to a new topic of conversation, my interviewees redirected our conversation, sometimes abruptly. Due to this, I believe my data also met this fourth criterion.

The fifth and six criterion are closely related, as the fifth addresses the extent to which the interview is interpreted throughout the conversation, and the sixth examines if the interview is self-communicating (Kvale, 1996, 144-5). In other words, these criteria suggest that additional information and explanation is not needed to understand the story encompassed in the interview. On the whole, I believe my data satisfied these two criteria. Dur to my clarification of meaning during our conversations, no further information was required.

To conclude, I believe the data resulting from my interviews are of high quality. As an interviewer, I could have allowed my participants more time to respond to my questions and been more selective about which of my interpretations I should have clarified; however, many of my questions produced beneficial results, and my participants felt comfortable enough to ensure there was space in the interview for their opinions to be heard. Further, I verified interpretations during my interviews, and my participants gave relevant and rich answers to my questions.

2.3. Analyzing Policy Options

Based on my literature review and semi-structured interviews, I determined three policy options aimed at improving interactions between police officers and PMI for cities

over 20,000.[6] To evaluate these options, I developed four criteria: (1) effectiveness, (2) police acceptance, (3) cost, and (4) equity. Each criteria is ranked out of five points, allowing a maximum score of five out of five, and a minimum score of one out of five. As previously mentioned, information for each option and criterion was gathered through the literature review and semi-structured interviews. After all the information was complied, I scored every policy option according to each criterion, and then I recommended the option with the overall highest score.

[6] It is estimated that a population of 20,000 people is served by approximately 34 RCMP personnel, containing a minimum of 16 general duty officers. This is the least number of general duty officers necessary to implement Crisis Intervention Team training for 25 percent of a detachment.

3. Interview Findings & Analysis

This section includes a thematic analysis of the conversations I had with the 17 participants in this study. Out of this data, I derived four global themes, and eight sub themes (See Table 1). A global theme can be conceptualized as an overarching pattern among my transcripts, while a sub theme can be thought of as a smaller pattern within a larger framework (Braun & Clarke, 2006, 79).

The first global theme is called "The Learning Curve" (3.1), and refers to the importance training plays in appropriately applying the Intervention Management/ Incident Model (IMIM) to crisis situations with PMI (3.1.1). The IMIM is a guide used to help officers visualize how to apply force in a situation, although it is not law or policy (RCMP, 2009b). There are also specific laws under the *Police Act of BC* referred to here as "use of force guidelines" that regulate types, maintenance, and training for all the weapons police forces may use. Turning to the second sub theme, there is a discussion around officers' desires for continuous professional development rather than modifications to basic training (3.1.2).

The second global theme I constructed was "Building Rapport" which emphasizes the benefits of positive social interaction between police officers, PMI, and mental health professionals, such as reducing stigma between these three groups (3.2.1). The second dimension of this theme is the significance of active listening in building a rapport with a person with mental illness who is in crisis (3.2.2).

The third theme, the "Information Bank", discusses the advantages associated with information sharing between the police and the health care system during a crisis incident (3.3.1), while also outlining the potential privacy dangers that arise for PMI after a crisis incident (3.3.2).

Lastly, "Mindsets" explores the resistance some officers feel towards mental health programs (3.4.1), necessitating the need for mental health champions to be present in the RCMP if a program is to succeed (3.4.2).

Table 1 Global Themes and Sub Themes

Global Theme	Sub Themes
The Learning Curve	Using Force
	Continuous Development
Building Rapport	Reducing the Stigma Triangle
	Two Ears, One Mouth
Information Bank	During the Incident
	After the Incident
Mindsets	Old School Thinking
	Champions

3.1. The Learning Curve

The Learning Curve theme refers to the frequent discussions I had with participants around the types of information taught to police officers about mental illness, and how they absorb this information in different settings. The two sub themes describe smaller patterns that I derived from these conservations.

3.1.1. Using Force

Since Robert Dziekanski's high profile death in 2007, there has been an on-going discussion in BC about whether the use of force guidelines need to be modified (Braidwood, 2009). The Braidwood Commission investigated this matter and has since recommended that use of force guidelines be changed. As a result, all officers will have specific training in conductive energy weapons as of January 30, 2012 (Ministry of Public Safety and Solicitor General, 2012). Having discussed use of force guidelines with many officers, multiple members suggested that these guidelines do not need to be modified once Braidwood's recommendations are fully in place; however, they did emphasize the necessity of having strong training, which results in strong planning skills.

One officer referred to the fluid nature of the use of force guidelines embodied in IMIM, and the importance training plays:

> I think our use of force is very adequate… but oftentimes I think…that we get trapped in trying to figure out -- because sometimes it's grey, right?... And oftentimes if you don't have any experience or -- if you're not trained, then it becomes -- those grey areas become a little bit more difficult. (personal communication)

Many other participants also mentioned the fluidity of a situation when responding to PMI in crisis, and emphasized that the use of force guidelines are intended to be flexible so as to respond to dynamic situations. Another officer echoed these sentiments: “training is your key of how you're going to use your resources and how you're going to also plan what you're going to do” (personal communication). Without adequate crisis intervention training, it is more difficult for an officer to plan the way in which he or she will try to de-escalate a crisis, and what use of force options are appropriate if that plan goes awry. It should be noted that an officer’s plan is also greatly influenced by the information available to him or her before arriving on scene – something that is often incomplete (Anonymous, personal communication).

3.1.2. Continuous Development

While many officers support crisis intervention training, some participants believe that this should be offered as continuous professional development rather than included in basic training. As one participant outlined, an RCMP cadet’s time at the training facility, Depot, is filled with absorbing copious amounts of information, practice scenarios, and physical education. For an exhausting six months, officers eat and breathe the RCMP. While this experience is often fondly remembered, many officers felt that basic training contained so much information that retaining more would be difficult. One participant said:

> There's only so much you can cover at basic training. And until you actually start to see these things in the field -- I'm not sure that all that textbook information would really be that useful. It's not until you start looking at these things I think that follow-up training would be more advantageous. (personal communication)

Implicitly, this participant is referring to the fact that like many professions, becoming a skilled police officer has a steep learning curve associated with it. After having field experience, the newness of policing seems to diminish, and it becomes easier to absorb additional information. Furthermore, an officer then has the opportunity to pose questions about past experiences to discover if those experiences could have been handled differently (Anonymous, personal communication).

Similarly, other officers and mental health professionals drew attention to the desire for continuous training as techniques, tools, and responses might be changed according to developing best practices (D. MacDonald, personal communication, November 8, 2011; Anonymous, personal communication). Some of this continuous training is possible through reading materials about mental illness, such as articles within policing journals (Anonymous, personal communication), although there do not appear to be any external incentives to engage in these activities. Additionally, many detachments have sporadic presentations throughout the year about mental health policy, and symptoms of mental illness (Anonymous, personal communication). These presentations are conducted during an officer's shift and are approximately 30 minutes in length.

3.2. Building Rapport

This global theme looks at the importance of building relationships, or rapport, with all of the various groups police encounter. This is of particular importance between three groups of people: police officers, mental workers, and PMI.

3.2.1. Reducing the Stigma Triangle

As with many Canadians, police officers, mental health workers and PMI can have negative or stigmatizing attitudes towards each other. Police officers and mental health workers, for example, may negatively stereotype PMI if their experiences largely involve responding to PMI in crisis. Similarly, mental health workers and PMI may have stigmatizing attitudes towards police officers if they have experienced inappropriate use of force by an officer, or had a discourteous encounter. Officers and PMI may also have

negative attitudes towards mental health professionals, finding these workers uncooperative, or disrespectful. In this sense, there is a “stigma triangle” between these three groups that can exacerbate a crisis situation.

To reduce these stigmatizing attitudes, the importance of including PMI in training sessions for professionals is often stressed (Anonymous, personal communication; Stuart, 2009; Moore, 2010, 335). Many studies have demonstrated that interactions with PMI when they are well is one of the most effective methods in reducing our society’s stigma towards mental illness (Stuart, 2009). When it comes to first responder training, this is particularly important, since first responders are usually arriving at crisis scenes, which can be traumatizing for everyone involved. In urban centres, including such a component in training is of utmost importance, because many first responders come across some individuals consistently, commonly those living with concurrent substance abuse disorders, unstable employment and unstable housing (Anonymous, personal communication). It is important, then, for first responders to have opportunities to interact with PMI when they are well, and to arrive at a more holistic understanding of what living with mental illness is like for the general population.

