

# **Understanding Mental Illness: A Review and Recommendations for Police Education & Training in Canada**

This report was prepared under contract for the Canadian Alliance on Mental Illness and Mental Health  
by

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July 2010

**CAMIMH gratefully acknowledges the financial support of the Schizophrenia Society of Canada in making this report possible.**

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Agreement between  
CAMIMH  
And  
PMHL Solutions (Terry Coleman and Dorothy Cotton)  
May 8, 2010

Terry Coleman and Dorothy Cotton will produce a document that includes:

**Section I.** A brief summary of the situation concerning police interactions with people with mental illnesses in Canada.

**Section II.** An overview of existing programs and knowledge related to police training/education about mental health and mental illness:

- A summary of current practice in regard to police training about mental illness at the academy/police college level, including the amount of time dedicated to the subject, the content, and general strengths and weaknesses of the training which is now being carried out;
- A review of a variety of current practices in the area of in-service training/education in Canada;
- A summary of police/mental health education and training in other countries of interest including the UK, US and Australia; and
- A review of the formal literature in this area, including issues related to outcome.

**Section III.** A proposed model of in-service training for police personnel including reference to:

- Overall content and scope;
- Competencies to be achieved;
- Appropriate considerations for methods of delivery, instructors etc; and
- Specialized or focused training for subgroups within the police population.

**Section IV.** Strategies for introducing the proposed model to the police world:

- Identification of policing organizations to be approached;
- Key contact persons; and
- General (police) cultural considerations to be taken into account.

## EXECUTIVE SUMMARY

In recent decades, the number and frequency of interactions between people with mental illnesses and police has increased significantly. While most of these interactions are minor in nature and are resolved uneventfully, there are unfortunately a few that result in significant negative outcomes. Whenever this is the case, one of the most frequent emerging from reviews is that police officers require education and training – learning – in order to give them the skills and knowledge necessary to interact adaptively with people with mental illnesses (PMI).

A review of current practice in a variety of jurisdictions across Canada as well as in the United States, the United Kingdom and Australia, suggests that there is considerable variability in existing learning programs both at the basic training level and among more advanced in-service programs. While many police agencies provide little or no learning in this area, others provide more comprehensive education that differ from a few hours to several days. The content of the training varies from an overview considered appropriate for a wide range of police officers up to and including highly focused training for specialist officers. While some police services provide ‘one-size-fits-all’ training, others deliver a variety of levels and degrees of training. However, there is little outcome research or databased evidence to inform the exact nature of an effective program; the research that does exist does not provide guidance as to which components of a learning program are most effective. Nevertheless, the existing research tends to support the contention that education and training is effective in improving outcomes overall.

While the specific content of a mental-illness related curriculum is crucial, it is not the only determinant of successful learning. It is necessary that police agencies attend to a variety of other factors that will have a direct impact on the learning outcome. These include:

- selection of appropriate ‘trainers,’ including those who are both subject matter experts and who are operationally credible;
- inclusion of local mental health professionals for the purposes of providing reliable information as well as to assist police to form local connections with mental health agencies;
- integrating people with mental illnesses and their families into the training in order to provide direct experience with this population;
- using a variety of forms of media including participatory strategies;
- a focus on cognitive determinants of behaviour including attitudes, exercise of discretion and stigma; and
- adaptability of the curriculum to reflect the population receiving education/training (e.g. new officers versus specialized teams versus dispatch personnel) as well as including local community needs.

By extracting components from a variety of education and training regimes already in place in Canada and other countries and then combining them with outcome research, a comprehensive education and training regime emerges; one that can be adapted to a variety of police agencies and police personnel. The proposed learning model is **TEMPO** — an acronym

for **Training and Education about Mental Illness for Police Officers.**<sup>1</sup>

The multi-level **TEMPO** learning model identified and described in this report is designed to accommodate the wide variety of police learning needs. While the content of each level will be drawn from, and reflect, the *Learning Spectrum* also described in this document, the specific content of each level can be adapted and adjusted in order to meet the specific and unique needs of various categories of police officers and police personnel.

**TEMPO**, in its entirety, is intended for all police personnel including police officers, call-takers, dispatchers, front desk staff and victim services workers who have contact with persons with a mental illness. This model has built-in flexibility to take into account local circumstances and the target group(s) for learning. The difference between each module is the target group, and thus the emphasis placed on each subject area, the degree of detail and the amount of practical or experiential learning.

However, regardless of the strength of a proposed education/training program, it will not be effective unless embraced and accepted by the police community. There is a range of police organizations concerned with police education and training, and these groups, along with individual police services and police governance authorities, must be constructively engaged in order for such a learning regime to be successful.

Two approaches can be taken, depending on the circumstance, to obtain acceptance of this model in the police universe. They are 1) the Political (policy level) Approach and 2) the Operational (practitioner) Approach. Each has value depending on where in attempts to gain acceptance discussions might be. For instance, to encourage and enable systemic change when considering the evolution to date of police/mental health learning, the appropriate initial approach is the Political Approach.

Notwithstanding police/mental health training is far more prevalent and of a higher quality than as recently as ten years ago, the authors of this report have not been able to identify provincially mandated police/mental health learning at either the basic training level or at the in-service level. Ideally, provincial police regulations should mandate this learning at both levels for all police personnel in the province who have contact with PMI and/or their families. To achieve such systemic transformational change requires working with the appropriate politicians and public servants identified in this report to bring this about.

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<sup>1</sup> Notwithstanding its name, the application of this model is not restricted to only police officers. It is intended for all police personnel who have contact with persons with a mental illness.

## **SECTION I: Interactions between Police and People with Mental Illnesses in Canada**

### *The nature and number of Police/PMI interactions*

It is widely recognized that in Canada, as in most Western countries, people with mental illnesses (PMI)<sup>2</sup> are frequently marginalized, and often have problems with employment, housing and social supports in general. While it is beyond the scope of this paper to examine all of the complexities of the social situation of PMI, it is apparent that one consequence of marginalization is that PMI tend to have more contact with the police than do other members of public. The most widely publicized interactions are those that result in injury or death — to a person with the mental illness, to a police officer or to another member of the public. However, while these types of events are high profile, they are not typical of the most common types of interactions between police and PMI.

Typical instances in which PMI might encounter police include:

- apprehensions under a Mental Health Act (MHA);
- arrests resulting from disturbances where the person turns out to be mentally ill;
- responding to unusual behavior in which a person appears to be mentally ill;
- situations in which a PMI is the victim of crime; and
- social support and informal contacts by police.

How often do police encounter people with mental illnesses? There is no definitive answer to this question. A study conducted in Belleville, Ontario (population 45,000) indicated that of all police occurrence reports in 2005, just over 6% included reference to a person with a mental illness (Belleville Police Service, 2007). A Vancouver Police survey suggested between 23% and 49% of calls for police service involved a PMI (Wilson-Bates, 2008). However, there were limitations in the methodology that render the numerical estimates questionable. The most rigorous Canadian investigation into police interactions with PMI (Hartford, Heslop, Stitt & Hoch, 2005) was conducted in London, Ontario. Some of the key findings included:

- PMI were more than three times as likely to interact with police than members of the general population;
- almost twice as many PMI were charged and/or arrested during the study period as compared to the general population;
- 40% of offences for which PMI were charged were for minor, nuisance type offences;
- once charged, PMI were more likely to spend time in custody both prior to conviction and as part of their disposition (respectively 37% and 57% more likely). PMI were more likely to be convicted of the offence than the general population (72% vs. 60%);

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<sup>2</sup> In this paper, 'Police/PMI' denotes contact and interactions of police personnel with persons with a mental illness as well as categorizing the learning to prepare police personnel for their contacts with persons with a mental illness.

- the rate of violent offenses committed by PMI was the same as the rate for the general population; and
- events involving PMI represented a considerable cost to the London Police; estimated to be between 3% and 9% of the annual operating budget.

Although studies from these three jurisdictions arrived at slightly different estimates, they all illustrate the issue of frequent and resource intensive encounters between police and PMI. Even in the small city of Belleville, with its relatively low reported rate of Police/PMI interactions, the data suggest that the average first responder officer would encounter about 40 PMI per year, and that the police service as a whole would have four such interactions every day (Belleville Police Service, 2007).

When one considers that these studies do not include informal support contacts or positive interactions that occur between police and PMI, it seems likely that the frequency is much higher than reported. For instance, Nandlal, Cotton and Coleman (2006) examined the phenomenon of police providing social support to PMI and found that police were often engaged in a variety of psychological, emotional and instrumental social supports. Indeed, these types of interactions are consistent with the contemporary policing models espoused by the majority of Canadian police services. Thus, most joint response programs in Canada that involve coordinated mental health and police response do not focus on solutions to such extreme types of interactions, but rather focus on the everyday activities of policing.

In Canada, deaths from interactions between PMI and police are, fortunately, rare. Between 1992 and 2002, for example, there were eleven such occasions across Canada (Coleman & Cotton, 2005). Obviously, even one such death is far too many — but it is important to keep this number in perspective given the overall number of interactions between police and PMI. The implication for education and training is, therefore, that while crisis intervention skills are critical and attention must be devoted to examining the use of force with PMI, this focus is insufficient to address the wider issue of how police interact with PMI.

### *The Social Context*

Increases in the frequency of police interactions with PMI reflect a variety of social, legal and demographic changes that have occurred in Canada during the past 20 years. The most obvious change has been the significant reduction in the number of psychiatric hospital beds. Between 1985 and 1999, the average number of days of care in psychiatric hospitals in Canada decreased by 41.6% (Sealey & Whitehead, 2004). The reduction in beds is not in itself problematic; largely, it reflects a move toward embracing and emphasizing the rights of PMI. In fact, simultaneous to the deinstitutionalization movement, there were also considerable changes in mental health legislation.

As Gray, Shone and Liddle (2008) pointed out, since the 1970s the trend in mental health law reform has been to increase rights protection to people involuntarily detained in hospital and decrease the number of people subjected to compulsory admission and treatment. Today, most legislation allows only for dangerous persons to be detained and there are few provisions for involuntary treatment. The desirability of these changes continues to be a subject of debate; they

also had the unanticipated effect of increasing the number of contacts that PMI have with the criminal justice system in general and police in particular, given that community based mental health services do not appear to meet community needs. In the absence of other 24/7 care, police services become the de facto provider of support for PMI in times of significant need.

A phenomenon simultaneous to deinstitutionalization and mental health law reform has been the increased numbers of homeless people on Canadian streets, many with a history of mental illness. Riordan (2004) noted 66% of homeless people have a history of mental illness of which the majority also has substance abuse problems. Not surprisingly, homeless people have a higher rate of interaction with police than other people do. For instance, Riordan (2004) notes that 30% of homeless people spent time in police custody in the year prior to becoming homeless. Zakrisson, Hamel and Hwang (2004) reported that 61% of homeless people in a Toronto shelter interacted with police in the previous year.

### ***Canadian Police/Mental Health Response Strategies and Models***

Given the variety of police organizations, mental health systems, and geographical and demographic considerations in Canada, it is not surprising that there are many different Canadian response strategies and models. Nevertheless, a common feature of these is the existence of community-based liaison committees with representation from numerous stakeholders, including police, others in the criminal justice system, key members of the mental health system, consumer and family groups, firefighters, ambulance services and housing agencies. The liaison committee is a primary and essential component in joint police/mental health initiatives. However, beyond liaison committees, the way in which individual police services operationalize working relationships with the mental health system varies significantly.

There are various ways police work with the mental health system to minimize criminalization of PMI. Informal diversion of persons from the criminal justice system, when appropriate, is an inherent part of police work facilitated through police discretion and is not restricted to PMI. This is consistent with the contemporary policing model widely adopted in Canada. In some jurisdictions, however, informal mechanisms evolved into formal joint response initiatives and police-based pre-charge diversion programs. The latter are typically directed toward PMI who have committed minor nonviolent offenses. Best practices related to police diversion identified by Livingston (2008) as well as Hall and Weaver (2008) included:

- appropriate training and tools for officers and dispatch/communications personnel;
- appropriate mechanisms for officers for on-site assessment and disposition; and
- a specialized crisis response location where police can take PMI rather than to hospital or cells.

As formal mechanisms to enable police to work with PMI and the mental health system have evolved, it has become clear that although a single model does not meet the needs of all Canadian jurisdictions, there are some elements that underlie all successful approaches. These form the basis of Guidelines developed by the Canadian Association of Chiefs of Police (CACP) (Cotton & Coleman, 2006) to encourage police services to foster a culture in which mental illness is viewed as a medical disability and not a moral failure thereby assisting to establish an

organized and coherent approach to issues related to working with PMI. At the same time, the Guidelines allow flexibility for each police organization and community to develop services that reflect local needs. The principles of the Guidelines include:

- designating specific police personnel responsible for mental health-related issues;
- establishing formal liaisons with the mental health system both through local or regional liaison committee participation and development of individual contacts;
- providing appropriate and ongoing training for police officers as well as dispatch, communications and victim services personnel, and ongoing access to information about mental illness;
- a method for accessing mental health expertise on a case by case basis;
- making information about local mental health resources available for police personnel and for PMI and their families; and
- creating a data collection system to inform improvement, development and monitoring of interactions with PMI.

These Guidelines have been operationalized in various ways. Some of the strategies employed include:

- **A designated mental health officer:** Many Canadian police services have designated at least one officer to serve as the mental health officer (sometimes on a part time basis). The primary task of the officer is to be the contact between the mental health and police/criminal justice systems. These officers might function primarily as first responders who provide information and support to other first responders, they might respond to calls directly on request, they might provide case management services for PMI in frequent contact with police or they might contribute to policy development for their organization. They often also serve on related community boards and committees. For example, Toronto Police, the Richmond, B.C. Detachment of the RCMP and the Kingston Police in Ontario all have such a person designated.
- **Mobile crisis teams:** This is arguably the predominant Canadian model. While such programs vary, their essential characteristic is that police and mental health workers co-respond to PMI calls: a nurse, social worker or other mental health professional travels with a designated trained police officer. Calls may come directly to the mobile response team from the police dispatcher, or the mobile team may be dispatched after initial attendance by police first responders. The presence of a mental health worker on the scene provides immediate and more accurate assessment of the scope of the mental health problem, and more efficient referral to appropriate mental health services. The presence of a police officer provides for immediate safety and stability in the event of violence or danger, and affords the use of police powers pursuant to the Mental Health Act when apprehension is appropriate. Many large Canadian urban centers (e.g., Hamilton, Ottawa, Edmonton) employ this model but adaptations of it exist in rural areas (e.g., Leeds and Addington County, Ontario), sometimes via telephone consultations rather than face-to-face assessment by a mental health worker.

