Police Act Reform Submission

Submitted to the Special Committee on Reforming the Police Act

April 30, 2021

Least Restrictive, Lowest Cost:
Crisis Centre of BC submission to the Special Committee on Reforming the Police Act

We are the Crisis Centre of BC. Since 1969, the Centre has provided help and hope to individuals, organizations, and communities. Spanning the spectrum of crisis support, suicide prevention, and postvention, we engage staff and volunteers in services and programs that educate, train, and support the strength and capacity of individuals and communities. We offer:

- Immediate access to barrier-free, non-judgmental, confidential support and follow-up to youth, adults, and senior through our 24/7 phone lines and online services
- Education and training programs that promote mental wellness and equip schools organizations and communities to assist people at risk of suicide.

Thank you for the opportunity to reflect on reforms to the *Police Act* that would support a "least restrictive, lowest cost" approach to responding to mental health crises in British Columbia.

The key aim of the *Police Act*, as laid out in Part 2, Section 2, is to *ensure that an adequate and effective level of policing and law enforcement is maintained throughout British Columbia.*

Although the *Police Act* is not meant to be a comprehensive approach to mental health care, police have taken an expanding role in responding to mental health crisis by virtue of being the sole 24/7 mobile response available, aside from paramedics and firefighters. Without a strong continuum of crisis care, police involvement in mental health undermines the ability of police to provide adequate and effective law enforcement by tying up police resources, and undermines the effectiveness of mental health crisis response by relying on officers with hours of mental health training instead of years as a mental health professional.

Police as "Informal First Responders" to Mental Health Crisis

Are police necessary for an effective response to mental health crisis in the community, or is mental health crisis response a responsibility transferred to police because of a lack of 24/7 access to mental health care?

This Committee has already heard from other speakers outlining ways in which police response to mental health crisis is less adequate and effective than it could be:

- The BC Ministry of Health reported to this Committee that one in five interactions with police involves someone with a mental health or substance use problem; 20 times the average rate of other jurisdictions. This suggests BC is overusing police response compared to other Provinces.

- The Vancouver Police Department estimated that 2,259 (16%) of their mental health calls may or may not have required police attendance - the equivalent of 8 policing positions ($1,051,935 annually).
- The Canadian Mental Health Association presented findings that less than 34% of RCMP responses to Mental Health Act occurrences lead into an involuntary admission, suggesting that many of the remaining 66% received unnecessary police contact, and/or were apprehended and brought to hospital unnecessarily, and may or may not have received appropriate help.
- CMHA and VANDU presented lived experience accounts of police contact resulting in trauma and unnecessary losses of freedom and self-determination. No matter how friendly, compassionate, or well-trained police officers are, police toolkits are stacked towards force: a gun, a tazer, a set of handcuffs, the right to arrest, the right to involuntarily apprehend individuals for immediate assessment and examination by a physician.

Justification for police as necessary first responders to mental health crises is generally rooted in safety concerns. The Vancouver Police Department's 2020 "Our Community in Need" report defines the role of police in collaborative mental health initiatives as ensuring healthcare workers are able to "fulfill their course of duty" with police available to shield them from "unsafe and volatile working conditions" arising from the risk that "individuals with untreated mental health and/or concurrent disorders may escalate to aggression and violence, both against themselves or others." (p 14)

As the Centre for Addictions and Mental Health points out in their October 2020 Mental Health and Criminal Justice Police Framework, the perception that people in mental health crisis are generally dangerous and unpredictable is rooted in stigma more than fact.

A growing number of communities are adopting civilian mobile crisis response teams; where these crisis models are in place, they find that police presence is not typically required. CAHOOTS, a team consisting of a medic and crisis worker, was established in Eugene, Oregon in 1989. A medic and crisis worker, dispatched through 911, provide immediate stabilization and support to people experiencing a mental health crisis in the community. Police back-up is available if needed, but is requested in less than 1% of cases. Many similar examples are found in *Crisis Services: Meeting Needs, Saving Lives*, a newly published best practice toolkit to "prevent and manage crises in a way that offers an immediately accessible, interconnected, effective and just continuum of crisis behavioral health services." (p.5)

A secondary reason for police involvement in mental health crisis is that only police have legal authority to involuntarily apprehend individuals and transport them to hospital under Section 28 of the *Mental Health Act*. Although the *Mental Health Act* is under review in a separate process,

it is worth noting that civilian crisis response teams can include physicians, in person or via mobile screens, who could determine whether a person in mental health crisis met the criteria for involuntary apprehension before police transport the individual to hospital. As noted by the CMHA, drawing from RCMP occurrence data, the majority of persons taken to hospital by police for assessment do not meet the criteria for involuntary admission to psychiatric care.