Many of my participants also emphasized this point, and elaborated upon it. One officer stated:

> It’s important for people to see persons with mental illness when they're well. So that is so key. Because if you only ever see the in-crisis version, you never really have an understanding of the goal you're working towards here. (personal communication)

An absence of contact with healthy PMI not only obscures the goal that police are working towards with an individual, it also reinforces the negative myths that PMI are dangerous, unpredictable, and violent. Given that de-escalation techniques often require establishing rapport with PMI, and that rapport is based on empathy, it is important for these myths not to be reinforced (L. Steward, personal communication, November 25, 2011). Needless to say, promoting positive interactions between police officers and PMI when they are well should be encouraged as much as possible.

In this area, some RCMP detachments have made great strides towards this goal, particularly the Richmond RCMP. Richmond is slightly unique in that the

municipality has a well-established Pathways Clubhouse funded by the Vancouver Coastal Health Authority (D. MacDonald, personal communication, November 8, 2011). The Clubhouse is well-known among the mental health community, and is outfitted with a large cafeteria, and thrift store. As a result of having one central location in which to interact with many mental health clients, the Richmond RCMP detachment has been able to create opportunities for mental health clients, officers and Clubhouse staff to interact together in a social setting. By encouraging new RCMP members to have a cup of coffee while on shift at the Clubhouse, and through attending events like the joint barbeque, everyone's negative conceptions of each other have been reduced. The manager of the Clubhouse, Dave MacDonald elaborates on this:

> The ideas of having a barbeque, the ideas of them coming to our fundraising dinners, the ideas of the officers being told you need to go in and just have a coffee, and say "Hi". Just that personal thing, I think makes such a world of difference, not just for the officers for getting to know our members, but for our members to know that when they are in a crisis it's okay. It's okay -- that these guys showing up in uniform are there to help. And to be able to interact with them while I'm well helps me when I am sick. They [officers] are there to help. I know some members still struggle, 'oh the cops have come,' but they do remember that they're to be helpful. That social part takes a bit of time, takes a bit of work, but is so valuable. (personal communication, November 8, 2011)

In a similar vein, having police officers and PMI interact positively also decreases any stigma mental health workers at the Clubhouse have towards police officers (D. MacDonald, personal communication, November 8, 2011). Thus, by having interactions between police offices and people living with mental illness when they are well, officers have positive experiences associated with PMI, and are in a better position to empathize and build rapport when they do respond to PMI experiencing crisis.

3.2.2. Two Ears, One Mouth

As Linda Stewart, a retired police officer and an instructor of Crisis Communication at the Justice Institute of BC repeats to her class, "there's a reason we have two ears, and one mouth -- so that we can listen twice as much as we speak" (personal communication, November 25, 2011; Epictetus). Her point is that the more police officers listen, the better they are able to deal with a crisis situation. This is

because one of the main focuses of her course is teaching recruits how to build rapport with PMI. As with all other people, she states, an officer must treat PMI with "respect, dignity, and sincerity" (personal communication, November 25, 2011). Generally, the steps involved in creating rapport begin with employing active listening skills, and showing sincere empathy (L. Stewart, personal communication, November 25). Part of this active listening is to ask questions about what the person with mental illness has said, whether it be about a previous diagnosis or the intent of the person. This helps ensure that the officer understands what the person in crisis is saying, and communicates to the person with mental illness that the officer is also listening. In a particular situation, using active listening skills also allows for an officer to develop sincere empathy towards a person, as an officer learns more about the individual's particular problem and mindset.

As Ms. Stewart underscores, a police officer's goal at any incident is to change the subject's behaviour from how they are acting to how the officer would like the person to act. If a person is about to jump off of a bridge, for example, an officer's aim is to have the person walk away from the side of the bridge. To accomplish this change of behaviour, an officer must have influence over what the person does. This influence can be done by building rapport, or as a last case scenario, by using force. Ms. Stewart underlines this:

> It is very common basic psychology, you know, if someone's being nice to someone for a long period of time, it's really hard for that person to continue to be a jerk back. There's the odd case it's not going to work, you know -- I'm respecting you, the likelihood of you wanting to communicate with me is higher because of that, right? (personal communication, November 25, 2011)

Consequently, by respectfully listening, asking questions and building rapport, an officer gains the trust of an individual. Given that the goal of crisis situations is to resolve the situation as safely and respectfully as possible, building rapport as an officer with a person with mental illness can make a significantly positive difference in the outcome of the incident.

3.3. Information Bank

During and after a mental health crisis, information plays a critical role for everyone involved. The following sections outline the positive benefits of having a cohesive "information bank," as well as the disadvantages that the sharing of this information can have for PMI after a crisis incident.

3.3.1. During the Incident

During crisis incidents, police officers and health care professionals are concerned with the amount of information they can legally share. As Kyle Friesen, legal advisor for the RCMP said, "too often people in mental health or in medical health will say, oh, no, no, I can't tell you anything, privacy rules, FOI [Freedom of Information] says I can't talk to you" (personal communication, December 12, 2011). This limits the amount of team-work between police and different actors in the health system, hampering emergency response coordination during a crisis incident, and possibly leading to less satisfactory outcomes for PMI. Due to the confusion around FOI and privacy laws, there are many skilled professionals unsure about the level of information sharing in which they can partake. Mr. Friesen has given many presentations on this topic to health care professionals and police officers, and he summarises his message:

> So the whole question comes up, 'how about information sharing?' Can the police talk to the fire department? Can the fire department talk to the hydro people to go out and shut off the power? And the gas company shutting off the gas. And then talk to the hospital staff and talk to the social workers, and talk to the church outreach worker -- things like that. Yes, we can talk to each other. That's been my message is, yes, we have legal authority under all the various levels of government that are involved here -- where we can actually have case management roundtables discussing what this person is all about, the challenges…And a lot of them seem to be extremely relieved to know. They're – 'I guess we really can speak with each other.' (personal communication, December 12, 2011)

He further elaborates that officers can bring their "police bucket" of information to the table, as can every other agency; however, this does not mean that all of the information from an agency will be fully shared with others, only the relevant tidbits. There are many positive benefits associated with this sharing. When officers and nurses

have more information, they are more effective at preventing or resolving a crisis situation.

3.3.2. After the Incident

There are benefits to having information shared between the police and other organizations, but there are also many reasons to be concerned about the information which is shared, especially between the health care system and police officers. While the health care system is focused on protecting individual safety, police officers are charged with public safety – a very different focus. When the two "buckets" of information get poured together, the relevant information becomes part of the other organization's report. This can become problematic for PMI applying for job working with children or vulnerable adults, as these jobs require an intensive criminal records check (Ministry of Public Safety and Solicitor General, Undated). In these checks, all relevant police records are eligible to be released, even if this information is not related to a conviction of a criminal offence. The traditional example cited is that if the police suspect an individual of child pornography, but do not have enough evidence to arrest the individual, they can divulge that information if the individual was applying for a job at an elementary school (Anonymous, personal communication). In cases of police record checks, what records are released is up to the discretion of an RCMP officer, depending on where the individual is applying for employment.

As Doug King from Pivot Legal Society mentioned, though, in worse case circumstances, people's mental health records have been released. While there are some circumstances in which this information may be pertinent to an employer, such as if the individual has had violent tendencies, there have been stories of entirely irrelevant mental health details being released. As Mr. King stated:

> One classic example is somebody who was denied a job because they had attempted suicide years before. The police attended and it was part of their record [inaudible] divulged that this person had attempted suicide and had a mental health issue…that's the worse case scenario right? (personal communication, November 18, 2011)

The mental health community is also quite concerned about such scenarios, especially since this information sharing may unduly violate a person's right to privacy,

and often has negative consequences on the person's prospects for employment. One officer summarised the situation succinctly: "the problem is lots of mental health issues do not present a risk to other members of the public. Some do. So to -- to have a blanket rule is a problem probably" (personal communication). On the whole, there are good reasons to be cautious about an officer's discretion when it comes to police records checks; however, there are many benefits for PMI when the health care system and the police interact together to assist them during a time of crisis.