- **Crisis intervention team (CIT):** This model, which arose in the US from concerns about safety for officers and PMI, dominates the field in the United States but is less common in Canada. Specially trained police officers are designated to respond to problematic situations, usually at the request of police first responders already in attendance. These designated officers are normally assigned to other duties (e.g., ‘traffic’ or ‘patrol’) from which they can be redeployed. An enhanced “value added CIT” has been developed in British Columbia (Hall & Weaver, 2008) and offers community-based cross-training to a core group of first responders (police, ambulance paramedics, emergency room psychiatric nurses, dispatchers, corrections officers) with appointment of post-training CIT liaisons in each agency in order to maintain relationships and collaboration in the community. This model is also used in smaller jurisdictions where the number of calls is insufficient to warrant a dedicated mobile response team or where geography makes reliance on immediate response by mental health personnel impractical (e.g., Chatham-Kent, Ontario). It has been suggested (M. Reuland, personal communication, November, 2006) that one of the reasons that this model is predominant in the US but not in Canada has to do with the greater number of deaths and injuries of both police and PMI in the U.S. versus in Canada.

In situations in which there is a significant risk of harm to first responders, police are less likely to want non-police (e.g. mental health workers) on scene. The CIT, as a police-based response, does not involve mental health workers as quickly as does the mobile joint response team. Thus in Canada, where weapons are less evident and the safety of the responders is less of an issue, the mobile response team may have some advantages.

- **Comprehensive advanced police response:** Some jurisdictions have developed strategies whereby all police first responders receive advanced mental illness education and training. All police officers are then expected to be able to handle most situations involving PMI. This model is expensive and difficult to administer in a large police service but might be the only option for small or isolated police services where mental health services are too remote for a timely crisis response. Both Toronto and Vancouver Police aspire to this model, but for logistical reasons face challenges in full implementation.
- **Sequential response model:**<sup>3</sup> In jurisdictions where mental health services are available locally but the number of calls to police does not warrant a fulltime dedicated response model, some police agencies have developed agreements with mental health agencies. Once a situation is stabilized and a police presence no longer necessary, a PMI can be taken to an agency that will immediately assume responsibility and ensure that s/he is connected to appropriate services. In

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<sup>3</sup> In the US, this model is often called the *Reception Centre Model*.

Ontario, court diversion services play this role in many jurisdictions. Montreal Police also have such a “hand-off” process with some local mental health agencies.

- **Community Development Model:** Some of the most successful cooperative police/mental health ventures have occurred where there is not a readily apparent ‘program’ per se. Such a strategy requires committed leadership by police and mental health organizations, as well as frequent training of first responder police officers and active inter-agency liaison committees. The term “community development model” is indicative not of a specific plan but rather a community attitude of cooperation and communication between agencies. Belleville, Ontario exemplifies this kind of approach. These models are of course more conceptual than literal and exist in a variety of forms, depending upon the jurisdiction. Some larger police agencies employ several models; Toronto, for example, has a designated officer, several joint response teams and also aspires to a comprehensive advanced response model.

Large organizations such as the RCMP and the OPP have different types of responses in different geographical areas. There is no “right” model. However, in all cases, some degree of education and training is required for police personnel.<sup>4</sup> The type of response initiative each police organization employs may affect the nature and extent of the education/training. For example, first responders who have access to a CIT team or other specialized response option might not have as great a need for training as would officers in an organization in which such an option is not available. In any case, a basic understanding of the dynamics of Police/PMI interactions is essential.

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<sup>4</sup> In this report, the term ‘police personnel’ refers to all employees and volunteers who have contact with persons with a mental illness and/or their families. It includes, but is not limited to, police officers, dispatchers, call takers, front desk staff and victim services workers.

## SECTION II: Police Education and Training in Regard to Mental Illness

### *Canadian police academies/police colleges*

Twelve police academies/colleges in Canada provide basic education/training to new police officers. Academies are national (as in the case of the RCMP), provincial or regional (Ontario Police College, Atlantic Police Academy, Saskatchewan Police College and the Justice Institute of British Columbia), or under the auspices of a particular police service (Royal Newfoundland Constabulary (RNC), Halifax, Winnipeg, Brandon, Calgary, Lethbridge, and Edmonton). Quebec uses a slightly different model whereby all police applicants must first obtain a college level diploma from a CEGEP<sup>5</sup> before accepted to the provincial police academy. Some police services (such as Toronto and the OPP) require that new candidates first attend the provincial or regional academy (such as the Ontario Police College) and then participate in additional training upon their return from the college/academy. Other jurisdictions (e.g. the Royal Newfoundland Constabulary) require specific prerequisite education before a candidate can be accepted into the police service or attend the academy.

A study of these academies by Cotton and Coleman (2008)<sup>6</sup> looked into:

- the number of hours of education/training related specifically to working with PMI;
- the nature and content of such education/training, and the topics covered;
- the teaching modalities employed and types of personnel involved; and
- other courses, modules and parts of the curriculum in which the topic of interacting with PMI was addressed.

At the time that study was completed, *all* Canadian police academies that provided basic police officer training delivered at least a minimal introduction to issues related to working with people with mental illnesses as a standard part of their curriculum.

However, while some academies have been including such training in their curriculum since 1974, fewer than half were doing so even ten years ago. Thus, many officers who began their careers before 2000 would not have had this training at the police academy. The number of hours of training was also highly variable. Given that the amount of time specifically devoted to this topic varied from one to 24 hours and total training (which includes discussion of mental illness in other courses or modules such as Use of Force, etc) varied from five to 30 hours, it can be reasonably concluded that there is a substantial variation in content. Virtually all programs addressed verbal strategies and dealing with aggression and suicide. Most also covered the basics of psychiatric symptomology, excited delirium, mental health law, dangerousness and use-of-force options.

While content is of course important, so is the method of transferring knowledge. With the exception of one online course, all training reported included a large lecture component. In a

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<sup>5</sup> CEGEP refers to *Collège d'enseignement général et professionnel*, meaning "College of General and Vocational Education." Generally, this is equivalent to a community college.

<sup>6</sup> This report is available in full from the authors or through the Mental Health Commission of Canada.

few instances, all the teaching is delivered in a lecture format. Training at most academies includes some role-play or simulation — but at five academies, this was not the case. It was also apparent that few academies (only four) are making use of online resources. Similarly, only five academies made use of films or videos to supplement classroom training. At the opposite extreme is the RCMP Academy that includes relatively little formal lecture material but relies heavily on problem-based learning (PBL) and the use of “real time” scenarios.

However, probably the most evident gap in education and training nationally is that only two academies involved a person in delivery of training who actually has a mental illness. The research literature indicates that exposure to a person with a mental illness is probably the most powerful tool available for changing attitudes toward mental illness. The exclusion of the very people who are involved in the police interactions is contrary to both contemporary policing models and current mental health treatment models. Many academies also did not include either mental health agencies or mental health professionals in the design and delivery of learning.

In summary, from a positive perspective, there seems to be consensus that information about mental illness is integral to police basic training. There also appears to be a consensus with respect to the most important areas that need to be covered in training. As noted earlier, most programs addressed verbal strategies, suicidal ideation and issues related to signs and symptoms. However, there remains significant disparity between programs concerning the nature and amount of training that should be provided. The aforementioned report by Cotton and Coleman (2008) thus offered the following suggestions for further consideration:

- Police colleges/academies might want to strive for the type of comprehensive training that is offered by the RNC and the Atlantic Police Academy. This includes not only 16-18 hours of direct basic training related to working with people with mental illnesses, but also a variety of learning media as well as direct contact with both people with mental illnesses and mental health professionals.
- To avoid duplication of efforts, the Canadian Association of Police Educators (CAPE)<sup>7</sup> might want to consider working with police learning institutions to develop or encourage a common core curriculum including reading lists and online materials to make use of some of the many outstanding resources that have been developed.
- There is general acceptance that information dissemination related to mental illness is best covered when it is integrated in multiple training courses, seminars or modules. The time could be distributed between focused sessions dealing exclusively with mental illness, or incorporated into other course work (e.g., learning with regard to use-of-force and provincial statutes) as well as being the subject of problem-based learning experiences (PBL).

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<sup>7</sup> CAPE’s membership includes representatives from most of the Canadian police learning institutions but also includes representatives from community colleges that deliver police related learning.

- Police agencies or police academies that rely on external prerequisite training — such as is the situation in Quebec — might want to ensure that training related to working with PMI is specifically identified in external course content and identified as a specific competency cluster to avoid inconsistency between programs.<sup>8</sup>
- Similarly, academies that take a more competency-based and problem-focused approach, such as the RCMP Academy, may want to develop goals and competencies that specifically identify issues related to working with people with mental illness to ensure all the primary goals related to this client group are indeed covered.
- All training programs should ideally include presentations from:
  - people who are actually living with a mental illness;
  - and their families; as well as
  - mental health professionals.
- Police services might want to pay attention to the degree and nature of training provided by their respective academies so that it can be supplemented as necessary by their police service (e.g., police officers trained provincially, regionally or nationally will likely not have learned about local resources or interagency agreements).

### ***Canadian In-service Education and Training***

A recent study by Coleman and Cotton (2010) examined what Canadian police personnel receive as in-service Police/PMI education/training—in other words, training and education at the post-academy level. As was the case with the review of academy training, they found a wide variety of Canadian police/mental health in-service learning programs. Not surprisingly, the variations in quality or availability of education/training programs are somewhat related to the size of a police organization. They ranged from no in-service learning in many small and even some medium-sized police agencies up to relatively comprehensive programs such as those developed by the Ontario Provincial Police, the Halton Regional Police, the Halifax Regional Police and CMHA-BC in collaboration with the B.C. Provincial Police (RCMP E Division).

Of the smaller police organizations that provided in-service training, it was often only an occasional short seminar from a representative of a mental health organization such as the Canadian Mental Health Association and/or the two-hour CPKN online course — *Recognition of Emotionally Disturbed Persons*.<sup>9</sup> Conversely, some large police organizations had well developed programs — but, overall, only a small fraction of their personnel received such training.

The following are some examples of in-service education and training programs that are arguably good models. While it would be desirable to identify ‘best practices,’ there are insufficient data or evaluations to draw such conclusions. The programs identified below are

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<sup>8</sup> Since the publication of this report (Cotton & Coleman, 2008), a review of the CEGEP training related to mental illness has been undertaken to determine required curriculum changes.

<sup>9</sup> Described later in this paper. Available at [http://www.cpkn.ca/course\\_detail/emotionally\\_disturbed\\_e.html](http://www.cpkn.ca/course_detail/emotionally_disturbed_e.html)

those that appear, at least on the surface, to be promising. They include a variety of approaches including:

- traditional lecture style training;
- online or Internet based courses;
- comprehensive courses designed to be taken by a wide variety of officers just once in their careers;
- brief modules to be delivered annually or less frequently as follow-up or refresher courses;
- specialized/advanced courses for officers in specific specialized assignments;
- educational and training that targets only police officers;
- education and training that targets police personnel such as dispatchers, call takers, and victim service personnel who have contact with PMI;
- education and training developed ‘in-house’ by police services for internal usage; and
- programs developed by external agencies for use by a range of police organizations.

#### ***Programs developed by, or provided to, police organizations***

The following programs are listed alphabetically in two groups. First, are those developed by and delivered to individual police organizations. Second, is a list of general resources, including online materials and learning programs available to any police agency. This is not an exhaustive list of all Canadian programs, but is a sample of programs that appear to be of high quality and collectively offer a wide range of strategies and options.

#### **Alberta Government**

The Office of the Alberta Solicitor General has developed an online course - *Policing and Persons with Mental Illness* - designed by a psychologist, two curriculum designers, a police officer and a representative from provincial corrections. It is suitable for both basic level police officer training as well as in-service training. The course is described as:

*not [being] a standalone segment, but an integral component of ongoing training. The broader curriculum structure in which this course is utilized draws upon adult learning techniques, ongoing cohort participation and the layering of foundational skills and knowledge (legal, operational and tactical). In a similar fashion, course modules are connected through ongoing application of Skills and Knowledge achieved via completion of the previous modules and associated evaluation.*

The six-module course includes:

- Placing Policing and Mental Illness into Context;
- Officer’s Perceptions and Stigma;
- Mental Disorders;
- Communication, De-Escalation and Responses;
- Procedures, Reporting, Authority and Process; and

- Suicide Intervention.

Of note is that this course is one of the few encountered during the literature review and direct enquiries of police agencies that includes a specific module with regard to “officers’ perceptions and stigma.”

### **Belleville (Ontario) Police**

Belleville Police is a small agency (80-90 police officers) that works well with its local mental health services by virtue of dedicated leadership and commitment on the part of both police and mental health systems. Given its small size, it relies heavily on external training to supplement the basic training received at the Ontario Police College (OPC). However, in addition, it provides suicide prevention training (ASIST) to all police officers as well as police dispatchers. This is delivered by a combination of police officers and community partners. Belleville Police expand on this by way of an annual two-day in-service interactive workshop for community partners as well as for police officers and dispatchers. The content of this workshop varies from year to year based on local issues. It is also delivered by a combination of police officers and community partners. Given its interagency nature, the workshop is considered beneficial from the perspectives of building relationships.

### **Calgary Police**

Further to a seven-hour course<sup>10</sup> during basic training, the in-service education and training for the Calgary Police has three levels. At the first level, the Calgary Police use a 24/7 online course constructed in-house and based on the handbook *The Calgary Police Service Officer’s Guide to Dealing with Emotionally Disturbed Behavior: 2<sup>nd</sup> Edition*.<sup>11</sup> At the second level, the *Mental Health Interdiction Program* extends classroom learning to hands-on community mental health practice. Police officers, trained by mental health professionals, together with psychiatric and forensic nurses and a psychiatrist have delivered the course. Ongoing semi-structured learning in the workplace follows the two-hour classroom training on mental health and mental illness.

At the third level, the Homeless Unit of the Police and Crisis Team (PACT) addresses persons in crisis who are presenting with public safety concerns, mental health and addictions issues and who, as a result, might be at risk of being homeless. The five-week training schedule has included:

- orientation and tours of mental health and homeless services and facilities in Calgary;
- various mental health assessment forms and checklists;
- a review of the Mental Health Act and the DSM;

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<sup>10</sup> Although there are differences between a ‘course,’ a ‘seminar’ and a ‘workshop,’ police organizations tend to use the terms interchangeably and or call all formal learning ‘a course.’ Hence, references in this report to a ‘course’ might be referring to a ‘seminar’ or a ‘workshop.’