Crisis Line Services and Police Response
The Crisis Centre of BC answers approximately 130 calls a day from individuals in crisis. On average:

- 40% of our calls are mental health related (1.5% of involve active psychosis)
- 20% of our calls require full suicide risk assessments and safety planning
- We offer daily support to individuals with chronic mental illnesses who cycle in and out of suicidality and remain at an elevated lifetime risk of dying by suicide.
- We routinely book follow-up calls with suicidal callers to track and maintain their safety over time.
- We routinely do outreach calls on behalf of people concerned about friends or loved ones, to determine needs and conduct suicide risk assessments and safety plans/referrals.

Our experience handling calls from individuals in crisis shows both that individuals experiencing mental health crisis can be de-escalated safely in community, and that integration of police and community-based crisis services still has room for improvement.

We successfully handle 98% of calls by providing emotional support and safety planning involving the caller's natural and community supports. The remaining 2% of our calls require in-person intervention. Currently, our only option for in-person intervention is to call 911.

In the 1990s, Car 87 was available for direct referral from the Crisis Centre; when a caller was at imminent risk and required in-person crisis assessment and support, it was much easier to persuade them to accept a visit from a psychiatric nurse accompanied by a plainclothes police officer than a visit from a patrol car.

Over time, Car 87 became a closed referral through the Access and Assessment Centre, and is now most often deployed to maintain connection with individuals whose chronic mental health conditions, resulting in Car 87 having 3-day waiting periods that make responding in to real-time crisis impossible. (CBC News, Car 87 where are you? Families say Vancouver's mental health emergency team is rarely available, February 21, 2021)

When a caller is at imminent risk of suicide, or are in the process of suicide, we call 911 and police are dispatched to the scene. Although we routinely ask that the dispatched officer to

contact us for details of our suicide risk assessment, we rarely receive any contact from police during or after their interaction with callers. If we hear back from callers, we often find out that police transported them to hospital, only for the hospital to assess them as not requiring emergency care and send them home. In some cases we lose callers to suicide when we are unable to clarify key information from our suicide risk assessment to police or to the hospital, and individuals whose lives may have been saved through emergency psychiatric care are released.

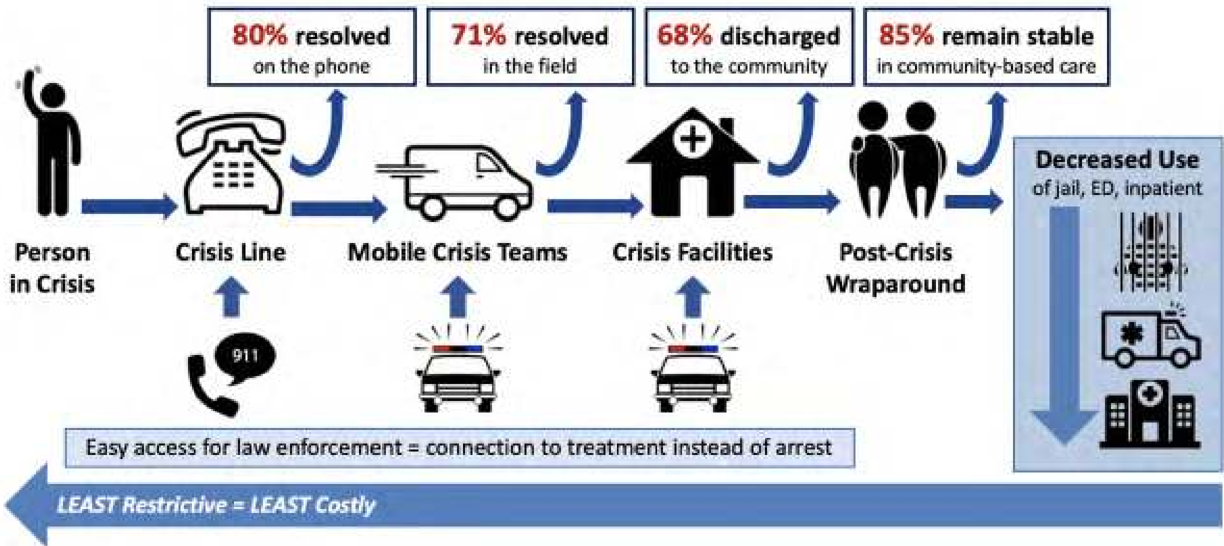
We are currently working with 911 and police agencies to create policy that will allow us to better ensure police intervention and psychiatric assessment goes smoothly, and to track how our calls for assistance were resolved. We are grateful that 911 and police are as interested in solutions as we are, and we appreciate the support of this Parliamentary Committee in reforming the *Police Act* in ways that will facilitate coordinated community-based crisis response in which police response is not the default.