3.4. Mindsets

The global theme of "Mindsets" refers to the ways officers think about their involvement in programs relating to PMI. The first sub theme explores the detriments that result from an "old school" way of thinking, which rejects the idea that assisting PMI in crisis is part of policing. It also discusses some police members' responses to these opinions. The second sub theme discusses the need for an officer to "champion" a program aimed at improving mental health, to combat this "old school way of thinking."

3.4.1. Old School Thinking

While many police officers believe they play a vital role in helping PMI resolve their mental health crisis, there is still the "old school thinking" that can be found throughout the RCMP. This mindset questions the police's role in dealing with PMI. A common question and statement coming from this group of officers is "why are we doing this? Why? ... It's not a police matter" (Anonymous, personal communication). In these officers' minds, programs aimed at improving interactions between police and PMI are a waste of time and human resources. While this attitude was more widespread many years ago, it still holds sway with many members today.

On the other hand, there are many officers who believe intervening in some mental illness crises fully falls within their job description. When asked if it was the police's job was to respond to these incidents, one participant responded: "Actually, it is. It's called the *Mental Health Act*. You know, our name is in there (the *Act*) to be able to apprehend" (personal communication). As noted, there is a direct piece of legislation

which explicitly states that it is a police officer's duty to apprehend individuals who are considered to be showing signs of mental illness, and are considered a danger to themselves or others, for an immediate psychiatric evaluation. Another participant echoed these sentiments, stating "we can say we're not social workers, but we are social workers" (personal communication). In essence, there is an implicit acceptance by some officers that helping PMI extends beyond the traditional role of keeping the peace, to actively offering assistance to people in need.

It is important to note that while many officers believe that apprehension under the BC *Mental Health Act* is well within their job descriptions, an overwhelming number of participants maintain there is still significant room for the health care system to offer more extensive and integrated support for PMI. As one participant said, "the mental health system is broken. I can't fix it. This is our part. We're obligated. We're duty bound to do it and we have to do it well and as best we can" (personal communication). In other words, these interactions with police officers and PMI will continue well into the future until the health care system, in conjunction with the BC provincial government, finds a better way to offer treatment and aid to PMI. It is important to note that this frustration that PMI do not receive enough aid to help them maintain a status of wellness was expressed by all participants in my study.

3.4.2. Champions

Despite more progressive police officers and programs, "old school thinking" is still evident throughout the police. As a result of this "old school thinking", there is a need for someone to champion mental health programs to combat this mindset. According to some participants, this "old school thinking" has disrupted the effectiveness of some mental health projects. As an officer indicated, "every program needs a champion. And with members going in and out…you don't have that consistent development because it's always going on to the next officer" (personal communication). Another participant highlighted the importance of a consistent advocate for the program, when she stated "you need to have somebody being the champion and taking it forward and making it happen" (personal communication). Without this support, other files and matters of the day take priority over a particular mental health program. Overall, the duty of a champion is to protect a program from the "old school" way of thinking about mental

health issues, and to ensure consistent development and improvement of a program. Without such a figure, a police detachment seems unlikely to make significant progress in improving interactions between PMI and officers.

3.5. Summary of Findings

Many of the above findings are relevant for improving interactions between police and PMI. First, from my discussions relating to the use of force guidelines, I have determined that these guidelines do not need to be changed; however, an emphasis should be placed on ensuring adequate training for de-escalating mental health crises. Second, it has become clear that adding more information to basic training for police officers will have limited effectiveness, due to the copious quantities of information already included in training. Consequently, policy options which favour continuous training are favoured in my policy analysis. Third, it is apparent that police training should include some element involving personal contact with PMI. This will help reduce stigma between PMI and police officers, and increase police officers' understanding of the lives of PMI. Fourth, mental health training must include a portion of crisis communication to ensure officers have the appropriate active listening skills necessary to defuse a crisis.

There are two other prominent points to remember when reading the following sections of this capstone, although these points do not directly affect my policy analysis. First, it is important to recognize that while sharing information between the police and the health care system can be beneficial during a crisis situation, such information sharing can produce detrimental effects for PMI in the years after an incident. Second, any programs focused on improving interactions between PMI and police officers are unlikely to succeed without an officer to champion the program's cause.

4. Review of Programs to Improve Interactions Between Police and PMI

From my literature review, I have identified three of the most popular methods to improve interactions between police and PMI. These methods are: (1) to include specific mental health training in basic training for police officers (2) to operate a police car that responds to mental health calls with a psychiatric nurse and (3) to certify general duty patrol officers in Crisis Intervention Team training and to deploy them as first responders to scenes involving PMI.

4.1. Basic Training

There is a consensus among researchers that providing basic mental health training to all police officers is a critical and necessary step to improve interactions between police and PMI (Coleman & Cotton, 2008, 3-5; Coleman & Cotton, 2010a,9; Commission of Public Complaints against the RCMP, 2010; Fyfe, 2000; Parent, 2011). While some police officer academies have offered training related to mental illness since 1974, less than half of national police academies were doing so in 1998 (Coleman & Cotton, 2008, 12). It was not until 2000 that such training became common throughout police academies in Canada (Cotton & Coleman, 2010a,9).

While there are limited evidence-based best practices for police training, researchers tend to agree on many common elements that should be included in the curriculum. These elements include information about identifying the symptoms of mental illness, training in suicide prevention, and education in principles of crisis negotiation (Borum, 2000, 533; Coleman & Cotton 2008, 5; Commission of Public Complaints against the RCMP, 2010; Council of State Governments Justice Centre & Police Executive Research Forum, 2008,3). Unfortunately, there is little outcome based research examining which of these elements are more effective than others (Coleman & Cotton 2010c,31; Commission of Public Complaints against the RCMP, 2010; Council of State Governments Justice Centre & Police Executive Research Forum, 2008, 3).

Regardless of the prevalence of basic police training programs related to mental illness, Coleman and Cotton (2008; 2010a; 2010b) have highlighted that the quality and structure of these programs vary greatly throughout Canada. For example, only two police academies in Newfoundland have people living with mental illness deliver the training to police officers (Coleman & Cotton, 2008, 17-18). Involving PMI in the delivery of training is important, as personal interactions with PMI have been very effective at reducing stigmatizing attitudes towards mental illness (Stuart, 2009). Similarly, it is not clear if academies that use problem-based learning models, such as the RCMP Academy, sufficiently cover topics related to mental illness, as there are not any specific goals or competencies about mental illness outlined in the curriculum (Coleman & Cotton, 2010c, 13-14). Despite the importance of mental health training for police officers, none of the Canadian provinces have mandated that mental health training be part of provincial policing requirements (Coleman & Cotton, 2010c, 14), until BC recently took this step.

4.2. Co-Responder Model

In addition to basic training, numerous cities have implemented co-responder models to improve interactions between PMI and police. In a co-responder model, a police officer, in conjunction with a mental health professional, nurse, or social worker, will respond to calls involving PMI (Adelman, 2003, 12; Hails & Borum, 2003, 54). This mobile team may receive phone calls from police dispatch directly, or through a first responder (Kisely, S. Campbell, Peddle, Hare, Pyche, Spicer, & Moore , 2010, 665). Having a mental health worker at the scene is intended to provide an immediate and accurate assessment of the mental health problem, while helping to connect PMI with more efficient referral services (Moore, 2010, 336). The fact that there is a police officer involved in the interaction provides safety in the event of violence, and allows for the police to use their powers under the *Mental Health Act* if the apprehension of the person is needed (Adelman, 2003, 11,15; Coleman & Cotton, 2010c, 10). Many large urban cities use this model, such as Vancouver (Car 87), Edmonton, and Ottawa (Coleman & Cotton, 2010b 45; Kisely et al., 2010, 666; Wilson-Bates, 2008, 29). There are also some adaptations for rural communities, so that consultations with mental health

workers can be carried out over a telephone during a crisis situation (Coleman & Cotton, 2010c, 45).