<sup>11</sup> Calgary police officers and mental health professionals developed the handbook. It presents important facts about mental illness and emotional disturbance and helps identify behavioral symptoms as well as providing information about community resources and the Mental Health Act. It also discusses effective ways of documenting observations and conducting interventions.

- job shadowing by the mental health clinicians with police officers; and
- team discussions on the philosophy of PACT.

### **Edmonton Police**

Although not common for Canadian police agencies, the policy and procedures of the Edmonton Police with regard to Police/PMI contact include the necessary ‘training’ requirements and expectations:

*In order to recognize and respond to incidents involving suspected mental illness, EPS members receive, during basic recruit training, principles for defining and dealing with mental disorder, instruction in powers of arrest, arrest and transport, and arrest with warrants under the Mental Health Act. Refresher training will be conducted at least every three years, or more frequently as appropriate.*

Of note is that compared to most Canadian police agencies, Edmonton police officers receive relatively extensive basic police/mental health training at their police college.

### **Halifax Regional Police (HRP)**

Halifax Regional Police have constructed a four-level education and training. This was developed collaboratively by HRP, the joint response Halifax Regional Mental Health Mobile Crisis Team (MHMCT) and the Department of Psychiatry at Dalhousie University

#### **100 level: Basic police training**

- 3-day training of all ‘recruit’<sup>12</sup> classes; and
- 1-day training for lateral hires.<sup>13</sup>

#### **200 level: Continuing education for first responders**

- three-hour training for police officers who have not received the basic training (Level 100);
- includes the CPKN online course; and
- a more interactive presentation with the MHMCT is under consideration.

#### **300 level – CIT training**

- 40 hours of education/training;
- delivered at least twice per calendar year.

#### **400 level – Advanced training for MHMCT police officers**

- prerequisite is successful completion of the 300 level;
- the one week Capital Health Mental Health Orientation which is delivered to all new mental health staff; and

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<sup>12</sup> The term ‘recruit’ is police jargon for a new police officer. Although it is usually used while the new officer is completing basic training, it is often also used for at least the first year of the officer’s service.

<sup>13</sup> Lateral hires are police officers who have already received acceptable basic training with another police agency and have experience as a police officer.

- a minimum of four job-shadow shifts with MHMCT.

### **Halton Regional Police Service (HRPS)**

**Training for new police officers:** Halton Regional Police provides additional training to new police officers upon their return from the Ontario Police College. This is to ensure they understand the COAST<sup>14</sup> program and know how to access community services in Halton Region. A COAST police officer and a COAST mental health worker deliver the 1½-hour module three times per year.

**Police/PMI “specialist” police officers:** As part of their structured multi-level approach to Police/PMI education, Halton Regional Police uses a modified CIT training model for their Police/PMI specialist police officers. This training, like most CIT training, is 40 hours in duration. Design and delivery is by:

- COAST mental health workers;
- COAST police officers;
- members of the community;
- Schizophrenia Society of Ontario;
- family member(s) of a PMI;
- a person(s) with a mental illness from TAMI (Talking About Mental Illness);
- local hospital staff; and
- the Halton Geriatric Outreach Team.

The course includes a broad overview of mental health issues including psychosis, mood disorders, dementia and substance abuse disorders. Simulations of ‘real’ police scenarios are used for which actors are trained to simulate symptoms. The course construction is such that it enables the establishment of new community relationships and the maintenance of existing relationships.

**In-Service/Block Training:** All police officers are required to complete annual Block Training, which provides an overview of psychosis and the COAST program. The 90-minute module, delivered at least 16 times per year, is designed and delivered by COAST mental health workers, COAST police officers and police Youth Justice Service social workers.

**Citizens Police Academy:** Although not strictly police in-service learning, it is likely that this is the only police agency in Canada delivering this type of community learning. The target group for the one-hour seminar is community members who volunteer to attend the Academy to learn about the police agency. The annual presentation by a COAST police officer and a COAST mental health worker provides an overview of the program and information on how to access their services.

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<sup>14</sup> COAST, which originated in Hamilton, Ontario, approximately 15 years ago is a police/mental health joint response model; the acronym refers to Community Outreach and Stabilization Team or a Crisis Outreach and Support Team. Over the last few years, other jurisdictions of the greater Toronto area have adopted this model.

**Victim Services:** The target group for this 90-minute seminar is the volunteers of the Police Service's Victim Services. A COAST police officer explains COAST and how to access services.

**Auxiliary Police Training:** The target group for this two-hour seminar is the Police Service's Auxiliary Officers who provide support and assistance to the Police Service. A COAST police officer and a COAST mental health worker explain the program and provide information about how to access their services.

### **Lanark County LEAD Team**

This group provides services to several smaller municipal police agencies in southeastern Ontario including Smith Falls, Perth, and Cornwall as well as the Leeds-Grenville, Lennox and Addington, Renfrew County and Lanark County OPP detachments.<sup>15</sup> All partner agencies have signed off on a protocol that includes the required police training:

*Training will be an important component of our ability to better serve the emotionally distressed person. Our partners are committed to assist each other in their training needs. Training will be constantly modified to enhance our ability to serve the emotionally distressed person.*

*LEAD Team members will attend an initial 16 hours of training under instructional supervision of trained professionals. LEAD members will then take their training back to the rest of the team to further develop and renew our program.*

Consequently, LEAD in conjunction with their member agencies, which include EMS and the hospital district as well as police, deliver annual in-service training to police first responders, hospital staff, Mental Health Crisis Team (MHCT) members and Emergency Medical Services (EMS). Their 16-hour provides an overview of serious mental illness, including symptoms, behaviors, risk assessments, de-escalation strategies and improved recognition of persons at risk of mental health crisis through exposure to the basic dynamics of common types of mental illness and to the viewpoints and feelings of mental health 'consumers' first hand. The training, which is designed and delivered to assist team members to better understand that mental illness is a disability/disorder and not a crime, includes skill development for de-escalating potentially volatile situations, gathering relevant history, assessing medical information and evaluating the individual's social support system.

### **Ontario Provincial Police (OPP)**

The OPP has several levels of education and training for their personnel relative to persons with a mental illness:

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<sup>15</sup> The protocol document, which includes training, is available at <http://www.pmhl.ca/webpages/reports/LEAD%20Team%20Protocol.doc>

***New Police Officers*** – In addition to ‘basic’ training with regard to police/mental health at the Ontario Police College (OPC), new police officers complete additional police/mental health training at the OPP Academy. This includes scenario-based sessions dealing with persons who apparently have a mental illness.

***In-Service Training*** – all uniform police officers must complete annual two-day ‘block training,’ which includes:

- mental illness and the Mental Health Act;
  - history of mental illness;
  - forensic services;
  - court support services;
- psychosis and schizophrenia;
- de-escalation techniques;
- dementia;
- mood disorders;
- personality disorders;
- anxiety disorders; and
- scenario-based training involving aspects of mental illness and Mental Health Act.

***Crisis Negotiator Training*** – police crisis negotiators<sup>16</sup> must complete the Ministry accredited Crisis Negotiator’s Course, which includes sessions on mental disorders and disturbed persons. A psychiatrist usually delivers this.

***Emergency Response*** – police personnel responsible for Search and Rescue (SAR) functions must complete the Search Management Course, which includes modules that address the psychology of lost persons, including those with a possible mental illness.

***Communication Centre Operators/Supervisors*** – in the OPP, police officers do not staff these positions. These personnel must complete required training at the Ontario Police College that is regulated by Ministry Adequacy Standards. O. Reg. 3/99. This training includes modules on mental illness and disturbed persons.

***Offender Transport Personnel*** – All Offender Transport Officers receive a two-hour presentation during their three-week basic training on mental illnesses and the Mental Health Act.

***Security Officers*** – All security officers receive annual training, which includes Mental Health Act scenarios and regulations.

***Prisoner Care*** – All personnel responsible for guarding prisoners must annually complete the Prisoner Care Workbook, which addresses aspects of suicide prevention and how it relates to mental illness.

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<sup>16</sup> Sometimes, although inaccurately, called ‘hostage negotiators.’

**Operational Field Briefings** – These scenario-based training documents are distributed to front-line police officers and support staff on a monthly basis. Some Briefings address the Mental Health Act and mental illness.

### **Peel Regional Police**

Peel Regional Police, which also uses a COAST joint mobile response model, provides a four-day in-service seminar, presented by police, mental health professionals and persons living with a mental illness that includes:

- presentation on and simulation of de-escalation and suicide intervention;
- presentation of the justice system;
- youth and mental health issues;
- autism and vulnerable people;
- dual diagnosis;
- a presentation by and engagement with a “survivor family;”
- introduction to mental health by a psychiatrist;
- mental health court;<sup>17</sup> and
- a panel from three local hospitals.

### **British Columbia Provincial Police (RCMP E Division)**

CMHA-BC, in collaboration with the B.C. Provincial Police, has implemented *BC-CIT* – a modified CIT training model. It involves a wide variety of agencies that plan and deliver a 40 hour CIT-type training program to police personnel, ER<sup>18</sup> personnel, emergency services dispatchers, ambulance paramedics, psychiatric emergency nurses, cell block guards, probation officers, parole officers, outreach and community service providers, social workers, corrections officers, mental health and addictions practitioners.

The *BC-CIT* program is guided by a cross-sectoral committee of the Provincial Police, municipal police agencies, the B.C. Ambulance Service (BCAS), Provincial Health Authorities, the Canadian Mental Health Association – B.C. Division, B.C. Schizophrenia Society, families and persons with direct experience of mental health services, the Commission for Public Complaints against the RCMP and Crown counsel. While initially established in the Lower Mainland of B.C., it is now a provincial program. The syllabus includes:

- B.C. Mental Health Act - *Role of Police, Physicians & BCAS*;
- Criminal Prosecution of the Mentally Ill;
- Developmental Delay & Fetal Alcohol Spectrum Disorder;
- Mental Health Disorders & Common Medications;
- Early Psychosis Intervention (EPI);
- Risk Assessment for First Responders;
- Complexity of Addictions;
- Excited Delirium and Restraint;
- Post Traumatic Stress Disorder – Compassion Fatigue;

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<sup>17</sup> A mental health court operates in the Peel Regional Police jurisdiction.

<sup>18</sup> Hospital Emergency Room.

- B.C. Schizophrenia Society (BCSS) Interactive Client & Family Panel;
- Adult Guardianship Act & Community Resources;
- Victim Precipitated Homicide “*Suicide by Cop;*”
- Health Authorities and the Police: *Disclosure Issues;*
- Crisis Communications Skills;
- EDP Simulations with *Ralston Studio Actors;*
- Stand Up for Mental Health – an anti-stigma through client comedy troop; and
- Cultural Awareness and Implications.

### **Royal Newfoundland Constabulary (RNC)**

Further to their comprehensive basic education/training program, which includes emphasis on the wise use of police discretion and police ethics (Cotton & Coleman, 2008), their in-service learning<sup>19</sup> includes:

- a three-hour session on Fetal Alcohol Spectrum Disorder (FASD) delivered by Choices for Youth during which a mother shares challenges with her son who is suffering from FASD;
- a three-hour information session on Autism delivered by the Autism Society; and
- a one-day Mental Health First Aid<sup>20</sup> seminar delivered by a mental health professional.

### **Vancouver Police (VPD)**

Vancouver Police base their education and training on the 40-hour CIT model. The VPD course is intended for new police officers as part of a five-year development plan. Although CIT guidelines suggest 25% of police officers should be trained, the goal of Vancouver Police is to train 100% of their ‘patrol’ officers.

The course/seminar includes:

- Overview of mental illness and its impact on society;
- Mood disorders, depression and suicide;
- Early psychosis intervention and schizophrenia including an overview of community resources in Vancouver; and a BCSS partnership presentation;
- Critical incidents, PTSD and self-care of the officer;
- Geriatric mental health;
- Developmental disabilities;
- Police tactical considerations;
- Drugs and psychosis;
- Victim-initiated homicide;
- Crisis intervention including a focus on communication theory and strategies for first responders; and
- practical application through a role-play(s).

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<sup>19</sup> The frequency and level of experience of the students is unclear from their response.

<sup>20</sup> For more information about MHFA, refer to Page 25.

*Resource programs utilized by some police services but available to all police services...*

### **Applied Suicide Intervention Skills Training (ASIST)**

This two-day highly interactive, practical, practice-oriented workshop provides valuable tools to help intervene when encountering a person at risk of suicide. It is offered by Living Works ([www.livingworks.net](http://www.livingworks.net)), a suicide prevention organization and is widely available. It is frequently used across Canada by mental health agencies, volunteer organizations and police services, among many others.

### **Canadian Police Knowledge Network (CPKN)**

CPKN offers three online learning programs related to mental illness. First, in collaboration with the Halifax Regional Mental Health Mobile Crisis Team (MHMCT)<sup>21</sup> and the Dalhousie University Department of Psychiatry, CPKN provides a two-hour online module – *Recognition of Emotionally Disturbed Persons*.<sup>22</sup> This module is used by several Canadian police agencies either as stand-alone training, or as part of a blended program.<sup>23</sup> It reviews the broad categories of Emotionally Disturbed Persons (EDPs) and provides recommended response strategies and approaches to deal with persons in crisis.

Second, the Ontario Police Video Training Alliance<sup>24</sup> DVD – *Psychosis* – is available through CPKN as a resource for training police personnel. Third, CPKN provides a program – *Excited Delirium Syndrome*.

### **Justice Institute of British Columbia (JIBC)**

*Police Intervention in Mental Illness Crisis (PIIMIC)*,<sup>25</sup> which was prepared by the British Columbia Schizophrenia Society (BCSS) in conjunction with the Justice Institute of BC Police Academy (JIBC), is a comprehensive and easy to understand online source of information about mental illness, legislation and related matters. While not a course per se, PIIMIC is an easily available and comprehensive resource for police officers and other police personnel who have contact with PMI.

### **Mental Health First Aid (MHFA)**

The Australian Centre for Mental Health Research developed MHFA in 2001. The purpose was to provide initial support for persons who might be developing a mental health problem or are experiencing a mental health crisis; its goal was to improve mental health literacy. Since then, the program has been developed, evaluated, disseminated and implemented internationally, including in England, Scotland and Canada. In 2010, the Mental Health Commission of Canada (MHCC) assumed responsibility for MHFA in Canada. While currently in Canada it seems that only the RNC and a few Alberta RCMP detachments use MHFA as a

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<sup>21</sup> A joint response program of the Halifax Regional Police and local mental health services.