RECOMMENDATIONS

Community-based crisis services like ours are collaborating actively with 911, police, and the mental health system to identify and fill service gaps. We are finding the places where the community can take the lead, places where the community and police work better together, and building relationships and policy to match.

Collaboration is not surprising, because effective policing and mental health care priorities go hand-in-hand. Best practices in mental health crisis care and policing call for a “least restrictive, lowest cost” approach, in which “healthcare and [law enforcement] stakeholders agree on a common goal of preventing avoidable jail, [emergency department], and hospital use by providing care in the **least restrictive setting that can safely meet the needs of an individual** experiencing a [behavioural health] crisis. Because less restrictive settings tend to be less costly, clinical and financial goals are aligned.” (p9)

The following figure shows the impact of a high-functioning crisis services continuum, with data drawn from the Arizona Complete Health service area. Crisis lines like ours are able to resolve 80% of crisis calls over the phone even when handling all 911 mental health calls. Mobile crisis teams are dispatched to mental health crises instead of police, and police on calls that turn out to have a mental health or crisis component can drop people in crisis at specialized crisis facilities without long waits in hospital emergency rooms.



Specific *Police Act* reforms that open pathways for a best practice community-based crisis response continuum could include:

2.2 The minister must ensure that an adequate and effective level of policing and law enforcement is maintained throughout British Columbia.

In order to ensure adequate and effective policing and law enforcement, the Ministry must have data to show how policing and law enforcement is performing related to mental health crises. If there is a crisis healthcare gap marked by police over-involvement in mental health crisis, it will appear as:

- High rates of police involvement in people accessing first-time mental health support
- High rates of arrest and/or incarceration of individuals with mental health challenges,
- High rates of police apprehending individuals for psychiatric evaluations in which the individual does not meet the criteria for hospital admission

We ask that police collect and share disposition data on the outcomes of mental health calls. Since poverty, discrimination and trauma align with mental health issues, we echo CMHA's recommendation that police forces in B.C. collect, analyze and disclose race-based and other demographic data to identify systemic issues underpinning police response to people in crisis.

2.2.1 The minister may establish priorities, goals and objectives for policing and law enforcement in British Columbia.

If you or someone you know is struggling, especially with thoughts of suicide, reach out:

- Vancouver Coastal Regional Distress Line: 604-872-3311
- Anywhere in BC: 1-800-SUICIDE: 1-800-784-2433
- Anywhere in BC: Mental Health Support Line: 310-6789
- Online Chat Service for Youth: www.YouthInBC.com (Noon to 1am)
- Online Chat Service for Adults: www.CrisisCentreChat.ca (Noon to 1am)

We ask that the minister specify priorities, goals and objectives for police collaboration with community-based crisis response services, focusing on least restrictive, lowest cost strategies that start with the input of people with lived and living experience.

2.4 Regulations respecting specialized policing and law enforcement

An advantage of the *Police Act* is it provides a route to relatively secure funding, especially compared to health funding. To the extent that police involvement in mental health crisis is unavoidable, the Lieutenant Governor of Council, on the recommendation of the minister, can regulate specialized service providers and determine how the costs of specialized service providers would be shared between the Ministry and municipalities.

Currently "Specialized Service Agreements" under Part 2, Section 4(3) are focused on criminal investigation services, traffic enforcement services, police communication services, and forensic services. If the Ministry wished to ensure behavioral health and crisis response supports were coordinated with policing within designated service areas, this section could be amended to include such supports, with regulations in place to limit the role of police officers in mental health response while providing access to alternative service agreements to support coordinated, community-based crisis response.

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REFERENCES

- Balfour, M.E., Hahn Stephenson, A., Winsky, J., & Goldman, M.L. (2020). *Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies.* Alexandria, VA: National Association of State Mental Health Program Directors. Available at: https://www.nasmhpd.org/sites/default/files/2020paper11.pdf
- Center for Addictions and Mental Health (October, 2020). *Mental Health and Criminal Justice Policy Framework.* Available at: https://www.camh.ca/-/media/files/pdfs---public-policy-submissions/camh-cj-framework-2020-pdf.pdf
- Pinals, D. A. (2020). *Crisis Services: Meeting Needs, Saving Lives.* Alexandria, VA: National Association of State Mental Health Program Directors. Available at: https://store.samhsa.gov/product/crisis-services-meeting-needs-saving-lives/PEP20-08-01-001
- CBC News. *Car 87 where are you? Families say Vancouver's mental health emergency team is rarely available*. February 21, 2021, Available at: https://www.cbc.ca/news/canada/british-columbia/bc-car-87-vancouver-mental-health-1.5919779
- Vancouver Police Department (November, 2020). *Our Community in Need: The VPD'S Community-Focused Safety Strategies.* Available at: https://vpd.ca/police/assets/pdf/reports-policies/our-community-in-need.pdf