4.3. Crisis Intervention Team Training

Throughout the USA, the Crisis Intervention Team model is predominantly used to ameliorate problems that arise during encounters with PMI (Hails, & Borum, 2003, 59; Teller, Munetz, Gil, & Ritter, 2006, 232). It was developed in Memphis, Tennessee in 1988, and involves specialized training for a select number of police officers in responding to calls involving PMI (Teller, Munetz, Gil, & Ritter, 2006, 232; Watson, 2010, 536). Commonly, an officer is assigned to patrol or traffic duty, so that if a call comes in concerning PMI, he or she can easily be deployed to the situation (Teller, Munetz, Gil, & Ritter, 2006, 235; New South Wales Police, 2011). The training usually involves 40 hours of class time in total. There has been little outcome research conducted assessing CIT training, and the reviews from the few studies are mixed about its effectiveness (Borum, 2000, 333 ; Teller, Munetz, Gil, & Ritter, 2006, 235; Watson, 2010, 541).

The RCMP E Division has provided CIT training to six different cities in BC, in conjunction with the Canadian Mental Health Association's BC Division, the BC Schizophrenic Society, the BC Ambulance Service and the Provincial Health Authorities. (Canadian Mental Health Association, BC Division, Undated). It appears that CIT training is still offered throughout BC, although it is dependent on individual police detachments scheduling these events (Anonymous, personal communication). The training sessions involved police officers, emergency room psychiatric nurses, correction officers, ambulance paramedics, and dispatchers (Canadian Mental Health Association, BC Division, Undated). It covered topics such as the role of police, physicians and the BC ambulance services in relation to the BC *Mental Health Act*, identification of different mental health disorders, information about early psychosis intervention and addictions, as well as training in risk-assessment for first responders (Canadian Mental Health Association, BC Division, Undated). Similarly, the Vancouver Police Department has a modified CIT training program of 36 hours, covering similar information topics, in which they are trying to train 100 percent of patrol officers (Wilson-Bates, 2008, 28).

5. Policy Options

The following policy options are directed towards the RCMP; however, they involve the cooperation of numerous stakeholders, and are applicable across independent municipal and/or provincial police forces. The options I discuss are (1) the status quo (2) enhancing basic training (3) the co-responder model and (4) Crisis Intervention Team training.

I also identified two policy options from my interviews which I have not included below. These are the establishment of a Mental Health officer position within a police detachment, and the involvement of police officers in assertive community treatment teams. These options were screened out of this study because neither option improves the immediate interactions between police officers and an individual experiencing a mental health crisis or symptoms of their mental illness.

5.1. Status Quo

As previously mentioned in Section 1.3, the current programs offered throughout BC are inconsistent across municipalities. How the status quo is defined is therefore dependent on each municipality. Some detachments have been very proactive and implemented many of the options below. Others have implemented fewer of these programs, for a variety of reasons including funding constraints. Given that current studies do not identify which areas are less successful at resolving interactions between PMI and officers, it is difficult to determine which communities need to improve these interactions the most. Consequently, the status quo will not be analysed in Section 7.

While I have focused my research on the Surrey RCMP detachment, I did not use Surrey as a case study for the status quo. This is because the Surrey RCMP detachment currently runs a co-responder car and has had experience with CIT training, which means it is already doing more than most police detachments in BC to improve interactions with PMI.

5.2. Enhancing Basic Training

One option to improve interactions between police officers and PMI in crisis is to modify the basic training delivered to RCMP officers in Depot. This would include a wider range of classes and role-plays focused on recognizing mental health behaviours, such as psychosis, without solely focusing on sucidality or suicide by cop.[7] While this information could be integrated into the current police curriculum, it is also possible to offer a specific two-day course on mental health, at the very end of the training program. Such a course could easily be modified from Mental Health First Aid Canada, a program sponsored by the Mental Health Commission of Canada, aimed at teaching the general public how best to respond to someone developing or experiencing a mental illness. A course could contain a half-day seminar focusing on behaviours associated with a wide range of mental illnesses, while an additional half-day could involve a discussion with PMI. Another entire day could focus on crisis communication techniques, as based on the CIT training model.

As highlighted in the global theme "Building Rapport" (4.2), there are a multitude of reasons for involving PMI who are well in a training session for police officers. This is particularly important as police officers are not required to have any previous knowledge of mental illness before entering training, nor should they. This means that the first time some individuals are learning about mental illness is in basic training. As Alex Berland, a nurse and the former public administrator of Riverview Hospital says: "if they can develop empathy towards people living with mental illness and they're exposed to that very early on as part of their group, it becomes part of their training group culture" (personal communication, November 4, 2011). Interacting with PMI during periods of wellness can increase this empathy, as officers realize how individuals can function incredibly well when they are healthy, versus how officers view PMI responding to emergency situations (L. Stewart, personal communication, November 25, 2011). One

[7] The term "suicide by cop" refers to a situation in which an individual is suicidal, and intentionally acts in a threatening way to provoke a police officer into using lethal force.

participant stated, “it's so hard to de-escalate someone if you don't know kind of where they're coming from” (Anonymous, personal communication). Overall, the importance of police officers being knowledgeable about mental illness and empathising with PMI can not be overstated.

Nevertheless, two particular challenges emerge when adding more information to basic training. First, as Dr. Bill MacEwan points out, it may be difficult to find PMI who have had previous interactions with the police, and who are willing to speak about their experience in a situation like Depot, as speaking to a room full of police officers can be incredibly intimidating (personal communication, November 21, 2011). Further, reliving the experience may be particularly traumatizing for some people, especially if the interaction was negative.

The second challenge relates to the amount of information cadets receive during their 24-week Depot training. Not only is the amount of information overwhelming and intensive, but as one participant mentioned, “they could have maybe done 20 situational things when it comes to mental health and that's not going to give me any more [experience] when it's in real life with real people too” (Anonymous, personal communication). This participant underscores the fact that situations involving actors who will not seriously injure officers are limited in teaching value, while also suggesting that retention of information might be minimal, due to the large quantities of material cadets are trying to absorb (See Section 3.1 “The Learning Curve” for more information).

5.3. Implement 24/7 Co-Responder Model

For cities with a population of more than 120,000 people, the co-responder model offers an alternative to enhancing basic training and CIT training. A co-responder model, involving a psychiatric nurse and a plain-clothes police officer, provides general duty officers with a valuable resource in resolving situations between PMI and police officers.

If a city is without a co-responder model, running a car part-time for a 12-hour shift is advised, to determine if the model is appropriate for the community. The program could run, for example, from 2pm to 2am every night. Typically, police officers work four

days consecutively, two days and two nights. In this circumstance, a police officer in a jurisdiction with 12-hour co-responder model will essentially work as a co-responder part-time. This means that the other part of an officer's time is spent on general duty, which is what occurs in Surrey.

If a co-responder model is already in place, expanding the number of co-responders is recommended, to provide 24-hour, seven days a week service. This is of particular significance, as mental health crises can happen 24 hours a day, seven days a week. Essentially, having a co-responder model in place all the time is a goal detachments should strive towards if they implement this option.

In the event that the co-responder car does not receive any calls during a shift, there are many other duties to which an officer can attend. Files relating to an officer's general duty shift may be worked on, or officers and mental health workers can engage in short-term follow-up with co-responder clients (Anonymous, personal communication). This outreach usually involves going to the home of the individual who was in crisis to discuss the recent emergency. Having discussed the situation with an individual, the information is usually passed to the individual's mental health team, assuming the person is in contact with health services.

If pursued, my findings suggest the co-responder model should rotate its police officers every six months. This limits the amount of experience and rapport police officers build with the mental health worker or psychiatric nurse, yet it allows more general duty police officers to gain experience in defusing mental health crises. In turn, the officers can disseminate this knowledge to other police officers while on the job.

One of the benefits of this is model is that it helps police officers determine if it is appropriate to apprehend a person under the BC *Mental Health Act*. Additionally, a co-responder car can provide assistance in de-escalating a situation; however, this can only occur in situations where there is no threat of violence, such as if there were a person considering jumping off of a bridge.

This raises one of the limitations of the co-responder model, namely that a co-responder car will arrive only after the scene has been secured. This is because the

mental health worker is a civilian, and not trained to defend herself if threatened. As a result, the car does not immediately assist in de-escalating a crisis.

Lastly, while the co-responders can engage in short-term follow-up with clients, the model is not equipped to engage in long-term follow-up for mental health clients. This is especially true because members work two day-shifts and two night-shifts per watch, disrupting any continuum of contact one police officer may have with a certain individual in crisis (Anonymous, personal communication).