<sup>22</sup> Available at [http://www.cpkn.ca/course\\_detail/emotionally\\_disturbed\\_e.html](http://www.cpkn.ca/course_detail/emotionally_disturbed_e.html)

<sup>23</sup> Blended learning, in this situation, is when a tool such as online learning is used in conjunction with other methods such as the conventional classroom and/or role-playing.

<sup>24</sup> Available at [www.opvta.com](http://www.opvta.com).

<sup>25</sup> Available at [http://www.jibc.ca/police/main/PIIMIC/piimic\\_introduction.htm](http://www.jibc.ca/police/main/PIIMIC/piimic_introduction.htm) & <http://www.piimic.com>

learning tool, MHFA has potential to be useful for police personnel at all levels of experience as part of a comprehensive learning scheme.

MHFA-Canada provides a 12-hour course delivered in four three-hour modules. According to their website, “participants will learn how to provide initial help to people who are showing signs of a mental health problem or experiencing a mental health crisis.” MHFA also provides a course focused on youth with a mental illness that “is designed to be sensitive to the unique aspects of mental health problems in young people.”<sup>26</sup> Although the intent of MHFA is not to teach people to be therapists, it does address how to recognize symptoms of mental health problems, how to provide initial help and how to guide persons to appropriate professional help (Bather, Fitzpatrick & Rutherford, 2008, p. 13).

### **Not just another call ... police response to people with mental illnesses in Ontario – a practical guide for the frontline officer.**<sup>27</sup>

The Ontario Police College (OPC) developed a comprehensive written guide for working with PMI - *Not just another call ... police response to people with mental illnesses in Ontario – a practical guide for the frontline officer.*<sup>28</sup> The guide, which is provided to new police officers as a resource during basic training at OPC, also provides police personnel with a useful ongoing reference.<sup>29</sup>

### **In the near future...**

Two developments currently underway will provide direction to police learning concerning mental illness. Subsequent to the death in late 2007 of a man at the Vancouver Airport after police had used a Conducted Energy Weapon (CEW) and the resulting concern about the circumstances of the death, the British Columbia Government convened an inquiry (the Braidwood Inquiry) to make recommendations to prevent similar future occurrences (Restoring Public Confidence, 2009). Of relevance to this report is that this incident was the impetus for a review by the B.C. Government of changes necessary to police education and training that will positively affect Police/PMI interactions.

The B.C. Government subsequently established the Braidwood Recommendation Implementation Committee (BRIC) chaired by a senior person in the Ministry of Public Safety and Solicitor General. The Committee is comprised of representatives from organizations such as CMHA, the B.C. Alliance on Mental Health and Addiction, the B.C. Chiefs of Police, the B.C. Provincial Police (RCMP), police associations (unions), B.C. Civil Liberties, First Nations, Sheriffs, Corrections, the B.C. Office of Police Complaints Commissioner, the Justice Institute of British Columbia (JIBC) and the Pacific Region Training Center (PRTC). Two working groups have been established for the development of standards and training:

- Crisis Intervention and De-escalation training (CID); and
- CEW training.

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<sup>26</sup> This is particularly relevant in Canada to Section 6 of the Youth Criminal Justice Act.

<sup>27</sup> Available online at the Ontario Police College website <http://www.opconline.ca/>

<sup>28</sup> Available online at the Ontario Police College website <http://www.opconline.ca/>

<sup>29</sup> A pocket-sized version has been developed for the use of ‘frontline’ police officers.

The intent is that the education/training will be built systematically using experts in curricula design and adult learning. Moreover, it will be performance based, so it will be ‘defensible,’ and will include the ability to evaluate the program(s). Directly relevant to this report is that a significant part of the new curricula will include verbal engagement and de-escalation techniques to avoid, whenever possible, the use-of-force.

Also of interest is a study currently underway, funded by the Mental Health Commission of Canada, which is examining the experiences and attitudes about police of people with mental illness. Researchers from the Forensic Psychiatric Services Commission of the B.C. Mental Health and Addiction Services, Simon Fraser University, and the University of British Columbia, in partnership with the Canadian Mental Health Association – B.C. Division are leading the study. The intent is that the findings will inform the development of Canadian guidelines for police education and training and support the police in relation to their interactions with people who have severe mental illness. Through a participatory research approach, this team of researchers is examining the diversity of perceptions regarding the police and their interactions from the perspective of people with severe mental illness in British Columbia.

### ***In-Service Police/Mental Health Education & Training in Countries other than Canada***

Because the issue of educating police personnel to work with PMI is not unique to Canada, it is appropriate to consider developments in other countries.

#### **United States**

The predominant model of police response to mental health crises in the US is the Crisis Intervention team (CIT), which originated in 1988 when the Memphis Police developed CIT in collaboration with the National Alliance on Mental Illness (NAMI). This approach uses specially trained police officers to provide police first response to calls-for-service involving a person with mental illness and then to liaise, as necessary, with the mental health system (Borum, Williams, Deans, Steadman & Morrisey, 1998).

The essential elements of CIT are:

- the forging of police partnerships with mental health community resources; and
- shifting the role of police and organizational priorities from the traditional policing model that dealt reluctantly with PMI to a service-oriented model (Watson, Morabito, Draine & Ottati, 2008, p. 361).

Critical to the successful operationalization of CIT is the 40-hour education/training program that has increasingly become the defacto ‘industry standard’ in the U.S. It is mental health professionals, police officers, mental health advocates and ‘consumers’ from the respective community who typically facilitate the learning, development and mastery of effective crisis intervention skills. Content usually includes education about the causes, signs, symptoms and treatment of mental illness; substance abuse; psychotropic medication; information on commitment criteria and procedures; consumer rights; personal stories from ‘consumers’ and family members; visits to mental health treatment providers and information about treatment modalities as well as training in communication and de-escalation skills. Notwithstanding

scholars such as Vermette et al. (2005) found police officers did not value role-plays, Reuland (2004) found that CIT training often includes role-play exercises. Moreover, although not always popular with police personnel, Reuland and Schwarzfeld (2008) suggested that experiential learning techniques<sup>30</sup> such as:

- role-plays;
- site visits;
- consumer and family member testimonials; and
- simulation exercises (p. 18).

should be included in learning.

While the CIT model is common in the U.S, it is not the only model used. Keram (2005) pointed out that in 2000 the California State Legislature required the Commission on Police Officer Standards and Training (POST)<sup>31</sup> to establish a training curriculum based on the premise that outcomes of Police/PMI contacts would improve with appropriate education/training of police officers. The legislation required:

- education/training to be long enough to be substantive but short enough so that police officers could attend without jeopardizing operational deployment; and
- that it should be suitable for officers in large urban areas as well as remote rural areas.

The result was an eight-hour program delivered by a police officer and a “mental health clinician” that embraced:

- concepts that emphasize de-stigmatization;
- the biological basis of mental illness;
- developmental disabilities;
- major mental illness;
- verbal intervention strategies;
- alternatives to lethal force;
- community and state resources suitable for referrals;
- state mental health legislation;
- the training inadequacies that had arisen in litigation against police agencies; and
- the inclusion of advocates of persons with a mental illness in program design (Keram, 2005, p. 48).

### **England and Wales**

The IPCC (Independent Police Complaints Commission) recommended that police officers be adequately trained to recognize the symptoms of mental disorders and understand their powers under the Mental Health Act (Mind, 2007; IPCC, 2008). Subsequently several

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<sup>30</sup> Experiential learning refers to structured activities designed to enable students to learn through experience (Reuland & Schwarzfeld, 2008, p. 18).

<sup>31</sup> Available at <http://www.post.ca.gov/>

national organizations including the Association of Chief Police Officers (ACPO)<sup>32</sup> and the National Police Improvement Agency (NPIA)<sup>33</sup> responded. ACPO,<sup>34</sup> for example, established a *Mental Health and Disability Committee*.

Of particular interest is the Association of Chief Police Officers (ACPO) Mental Health Strategy for England and Wales that was approved and released to the public in early March 2010. This strategy, which is worthy of emulation,<sup>35</sup> was developed in collaboration with several agencies including the U.K. Government's Department of Health as a means of demonstrating ACPO's commitment to the improvement of service provided by the police to PMI and people with a developmental disability.<sup>36</sup>

The Mental Health Strategy will help police to:

- reduce crime and victimization involving people with mental ill health or learning disabilities;<sup>37</sup>
- reduce the use of police custody suites for Section 136 Mental Health Act detentions - in accordance with MHA Codes of Practice;
- increase the use of diversion and liaison schemes for people with mental ill health or learning disabilities so as to reduce offending, manage health needs and avoid future problems;
- make people experiencing mental ill health or learning disabilities feel more confident in reporting offences to the police and giving evidence;
- support and inform the development of force policies and procedures and bespoke Service Level Agreements;
- achieve better partnership working through improved relationships with statutory and voluntary social and healthcare agencies and a better understanding of each other's skills, knowledge and responsibilities; and
- reduce the number of public enquiries, IPCC investigations, and Coroners Inquests, and subsequent costly litigation, arising from poor responses by the police service to people with mental ill health or learning disabilities.

### **Dyfed Powys Police**

Notwithstanding the more recent substantial progress of the NPIA and ACPO, in 2004 the Dyfed Powys Police in collaboration with a local mental health agency implemented a Community Police Development (CPD) program relative to Police/PMI interactions. The objectives were:

- to enhance the skills and knowledge of new (student) police officers about mental health issues through a better understanding of mental illness and treatments,

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<sup>32</sup> Available at <http://www.acpo.police.uk/>

<sup>33</sup> Available at <http://www.npia.police.uk/>

<sup>34</sup> The equivalent of the Canadian Association of Chiefs of Police (CACP) - <http://www.cacp.ca/intro/>

<sup>35</sup> Canadian mental health advocacy groups might want to consider this.

<sup>36</sup> Available at [http://www.acpo.police.uk/pressrelease.asp?PR\\_GUID={3F40855B-2EA1-4B10-8225-648D90FB08F5}](http://www.acpo.police.uk/pressrelease.asp?PR_GUID={3F40855B-2EA1-4B10-8225-648D90FB08F5})

<sup>37</sup> The UK term 'learning disabilities' refers to what in Canada is known as 'developmental disabilities' or 'mental retardation.'

relevant legal aspects and practical skills in communicating with people experiencing mental distress; and

- to ensure the most appropriate use of mental health resources in a way that best meets the needs of service users.

The six-day training program, intended for each intake of new police officers, operates four times a year. The program starts with a two-day course on Mental Health First Aid followed by a four-day placement in the mental health service of their respective home policing jurisdiction. The program can be summarized as:

*Service users are involved in the program planning and delivery and discuss their experiences of mental illness with the officers. There are opportunities to meet other members of the multidisciplinary team, and to spend time on the unit. The police engage in learning sessions about the prevalence of mental health problems, how these may present and the most appropriate skills to use with people experiencing mental health distress.*

*Other learning experiences include a short ward placement, role-playing essential communication skills, observing various treatment techniques and participating in a simulated voice hearing exercises. Officers also attend ward rounds, spend time with patients, visitors, staff, and patients' advocates; and have attended Mental Health Act Tribunals. They have also accompanied Crisis Resolution Teams (CRT) on home visits and the daily organization of Community Mental Health Teams (CMHTs) in Adult Mental Health, in areas that they would eventually police.*

Since the program was first established for new police officers, Community Police Development training is now also delivered to custody sergeants, Community Support Officers, firearms officers, incident commanders in the Firearms Division and police crisis negotiators.<sup>38</sup> Evidence to date has shown a reduction in the use of Section 136 of the Mental Health Act (Department of Health, 2008) and improved relationships between the police and mental health services.

### **Australia**

As described by Clifford (2010), the situation in Australia with respect to Police/PMI interactions is similar to that found in Canada, the U.S. and the U.K. Consequently, initiatives have been developed in Australia “to improve the capacity of police officers to respond effectively to mentally ill individuals, using less coercive methods of event resolution and interaction during mental health crisis interventions” (Clifford, 2010, p. 1). This is achieved across Australia through the introduction of specialist mental health training for police officers

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<sup>38</sup> Sometimes referred to in common parlance as “hostage negotiators.”

such as modified CIT models as well as other mental health/policing response models. These include the Queensland Police Service's Mental Health Intervention Project (a tri-agency partnership with Queensland Ambulance Service and Queensland Health) and the New South Wales (NSW) Police Force's Mental Health Intervention Team (MHIT) pilot program.<sup>39</sup>

The goals of the NSW project include:

- reduction of the risk of injury to police and mental health 'consumers' when dealing with mental health related incidents;
- increased awareness of 'front-line' police of the risks involved in the interaction between police and mental health 'consumers';
- improved collaboration with other government and non-government agencies in the response to, and management of, mental health crisis incidents; and
- reduction of the time taken by police in the handover of mental health 'consumers' into the health care system (NSW Police Force, 2008).

The New South Wales Police use a four-day course/seminar, similar to the CIT training model, to address frontline issues involving mental health and an understanding of the relevant mental health legislation. It is designed to develop the skills, knowledge and abilities of first responder police officers such as communication strategies, risk assessment and crisis intervention techniques so that they are able to effectively and efficiently manage incidents in which mental illness is an issue. Similar to the U.S. CIT model, police officers who successfully complete the training are awarded a distinctive MHIT badge to be worn on their uniforms.

Starting in 2005, the Australian Federal Police contracted with O<sup>2</sup>C Solutions, a private sector provider, to deliver two days of mental health in-service training to police first responders. This training, which includes a presentation by a person with a mental illness, addresses:

- prevalence of common mental disorders;
- suicide;
- depression;
- substance use disorders;
- anxiety disorders;
- schizophrenia;
- personality disorders; and
- mental health resources.

Based on evaluation by way of a pre-test/post-test questionnaire of training participants, O<sup>2</sup>C concludes the training to be successful.

### ***Outcome and evaluation studies in regard to police/mental health learning***

There are two fundamental questions concerning police training about mental illness. First, what (if any) effect does education and training have on the behaviour of police, their attitudes toward mental illness and the outcomes of Police/PMI interactions? Second, what are

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<sup>39</sup> Additional information at <http://www.mhca.org.au/MediaReleases/2007/NSW%20police%20trial%20welcome.pdf>

the essential and effective components of an education program that would yield such changes? Alas, the state of the literature does not allow us to answer these questions with any degree of certainty.

Research about the effectiveness of Police/PMI education and training programs has not been comprehensive or widespread. Of the extant literature, the majority has been focused on Crisis Intervention Team (CIT) education/training; yet, even that is arguably less than robust in the general quality of studies making its basis for designing ‘evidence-based’ learning programs questionable. The research/evaluation of non-CIT based training programs will be briefly reviewed. CIT related evaluation and research as well as the aforementioned issues, will follow.

An informative study across 50 U.S states focused on the content of police education and training relative to contacts with PMI and identified the following as common themes:

- crisis intervention;
- interpersonal communication/human relations;
- mental illness/mental retardation;<sup>40</sup> and
- mental health referral agencies (McAfee & Musso, 1995, p. 57).

Of the 20 states for which the amount of dedicated ‘training’ time with regard to Police/PMI encounters could be determined, they found a range from 2 hours to 55 hours. This is similar to the range identified across Canada (Cotton & Coleman, 2008). McAfee and Musso (1995) concluded, “the majority of states provide[d] training in the area of mental illness and in generic skills (e.g. crisis intervention) .... to avoid inappropriate confrontations” (p. 61-62). They added,

*new police officers must be sensitized to a recognition that many citizens have special needs, may not easily understand police commands, cannot understand the concepts of a police caution and may have difficulties communicating information about a crime (p. 62).*

A U.S. survey of 150 police officers sought to determine their opinion about what was important to include in Police/PMI related training (Vermette, Pinals & Applebaum, 2005). They identified dangerousness, suicide by cop, decreasing suicide risks, mental health law and the “potential liability for bad outcomes” as being the most important to police officers. It is interesting that in the current era, which promotes ‘community policing,’ de-escalation skills, collaboration with other agencies and communication skills in general were not considered by police officers to be priorities. Of note, and informative for curriculum design, is that ‘role-playing’ as a learning modality was rated as low by the officers. Another U.S. study by Janus, Bess, Cadden and Greenwald (1980) was based on the delivery of 16 hours of instruction covering abnormal psychology as well as psychiatric description and syndromes to an “experimental” group of police officers. They found positive attitudinal changes of police officers in the experimental group (compared with the control group who received no instruction) and concluded that they were brought about by intensive instruction. Interestingly,

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<sup>40</sup> This is the language used in their paper.

though, despite the observed attitudinal changes of the experimental group, they still found evidence of bias toward persons with a mental illness. However, although they were unable to determine whether it was due to fear or to ignorance, they were confident that “it could be minimized through instruction” (p. 229). While somewhat informative, the methodology of their study makes it difficult to evaluate the sought after mid- to long-term changes in police behavior. Said differently, although education showed initial attitudinal changes, it is still unclear whether the education such as was delivered can lead to lasting positive changes of police behavior.

Research by Godschalx (1984) in the U.S. concluded that whereas a brief education seminar was effective in increasing knowledge of police officers, it was ineffective in changing attitudes. Based on a U.K. evaluation, which used pre and post questionnaires, Pinfold, Huxley, Thornicroft, Farmer, Toulmin and Graham (2003) concluded that short educational interventions can produce changes in participant’s reported attitudes and can leave police officers feeling better informed and with increased confidence to support people in mental distress. Studies such as these are hampered, however, by small sample sizes and weak methodology.

As noted earlier, Cotton and Coleman (2008) found that most Canadian police basic education/training did not include ‘consumers’ or representatives of mental health organizations or agencies. The literature, overall, is clear that these are essential elements. For instance, Pinfold et al. (2003), citing Penn, Guynan, Daily, Spaulding, Garbin and Sullivan. (1994); Angermeyer and Matschinger (1996) and Corrigan, Green, Lundin, Kubiak and Penn (2001), determined that a consistently effective strategy for improving public understanding is personal contact with someone with a mental health problem. This exposure provides a believable and positive experience to dispel myths and stereotypes. In other words, experiential mental health awareness training that involves direct contact in a learning environment with persons with a mental illness and/or their families was found to be beneficial (Pinfold et al., 2003). The result was that police officers felt better informed and had increased confidence for their future contacts with PMI. However, the foregoing examples, which focused on non-CIT programs, are from the U.S. The literature review did not reveal the existence of similar Canadian research.

Although the models of Police/PMI learning are varied across Canada, the trend appears to be toward the adoption of the education/training model that was initially designed to operationalize the U.S. CIT deployment model. However, while much literature is available that explains what constitutes a CIT program, there is little published research on its effectiveness (A. Watson, personal communication, January 2010; Compton, Badora, Watson & Oliva, 2008). As the result of a wide literature review, Compton et al. (2008) found only twelve reports that described empirical CIT research. They concluded that “the CIT model may be an effective component in connecting individuals with mental illness who came to the attention of police officers with appropriate psychiatric resources” (p. 52). Furthermore, “early research indicates that the training component of the CIT model may have a positive effect on officer’s attitudes, beliefs and knowledge relevant to interactions with [persons with a mental illness]” (p. 52). They reported that, at a systems level, “CIT in comparison to other pre and post-diversion programs may have a lower arrest rate and lower associated criminal justice costs” (p. 52). They acknowledged, though, that considerably more research is necessary.

Compounding the dearth of research is the issue of the quality of studies as well as the nature and value of the research to the establishment of ‘evidence-based’ education and training. Even though, intuitively, it might seem that police education/training is necessary for improving interactions with people with mental illness, Watson et al. (2008) were clear that “the existing research does not focus on whether training and how much is sufficient for improving outcomes” (p. 363). They cautioned that while the CIT model might seem to be attractive, there is an absence of a “solid evidence base for CIT or other interventions to improve police intervention with mental illness” (p. 366).

The literature to date includes several examples of pre-test/post test evaluation of CIT training. For instance, research by Compton, Esterberg, McGee, Kotwicki and Oliva (2006) based on a pre-test/post-test evaluation of 159 police officers,<sup>41</sup> indicated that:

*CIT programs may effectively correct myths, enhance understanding and support, and reduce reports consistent with holding stigmatizing attitudes in the context of officers’ responding to calls involving individuals with schizophrenia. This may lead to improved rapport-building skills, de-escalation abilities, and communication between officers and family members; improved patient and officer safety; better outcomes for patients in terms of referrals to mental health services; and fewer incarcerations for minor infractions related to externalizing behaviors of serious mental illnesses (p. 1201).*

Bahora, Hanafi, Chien and Compton (2008) came to a similar conclusion by means of a pre-test/post-test evaluation of 40 hours of CIT training. Their study involved 92 police officers.<sup>42</sup> Steadman, Deane, Borum and Morrissey (2000) concluded that the deployment of CIT in Memphis was successful in that it had reduced the “arrest rate” resulting from Police/PMI contact as well as increasing referrals to mental health resources.

By means of qualitative methodology, Hanafi, Bahora, Demir and Compton (2008) used thematic analysis of focus group discussions post-CIT training to evaluate its effectiveness and noted that officers experienced an increased knowledge of mental illness, increased patience when dealing with PMI, an increase in referrals and a decrease in criminal charges/arrests as well as improved application of learned skills. They determined that CIT training reduced the unpredictability of crisis interventions and reduced the risk of injury (p. 427). However, given the methodology, they cautioned about the generalisability of their findings.

Evaluations of CIT, and thus the education and training to prepare police officers for CIT assignment, are also hampered by the absence in many police agencies of the necessary “internal record keeping capabilities to determine if CIT has met its goals” (Watson et al., 2008, p. 362). Overall, Watson et al. (2008) lamented, “the existing conceptualizations and research on CIT effectiveness have been narrow in scope and have lacked attention to broader contextual forces

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<sup>41</sup> A control group was not used.

<sup>42</sup> This included a control group of 34 police officers.

that may shape implementation and outcomes” (p. 362). Nevertheless, CIT is presumed to have wide-ranging effects and outcomes. From the perspective of Watson et al. (2008), CIT training should enhance the skills of officers in encounters with those who have mental illness, reduce the need for force, reduce the incidence of violence, reduce the incidence of arrest, reduce the incidence of injury to all parties involved, and increase access to services. However, these authors also note that it is a more challenging question to study change in a way that can assess the effectiveness of police interventions such as CIT.

Despite some reservations about evaluations to date, Watson et al. (2008) agreed, “the current research supports CIT as a promising approach to improving police response to persons with mental illness” (p. 366). It is apparent that even though some literature is available with regard to education and training for Police/PMI interactions in general and for CIT in particular,<sup>43</sup> scholars, overall, have concerns about the methodology of the research (e.g. study quality), including the often-small sample sizes and the frequent use of pre-test/post-test methodology.<sup>44</sup>

### **SECTION III: A proposed model of in-service education and training for police personnel**

#### *The basis...*

In an ideal world, the framework for in-service education and training would be databased and formulated around outcome research. It would advocate a general model in addition to identifying the actual content of the training. Alas, as noted earlier, such data do not exist. Nevertheless, there are common themes and common threads that run through many existing programs, both in Canada and internationally. In addition, research is available on related topics relevant to the development of an in-service education model such as:

- surveys of the nature and extent of interactions police have with PMI;
- identification of the circumstances surrounding the more negative outcomes;
- knowledge about adult learning in general;
- models of contemporary policing; and
- information about how to change behaviors and attitudes about mental illness.

It would also be prudent to consider the expert opinion of both police and mental health professionals who, based on a wide range of experience, have developed such programs. The ideas of these ‘subject matter experts’ show convergence in many areas. These are reflected in the model proposed below.

The learning objectives, the factual content of the learning/training, the process and the desired outcomes described in the proposed model generally represent the areas of commonality

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<sup>43</sup> On both counts, most of this is U.S. based.

<sup>44</sup> Pre and post-test evaluations identified in the literature review were conducted immediately before the learning event and soon after completion of the event. Thus, they are unable to account for the necessary mid to long-term behaviour change of police personnel. The value of the findings was compounded by the often-small sample sizes used for these evaluations.

between established programs. However, the model also includes some of the unique components of the various models in existence, as well as additional information from subject matter experts. Thus, we present a model that comprises the most promising practices to date.

However, there are gaps. The opinions and knowledge of ‘consumers’ of these police services — the people with mental illnesses — are debatably not as well represented as they should be in the design of Police/PMI learning programs. They are not overlooked altogether; many of the existing educational models were developed with the involvement of PMI. Nevertheless, additional input is currently being gathered in the aforementioned MHCC consumer-based study in British Columbia.

Furthermore, it is apparent that two issues, which do not appear have received sufficient attention in most police/mental health learning programs, are (1) stigma and (2) rights protection. In most societies, including in Canada, there remains a deep-seated stigma associated with mental illness, and often an unwillingness to recognize or deal with the resulting discrimination. For instance, PMI often indicate that the stigma of mental illness can be more debilitating than the illness itself (Thornicroft, 2006). The experience of the authors of this report, as well as that of various colleagues in policing, the community and mental health agencies in addition to ‘consumers’ and families of PMI, is that stigma with regard to mental illness, and, thus, with regard to persons with a mental illness, is present in police agencies. While this likely does not apply to all police personnel, its presence is such that it is a concern and must be a focus of education integrated throughout police learning curricula. Sometimes this stigma is subtly, even if unintentionally, reinforced by language of police policies and procedures (Coleman, 2010).

Indeed, the literature suggests police education should include anti-stigma initiatives to challenge the attitudinal barriers of police personnel that lead to discriminatory actions. For instance, curricula designed to prepare police personnel for interactions with persons with a mental illness should include more than fleeting attention to an explanation of why it is that police interactions are important and, indeed, are an integral element of contemporary policing.

Similarly, it is easy for police to be frustrated by the relatively recent trend toward rights protection in mental health legislation. While it might be debated whether this does or does not make a police officer’s job more complex, this argument needs to be positioned within an understanding of basic human rights and freedoms, regardless of the mental health or treatment needs of the PMI as perceived by the police or the community. Consequently, this should be included in police learning.

### *The model...*

Education and training models for police personnel should address a variety of considerations. These include:

- in what context will the training take place?
- who is going to receive the training?
- who is going to deliver the training?
- what will the learning objectives be? and
- what is the training model?

While discussion of some of these considerations is beyond the scope of this report, it is important to situate the recommendations that will be made within the framework of police discretion, ethical decision making, and the police culture in general. Most importantly, as was stated earlier, simply educating police about the facts of mental illness will not achieve the desired goals and outcomes.

### ***In what context should learning take place?***

While education is, of course, an essential component of competent police response, it needs to occur within a context of organizational policies and structures, and furthermore needs to be supported by constructive leadership and cooperation between agencies. For example, police education and training is only one of the eleven points identified as essential in the Canadian Association of Chiefs of Police's *Contemporary Policing Guidelines for Working with the Mental Health System* (<http://pmhl.ca/webpages/Tips.html>)

Contextual considerations are particularly important given the fact that police are accorded substantial discretion in how they resolve calls-for-service. Logically, the application of discretion is enhanced when a police officer has the appropriate knowledge, understanding and experience with which to make the best decisions from all available options. For instance, discretion is required when decisions such as whether to apprehend involuntarily or whether or not to make referrals to mental health agencies rather than arrest/charge for an offence. It also applies to situations that present an ethical dilemma.

In police encounters with PMI, discretion must be based on sound reasoning and unbiased good judgment in order to determine which of several options is most appropriate in resolving the situation. This has implications for police personnel education and training, and even hiring, with regard to being prepared for such encounters. The resolution of Police/PMI situations will be improved if the police personnel have been educated with regard to the options and consequences of the various options. With regard to the discretion required to resolve ethical dilemmas, significant time is required during formal learning to discuss the situations likely to be encountered, including both the practical options available and the rights of the PMI, and then work through them with experienced police and mental health personnel. The point is that the issue of discretion (decision-making) as well as the resolution of ethical dilemmas must be included in formal learning *and* be reinforced at the operational level. Notably, it does not appear this subject is adequately covered in current Police/PMI learning.

### ***Who should receive the education and training?***

Traditionally, police/mental health training has only included police officers. However, it is clear from the literature that education and training relative to Police/PMI interactions should not be limited to police officers. At a minimum, it should include all of those police personnel who have contact with PMI. Schwarzfeld, Reuland and Plotkin (2008) were emphatic that all personnel who are likely to be involved in interactions in which mental illness appears to be a factor should receive such training, including:

- all frontline and first responders;

- officers in specialized assignments including those on mental health teams and tactical teams;
- dispatchers and call takers;
- ‘front desk’ personnel; and
- victim services staff and volunteers.

The literature also suggests local mental health personnel who are, or will be, working in conjunction with police officers should be included in the necessary education and training, both as presenters and participants.

### ***Who should deliver the education and training?***

The careful selection of those who carry out the training can greatly affect success in shifting police personnel behaviour. Reuland and Schwarzfeld (2008) pointed out the obvious necessity to identify and utilize police and mental health ‘trainers’ who have the required competencies, experience and credibility to ‘teach’ their colleagues. Reuland and Schwarzfeld (2008) recommended a “multidisciplinary planning committee to discuss all issues related to program planning, including training” (p. 4) as well as for determining the composition of the training cadre. Lamb et al. (2002) posited that the most effective learning process to prepare police officers for Police/PMI contact is led by, and includes, both police and mental health professionals. Trainers should have an understanding and appreciation of the goals of the respective police/mental health response model and have experience with PMI in the criminal justice system. Although it is important to include mental health professionals as well as persons with a mental illness and their families as ‘trainers,’ those who are selected should have a positive attitude toward the police. That is, they should “have moved beyond any negative outcomes of [past] encounters [with police]” (Reuland & Schwarzfeld, 2008, p. 12). Overall Reuland and Schwarzfeld (2008) maintained, the trainers, including police personnel, should “be prepared to contribute in a constructive, positive manner” (p. 12).

The need for qualified and credible trainers is critical to the effectiveness of not only training but also the success of the service delivery model and, thus, the practices used to interact with PMI. For instance, as Reuland and Schwarzfeld (2008) clearly pointed out, it is important for police personnel to understand the occupational culture of the mental health profession and for mental health professionals to understand the occupational culture of police organizations. It is, thus, essential that the messaging during learning also speaks to the commitment of police and mental health professionals to work together for the achievement of better outcomes for all parties, notwithstanding their different occupational cultures as well as legislative and regulatory regimes.

Ideally, trainers will also be ‘local.’ In other words, they will represent the police and mental health organizations who will actually be working together. While one purpose of training is to impart formal knowledge, it is equally important to lay the groundwork for successful joint ventures between police and mental health organizations. Thus, the greater the integration of trainers and attendees between local agencies, the more effective the training should be. This model can pose problems for large provincial or federal police services who may find it more straightforward to have a “flying” team of trainers who travel from detachment

to detachment or who might prefer to hire external experts under contract. There is no doubt room for such subject matters experts and they can be integrated into training—but the presence of local experts is equally important. While the message may sometimes get lost in discussions of training, it is essential to bear in mind that the overall goal of training is not simply for police officers to know more—it is to improve the processes and outcomes of interactions with people with mental illnesses. Knowledge is a key component—but interagency cooperation is critical. Having people who are going to work together sitting in the same room at the same time hearing the same message facilitates this. It is about relationships.

Furthermore, with regard to delivery, the literature is clear that it is important to include a person with a mental illness and or a family member. For instance, Pinfold et al. (2003), citing the work of Penn, Guynan, Daily, Spaulding, Garbin and Sullivan (1994); Angermeyer and Matschinger (1996) and Corrigan, Green, Lundin, Kubiak and Penn (2001), determined that “a consistently effective strategy for improving public understanding is ... personal contact with someone with a mental health problem, providing a believable and positive experience to dispel myths and stereotypes through direct experiences” (p. 337). The result, they concluded, was that police officers felt better informed and had increased confidence for their future contacts with PMI (p. 343).

### *What are the necessary learning objectives?*

A learning program or a learning continuum must maximize knowledge exchange such that it not only imparts factual knowledge but also examines the process and outcomes of Police/PMI interactions. As we have seen, the extant evaluation and research is only moderately helpful. Nevertheless, in the absence of comprehensive and conclusive evidence, it is reasonable to use such programs as CIT curricula as a foundation. Complementary to what is included in CIT curricula, Lamb et al. (2002) found, in a U.S. context, police officers wanted to know:

- how to recognize mental illness;
- how to deal with psychotic behavior;
- how to handle violence and potential violence;
- what to do when a person is suicidal;
- what community resources were available as well as how to gain access to them; and
- when to call a specialized mobile crisis team (p. 1269).

Lamb et al. (2002) concluded that the education/training of police officers at a minimum should include:

- familiarization with the classification of mental disorders;
- learning and demonstrating how to manage persons with mental illness, including crisis intervention;
- how to gain access to meaningful resources less restrictive than hospitalization; and
- the laws pertaining to persons with mental illness, in particular the criteria specified for involuntary psychiatric evaluation and treatment (pp. 1269-1270).

In addition, they added, “considerable emphasis should be placed on de-escalating situations that might otherwise lead to the use of deadly force on persons with mental illness” (p. 1269).

Based on their extensive experience in the police and mental health universe, Cotton and Coleman (2008) suggested that police officers should at least:

- know the signs and symptoms of mental illness to enable recognition of a person with a mental illness;
- know about mental illness to make an assessment about how much control the subject is likely to have of their behavior;
- know whether it is likely that the PMI is capable of understanding and responding to the directions given by police;
- know that the standard police procedures that would typically disarm a non-mentally ill person, stabilize the situation or lead to co-operation might have the opposite effect on a person who is experiencing a mental health crisis;
- know how to appropriately adjust decision-making regarding when to apprehend, when to arrest, when to divert, when to seek additional input;
- be comfortable with techniques for defusing and calming situations involving PMI;
- be able to reasonably assess suicide risk;
- be familiar enough with mental health legislation to take appropriate action;
- be aware of mental health agencies and options, and who to call for consultation and/or assistance; and
- be aware of the stigma and bias with which most people — including both the public and the police — approach people with mental illnesses so police can adjust their own behavior accordingly (pp. 4-5).

There are of course many important elements of police/mental health learning design and delivery. It is beyond the scope of this report to delve into the details of education and training and in ethical decision-making, procedural justice, human rights protection, and contemporary policing models—all of which must inform learning concerning Police/PMI contact.

Nevertheless, the overriding theme of learning about mental illness should be:

- a focus on anti-stigma education to challenge the attitudinal barriers that lead to discriminatory action; and
- ethical decision-making, human rights protection and social responsibility.

Based on the aforementioned, the authors recommend that learning be based on the following *Learning Spectrum*.

### *The Learning Spectrum*

#### **The objectives...**

Considering all factors, the objectives required to prepare police personnel with regard to Police/PMI encounters are:

- *to understand:*

- the importance of adherence to the fundamentals of contemporary policing, such as:
  - a client focus;
  - procedural justice;
  - relationship building;
  - an outcome focus; and
  - a multi-agency approach
- the role of police personnel in encounters with PMI; and
- the role of mental health professionals, family and community supports in police encounters with PMI, consistent with a systems approach.
- *to understand:*
  - the symptoms such as hallucinations, delusions, paranoia, thought disorder, mood disturbances, intellectual impairments, memory problems, dis-inhibition, behavioral disturbances and other signs and symptoms that may accompany major mental illnesses and related problems; and
  - knowledge about mental illness sufficient to make an assessment about the influence that mental illness may be having on a person's behaviour and ability to comprehend and respond to a police officer's requests or instructions.
- *to understand:*
  - the importance of fostering of police/mental health agency relationships;
  - the importance of information sharing protocols between police and mental health agencies;
  - local mental health legislation sufficient to take appropriate action when necessary;
  - other relevant legislation including that which defines privacy rights and human rights;
  - the function of local mental health agencies and options and where/how to call for consultation and/or assistance and/or to make referral(s); and
  - organizational policies and procedures relevant to Police/PMI encounters.
- *to understand:*
  - how to use communication skills and de-escalation techniques for defusing and calming situations involving PMI;
  - how to determine whether it is likely that the PMI is capable of understanding and responding to the directions given by police; and
  - that the standard police procedures, which might typically disarm a non-mentally ill person, stabilize the situation or lead to co-operation, might have the opposite effect on a person experiencing a mental health crisis.
- *to understand:*
  - the relationship between mental illness and dangerousness; and
  - be able to assess suicide risk and how to contain the situation and/or when to intervene accordingly.
- *to understand:*
  - how to appropriately adjust decision-making regarding when to apprehend, when to arrest, when to divert/refer, when to seek additional input;

- how to apply problem-solving in the police/mental health environment; and
- how to apply ethical decision-making.

### **The Learning Model: *TEMPO***

Based on an extensive review of literature, programs, and experiences of police agencies and mental health services in both Canada and internationally, the *TEMPO* model - **T**raini**ng** and **E**ducation about **M**entalhealth for **P**olice **O**rganizations (*TEMPO*) - has been constructed for Canada.<sup>45</sup> It is recommended that Canadian police agencies be encouraged, in collaboration with their local mental health professionals, to adopt this multi-module learning delivery to address the learning necessary to prepare police personnel for encounters with persons with a mental illness (PMI).

**TEMPO**, in its entirety, is intended for all police personnel such as police officers, call-takers, dispatchers, front desk staff and victim services workers who have contact with persons with a mental illness.<sup>46</sup> This model has built-in flexibility to take into account local circumstances and the target group(s). The recommended content of each module, which can be finalized by local subject matter experts, is based on the *Learning Spectrum*. The difference between each module is the target group and thus the emphasis placed on each subject area, the degree of detail and the amount of practical or experiential learning. Consequently, the duration of each module differs.

#### **TEMPO 100:**

The focus of learning at the **TEMPO 100** level is to ensure that police first responders have sufficient knowledge and skills to be able to manage the types of encounters that police personnel have on a regular basis and to know when to seek additional support or, when available, more skilled intervention.

#### **TEMPO 101: Police Basic Training<sup>47</sup>**

This four-day module for ‘new police officers/police cadets’ in police college/academy should cover the entire recommended *Learning Spectrum*. Students will receive reinforcement of some of the subject matter during their recommended modified use-of-force training (Refer to **TEMPO 500**).

#### **TEMPO 102: Lateral-Hire Police Officers**

A two-day module for lateral-hire<sup>48</sup> police officers that might not have previously received the comprehensive police/mental health learning such as found in **TEMPO 101**. The purpose being that these officers will then be able to operate at the same level of understanding as those who

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<sup>45</sup> Notwithstanding its name, the application of this model is not restricted to only police officers. It is intended for all police personnel who have contact with persons with a mental illness.

<sup>46</sup> With relatively little modification, the *TEMPO* learning model can also be used in a corrections environment.

<sup>47</sup> Also known as ‘recruit’ or ‘cadet’ training.

<sup>48</sup> Police officers who have already received acceptable basic training with another police agency and have experience as a police officer.

received this education during standard basic training – **TEMPO 101**. This module should cover the entire recommended *Learning Spectrum*.

### **TEMPO 103: Police Personnel/Support Staff**

A one-day to two-day learning module for personnel such as Communication Centre operators/supervisors, ‘front desk’ personnel and victims services workers.

The module should cover the recommended *Learning Spectrum*. The CPKN course *Recognition of Emotionally Disturbed Persons* or the Alberta Government course *Policing and Persons with Mental Illness* could also be useful as a learning tool within this module.

Given that the contact Communication Centre Operators/Supervisors usually have with PMI, their family and/or their friends as well as the public with respect to ‘bizarre’ behavior or identified mental illness is in large part by telephone, role-plays/simulations based on their work environments should be included in learning.

### **TEMPO 104: Offender Transport/Prisoner Care Personnel**

A one-day module covering the learning objectives of the recommended *Learning Spectrum* for personnel responsible for prisoners. A particular emphasis should be placed on symptoms of mental illnesses and suicide awareness in the context of working with both young offenders and adult offenders. The CPKN course *Recognition of Emotionally Disturbed Persons* or the Alberta Government course *Policing and Persons with Mental Illness* could also be useful as a learning tool within this module.

### **TEMPO 200:**

The **TEMPO 200** level learning assumes a pre-existing basic level of competence, and builds on it, but is still focused primarily on the first police responder. It includes both a refresher/review of previously taught information and an update on new developments.

### **TEMPO 201: Continuing Education (In-Service Training) for Police First Responders**

A minimum one-day module:

- for police officers who did not receive the ‘training’ during their basic training,<sup>49</sup> and
- for each first responder police officer approximately every 3 years.

This module, which should cover the recommended *Learning Spectrum*, could use a classroom format blended with an online resource such as the CPKN course *Recognition of Emotionally Disturbed Persons* or the Alberta Government course *Policing and Persons with Mental Illness*. This module should also include a case study critique of recent Police/PMI encounters to enable discussion of the positives and the negatives of each situation. It might be appropriate to focus on specific subject matter that has not been well applied during past situations. Changes in legislation as well as changes in the operation of the local mental health system should also be

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<sup>49</sup> These are the police officers, sometimes with many years of service, who completed basic police ‘training’ when the police college/academy provided either no ‘training’ with regard to police/mental health contacts or very little ‘training.’ They will, however, have gained some ‘on-the-job’ learning. This module is intended to update them and bring them to the level of those who completed **TEMPO 101** in basic training.

reviewed. Police agencies with specialist mental health response teams should include team members as facilitators.

### **TEMPO 202: Field Training Officers (FTO)/Officer Coaches & newly promoted Supervisors**

This two-day module is intended for two target groups:

- designated FTOs/Officer Coaches to enable them to re-enforce the learning their ‘new’ police officers experienced in basic training; and
- newly promoted supervisors (corporals/sergeants).<sup>50</sup>

With respect to FTOs/Officer Coaches, it is safe to assume in the early days of **TEMPO** implementation, that FTOs, who usually have approximately three years of service, will not have completed **TEMPO 101**. Thus, a minimum of two days is considered necessary for **TEMPO 202**. This could be reduced to a minimum of one day when the majority of new FTOs have completed **TEMPO 101** during their basic training.

Although this module ought to cover all of the recommended *Learning Spectrum*, given the role of an FTO/Officer Coach/Supervisor, this module is intended to focus on what new police officers should experience as part of their workplace learning. Because this is an important phase in the socialization of new police officers, it is critical to emphasize subject matter such as understanding mental illness, police officer attitudes and stigma related to mental illness as well as de-escalation techniques.

### **TEMPO 300:**

The 300 level learning is for police personnel in specialized assignments that require either a more in depth and higher level of skill and knowledge, or a more focused understanding compared to the first responder.

### **TEMPO 301: Specialized Assignments**

A one-week (40 hour) learning module for personnel such as police crisis negotiators,<sup>51</sup> incident commanders, firearms/use-of-force instructors, ERT/SWAT commanders and search and rescue managers.

In addition to covering the recommended *Learning Spectrum*, a case study(s) is recommended to enable learning from past situations. An emphasis should be placed on the value of working with mental health professionals to plan and implement tactics for a satisfactory resolution.

### **TEMPO 400:**

The **TEMPO 400** level is learning for specialist officers who will be providing expert or consultative services with regard to Police/PMI contact.

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<sup>50</sup> Many Canadian police agencies and police colleges currently do not provide ‘training’ with regard to Police/PMI encounters for newly promoted supervisors.

<sup>51</sup> Sometimes, although inaccurately, called ‘hostage negotiators.’

**TEMPO 401: Advanced learning for police personnel assigned to a joint police/mental health response team and/or for police specialists<sup>52</sup> with regard to mental health response.** This one-week (40 hour) intensive module should cover the entire recommended **Learning Spectrum**. The module should also include proficiency in reporting observations both verbally and in writing. It should also include, in addition to the 40-hour formal learning, workplace learning in the form of a minimum of four job-shadow shifts with their police/mental health response team, if their police agency has one, and a minimum of four job-shadow shifts with a mental health facility.

Personnel who successfully complete this module, as evidenced by an exam, will be awarded the **TEMPO** insignia to be worn on their uniform or, if working in 'plain clothes,' on their jacket.

### **TEMPO 500:**

#### **Learning Module to be integrated into Use-of-Force training**

It seems that police officers might be spending too little time and energy at the lower end of the use-of-force continuum (Refer to Appendix A) before progressing to physical contact. This one-day module is intended to be integrated into what has traditionally been stand-alone use-of-force training. It should complement and reinforce the learning of all other **TEMPO** modules. While it should cover the learning objectives of the recommended *Learning Spectrum*, particular emphasis, and thus reinforcement, should be placed on:

- an understanding of symptoms such as hallucinations, delusions, paranoia, thought disorder, mood disturbances, intellectual impairments, memory problems, dis-inhibition, behavioral disturbances and other signs and symptoms that may accompany major mental illnesses and related problems;
- knowing about mental illness sufficient to make an assessment about how much control the subject is likely to have of their behavior;
- communication skills and de-escalation techniques for defusing and calming situations involving PMI;
- whether it is likely that the PMI is capable of understanding and responding to the directions given by police;
- knowing that the standard police procedures, which might typically disarm a non-mentally ill person, stabilize the situation or lead to co-operation, might have the opposite effect on a person who experiencing a mental health crisis;
- having an understanding of the relationship between mental illness and dangerousness;
- being able to reasonably accurately assess suicide risk and know how to contain the situation and/or when to intervene accordingly;
- knowing how to apply problem-solving in the police/mental health environment; and
- knowing how to apply ethical decision-making and to exercise of police discretion.

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<sup>52</sup> This would be similar in concept to the CIT officers in the U.S.

#### **SECTION IV: Strategies for mental health agencies and organizations to utilize in facilitating police/mental health learning within the police community**

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

The previous sections of this report were based on extensive research, a review of existing programs and the informed opinions of police and mental health personnel across Canada. In contrast, this section is, by necessity, largely based on personal experience and accumulated wisdom of the authors. There is no 'magic' answer to the question of how to approach and initiate change in a local, regional, provincial or federal police service, just as there is generally no tried and true or established mechanism for facilitating the cooperation of any two large and complex systems. The good news is that many police organizations and mental health services have collaborated to develop and deliver not only comprehensive education and training programs but also viable and successful joint mental health response initiatives. This provides a useful foundation.

In this section, we will explain the police environment and some of the key influences on police decision-making so that the readers of this document (assumed to be mental health organizations) can optimize the likelihood of establishing mutually beneficial relationships with police decision-makers. While some of these recommendations are self-evident, they are included here as it has been our experience that not all mental health organizations are aware of these factors. It is also our experience that a lack of awareness of these factors on the part of some mental health organizations has on occasion compromised relations between police services and mental health organizations.<sup>53</sup>

##### ***Limiting factors***

In some provinces, police services are mandated by provincial regulations to ensure specific education and skills training. Unfortunately, education and training related to mental illness does not, at least as of yet, fall within the category of required or mandated police learning.<sup>54</sup> Some of the limiting factors for police organizations when attempting to provide any type of in-service education are the issues of financial resources, capacity to deliver and the time necessary for delivery as well as the logistical challenges of 'freeing up' police personnel for the desired education and training.

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<sup>53</sup> This is not to suggest that such failures are always the fault of mental health organizations. Clearly, this is not the case. However, this report is directed toward mental health organizations not police organizations and, thus, the recommendations are intended to assist the former in dealing with the latter.

<sup>54</sup> This is another area that mental health advocates could consider gaining some traction. I.e. advocating changes to provincial police acts and 'training' regulations. Refer to *Political Approach* on Page 49.

Given the 24/7 nature of police work and the necessity of replacing operational police personnel when they are engaged in training activities, the cost of training can be prohibitive for many police services. Moreover, even when learning programs are provided free of cost, there is still significant expenditure required to replace personnel who are attending these programs. Further complicating this is the difficulty of providing consistent training to personnel who work on a rotating shift schedule, with shifts that might be 10 or 12 hours in length and consequently extended days off work. While it might appear to be relatively easy to deliver learning that takes place Monday through Friday, from 9 AM to 5 PM, such a schedule is significantly at odds with the hours police personnel generally work and thus often results in a police service incurring significant additional expenditures for, but not limited to, overtime pay. With that caveat in mind, we share the following:

### ***The Structure of the Canadian Police Environment***

The purpose of Section IV is to identify strategies for introducing the proposed Police/Mental Health learning model to the police ‘world.’ However, given the somewhat complex structure of Canadian policing, this might not be straightforward. It is useful, therefore, to explain that structure and the context within which the accompanying recommendations are made.

In Canada, policing and the administration of justice along with other public services such as health and education are provincial rather than federal responsibilities. In other words, in somewhat simplistic terms, each province is responsible for establishing and regulating their provincial and municipal police services. Consequently, each province has a police act and associated regulations. It is the latter, in particular, that provides standards in some provinces with respect to training of police officers and police personnel including some that has been identified as mandatory. The respective police acts also provide for the establishment of police governance authorities – police boards and police commissions. This, in particular, is of relevance to this report and is further discussed later.

As mentioned previously, because policing is a provincial responsibility each province is required to establish a provincial police agency. In Ontario and Quebec, this is achieved through the establishment of the Ontario Provincial Police (OPP) and the Sureté de Quebec, respectively. In Newfoundland and Labrador, the provincial policing role is shared geographically between the province’s Royal Newfoundland Constabulary (RNC) and by means of a contract with the RCMP. The latter organization, which is a deployed police agency, is of particular interest with respect to the requirement of this report with regard to “identification of policing organizations to be approached.”

The RCMP operates nationwide but has multiple and often confusing roles. One of their roles, which in itself is multifaceted, is that of federal policing. This is not of direct concern to the subject of this report. What does have relevance to this report is that B.C., Alberta, Saskatchewan, Manitoba, PEI, New Brunswick and Nova Scotia have chosen not to establish and maintain their own provincial police agency but to contract this function to the RCMP. That is, the RCMP functions as the provincial police, the equivalent of the OPP and the Sureté, in these provinces. The RCMP also serves as the territorial police in the three northern territories. This is not by virtue of contract per se but rather by virtue of the status of the territories versus that of

the provinces. The RCMP is a complex organization for several reasons. For instance, their country-wide ‘command and control’ situated in Ottawa conflicts with their status as provincial police acting on behalf of and accountable to the respective provinces. This arrangement, which dates back to the late 1920s and early 1930s, obfuscates the issue of who to approach on issues such as those subject of this report. That is, should it be each provincial police agency managed by the RCMP that is approached, their parent organization in Ottawa or both?

To complicate matters further, each province establishes criteria for the establishment of municipal police agencies (such as Regina, Winnipeg, Virden, Brandon, Red Deer, etc). The criteria usually require that a municipality in excess of a specific population<sup>55</sup> is required to establish a municipal police agency. Police acts in other than Ontario and Quebec provide for municipalities, rather than to establish their own local police agencies, to contract with the RCMP. For example, Regina established its own municipal police service but Red Deer, Alberta and Virden, Manitoba contracted the RCMP to function as their municipal police services.

In addition, there are differences articulated under the respective police acts with regard to local governance and accountability of the RCMP when functioning as a municipal police agency and the governance and the accountability required of a locally established municipal police agency. In short, although the situation is slowly changing in some limited respects, the RCMP are subject to the federal RCMP Act and not to the respective provincial police acts even when they function as municipal and provincial police.

The result, with respect to municipal police functions contracted to the RCMP, is that they are not subject to the same type of governance and accountability as locally established municipal police agencies. In the latter case, a municipality is required by the respective provincial police act to establish a police board/police commission that has specific parameters and responsibilities established in that act – whereas the RCMP is not subject to the same mechanisms. Notwithstanding that difference, in relatively recent years, in many communities in which the RCMP operates under contract as the local police, the municipality has established a ‘police management board.’ Of note however, is that compared to police boards/police commissions, these are relatively informal and do not have the same accountability authorities and responsibilities as police boards/commissions.

Now, as if that is not complicated enough, the education and training of Canadian police officers is similarly complex.

## ***Education & Training***

### **RCMP**

The RCMP delivers much of its training, both basic and in-service, through the RCMP Academy in Regina and the Pacific Regional Training Center (PRTC) in Chilliwack. The curriculum for these learning centers is largely established and/or authorized centrally from

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<sup>55</sup> This differs between provinces.

RCMP HQ in Ottawa.<sup>56</sup> Of relevance to this report, and helpful to identify one possible access point is the following statement on the Government of Canada website:<sup>57</sup>

***Learning and Development***

*The Employee Continuous Development Process fosters a continuous learning culture within the RCMP. It ensures RCMP employees have access to modern, cost effective learning/training opportunities consistent with the competencies required to deliver quality service to internal and external clients, to adapt and respond to diverse changing needs, and contribute to the evolution of the RCMP.*

While this statement is broad, it certainly is open to the “diverse changing needs” of police/mental health learning.

***Provincial Police Colleges/Academies***

British Columbia (Justice Institute of BC), Saskatchewan (Saskatchewan Police College), Ontario (Ontario Police College), and Quebec (Ecole Nationale de Police du Québec), operate provincial police colleges for all basic police officer training and some in-service training. The Atlantic Police Academy (Summerside, PEI), which is a division of Holland College,<sup>58</sup> is not operated by a province or a police service. It provides basic police officer training<sup>59</sup> for the primary benefit of the municipal and regional police agencies within Atlantic Canada.<sup>60</sup>

The respective province, usually in consultation with the municipal police agencies, determines policies, and thus the curricula of the provincially operated learning institutions. The Atlantic Police Academy has a board of directors comprised of police agency representatives and educators that establishes policies and curricula.

***Locally operated Police Colleges/Academies***

In addition to the above, many police services, primarily municipal police agencies, provide their own basic and in-service training through their in-house colleges/academies (e.g., Calgary, Edmonton, Winnipeg) or in partnership with a local college/university (e.g., Lethbridge, Brandon, and the Royal Newfoundland Constabulary). However, many smaller police agencies across Canada are unable to do this.

The policies and curricula for these local police learning institutions are established by the respective police agency under the authority of their police board/commission.

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<sup>56</sup> By the RCMP Chief Learning and Development Officer, Learning and Development Branch.

<sup>57</sup> <http://www.infosource.gc.ca/inst/rcm/fed04-eng.asp>

<sup>58</sup> This is a community college. Refer to <http://www.hollandcollege.com/>

<sup>59</sup> This includes ‘training’ for most of their needs including for their police officers serving as provincial and municipal police officers.

<sup>60</sup> Halifax Regional Police and the RNC also provide basic police officer training to meet their own needs.

## ***Police Professional Organizations***

To a small extent, two professional associations bring these disparate learning institutions and programs together. They are the Canadian Association of Police Chiefs - Human Resource and Learning Committee (CACP-HRL)<sup>61</sup> with representatives from a cross section of municipal, regional, federal and provincial police agencies and the Canadian Association of Police Educators (CAPE).<sup>62</sup> CAPE's membership includes representatives from most of the previously mentioned Canadian police learning institutions but also includes representatives from community colleges that deliver police related learning.

Some of these, which are primarily in Ontario, such as Humber College, Seneca College and Mohawk College provide 'police foundation' programs further to requirements and standards of the Ontario government.<sup>63</sup> These programs are intended to prepare potential applicants for a career as a police officer. An example of the subject matter of these programs can be found at Humber College's website.<sup>64</sup> As can be seen, the curriculum does not include the issue subject of this report. Some of the external colleges (e.g., Dalhousie University College of Continuing Education)<sup>65</sup> do not provide basic police training but do provide in-service learning with regard to matters such as police leadership, legal issues in policing and strategic human resource management. However, they also do not address the subject of this report.

The authors explain the above, which has been somewhat simplified, to demonstrate the numerous potential 'access points' in order to advance the concept of enhanced learning for police personnel with regard to improving Police/PMI interactions. These potential access points are further discussed below.

## ***Strategies for introducing TEMPO to the Police World.***

Having considered some of the potential learning access points that might influence police learning, the questions remain: What are the strategies for introducing the proposed model to the police world? What are the policing organizations to be approached? Who are the key contact persons; and what are the police cultural considerations to be taken into account?

### **Who to approach**

As we have seen above, there is not one single access point. This presents challenges in initiating change in what is a very fragmented system. Nevertheless, two broad strategies can be utilized to achieve system-wide change:

1. A Political Approach – the Policy Level.
2. An Operational Approach – the Practitioner Level.

#### **1. A Political Approach – the Policy Level**

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<sup>61</sup> Available at <https://www.cacp.ca/default/committees/viewcommittee?committeeId=2>

<sup>62</sup> Available at <http://www.cape-educators.com/>

<sup>63</sup> Available at <http://www.edu.gov.on.ca/eng/general/college/progstan/humserv/police.html>

<sup>64</sup> <http://www.humber.ca/program/11071>.

<sup>65</sup> Available at

<http://collegeofcontinuinged.dal.ca/Continuing%20Management%20Education/Police%20Leadership/index.php>

All police agencies are accountable to at least one of the three levels of government. For instance, the RCMP in its entirety is accountable to the federal Minister of Public Safety (currently Minister Toews). However, the RCMP is also accountable, albeit sometimes not as effectively as would be optimum, to the provincial governments where they function as the provincial police and to the municipal governments where they function as municipal police agencies.<sup>66</sup>

Provincial police in Ontario, Quebec and Newfoundland and Labrador (i.e. the RNC) are accountable through their respective ministries responsible for policing. Municipal police, although they are subject to provincial police acts and regulations are accountable to their respective municipal government through their appointed municipal police boards and commissions.<sup>67</sup>

Of relevance to systemic change, many of the municipal police boards/commissions belong to the Canadian Association of Police Boards (CAPB).<sup>68</sup> While CAMIMH might be interested in directly approaching the federal and/or provincial ministers responsible for policing, the authors suggest that CAMIMH initially approach the CAPB to meet and discuss this matter. The members of CAPB have direct ‘control’ at the policy level over many police agencies (including Toronto, York Regional, Calgary and Edmonton).<sup>69</sup> They have the authority to influence, and to some extent direct, the learning required by and delivered to, their police personnel.

CAPB is aware of the issue of police interaction with people with mental illnesses and is aware of the need for police education and training. In 2006, they passed a resolution related to police training about mental illness.<sup>70</sup> The matter was also raised by Dr. Alok Mukherjee, the Chair of the Toronto Police Services Board, in his opening remarks of the 2009 CAPB Conference. It is likely timely, therefore, to meet with them to follow up on their 2006 resolution and bring them up to date from the perspective of mental health organisations. It would also be a good opportunity to solicit their support with regard to influencing provincial politicians to make changes to police standards and regulations that include mandatory police/mental health learning.

Notwithstanding this matter has been on prior conference agendas in 2002 and 2006, it is timely to get this subject, in particular *TEMPO* and mandatory training for police personnel as opposed to just police officers, on their conference agenda. The conference is held each year in August. This would provide the opportunity to engage in a public dialogue with those who have the opportunity to initiate change – the implementation of *TEMPO* either in total or in part.

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<sup>66</sup> As already alluded to, these are imperfect relationships. Ultimately, RCMP commanders tend to take direction from Ottawa when there is even a perception of conflicting direction.

<sup>67</sup> These are not found in Manitoba, Quebec or Newfoundland and Labrador or in municipalities policed by the RCMP.

<sup>68</sup> Available at <http://www.capb.ca/>

<sup>69</sup> CAPB represents more than 75 municipal police boards and commissions across Canada that together employ in excess of 35,000 police personnel. That is, approximately three-quarters of the municipal police personnel in Canada.

<sup>70</sup> Available at <http://vancouver.ca/police/policeboard/documents/20060913BULL91Edmonton.pdf>

While CAPB and its members have no formal authority with respect to the RCMP when they function as municipal and provincial police, CAPB members are, as can be seen, responsible for a large percentage of Canadian police agencies and police personnel.<sup>71</sup>

In addition to the nationwide CAPB, most provinces also have a provincial association of police boards/commissions who are usually members of CAPB. For example, the Ontario Association of Police Boards and the Alberta Police Governance Association. The latter also includes members of the police management boards that operate in municipalities policed by the RCMP. The 2011 annual meeting of the APGA is at Lethbridge in April 2011.<sup>72</sup>

### **Recommendation:**

*That CAMIMH approach the CAPB to solicit their support for implementation of **TEMPO** in their respective jurisdictions and gain their support to approach provincial governments to make Police/PMI learning a mandatory subject for police personnel.*

In the context of encouraging and facilitating change, it is important to remember that it is the provincial governments, either directly through the respective ministry or indirectly as in the case of Saskatchewan, through the Saskatchewan Police Commission, that in consultation with police agencies determines mandatory police education and training and the related standards. In addition, the provincial governments establish policy and operate the provincial police colleges. In the circumstance of the RCMP operating as the provincial police, the provincial governments have some influence, although not always control over, the education and training of the RCMP.

### **Recommendation:**

*That CAMIMH directly approach provincial ministers responsible for policing to include police/mental health learning as a mandatory course at both the basic police training level and during periodic in-service training for police personnel who have contact with PMI, and*

*Furthermore, that these discussions include the solicitation of provincial government support for such mandatory learning to be part of provincial police training in situations where the RCMP operates as the provincial police.*

## **2. An Operational Approach – the Practitioner Level**

By this we mean, directly approaching police colleges and police services – municipal, regional and provincial. In this regard, of note is that many, but not all by any means, police agencies have police/mental health learning programs far superior to what they had in place 5-10 years ago. In general, the authors do not recommend a direct approach to police organizations and police colleges and academies at this time – the political approach is the preferred place to start. A recommended exception to the above is to approach the Canadian Association of Police

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<sup>71</sup> Approximate Canadian total of police officers = 67,900. This includes federal, provincial and municipal police officers.

<sup>72</sup> Terry Coleman is currently scheduled to present on a matter unrelated to mental health.

Educators (CAPE). As previously mentioned their membership includes community colleges across Canada as well as police colleges/academies established by provincial governments and by some municipal police boards/commissions.

While the community colleges serve only to prepare students to be police officers, early introduction of these students to the subject of police mental health education has several benefits. For instance, it introduces the subject such that potential police officers understand that much of police work is other than chasing ‘bad guys’ and making arrests.<sup>73</sup> Furthermore, although not all students will become police officers, the opportunity to educate the other students will be of long-term benefit.

Although CAPE is comprised of those involved in the design and delivery of learning, not all are trained educators. However, the opportunity to present CAMIMH’s concerns and a learning proposal would be beneficial in the context of educating the educators. CAPE usually holds an annual conference in approximately June of each year.

### **Recommendation:**

*That CAMIMH approach CAPE to discuss police/mental health learning and to get on their 2011 conference agenda.<sup>74</sup>*

Determining the appropriate access point(s) to the RCMP with regard to police/mental health learning is difficult. This is primarily due to it being a large, unwieldy and bureaucratic organization trying to satisfy a multitude of mandates. While a political approach through the federal Minister of Public Safety is theoretically ideal, it is unlikely that CAMIMH could secure such an audience. Similarly, it is unlikely, but not impossible, that CAMIMH would be able to secure a productive meeting with the RCMP Commissioner. He is likely to pass it off to a Deputy Commissioner and/or the Chief Learning and Development Officer (CLDO). The most practical is to arrange a meeting with the CLDO. Although the RCMP is experiencing significant retirement turnover, Terry Coleman knows the current CLDO. Of note is that the CLDO is a member of CAPE. Approaching the Directors of the RCMP Academy and the PRTC or the chief officers of the provincial police agencies operated by the RCMP is not likely to be productive. A direct approach to chiefs of municipal police agencies is also not recommended at this time given it is system-wide change that is preferred. Direct approaches to selected chiefs of municipal police agencies who are identified as supportive of systemic change can be made in the future.

### **Recommendation:**

*That CAMIMH meet with the Chief Learning and Development Officer of the RCMP to discuss police/mental health learning recommendations for RCMP personnel serving in federal, provincial and municipal policing roles.*

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<sup>73</sup> Research indicates that only about 7% to 12% of police work involves enforcement of the law.

<sup>74</sup> The president, Dr. Curtis Clarke, can be contacted at [Curtis.Clarke@gov.ab.ca](mailto:Curtis.Clarke@gov.ab.ca). Of note is that it is he who engineered the highly regarded online police/mental health learning product for the Alberta Government. Refer to page 17.

Following are considerations with regard to making either the political or the operational approach.

### **Factors to consider when taking the Political and Operational Approach**

The following are not intended to be recommendations but are intended to provide a framework for discussion with the various groups and persons recommended in this report.

#### **1. The Police Culture**

Although policing has become more ‘open’ in ways it conducts its business and works with those outside police organizations, the police universe still contains a substantial element that feels only police officers know police business. That is, there is often at least initial resistance to those considered ‘outsiders’ who do not understand their business. As already stated, although this situation has improved it is still a factor and a challenge to be managed.

Unfortunately, although many police personnel understand and appreciate that Police/PMI interactions are part of police work, there are still a significant number who do not. Furthermore, stigma with regard to mental illness can still be found in police organizations (Coleman & Cotton, 2010).

If CAMIMH decides to approach police agencies and/or police colleges and/or police governance authorities directly, it would be useful to be accompanied by one or both of the authors of this report. This will help to overcome any resistance.

#### **2. Learning is most effective when delivered at the local level**

As has been noted above, training is best delivered by people who will eventually be working together. Given the variability of both police services and mental health services across jurisdictions or locations, it is unlikely that a ‘one-size-fits-all’ model of training will be effective. This is particularly true for large multi-detachment deployed police agencies such as the RCMP, the OPP, and the Sureté. It is preferable for training to be decentralized and to involve the mental health agencies and providers from various areas, reflecting local needs, rather than having ‘canned’ training at a central location. There will, of course, be much overlap from one geographic area to another and some components of training might be transferable — but as has been noted elsewhere, establishing links and becoming familiar with local resources is a key component of successful learning.

#### **3. An approach by a coordinated and comprehensive group of mental health agencies is more to be likely successful**

Even when there are funds available for training that goes beyond the mandated training, there are many different external organizations and agencies vying for police time and resources. In fact, it is a common dilemma for police organizations to be approached by community groups who want the police to provide education and training specific to the interest of that group. While each of these organizations may have a legitimate demand on police time, the sheer numbers of organizations and a fragmented approach make the situation problematic for all involved. Even just within the mental health arena, a police agency might find itself approached by groups who represent mental health ‘consumers,’ and/or their families, as well as various groups representing

people with schizophrenia, mood disorders, autism, acquired brain injuries, developmental delays, learning disabilities, dementia and related disorders, and a host of other matters related to mental health. While each of these requests for police time is somewhat legitimate, it is easy to see how a fragmented approach might result in a police service simply declining all requests.

#### **4. Determine the education and training in place before making suggestions for additional or different training<sup>75</sup>**

As has been noted elsewhere, it is common for coroners' reports, 'consumer' groups and even some mental health organizations to insist that unsatisfactory outcomes of Police/PMI interactions only require education and training, or more education and training to improve these interactions. While this might be true in some instances, it should be noted that many police organizations already provide extensive education and training in this area. For a mental health organization to assume that no training has taken place might serve to discredit the mental health organization and strain relationships between organizations. It is therefore prudent to make enquiries first about education and training in place before making suggestions, recommendations or offering assistance.

As mentioned above, police officers, like most people, do not like to be told how to conduct their business by people who have not "walked in their shoes." Historically, there has been an unfortunate tendency for mental health professionals to approach police organizations with the offer to "train" them in the fashion in which the mental health providers think the police should be trained. Not surprisingly, police organizations might take some exception to this. Fortunately, training and program development related to mental illness is a priority in most police services. Therefore, when approached appropriately, police organizations are likely to be responsive to offers of assistance from mental health agencies who use a 'how can we work together' approach.

In many Canadian jurisdictions, police already work closely with mental health professionals from health regions and similar agencies. In some instances, it might be best for a mental health advocacy group or a consortium of mental health organisations to approach the police leaders in that jurisdiction and the corresponding mental health agency leaders at the same time. A well-prepared 'soft' approach will reduce the likelihood of both the police organizations and the mental health agencies being defensive.

#### **5. Establish working relationships with people who have influence and decision-making authority.**

If, and when, engaging a police service concerning mental health learning, identifying the appropriate person to speak to is essential. Many police services, including most large organizations, have dedicated police personnel who are responsible for relationships with the mental health community. These persons are often also involved in local or regional liaison committees. Although these designated personnel might be the first point of contact for mental health organizations, they are rarely the decision-makers with regard to policy.

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<sup>75</sup> The authors can ascertain this information if they do not already have it.

If the community mental health organization is already involved in a liaison committee and is familiar with the designated officer in charge of mental health issues, gaining the support of that person is important. An approach by a mental health organisation or a consortium of mental health organisations should initially be made to the chief of police or equivalent. To reduce the likelihood of a written communication being ignored or passed to a subordinate, the mental health organisation should request a brief meeting and follow up accordingly. Again, it should be noted that particularly if a mental health organization is approaching the chief of police, it is essential that the approach be made on behalf of the mental health system at large, rather than on behalf of a single agency.

#### **6. Providing tangible assistance to police colleges/academies and police agencies**

The principles described earlier in this report that suggest that training should be delivered jointly by persons with a mental illness, family members and mental health personnel are generally well known to police agencies. Although they welcome the opportunity to include mental health professionals, ‘consumers’, and family members in design and delivery of their training, they often do not have direct access to these groups and/or do not know how to approach such groups. This is particularly so in the case of family members and people who are living with mental illness. In the survey of academy level training conducted by Cotton and Coleman (2008), several academies indicated that while they generally tried to include PMI in their training, they were not always able to find anyone willing to participate. This provides an opportunity for a local mental health organization to start to build a relationship with the police agency by introducing the police agency to PMI and/or their families.

## CONCLUSION

Although police interactions with persons with a mental illness have long been a component of policing (Bittner, 1967), there is little doubt that police personnel now have more frequent contact with PMI than they did 20 or more years ago. There is also little doubt that the public now has much higher expectations of the police than in the past about how police should interact with PMI. The literature is clear on several counts. While the literature reminds us that the intent of education and training – learning – for police personnel is not to enable them to be diagnosticians, it is essential that they possess sufficient knowledge and skill to be able to resolve a Police/PMI contact within a framework of procedural justice and a client/customer focus. The literature is also clear that police/mental health learning should be transformational – a significant system-wide change. The literature is unequivocal that all police personnel whose work includes contact with PMI, should be well prepared for their interactions with PMI. The reason proffered is simply that such preparation will lead to better outcomes all around, in particular, for PMI.

The thrust of the literature is that preparation should include structured and focused learning. Even though the literature is not clear about what works and does not work with respect to improving outcomes, there are strong indications that de-escalation techniques based on understanding mental illnesses and their attendant symptoms as well as appropriate oral communication skills are just two of the key elements for success. Consequently, based on a) what is emerging in Canada as appropriate learning and b) the extant literature, which suggests preferred learning content and delivery, this report suggests a comprehensive and multilevel, yet flexible, model for police personnel based upon the identified *Learning Spectrum* — that is, the *TEMPO* model.

Although this report has proposed a structured, comprehensive and flexible formal learning model, it is important to recognize that learning is not a one-time event. It is an ongoing process of renewal and reinforcement both through formal learning and through semi-structured workplace learning. Although the latter in many police organizations will require a shift of the corporate culture, this is possible when police agencies work collaboratively with each other, with mental health professionals, mental health advocates and persons with a mental illness as well as scholars. It is only through ongoing continuous evaluation and improvement that the outcomes of Police/PMI interactions will be responsive to our dynamic environment.

Notwithstanding police/mental health training is far more prevalent and of a higher quality than as recently as ten years ago, the authors of this report have not been able to identify provincially mandated police/mental health learning at either the basic training level or at the in-service level. Ideally, provincial police regulations should mandate this learning at both levels for all police personnel in the province who have contact with PMI and/or their families. To achieve such systemic transformational change requires working with the appropriate politicians and public servants identified in this report to bring this about.

Depending on the province, current mandatory training includes such matters as use-of-force training, investigative training and some aspects of supervision and leadership training.

Given the importance of successful outcomes of Police/PMI interactions, some of which unfortunately in the past have ended in tragedy, the institution of mandatory police/mental health learning is essential. It is arguably overdue.

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## APPENDIX A

### Canadian National Use of Force Model