5.4. Train 25 percent of Patrol Officers in CIT Training

As of January 30, 2015, all police officers in British Columbia will be required to participate in Crisis Intervention and De-escalation training, which will contain an online and a face-to-face component, likely totalling two days of instruction. While it is currently unknown what this course will actually entail, police detachments should still strongly pursue Crisis Intervention Team training, which was previously offered in various detachments throughout BC.

The CIT training for police officers involves a 40-hour course that brings together a variety of stakeholders in one community, such as paramedics, crown counsel, psychiatric nurses, parole and correction officers, and firefighters, to discuss how best to interact with people experiencing crisis. The training focuses on assessing suicide, symptoms of psychosis, and models in crisis communications.

The training also includes role plays, where, for example, a person is given an MP3 player with a recording of voices, scripted with the help of a person living with schizophrenia. While listening to MP3 player, the person is then sent out into the community, and instructed to ask for directions to a particular location. This type of exercise has received very positive feedback, as it presents participants with a difficult challenge, and helps them understand with the difficulties people may experience during a mental health crisis involving auditory hallucinations. CIT training also includes panels of mental health clients and family members so that officers have the opportunity to see PMI when they are well, as well as the chance to ask PMI questions about their experiences.

To be eligible for CIT training, a police officer must go through an application process, involving a questionnaire as well as a recommendation from a superior officer. Supervisors should place a priority on members recently out of training, and should request the officer sign a contract to work for three to four years in the same detachment on general duty. In the beginning of their career, many young police officers may be more likely to take a longer work contract, as their interest and passion for general duty policing may still be strong. Moreover, this contract situation would also limit the number of CIT trained officers moving to another detachment, ensuring that any personal relationships developed cross-sector are allowed to grow..

To augment the original version of CIT training, the contract between Metro Vancouver and the ECOMM emergency dispatchers should stipulate that dispatchers also participate in crisis intervention training. This will ensure that emergency dispatch throughout the Lower Mainland will be able to pass relevant information about PMI to first responders. Similarly, BC Ambulance Service dispatchers should also be party to the training, to ensure all emergency call dispatchers can pass along as much information as possible about mental illness. In areas with significant interaction between RCMP forces and other municipal police forces, it is worthwhile to ensure that members from both the RCMP and the municipal police force attend CIT training as well.

If used in a detachment that has a co-responder model in place, Crisis Intervention Team training is recommended before participating in the co-responder model. That said, completing CIT training after working on the co-responder car is not wasted time, as this training is as much about the team building as it is the training.

One of the benefits of including so many community stakeholders in this training session is that it allows relationships to be built between participants. In turn, this encourages cooperation in future interactions related to resolving an emergency. It also provides everyone an opportunity to learn about each other's policies, fostering a greater understanding and efficiency at the scene of an emergency. Additionally, it provides an opportunity for these agencies to align their goals, and work together cohesively.

6. Criteria and Measures

To analyse the policy options listed in section 5, I developed four criteria based on my interview analysis and literature review. The definition and description of each criteria is contained in the following section. These criteria include (1) effectiveness (2) police acceptance (3) cost and (4) equity. For the measurement scales of each criteria please see Table 2.

Table 2 Criteria and Measures

Criteria	Description	Measures
Effectiveness	Extent to which policy option improves or does not change interactions between police and people living with mental illness	5. Very effective 4. Effective 3. Moderately effective 2. Somewhat effective 1. Ineffective
Police Acceptance	Extent to which policy option (1) helps RCMP officers determine if it is appropriate to apprehend an individual under Section 28 of the BC *Mental Health Act*, (2) provides any resources that prevent future emergency calls.	5. Widely accepted 4. Somewhat accepted 3. Neutral 2. Somewhat unacceptable 1. Widely unacceptable
Cost	Cost of operating policy for one year for all government-funded parties involved in Canadian dollars.	5. $0-$260,000 4. $260,001-$520,000 3. $520,001 - $780,000 2. $780,001- $1,040,000 1. $1,040,001 - $1,300,000
Equity	Extent to which policy option educates front-line general duty officers, and the number of general duty officers who are affected by the policy option.	5. Equitable 4. Somewhat equitable 3. Neutral 2. Somewhat inequitable 1. Inequitable

6.1. Effectiveness

The effectiveness of a policy will be evaluated by looking at the extent to which the policy improves interactions between police and PMI. A policy is determined to improve these interactions if it increases PMI's satisfaction with their encounters involving the police. An assessment of this was made by examining the policy suggestions developed by PMI, in Brink et al.'s study, and by qualitatively analyzing if the option would improve police's understanding of how to interacte with people in crisis.

This was gauged by assessing if the option satisfied the following four aspects: (1) the policy increased understanding and empathy towards PMI (2) the option improved an officer's ability to build rapport with PMI and mental health workers (3) the option helped officers communicate with a person in crisis; and (4) the option assisted an officer in recognizing behaviours associated with mental illness.

The policies that greatly improve interactions between PMI have been categorized as highly effective, whereas policies that only minimally increase understanding of different behaviours associated with mental illness are considered somewhat effective. If a policy does not improve any of these areas it is deemed ineffective (see Table 2).

6.2. Police Acceptance

This criterion examines how widely accepted the policy option is among police. There are two aspects to this criteria. The first aspect examines whether a policy helps an officer improve his ability to determine if an individual should be apprehended under section 28 of the BC *Mental Health Act* (1996, c. 288). Apprehensions to the hospital for an emergency psychiatric examination are encouraged if a person appears to pose an immediate danger to his or herself, or others.

The legitimacy of apprehensions are often questioned by PMI after the incident, as evidenced by complaints launched against the police (D. King, personal communication, November 18, 2012). Consequently, many police officers have become very concerned as to whether they have legal grounds to apprehend an individual. If the

policy option helps general duty patrol members answer this question, then the policy receives high acceptance. If it does not, then the option receives a low score, such as "somewhat unacceptable."

Similarly, my interviews with police officers indicate that programs placing a large emphasis on preventing future emergency calls are strongly praised. Thus, any policy which has a component preventing future crisis calls is considered to receive a higher level of police acceptance.

6.3. Cost

The cost criterion examines the direct and indirect costs the policy imposes on taxpayers per year. Costs such as equipment, personnel, replacement personnel, as well as administration costs have been considered.

While I could have examined the costs of a policy option to an RCMP detachment only, this would have neglected the costs borne by other government-funded systems, such as health care. Including these costs becomes particularly important for the co-responder model option and CIT training, since these involve partnerships with different sectors of government. The intent is to provide a more holistic analysis of the costs associated with each policy by assessing the expenditure to the taxpayer and not a detachment.

That said, there are three drawbacks to defining the criterion this way. First, the criterion does not incorporate any benefits to society that the option may provide. Some options may reduce the likelihood of emergency calls from occurring, for example, but such benefit has not been included in this analysis. In essence, this criterion is not a benefit-cost analysis, as I felt far too many ungrounded assumptions were required to assess the potential benefits to society.

Second, any police detachment interested in the costs of each program will not be able to make an accurate assessment on the basis of this criterion, as the inclusion of costs across the health care system and police departments have skewed the direct expenditures felt by each particular organization.

Third, analyzing the policy options according to the costs to taxpayers for a year can be slightly misleading. Enhancing basic training for RCMP members must account for the fact that this is training received by all RCMP officers throughout Canada. On the other hand, CIT training affects fewer police officers, but involves a longer training session. Due to this, I have included both the total outlay of the option for one year as well as a per RCMP member cost in my analysis of these options in Section 7.

Policy options ranging between approximately $0-260,000 received a score of five, whereas any policy options costing between $1,040, 001- $1.3 million received a score of one (see Table 2).

6.4. Equity

When examining policy options to improve interactions between PMI and the police, it is particularly important to consider how the option affects different income groups. PMI in low-income situations without homes are far more likely to encounter police during a mental health crisis, for example, as they are living on the streets which police are patrolling. This means that PMI without homes will likely have more encounters with general duty patrol officers throughout their life. Also, homeless PMI are more likely to carry items that can be used as weapons to protect themselves while on the street (D. King, personal communication, November 18, 2011). This means that their interactions with police officers during mental health crises are more likely to involve a weapon, and thus escalate more quickly.

As a result of these factors, a policy option is considered more equitable, if the option helps frontline general duty officers increase their recognition of mental illness, and if the option enhances their ability to de-escalate situations in which people are in crisis. Further, an option is considered more equitable if the option affects more police officers, rather than fewer police officers, increasing the likelihood that members encountering people randomly on the street will be appropriately trained for such interactions.

7. Policy Analysis

This section contains my analysis of the policy options presented in Section 5. These options are analysed according to the four criteria detailed in Section 6. For a summary of my results please see Table 3 below.

Table 3 Policy Analysis Matrix

	Basic Training	**Co-responder**	**CIT Training**
Effectiveness	Somewhat effective (2)	Effective (4)	Highly Effective (5)
Police Acceptance	Somewhat Unacceptable (2)	Widely Accepted (5)	Somewhat Accepted (4)
Cost	$260,000-$520,000 (4)	$1 – $1.3 million (1)	<$260,000 (5)
Equity	Equitable (5)	Inequitable (1)	Somewhat Inequitable (2)
Total	**13**	**11**	**16**

7.1. Enhancing Basic Training

Enhancing basic training involves practising more scenarios focused on de-escalating mental health crises, or implementing a two-day course at the end of basic training which focuses on crisis communication and meeting with PMI (for more information please see Section 5).

7.1.1. Effectiveness

Modifying basic training at Depot is considered to be somewhat effective, and receives a score of two points out of five. While the training directly focuses on crisis communication techniques, (installing a sense of empathy in an officer and helping the officer recognize symptoms of mental illness), the amount of information delivered through Depot brings into question whether such specific details would be remembered.

As one officer summarized, “There's only so much you can cover at basic training” (Anonymous, personal communication). In essence, there is concern that officers might be overloaded with knowledge and adding more information would likely not be retained.

7.1.2. Police Acceptance

In regard to police acceptance, augmenting basic training receives a score of two out of five, or a classification of “somewhat unacceptable.” While training can help cadets and officers recognize symptoms of mental illness, which in turn may help them decide whether an individual can be apprehended under the BC *Mental Health Act*, Depot training is for all RCMP officers throughout Canada. Because of the facility’s wide range of students, it does not and should not specify the particulars of provincial mental health legislation. All in all, it is unlikely that basic training is sufficient to provide all officers in Canada with adequate information to decide if a person should be apprehended and thus does not meet my definition of police acceptance.

Moreover, the option does not help officers prevent any future calls, as information regarding mental health resources in different provinces is not offered.. Once again, this is not to suggest that Depot training should be changed, but to emphasise that Depot may not be the most appropriate place to distribute this particular geographic knowledge. On balance, this option has a moderate impact on assisting police in deciding whether to apprehend an individual or not, and does not provide officers any resources to prevent future emergency calls.

7.1.3. Cost

Providing an additional 16 hours of training for each RCMP cadet costs approximately $300,000 per year, and earned a score of four out of five. This was calculated to include the training of 1,020 police officers, the average number of cadets that Depot trains per year (RCMP 2004). Generally, this modification works out to $300 dollars per member. The cost includes the cadet stipend of $100 a day, the cost of a skilled RCMP trainer estimated at $138,000 per year with benefits and administration costs, and honorariums for guest presenters such as PMI, and their family members. It was assumed that an entirely new curriculum would not have to be developed, since

many courses across Canada focus on this type of information. Due to this, the cost of developing a curriculum was not included. While this option is less expensive than others on a per member basis, it is important that to note that all RCMP members across Canada must receive this training, increasing the cost to the taxpayer.

7.1.4. Equity

This option receives a high score of equity (five out of five), because it focuses on training all RCMP officers who will be dispatched throughout Canada. This means that the largest policing force in the country would offer more in-depth basic training, fully satisfying the principle that the more police officers affected by the policy, the more equitable the option is. Also, every RCMP officer must become a general duty officer for the first two to three years of his or her career, which means that basic training would encompass all general duty officers throughout Canada (RCMP 2004). This means that if a low-income PMI was to be encountered by an officer while on the street, the likelihood that the officer will be prepared for such a situation is much higher.

7.2. Implement 24/7 Co-responder Model

As previously mentioned, the co-responder model involves a police car in which both a psychiatric nurse or mental health worker accompanies a police officer to emergency calls. If the co-responder model is to be implemented, a detachment should strive to achieve 24-hour, seven day a week coverage, since mental health crises may occur at any time of the day.

7.2.1. Effectiveness

In terms of effectiveness, the co-responder model is considered “effective,” and receives a score of four out of five. For the officers who ride side-by-side with a mental health worker, it is as though they are completing a practicum with a psychiatric nurse. As one officer said, “you're seeing the client and then you're quizzing the nurse on what is it exactly that you saw -- and that's a fantastic learning experience” (personal communication). Having such a readily available, well-informed resource in the car provides consistent information about mental illness, and can help officers recognize

mental health issues. All in all, this greatly increases an officer's ability to recognize behaviours, as well as his or her ability to build rapport with individuals in crisis.

Also, the co-responder model facilitates information sharing between the health care system and the police system. This may assist in the de-escalation of a contained situation, by providing more information about the individual, if the person has already been in contact with the health care or justice system.

However, a restriction of the co-responder model is that it cannot respond to calls in which there is immediate danger to a person, or if there is a weapon present. This significantly limits the effectiveness of de-escalating a situation within the first five minutes of an encounter.

That said, as another participant mentioned, the learning from the car persists throughout an officer's career: "So it's the learning, right - that helps you down the road once you're off the car and you're actually working in, you know, general duty and - working - with the clients" (personal communication). This suggests the possibility that members of the co-responder model will take their knowledge and disseminate this information to their fellow officers.

Overall, the co-responder model is very effective in helping officers increase their de-escalation and rapport buildings skills, as well as their ability to recognize symptoms of mental illness. Since the co-responder model does not result in officers arriving first on scene, the option receives a score of four out of five rather than five out of five, as this expertise will not be available in the first five minutes of a mental health call.

7.2.2. Police Acceptance

The co-responder model is widely accepted among police officers, as it helps resolve officers' questions as to whether to apprehend an individual, and it also helps prevent future mental health emergency calls, by ensuring that PMI are connected with appropriate health care supports. Consequently, the option has been awarded five out of a possible five points. As one officer mentioned, a co-responder car is best designed for ambiguous calls, when the officer is unsure as to the best course of action with an individual (Anonymous, personal communication). Since the co-responder model has a

nurse accompanying a police officer, the nurse is more qualified to make an assessment as to whether the individual might be a risk to himself or herself or someone else. Thus, having a nurse in the car can provide an officer with more confidence as to whether or not they should legally apprehend an individual.

In terms of prevention, the mental health worker may provide community supports which the PMI can contact, as well as short-term follow-up with the PMI. These actions may prevent future emergency calls, as people in crisis are connected with treatment programs before they reach a state of crisis. Further, the co-responder model ensures that if the individual is seeing a mental health team, then that team will be alerted as to an individual's interaction with the police. In essence, it allows the knowledge of what is occurring out in the community to enter the health care system. The hope is that once notification of this interaction has taken place, the mental health team will be in a position to better help the individual reach a place of wellness.

Lastly, since the co-responders are second on scene, the nurse is readily available by telephone to answer other members' questions about behaviours they are seeing, and whether there is a more appropriate resource for the individual to use other than going for an emergency psychiatric evaluation.

7.2.3. Cost

The co-responder model is an expensive option, costing approximately $1.2 million dollars to staff for 24 hours a day seven days a week. As a result, this option scores one out of five, as it is the most expensive policy examined in this study. This costing includes personnel for two cars, as well as the cost of police cars and maintenance. Once again, it was assumed that all skilled personnel cost approximately $138,000 per year, and that each person worked approximately 2,000 hours a year. Due to the expense associated with this option, it is only recommended for municipalities with more than 120,000 people, to ensure that adequate resources between both the municipal police force and health care systems exist.

7.2.4. Equity

When it comes to equity, the co-responder model is "inequitable," and receives a score of one out of five. The option is considered inequitable because the co-responders will not respond to scenes in which a weapon is present. Since most homeless PMI carry small weapons for defence, the likelihood that a co-responder car will be able to assist a homeless PMI is low. This means that the co-responder option is more likely to help PMI who have higher incomes than PMI with lower incomes.

Moreover, while participating in the co-responder model provides an officer with a fantastic learning experience, the model only educates a few officers when compared to the whole police force. It is true that other policing members will call officers who have past co-responder model experience for advice; however, compared to enhancing basic training for RCMP members, this option provides a unique learning experience to a few select officers. Because this model affects a limited number of officers, it is less likely that a member on patrol will be prepared to deal with a low-income individual experiencing mental health crises, making this option less equitable.

7.3. Allocate 25 percent of patrol officers in CIT Training

This option aims to educate 25 percent of all general duty patrol officers in a detachment in Crisis Intervention Team training, involving a 40-hour training course focused on crisis communication and mental illness recognition. In practice, CIT trained officers would be the officers deployed to any emergency calls identifying mental illness as a factor in the situation.

7.3.1. Effectiveness

CIT training is considered very effective and is awarded a score of five out of five, for two reasons. A consistent finding from across studies is that after CIT training has been implemented in different jurisdictions, the number of calls identifying mental health as a component has greatly increased. These results suggest that the CIT training materials provided adequate information to recognize behaviours associated with mental illness (Watson, 2010, 541). Likewise, studies such as Stuart (2009) also show that CIT

trained officers are less likely to use force, or are likely to use less lethal versions of force in these calls. This indicates that the empathy and rapport building skills learned in CIT training are actively used in the field, resulting in an improvement to both police officer as well as PMI safety.

7.3.2. Police Acceptance

CIT training is considered somewhat accepted by police, and receives four points out of five for two reasons. First, CIT training focuses on improving officers' recognition of mental health systems, which assists them in assessing whether the individual with when they are dealing shows "apparent signs of mental illness." In turn, this helps an officer assess if an individual poses a harm or threat to himself or herself or anyone else. If these two criteria are present, then the person may be apprehended under the BC *Mental Health Act* (Kerr, 2010, p. 118). This option did not receive five out of five points because the expertise of a CIT trained officer is still less than that of a psychiatric nurse.

Second, while Crisis Intervention Team training does not have an explicit focus on preventing future mental health emergency calls, aspects of the training can lead to preventative measures. For one, the connections made between members and first responders encourage more collaboration and information sharing practices among these agencies. Many police officers have found that after completing CIT training, they emerge with a wealth of mental health resources to which they can refer PMI, especially if the individual does not meet the qualifications for apprehension (Anonymous, personal communication). By educating police officers about these resources, and by forming relationships between the health care sector and police officers, the number of PMI connected with appropriate mental health resources is increased. In turn, this assists PMI in reaching a state of wellness, decreasing the likelihood that PMI will experience major crises that involve the police. As Teller et al. have demonstrated, in fact, the CIT partnership has been shown to increase linkages to the treatment and the health care system, where individuals in crisis are better served (2006, 232).

7.3.3. Cost

The CIT training policy option receives a score of 5 out of 5, as it is inexpensive, and costs approximately $200,000 per year to train 25 percent of general patrol officers. The number of officers necessary to train was based on Surrey's RCMP detachment, which is the largest detachment in Canada. The costing of this option was determined by making a few general assumptions. First, it was assumed that Surrey had approximately 240 general patrol officers, and thus a total of 60 officers are to receive CIT training.[8] Second, it was assumed that an average skilled worker, nurse, and police officer, with benefits and overhead costs associated with the personnel, totalled $138,000 per year, or approximately $69 per hour (UBCM, 2009, p. 8). It was also assumed that no more than 10 police officers should attend each training session, and that a total of 40 skilled professionals would be in each class. Factoring in the indirect costs of a person attending CIT training to the taxpayers, classroom costs, administration of the training, honorariums for guest speakers, and ongoing team meetings, the total cost of this option is slightly under $200,000 for 60 RCMP members, or approximately $3,200 per officer.

7.3.4. Equity

This option is considered "somewhat inequitable" and receives two out of five points, because CIT training is only targeted at 25 percent of patrol officers. While this is effective training for a sizeable number of officers, it does not directly assist the other 75 percent of patrol officers to be more prepared when encountering PMI on the street. Even though it is possible for general patrol members to call designated CIT trained members for resources, if a decision needs to be made quickly, the rest of these officers must rely on basic training. On the whole, this option is not as equitable as enhancing basic training to all police officers, since people who have more contact with patrol

[8] This was determined by calculating the composition of constables to RCMP personnel nationally, which was 40%, and applying that to Surrey's 600 RCMP personnel.

members are likely to experience many interactions that do not involve a CIT trained officer.

8. Recommendation: CIT Training

Having assessed all of the policy options according to my four criteria, enhancing basic training earned a total score of 13 points, while the co-responder model totalled 11 points, and CIT training received 16 points. Please see Table 3 for a complete breakdown of each option's scores.

As a result of this policy analysis, it is recommended that 25 percent of all general duty officers become involved in CIT training for cities over 20,000 people. This training should include stakeholders in a community, such as addictions counsellors, mental health workers, psychiatric workers, firefighters, and paramedics, and entail a total of 40 hours. A particular effort should be made to involve both ECOMM dispatchers as well as BC Ambulance dispatchers in this training. Training should be focused on assessing different types of behaviours associated with mental illness, as well as crisis communications. Additionally, a key component should include a discussion with PMI to facilitate a positive experience for officers with PMI who are well. Sharing such an experience with members from different professions will also help create a cooperative environment among trainees.

Furthermore, there should be conditions associated with attending CIT training. For example, officers should be required to apply for CIT training, and to have a recommendation from their supervisors. On this topic, supervisors should strive to recommend officers who are relatively new to the force, ideally recommending those who have become police officers within the last two years. Given that all officers begin their careers as general duty patrol officers, they are more likely to be willing to remain as a general duty patrol officer for a longer period of time than a more senior RCMP member. Moreover, the officer should be asked to sign a contract of three to four years within the detachment as a general duty officer. This will ensure that there is sufficient continuity for team-building exercises within the community to solidify relationships.

Finally, at least five members from different organizations who have participated in the training should continue to have conference calls at least four times a year, to discuss any problems that arise during the community. Overall, continuing these team

meetings allows for a permanent line of communication between the variety of partners who interact together when responding to a crisis situation.

On balance, this option is very effective, inexpensive, and accepted by the police. While the policy option is somewhat inequitable, my interview findings suggest that the benefits offset this disadvantage. To conclude, CIT training offers a promising resource for police detachments and BC communities in an effort to improve interactions between PMI and police officers.

9. Conclusion

This study has underscored the importance of building relationships between police and a variety of other actors, such as mental health workers, PMI, and emergency dispatchers. It appears that Crisis Intervention Team training is the best way to achieve this goal. CIT training provides an opportunity for these groups to come together in positive situations, encouraging collaboration between these actors. In turn, this leads to improved cooperation at a crisis scene, potentially resulting in improved interactions between police and PMI.

Furthermore, CIT training includes all of the integral training aspects my participants highlighted during our conversations. Not only does it contain a section on crisis communications with PMI, it also helps officers identify mental illness, and gain a greater understanding of what living with a mental illness would be like. Coupled with a discussion with PMI about their previous interactions with police officers and their mental illness, these activities reduce first-responders' stigmatizing attitudes towards people living with mental illness, and increase their ability to defuse a crisis situation.

While enhancing basic training and implementing a co-responder model received lower scores than CIT training in my policy analysis, these options should not be discounted. As previously noted, the BC government decided that basic training regarding crisis communications and mental illness is insufficient across BC. This is evidenced by the new requirement for all police officers in BC to be trained in a two-day Crisis Intervention and De-escalation program by 2015 (Ministry of Pubic Safety and Solicitor General, 2011). Thus, it is worthwhile for police detachments to review their training practices, and to determine the extent to which their training focuses on mental illness. If police detachments do review their practices, BC's CID training may be used as a general guide to determine if a detachment or province's training is adequate.

Additionally, a 24-hour, seven day a week co-responder model might be an appropriate long-term goal for large police detachments, such as Surrey, BC. While the co-responder car is often limited by arriving second on scene, there are numerous incidents in which PMI do not have weapons, and hence the co-responders arrive first, thereby offering valuable assistance in de-escalating a crisis.

Further, if apprehension is not the appropriate course of action during a PMI incident, there are mental health resources the individual can access through the nurse or mental health worker. Co-responders can also pursue short-term follow-up with the PMI in crisis, possibly preventing future mental health emergency calls.

Moreover, the co-responder model provides a rich field-training experience for police officers, who can watch the nurse or mental health worker de-escalate a situation, while also questioning his or her partner about what the officer has observed. Consequently, police officers can improve their skills in recognizing symptoms of mental illness, as well as in crisis communication.

This close partnership also allows for better information sharing between the police and the health care system in crisis situations. As highlighted in my interviews, such information sharing in these situations can help improve outcomes for PMI, as the nurse or police officer may have vital information about the person's condition that the other partner does not have. However, as previously indicated in my thematic analysis, police need to be particularly careful about what mental health information is released to employers and the public through police record checks.

Lastly, it is important to keep in mind that for any mental health program in a police detachment to succeed, a champion of the program is essential. This is to guarantee consistent development of any such program, and to ensure that other priorities do not overshadow improving interactions between PMI and police officers. Additionally, champions must protect their program from the "old school thinking" mindset which views these programs as a waste of time and money.

9.1. Moving Forward

I recommend future scholars focus their research on three main areas. The first area relates to the experience health care workers have in the co-responder model. Since I did not interview mental health workers with this experience, there may be unknown problems that arise for a health care provider. For example, it may be a particularly stressful line of work for nurses to undertake, especially those who are not trained in self-defence. Similarly, some officers stipulated that the situations

encountered by co-responders were much more dynamic than those situations encountered working in a hospital emergency room, which may make this position unappealing (Anonymous, personal communication). These issues could limit the sustainability of the model and limit the feasibility of this option.

The second area researchers should investigate is barriers to establishing active community treatment models (ACT). Many officers feel the mental health system is "broken" and are greatly frustrated that PMI are not receiving adequate health care support. As a result, many officers expressed their desire to see an ACT model implemented, to both help PMI, and prevent future crisis situations (Anonymous, personal communication). This would lead to higher satisfaction for PMI as well, as they would receive more consistent treatment to help them maintain happy and healthy lives.

Lastly, this capstone does not address how to appropriately respond to people with concurrent mental health and substance abuse disorders. My interviews reveal that with or without mental illness, substance abuse increases the potential for violent behaviour from an individual interacting the police. When police encounter people with this concurrent disorder, then these situations become more dangerous for both police officers and PMI (Anonymous, personal communication). Given the benefits of preventing these encounters involving substance use, it seems logical to prioritize the provision of high quality community-based care for PMI, with a focus on concurrent disorders.

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Appendices

Appendix A.
General Interview Schedule

Purpose

1. Current programs for police responses to people living with mental illness;
2. Effective police practices in Commonwealth Countries
3. Recommendations to the RCMP or BC provincial government to improve encounters between police and people living with mental illness.

Interview Style: Semi-Structured Interview

Signed Consent Form? Yes/No (Any Questions?)

Questions:

- Could you tell me a bit about your specific role?
- What's it like to respond to a call involving a person with mental illness?
- How do you perceive interactions between the police and people living with mental illness?
- How do RCMP responses to people living with mental illness in BC compare to other Commonwealth Countries, like New Zealand, Australia, or other Canadian provinces?
- Do you feel that you were trained adequately for these situations?
- What training did you go through?
    - Room for improvement?
    - Recognizing symptoms?
    - De-escalation / Withdrawal tactics
- Some people, especially media reports, mention changing use of force guidelines.
    - What is your opinion?
    - Any modifications?
- Have you heard about co-responder training programs?
    - If so, do you approve or disapprove of this model?

- Have you heard about the Crisis Intervention Teams?
    - If so, do you approve or disapprove of them?
    - How would you improve the model?
        - Are you aware of any implementation difficulties associated with this model?
- What are your opinions on the current police guidelines for using force during encounters?
    - Would you modify them?
    - What would be some implementation difficulties associated with doing so?
- Are there any strategies you would suggest the RCMP employ to improve interactions between police and people living with mental illness?
- Positives/negatives/Cost/Equity/Logistics/Effectiveness/Acceptance

Appendix B.
List of Participants

Name	Relevant Experience	Date of Interview
Alex Berland	Former Public Administrator of Riverview Hospital, Nurse, and Health Policy Consultant	November 4, 2011
Dave MacDonald	Executive Director of Richmond's Pathways Clubhouse	November 8, 2011
Doug King	Lawyer, Pivot Legal Society	November 18, 2011
Bill MacEwan (Dr.)	Mobile Psychiatrist in Vancouver, BC	November 21, 2011
Linda Stewart	Retired VDP officer, Teacher at Justice Institute of British Columbia	November 25, 2011
Kyle Friesen	Lawyer, Legal Advisor to RCMP	December 12, 2011
Diane Watts	Mayor of Surrey, BC	January 12, 2012

Appendix C.
Introductory Email

Hello,

My name is Kat Sorfleet and I am Masters of Public Policy student at Simon Fraser University in Vancouver. I am currently conducting a capstone project on improving interactions between police and people living with mental illness in BC. Given your expertise and experience in this area, I would very much appreciate being able to speak with you about your perceptions regarding any current police programs and how interactions between people living with mental illness and the police could be improved. Your participation in a semi-structured interview (approximately an hour) would help to formulate my understanding of this issue and assist in the development of practical policy recommendations for addressing this problem. For your information, I have attached a written consent form, which contains detailed information about the interview process and my project.

I appreciate your time and consideration, and I look forward to hearing from you.

-Kat Sorfleet

Kat Sorfleet
School of Public Policy 2012
Simon Fraser University
kat_sorfleet@sfu.ca
778.895.4605

Appendix D.
Consent Form

Kat Sorfleet
Master of Public Policy
Application #: 2011s0619

Consent Statement Form

Research Study: "Improving Interactions between the Police and People Living with Mental Illness"

By signing this form, I agree to be interviewed for a research project about interactions between police and people living with mental illness in BC.

I understand that:

- The research is about the interactions between police and people living with mental illness in BC. The study also looks at what kinds of government policies or programs could help improve police officers and people living with mental illness's satisfaction with these interactions.
- The researcher is a Master candidate at the School of Public Policy at Simon Fraser University in Vancouver, Canada.
- I am being asked for this interview because I can offer important information and experiences to help understand the interactions between police and people living with mental illness, and how these interactions can be improved in BC.
- The information from my interview will be used in the researcher's master thesis.

- My interview will be recorded in written notes, or on a digital recorder. All the information provided in the interview will be confidential and anonymous. Names will be changed in any documents related to this study, unless I give my express consent to use my name in the study.
- Participation in this study is completely voluntary. That means that I do not have to participate. I may also stop the interview at any time if I am uncomfortable or do not wish to continue and all records of the interview will be destroyed. Refusing to participate will have no adverse effects on my employment or any project or initiative in my community.
- I also understand that the researcher **has not** obtained permission from my organization, employer or community, and that I have been contacted personally. In the unlikely event that confidentiality is breached, there is a low risk that this will have adverse effects on my employment. Other than this, there are no risks associated with this study other than those encountered by me in the aspects of my everyday life.
- There are no benefits associated with the study other than those encountered by me in the aspects of my everyday life.
- This research is being done according to research ethics policies at the researcher's university in Canada.
- I do not need to answer any question or give any information that I feel could harm my reputation or role in the community.
- If I have any concerns or questions about this study or my interview, I can contact:

Principal Ethics Supervisor:

Dr. Royce Koop
Assistant Professor
Email: royce_koop@sfu.ca
Phone: (1) 778 782 7913
Mail: School of Public Policy

Simon Fraser University
515 West Hastings Street
Vancouver, BC V6B 5K3
Canada

or

Secondary Ethics Supervisor:

Dr. Hal Weinberg,
Director,
Office of Research Ethics, Simon Fraser University
E-mail: hal_weinberg@sfu.ca
Phone: (1) 778 782 6593
8888 University Drive, Multi-Tenant Facility Burnaby, B.C., Canada V5A 1S6

If I would like to receive the results of the research, I can contact:

Kat Sorfleet
Email: kat_sorfleet@sfu.ca
Mail: School of Public Policy
Simon Fraser University
515 West Hastings Street
Vancouver, BC V6B 5K3
Canada

CONSENT

With this information in mind, do you agree to participate in this study?

Yes _____ No _____

Do you consent to having your name used when referencing your comments on interactions between the police and people living with mental illness and the policy options discussed with you (please check one)?

Yes _____ No _____

Name of Participant:

Date:

Signature:

Organization or Institution: