



Integrated Mobile Crisis Response Team (IMCRT)

Review of Pairing Police with Mental Health Outreach Services

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Acronyms

C&Y	Child and Youth
CCP	Community Care Plan
CPIC	Canadian Police Information Centre
CRD	Capital Regional District
Cst.	Constable
EMHS	Emergency Mental Health Services
ER	Emergency Room
ERP	Emergency Room Physician
FOIPPA	Freedom of Information and Protection Privacy Act
IMCRT	Integrated Mobile Crisis Response Team
INSET	Integrated National Security Enforcement Team
MDT	Mobile Data Terminal (Police Computer in Patrol Vehicles)
MHA	Mental Health Act
MHAS	Mental Health and Addictions Services
PES	Psychiatric Emergency Service
PRIME	Police Records Information Management Environment
RJH	Royal Jubilee Hospital
SN	Support Nurse
SPO	Social Program Officer
VCP	Victoria Police Department
VICHI	Victoria Inner City Health Initiative
VIHA	Vancouver Island Health Authority

1 EXECUTIVE SUMMARY

The Integrated Mobile Crisis Response Team (IMCRT) represents the culmination of a community consensus building process started in 2002 related to improving efficiency and quality of mobile crisis response services in the Capital Region.

The objective of IMCRT is to combine varied front-line crisis responder elements into a more efficient, responsive, and interdisciplinary crisis response team that can attend to the full continuum of community crises irrespective of age, preponderance of addictions or mental health issues, or public safety concerns.

It is anticipated that an integrated partnership between police services and mental health and addictions services will promote diversion from acute hospital resources, enhance linkage to community service providers, and more effectively fulfill the requirements for a community-based mobile crisis response service, one of the five core components of a crisis/emergency response network cited in BC's Provincial Best Practices (1998).

Part of the initiative was to conduct a program evaluation of this integration of services. The purpose of this evaluation is to provide information about the goals, benefits, objectives, performance, and any shortcomings of pairing police with Mental Health Outreach Services to Vancouver Island Health Authority (VIHA) management and Victoria City Police (VCP). Data was collected between November 2004 and June 2005.

Key Findings

GENERAL GOALS	OUTCOMES
Increase the number of crisis calls that can be attended to in any given shift.	Crisis responders were able to attend <u>more than double</u> the amount of high acuity calls when the plain-clothes officer was on shift.
Decrease Emergency Room Wait Times.	On average, patrol officers waited 45 minutes in ER when assisted by IMCRT staff versus 121 minutes when patrol officers attended ER on their own.
Reduce the amount of time spent coordinating a joint response (e.g. communicating with dispatch, officers on scene, road supervisor, etc.) and decrease in time waiting for police assistance.	IMCRT wait times for and coordination with police is virtually eliminated when plain-clothes officer was on shift. With the IMCRT officer, response times to crisis calls are most frequently occurring within 30 minutes, versus several hours historically.
Enhanced ability to respond flexibly to fluctuations in service demand in a timely manner.	An advantage of the IMCRT officer is not being restricted when a response can occur, which results in more clients seen in a timely manner and the ability to respond flexibly to fluctuations in service demand and proportion of high acuity calls.

<p>Improve privacy/confidentiality for clients.</p>	<p>Introduction of plain-clothes police officer has resulted in positive initial feedback from other service providers and families, related to the level of intrusion.</p>
<p>More effectively address staff and public safety issues.</p>	<p>More efficient transfer of public safety related information between police and clinical staff, thereby more effectively managing risk for the public and for crisis responders.</p> <p>Clinical staff reports a marked increase in perceived safety attending to community crisis calls when the IMCRT police officer is on shift.</p>
<p>Reduced Reliance on Hospital-Based Resources.</p>	<p>Out of 1200 referrals less than 15% were directed to ER.</p> <p>This accounted for a 7.8% decrease in the use of hospital resources compared to historical data.</p>
<p>Improved Accessibility/Information Sharing</p>	<p>Police dispatch can immediately access the team via police radio.</p> <p>Patrol officers have direct contact with the IMCRT officers enhancing the ability of patrol officers to defer cases to the integrated team.</p> <p>IMCRT officers can provide patrol officers with hospital-based information on client's that can impact critical care decision-making on scene and potentially divert patrol officers from attending ER.</p>
<p>Matching the right combination of clinical/law enforcement expertise to each specific call, thereby promoting the most informed assessment and clinically appropriate disposition.</p>	<p>Data analysis reveals that the right combinations of professional staff and law enforcement are attending to crisis situations the majority of the time.</p>
<p>Raise the level of education for police officers regarding mental health issues.</p>	<p>The IMCRT officers report that they have a better understanding of mental health diagnostic criteria and behavioral interventions with the mentally disordered.</p>
<p>Respond to Inquest jury recommendations related to improved partnership between police agencies and VIHA.</p>	<p>The functional integration of plain-clothes police officers into EMHS was examined by and supported in the recommendations from two public inquests (Pagnotta 2004, Camaso 2005).</p>

2 IMCRT OVERVIEW

The Integrated Mobile Crisis Response Team (IMCRT) represents the culmination of a community consensus building process started in 2002 related to improving efficiency and quality of mobile crisis response services in the Capital Region. A development partnership was forged between Victoria City Police (Inspector Darrell McLean) and two Vancouver Island Health Authority (VIHA) programs, Access and Crisis Response Services within the Adult Mental Health and Addictions Services (Devin Lynn, Program Coordinator), and Child & Youth Mental Health within Child, Youth, and Family Health Services (Steve Lennon, Manager).

Part of the initiative was to conduct an ongoing and comprehensive program evaluation of the integration of services during the pilot stage. The purpose of this evaluation is to provide information about the goals, benefits, objectives, performance, and any shortcomings with the bridging of police services with mental health services.

The staffing for the pilot project remains within the existing VIHA budget for Access/Crisis Response and Stabilization Services. Victoria City Police (VCP) and Child and Youth (C&Y) Mental Health Services allocated a budget and/or determined staffing redeployment options for this pilot project. VCP will be responsible for 50% of wages and benefits to field a police officer during the pilot project period. The remainder of wages and benefits funding for the police officer will be paid by VIHA.

The Victoria Police Department will outfit police officers with all necessary equipment to fulfill their role (e.g. radio, plain-clothes allowance, access to police records, firearm, handcuffs, gloves, etc.)

Two dedicated vehicles are available to the team, a new Van provided by the Victoria Hospital Foundation, and an existing sedan provided by VIHA. A third VIHA vehicle is available as necessary. The team is stationed out of the new Archie Courtnall Centre Psychiatric Emergency Service (PES), located adjacent to the Medical Emergency Room (ER) at the Royal Jubilee Hospital (RJH), opened to clients with psychiatric and addiction emergencies on October 19, 2004.

The IMCRT service operates seven days a week, 365 days a year. With a focus on adult outreach, two clinicians, a nurse and a social program officer (SPO) work between 13:00 hours and midnight. There are four full time clinicians on the adult team and shifts rotate 5 days on 5 days off. Each day of the week a support nurse (SN) functions in the role of providing support and stabilization to registered clients of VIHA mental health outpatient programs between 14:00 and 22:00 hours. Two police officers have been seconded from VCP. The police officers work back to back on a four-day rotation working between noon and midnight. Re-allocation of two C&Y staff members from C&Y Mental Health Services completes the team. A C&Y clinician rotates on a five-day schedule between 11:00 and 22:00 hours.

Each police officer and clinician will be responsible for maintaining the professional standards of his or her discipline, and adhering to the provisions of relevant Criminal and Mental Health Act legislation.

Police officers and clinicians will be responsible for maintaining privacy of clients in accordance with respective British Columbia Freedom Of Information and Protection of Privacy Act (FOIPPA) policies.

Regional Police representatives and those from VIHA were asked to enter into a Letter of Understanding regarding the issue of information sharing between members of IMCRT.

A Task Group will be formed to oversee the operational development and evaluation of the pilot project and 2005/06 implementation, including representatives from police services, VIHA MHAS and C&Y Services, and community partners.

The services provided by IMCRT include:

- Telephone triage, consultation, and alert posting.
- Face-to-face emergency psychiatric assessment of the individual and the biopsychosocial context within which the problem has emerged (Best Practices for Crisis/Emergency Response, 1998, p. 19).
- Same-day crisis intervention and short-term outreach stabilization/support until other longer-term urgent follow-up services can be accessed.
- Urgent linkage with other service providers in the community, to facilitate options for service that preserve to the greatest extent the person's sense of autonomy (includes case conferences).
- Education to clients and families regarding mental health and addictions issues and resources, and identification of gaps in service.
- Facilitate transport and admission to hospital when appropriate.
- Assist police in making decisions around provisions for involuntary conveyance and committal under the Mental Health Act (MHA), Section 28.
- Peer and volunteer support; working closely with consumers to establish consumer support programs, and with crisis line and other volunteers to provide basic support and information post-crisis.
- Clinician(s) and police officer response when information received suggests a significant danger to self and/or others or gross disorganization. Two-clinician response when information received suggests no imminent danger to self and/or others.
- Psychiatrist on-call consultation and regular weekly case review time available to crisis responders.
- Facilitate Mental Health Act (Form 21, Form4) conveyances on those referred from Eric Martin Pavilion, Mental Health Services (Children/Youth and Adult), and family physicians.
- Follow-up on patrol officer interventions from the various police departments (patrol officers would request that the IMCRT plain-clothes officer would follow-up with assessment and/or confirmation of disposition and safety).

3 FEEDBACK FROM IMCRT POLICE OFFICERS

The two IMCRT police officers, Constables Matt Waterman and Greg Holmes, provided feedback regarding their experiences working alongside mental health clinicians and within mental health services.

3.1 Questionnaire

Cst. Holmes provided answers to a number of questions regarding the benefits and contributions the IMCRT police officers bring to mental health services.

3.1.1 What is the impact on the public/clients having IMCRT attend in the company of a plain-clothes officer?

The ability to have plain clothes police officers attend with IMCRT clinicians allows the team to respond to critical psychiatric emergencies while respecting and maintaining the dignity of both the client and the family member who may be involved. Many times the officer is never identified; therefore, the potential for escalation in the individual's behavior is minimized.

IMCRT clinicians have stated that when the officers have been present in plain clothes it appears to be a more stress free environment for them to perform a thorough assessment of the individual. In some cases having uniformed members present has lead to some clients showing signs of stress and anxiety. IMCRT clinicians have stated that they are relieved to work in an environment that is less intrusive which enhances the opportunity for the mental health examination to be precise and thorough.

***Example:** Family members of a client whom they were quite concerned about contacted IMCRT. This client was dealing with depression and talking of suicide with family. When IMCRT, including the plain-clothes officer arrived at the client's residence, she would not allow them into the suite. Finally with assistance of family the team was able to conduct an examination and actually get into the client's suite. On the way to the hospital the client told the officer how relieved she was that IMCRT did respond with a plain-clothes officer and that she felt she was dealt with respect and was allowed her to keep her dignity in a very embarrassing moment in her life.*

3.1.2 What contribution does the police officer add to the IMCRT team?

- Knowledge of policing and a thorough understanding of both the Criminal Code and Mental Health Act.
- Information sharing. Critical information that may be required to conduct a proper and complete triage of a client.
- Clinicians feel safer having the IMCRT police officer with them. Occasionally, prior to the integration of the new team, clinicians were nervous when conducting assessments with clients, as they never knew if the interview might take a turn for the worse resulting in an unsafe environment or possibly an assault occurring.
- IMCRT officers are able to fill in some of the gaps in information to community supports that IMCRT clinicians may not be able to explain.

Example: IMCRT received information from Victoria Mental Health Centre (VMHC) regarding a client who was in the early stages of diagnosis for schizophrenia. Information was that the client was very concerned that the police were going to come to his house and take him away. The client's family stated that he had become obsessed with studying police tactics and "warfare" on the Internet. The client wanted to be prepared for when the police came to get him. Additional information revealed that the client was going to apply for a firearms license so that he would be able to buy a firearm.

Cst. Holmes worked with the client's case manager and was able to contact the police agency in the client's jurisdiction. The client was entered on the PRIME system with a hazard file attached. This enables police officers that may attend the residence to be prepared. Cst. Holmes was also able to contact the area firearms officer with the information to ensure that the client would not be eligible to acquire a firearm license. This sharing of information would probably have not occurred without the initiative of the IMCRT officer.

3.1.3 What benefits have you seen from your experience with IMCRT in terms of personal learning?

- Better understanding of mental health diagnostic criteria and behavioral interventions with the mentally disordered.
- Mental Health examination and how it applies to different mental illnesses. The ability, through experience, for the EMHS officer to contribute with the examination.
- Working with a team of non-police personnel in triaging and prioritizing crisis calls. Conducting risk assessments for both clinicians and the client.
- A thorough understanding of the Mental Health System.
- Increased knowledge of community based programs.

Over a short period of time Cst. Holmes has learned that persons who suffer from some mental illnesses deal with suicidal thoughts as a day-to-day symptom of their illness. Some of those individuals often cut themselves in an attempt to reduce anxieties and often it is for relief from distressing emotions and not an attempt to kill him or herself.

Police often receive calls from the Need Crisis Line or families stating that the client is suicidal and have cut him or herself. Historically police will arrive on scene with the pre-conceived thought that this individual will have to go to hospital as they have attempted suicide. Cst. Holmes believes that this would be an appropriate example of how police and police managers can be educated so that hospitalization is not the first course of action for these persons. If police had a better understanding of these illnesses the amount of time required by the police would be reduced immensely.

3.1.4 What are the general benefits to policing?

- The IMCRT police officer has the ability to make informed decisions with regards to mental health calls.
- Up to date information provided by the IMCRT police officer on local community supports that can assist police members with investigations.
- Decrease in the time uniformed members are required for mental health calls.

- Educating police on effective strategies for dealing with clients, i.e., community care plans, the mental health system, and specific information re: certain diagnosis. Sharing the IMCRT police officer's experiences and knowledge with police agencies and police officers.
- Assisting uniformed members with hospital wait times.
- The IMCRT police officer has the ability to monitor various police radio frequencies and police calls on the Mobile Data Terminal (MDT- police computer). The IMCRT police officer has been a vital liaison for CRD police agencies that were investigating the same mental health call.
- To be able to assist uniformed members with a file where they request intervention by IMCRT. At the conclusion of the assessment the IMCRT police officer is able to create a follow-up report as to the conclusion of the assessment. This allows the primary investigator to conclude his/her file completely and thoroughly. The IMCRT police officer often leaves a follow-up voice mail as well.

Example: Cst. Holmes was monitoring the MDT calls when he observed Saanich Police investigating a missing person file, which involved a mentally challenged male who had left his residence and failed to return. Later Cst. Holmes was monitoring the West Shore RCMP radio frequency and heard an officer attending a call for a suspicious male in their jurisdiction. When the member requested a CPIC check of the male, the name matched the individual involved with the Saanich file. Cst. Holmes was able to contact the RCMP member and advise him of the Missing Persons file. **Cst Holmes feels that he significantly reduced the time that the patrol officers would have spent on this file if he had not been able to liaison with the two agencies.**

Example: Cst. Holmes was starting his shift at the Victoria Police Department when Cst. S. Hamilton advised him of a file she was investigating. Hamilton stated that she thought there might be some mental health issues and was looking for some assistance. When Cst. Holmes arrived at the IMCRT office he observed the name of the person who was the primary subject of Cst. Hamilton's investigation listed as an alert. This client had similar calls in the community over the past few days. IMCRT went to the client's residence and was able to conduct a mental health examination and determine that in fact he was suffering from the effects of his illness. The client was taken to hospital and seen by the on call psychiatrist. Cst. Holmes then forwarded the outcome of the IMCRT assessment to Cst. Hamilton who was therefore able to conclude her file without having to continue her investigation or make a formal request to have IMCRT check on the client.

In addition to the above examples, police officer Cst. Andy Stuart sent the following email to Cst. Holmes as transcribed below:

"Greg,

Just wanted to pass along my thanks for attending on some of my MHA files over the last few months.

It is a much more efficient way of dealing with MHA files, where the person has not met the requirements of Sec. 28 but are definitely in need of some attention/evaluation. The time saved by having IMCRT, along with a police member is huge. As you know, before we were always attending for assist files. One of the other benefits is being able to leave a message, have IMCRT attend, and then come

back to work the next day and see an occurrence report on my file and subsequently conclude it. I think that the knowledge sharing is important as we now have a link between the police and mental health.

Thanks again,

Andy.”

3.1.5 Would you like to see IMCRT continue?

Emergency Mental Health Services has recently undergone changes that appear to reflect the future of Mental Health and Police working together to provide a complete service that is safe for the public as well as clinicians. The addition of plainclothes police officers and a child/youth clinician has resulted in better service for the public.

EMHS clearly benefits from having both a plain clothed police officer and a child/youth clinician attached to the team. The integration of the new team has only improved the quality of service that it provides to both the community as well as area police agencies.

The integrated EMHS team provides police with the necessary support and information to remain both professional and thorough when dealing with mental health issues in the community. Police calls for service and costs have been reduced in the short time the program has been fully operational.

Future educational opportunities that the team can provide the community police agencies will only enhance the service provided and further cuts to the amount of time uniformed members are spending on mental health calls. The new IMCRT team has proven itself worth on a daily basis.

3.2 Special Duties and “A Day in the Life”

3.2.1 Special Duties Outside of Regular Activities

Cst. Matt Waterman provided examples of situations that arise outside of the normal activities related to assessing persons in the community who are in psychiatric crisis. The following two vignettes were provided by Cst. Waterman as examples of the type of work being done on a regular basis by the IMCRT officers.

01 June 2005 – Community Care Plan

Cst. Waterman met with C&Y, Ministry of Children and Families and Balmoral House Coordinator on this date to discuss a Community Care Plan (CCP) for a difficult female youth who was expected to return to Victoria after a brief time in custody in Vancouver.

Part of the CCP included protocols for when the youth acts out and requires the police attendance to the group home. Cst. Waterman offered to assist with having the CCP distributed around the Greater Victoria area in order for all police agencies to be aware of the CPP. Cst. Waterman also contacted the Prime system coordinator to have the plan readily accessible through the MDT's in each police vehicle. After distributing the

CCP by email that very evening resulted in Saanich Police having to attend the group home and activating the CCP. Cst. Waterman was also able to consult with the attending officers by telephone.

13 June 2005 – Hospital Follow-Up

An assessment of a male presenting with psychosis secondary to crystal methamphetamine misuse resulted in the disposition of the IMCRT leaving the male with his family at home. The following day Cst. Waterman was going through the Emergency Room at RJH and saw the male's family in the waiting room. Cst. Waterman approached and learned that they were able to convince the client to come to the hospital for a blood test.

Cst. Waterman immediately determined who the Emergency Room Physician (ERP) was handling the case and obtained the written IMCRT assessment from the Mental Health Database. Cst. Waterman then approached the ERP and conveyed both IMCRT's findings and those of Car 87 (Mental Health Outreach) from Vancouver.

It turned out that the ERP was considering utilizing the Mental Health Act to hold the male and was very thankful for the additional information. In the end, the client was admitted to EMP on an involuntary basis for further assessment and treatment for ten days. The client is now residing in Winnipeg with his family and maintaining abstinence from illicit substances.

3.2.2 “A Day in the Life” of an IMCRT Officer

Cst. Waterman recorded his activity over a typical three-day work period, which provides some of the many examples of improved communications between Mental Health and other agencies.

27 June 2005

1100 hrs.

Cst. Waterman was invited to speak at the Queen Alexander Hospital to the “Complex Care Workshop” which focuses on Geriatric Psychiatry and for facilities that house residents with Mental Disorders or Addictions. They wanted to know about “what to expect” when the police arrive (in uniform or plain clothes). It was apparent that more and more care facilities are finding themselves un-prepared to deal with residents with serious psychiatric and addiction problems. The focus of the lecture was to provide education to the staff on what signs to look for prior to “all hell breaking loose”.

Feedback from the workshop questionnaire provided a sense that staff were very appreciative of the police perspective and the information provided to them about the option of IMCRT.

1300 hrs.

Cst. Law of Victoria Police requested advice regarding a male being housed at Glengarry Hospital who has a Community Care Plan in place. The reason police were called was because of the client acting out within the facility.

Cst. Law's concern was that “police” were included in this CCP, however, were not consulted on the plan development and that improper expectations might have been

given to staff. It was discussed with her to speak with staff at the hospital and attempt to have police properly consulted with plan development in the future and to outline what police are able to do according to the law.

1500 hrs.

Sgt. Wickes of the Victoria Police Internal Investigation Section contacted writer to request participation in a meeting with a father making a complaint to the police department regarding the handling of his son, who suffers from Schizophrenia, during a recent arrest. He was very concerned that police are not properly trained to deal with persons with Schizophrenia.

Cst. Waterman attended the meeting and provided an overview of how IMCRT operates and how the communication between Mental Health and Police is improving. The father of the male was thankful for the opportunity to speak with a front line officer who understands the Mental Health System and now seems more comfortable with both the Police and Mental Health. The involvement of the IMCRT officer helped to satisfy the father that police are sensitive to the proper treatment of persons in the community suffering from mental disorders.

28 June 2005

1330 hrs.

Cst. Sorenson from the Integrated National Security Enforcement Team (INSET) contacted IMCRT to advise that he was dealing with an investigation where the suspect had made death threats against the Prime Minister. This male is listed on the police database numerous times with some indication that he may suffer from a mental disorder.

Cst. Sorenson's information was sufficient enough to warrant the assistance of IMCRT and to continue the investigation from a mental health angle rather than dealing with the male as a National security threat and criminal. This incident makes the point of it being possible to quickly exchange information on an individual and more effectively deal with the situation.

1430 hrs.

The Archie Courtall Centre Social Worker approached the IMCRT police officer prior to the release of a patient to the community who had been brought in after making threats towards another person. The treating psychiatrist was concerned for the safety of a person in the community if he released this patient and couldn't confirm if the two individuals knew each other.

The hospital staff did not have records of either individual that would indicate whether a history for violence was indicated. Through Police records it could be determined that the male in question was known to the police but that he had no serious violence background. Based on the available information the psychiatrist was able to release the male back into the community with some comfort that neither male's safety was in jeopardy.

2000 hrs.

Victoria Police contacted IMCRT to consult on a well-known male who had just been released from PES earlier in the day. This male was found down in the Inner Harbour

area with no clothes on and jumping into the water. The question was how the police best could deal with this individual, recognizing that he was likely not going to be re-admitted into the hospital system.

It was determined that the Mental Health Social Worker had acquired some housing for this individual prior to his release into the community. Police were then able to contact that location and confirm his bed availability; he was held in cells for a few hours and delivered to his pre-arranged housing for the remainder of the night. This ability to communicate between all the different agencies made the resolution much smoother and reduced a number of improper steps in the treatment and care of the male.

28 June 2005

1100 hrs.

Cst. Waterman had been in contact with Saanich Police training staff about the implementation of the Camaso Inquest Recommendations. Cst. Waterman arranged a meeting with SPD training, VCP training and the IMCRT coordinator to discuss the implementation of one recommendation that surrounded the idea of police recruits being exposed to the Mental Health System for one 4 day block of training.

Cst. Waterman was able to explain to both training sections, from a police perspective, the experience of conducting an orientation shift with one Victoria Recruit earlier this year. Points were made to show that this type of training/orientation may not be best suited for the Block II portion of their training. However, some other plans were made to reduce the amount of exposure time during Block II and to include some classroom time as well for a better understanding of the new IMCRT team.

It will be a significant part of the EMHS Officer's role in the future to assist with how best to deliver the training to recruits returning from the Police Academy.

1700 hrs.

Sgt. Sawyer of the Victoria Police Detective Section contacted IMCRT to request assistance locating a female believed to be staying in EMP. Sgt. Sawyer is investigating a Missing Persons file where the patient was believed to be a close friend of the victim and may be able to provide details important to the investigation.

Sgt. Sawyer was provided with the name and phone number of the nurse in the ward responsible for the patient to better identify when it would be most appropriate to speak with the patient. This approach could likely reduce any distress of the patient and increase the chances of a positive resolution. Sgt. Sawyer's personal knowledge of the members attached to the team made that connection very smooth.

4 FEEDBACK FROM PROFESSIONALS AND THE PUBLIC

This section of the report provides comments from professionals and family members regarding the blending of the IMCRT police officers with Mental Health Services.

4.1.1 Feedback from Professionals Working in Mental Health

1) A case manager provided the following vignette:

I would like to extend my appreciation for the recent assistance provided to me by one of your police liaison members, Constable Greg Holmes. I recently had an early psychosis patient who was experiencing violent thoughts and was discussing with his family that he was planning on purchasing a gun on his 19th birthday, he was also carrying a knife on him at all times. I put this information and the plans the psychiatrist and I had for the treatment of this young man on the Mental Health Database with an alert to IMCRT in case they were called to respond at the patient's home.

In his liaison role Cst. Holmes was not only able to discuss this case as an IMCRT team member, but he was also able to give me valuable information on specific interventions I could put in place at the police end to assist them if they were called to respond to an incident at the patient's residence. Specifically, that on my recommendation, the patient could be flagged as potentially dangerous to police because of his weapons and because of his violent thoughts entailing plans for a "fall back" war which usually consists of engagement between one individual and the police.

I was also able to have the gun license in firearms branch flagged so he would be prevented from being issued a license to purchase a firearm. These were positive prevention measures that have and will in the future assist in the recovery of this young man's mental health, which I would not have been aware of in my role as a nurse. I would like to thank Cst. Holmes for his caring and supportive approach to assist me in providing the best care possible to this very ill and difficult to manage young man.

2) Two situations involving physicians issuing Form 4, Medical Certificate, Mental Health Act certificates demonstrated the efficiency of the IMCRT officer being able to assist in transporting client's to hospital and preventing patrol services from being tied up in lengthy mental health calls. The physicians expressed their gratitude regarding the least intrusive approach been taken to provide care to their patients.

In the first case a GP in the Sidney area initially contacted RCMP to transport his patient to hospital under the Mental Health Act. The RCMP did not have the resources at the time of the request, and suggested ambulance as an alternate resource. The GP was concerned regarding the client's potential from eloping from the ER and preferred that police be involved. The team attended the call including the police officer and the client was transported to ER in the team's van. **Ultimately, the RCMP did not need to be involved and were saved the time of transporting the client and waiting in ER.**

In the second case a Mental Health Certificate was issued on a 99-year-old male in the Saanich area. The team attended and brought the client to ER in the team's van. **Saanich Police were not involved and due to the wait on the medical side of the ER (the client needed to be medically cleared first), Saanich Police would have been detained for some time, but due to the team's officer on shift, Saanich Police had no investment of time at all.**

3) A new hire to the IMCRT team wrote the following observations:

Being a new clinician to the IMCRT team, I have had the opportunity to work with the IMCRT police officer and uniformed police during emergency calls. During this time, I have noticed differences pending on the type of police response in the clinician's ability to complete thorough psychiatric and risk assessments, provide support and advocacy for clients, support to family members involved in the emergency and clinical follow-up.

When working with uniformed police, the thoroughness of an assessment is sometimes dependent upon time: time that an officer can spend at the assessment, time they can spend in the hospital until the client is certified and medically cleared, time away performing other police duties, to shift-change schedules. These factors, in addition to not being able to work with specially trained mental health police officers can negatively impact the outcomes that we hope to achieve with involvement from IMCRT.

Time is a factoring in ensuring a positive outcome during an emergency response for a client. When time is spent with a client there is an increased openness about the problems they are having difficulties in coping with and clinicians are able to conduct thorough assessment. Clinicians are better able to advocate and provide support and follow-up care for clients, whether that be through hospital or contact with community supports.

Often mental health interventions require the support of the police and with plain-clothed police officers that are trained in mental health emergency situations outcomes for clients, clinicians and police officers are increasingly more positive and conducive to providing safe and thorough assessments that respect the rights of all clients.

4.1.2 Feedback from Family Members

The following are quotes submitted by family members in response to a Program Satisfaction Questionnaire currently being circulated with a specific focus on the addition of the police officers:

- “We very much appreciated the sensitivity and knowledge of the police and mental health workers who responded to our son’s pre-manic condition. The team’s thoroughness in checking the situation out, and following it through, probably averted a larger problem from developing. Our son felt he was treated with respect, which was very important to him. Thank you. This program is a valuable support for families of those with chronic mental health disorders.”
- “I was very surprised & grateful at the efficiency as to how the team worked. It is just unfortunate that the rest of the public isn’t aware of this service and you become more appreciative when you are affected. Too bad as parents we wait to long to react but thanks to the team for being there.”
- “Professional, considerate team who clearly explains their purpose to clients and takes least-intrusive approach.”
- “I have worked with this team on a professional level & personal level. On both levels this team meets & sometimes exceeds expectation. My only criticism is the need for more teams similar to this one for mental health & other crisis situations in the community.”
- “Only thing missing: full time police on board.”

5 STATISTICAL REVIEW

5.1 Increased Availability to Respond to Crisis Calls

The introduction of a plain-clothed police officer on the team had the anticipated outcome of an increase in the number of crisis calls that can be attended to on any given shift.

With the pairing of police and clinicians the amount of time spent coordinating a joint response between clinicians and patrol officers (e.g. communicating with dispatch, officers on-scene, road supervisor, etc.) is eliminated. **Further, clinicians did not need to wait on average 30 minutes and sometimes up to several hours per call for patrol officer assistance to arrive on scene, when the IMCRT police officer was available.** The time saved translates into more calls attended to during a shift.

The table below illustrates the utilization of the IMCRT police officer between December 2004 and June 2005, utilization of patrol officers when the IMCRT officer was not available, and the acuity level of calls that were attended to.

IMCRT Police Officer vs. Patrol Officer Utilization

Officer Category	Number of Calls (n = 259)	Acuity of Calls		
		High Risk	Medium Risk	Low Risk
IMCRT Officer	200 (77.2%)	112 (43.3%)	77(29.7%)	11 (4.2%)
Patrol Officer	59 (22.8%)	45 (17.4%)	12 (4.6%)	2 (0.8%)

Data analysis revealed that the number of high-risk calls that clinicians were able to attend over the period was **over double** when the IMCRT police officer was available versus utilizing patrol officers. Additionally, the IMCRT police officer was able to join clinicians on medium risk calls considerably more often than patrol officers, 29.7% versus 4.6% respectively.

The types of responses IMCRT provides includes face-to-face assessments, one-to-one support visits or telephone calls, medication visits or telephone calls, third party consultations, alert taking, and community liaison.

The IMCRT officers were available 53 (42.8%) days and unavailable 71 (57.2%) days during the study period between March and June 2005. The frequencies of the types of response were observed when the IMCRT officer was available vs. unavailable.

Spearman's correlation was utilized to assess the significance of relationships between IMCRT officer availability and response types as reflected by cross-tabulation cell count frequencies being different from expected counts. Analysis revealed a significant relationship between whether the officer was available or unavailable and frequency of response types as reflected by cell count frequencies being different from expected

counts ($r_s(631) = .17, p < .001$). The table below illustrates the cross-tabulations for response types including counts and expected counts.

Response Type Frequencies Concerning IMCRT Officer Availability (n = 631)

Response Types	IMCRT Officer		Total
	Available	Unavailable	
Face-to-Face Assessments	135 (107.5)	119 (146.5)	254
One-to-One Support Visit/Call	33 (45.3)	74 (61.7)	107
Medication Visit/Call	8 (8.5)	12 (11.5)	20
3 rd Party Consult	81 (82.1)	113 (111.9)	194
Alert Only	10 (14.7)	25 (20.2)	35
Community Liaison	0 (8.9)	21 (18.8)	21
Total	267 (267)	364 (364)	631

Note. The numbers without brackets are the counts and the numbers within brackets are the expected counts.

Data analysis suggests that IMCRT clinicians attend more face-to-face calls when the IMCRT officer is available. Alternatively when the IMCRT police officer is not available clinicians spend more time providing support visits/calls, 3rd party consults, and community liaison. **Therefore, it is hypothesized that when the IMCRT officer is available, patrol officers are utilized less to respond to face-to-face mental health calls.**

5.2 Timeliness of Response

A goal of IMCRT service delivery is to provide a timely response to individuals experiencing a mental health crisis. Clinicians were requested to note the time a referral came in and the time it took to arrive on scene for high acuity calls.

Data analysis of 66 recorded response times yielded an **average response time of 2.1 hours**, with a median time of 67 minutes, and the **most frequently occurring response time being 30 minutes**.

In comparison, an evaluation of the Newcastle upon Tyne emergency response service by Tacchi, Joseph, and Scott (2003) concluded that the majority of people who were assessed “were seen in their own home within 2 hours.”

Patrol officers are often not readily available around shift change, between 17:00 and 19:00 hours, or towards midnight when workload increases for patrol officers. This can delay response until later into the evening and thereby either reduces the amount of calls attended to in a day, incurring overtime costs if calls cannot be left until the next day, or worse leaving high-risk calls until the next day. **An advantage of the IMCRT officer is not being restricted when a response can occur, which results in more clients seen in a timely manner and the ability to respond flexibly to fluctuations in service demand and proportion of high acuity calls.**

A case example regarding timeliness of response occurred when a Street Shelter called at 23:30 hours concerned about a guest who was presenting with subtle signs and symptoms of psychosis. Database records revealed the client had a history of violence

when ill. The client was asleep at the time of the call and therefore it was decided the team would see the person the next day after the shift started at 13:00 hours. There is always concern leaving a potentially high-risk situation over until the next day. The next day clinicians learned that police had stopped the client on the street considering he fit the description for a person they were looking for. The client was not the person police were looking for, but in the course of running his name on the police system it was discovered that he had eloped from a psychiatric hospital from the Interior of BC and a Warrant B, MHA, certificate had been issued. Police, acting on the Warrant, took the client to RJH ER. Had the IMCRT officer had been available, and run the client on the police system, the Warrant would have been known about, and IMCRT clinicians/police officer would have attended the Street Shelter at the time of the call and transported the client to hospital.

5.3 Emergency Room Wait Times

The time to triage patients at the emergency room (ER) was compared between two groups a) patrol officers with IMCRT staff and b) patrol officers attending alone.

Data analysis revealed that patrol officers with IMCRT staff assistance had significantly lower ER wait times ($M = 45.50$, $SD = 15.20$) than patrol officers attending ER on their own ($M = 121.10$, $SD = 66.49$), $t(29) = -6.69$, $p < .001$.

On average, patrol officers waited 45 minutes in ER when assisted by IMCRT clinicians versus 121 minutes when patrol officers attended ER on their own.

5.4 Emergency Room Disposition

Emergency psychiatric teams have demonstrated that efficient, well-run services, can reduce unnecessary inpatient admissions and lead to a more efficient use of hospital beds (Kates, Eaman, Santone, Didemus, Steiner, & Craven, 1996).

During the pilot phase of this study between November 2004 and June 2005 **IMCRT managed 1200 psychiatric referrals and less than 15% of these referrals were directed to the hospital emergency room.**

5.5 CRD Geographical Representation of Calls

The team is able to respond to individuals residing in any area of the CRD district, including Greater Victoria/Esquimalt, Oak Bay, Saanich, Central Saanich, Sidney, Westshore, and Sooke.

The table on the next page represents the frequency of face-to-face calls attended to between March and June 2005 by jurisdictions.

Geographical Frequency of Calls (n = 202)

Location	Frequency	Percent
Victoria/Esquimalt	120	59.4%
Saanich	53	26.2%
RCMP (Sooke, Westshore, Sidney)	4, 17, 2	11.4%
Central Saanich, Oak Bay	2, 4	3.0%
Totals	202	100.0%

5.6 Estimated Cost for Police Response to Mental Health Issues

It is difficult to quantify the number of calls that the individual police departments in the CRD receive which involve people with mental illnesses because of inconsistent and inadequate data recording systems. For example, calls best recorded as mental health related may be entered as “public mischief” if a mentally disturbed individual is causing a disturbance in a public place.

Estimates in the literature suggest that 7-15% of police calls involve people with mental illnesses (Holley & Arboleda-Florez, 1988; Teplin & Pruett, 1992; Borum, Deane, Steadman & Morrissey, 1998). According to Cotton (2004) data from the London (Ontario) Police Service suggest that in 2001 approximately 2.4 to 5.8% of the total budget was utilized handling mental health calls.

Utilizing the above percentages one could estimate that Victoria Police spent between \$685,944 and \$1,657,698 in 2004 and Saanich Police spent between \$430,351 and \$1,040,016 in 2003 doing work that in part or in whole could have been done by IMCRT.

Efficiency of pairing patrol officers with mental health clinicians can be evaluated by comparing the cost per case for regular police services versus the pairing of patrol officers with IMCRT clinicians. Average police officer salaries were multiplied by the average amount of time required per face-to-face intervention (including ER wait times). **Data analysis suggested that the average cost per case was \$300.00 for situations handled by regular police intervention versus \$190.00 per case when IMCRT clinicians were paired with patrol officers.**

5.7 Delegation of Disciplines

Matching the right combination of clinical/law enforcement expertise to each specific call is a key goal of IMCRT, thereby promoting the most informed assessment and clinically appropriate disposition. The table on the next page illustrates the division of disciplines for adult, support nurse, and C&Y calls involving client intervention, follow-up, and third party consultation.

IMCRT Division of Disciplines

Discipline	Adult Calls (n = 202)	SN Calls (n = 191)	C&Y Calls (n = 160)
Social Program Officer	139* (67.8%)**	n/a	n/a
Adult Nurse	155 (75.6%)	n/a	n/a
Police Officer (half-time)	61 (29.8%)	9 (4.5%)	6 (3.4%)
C&Y Clinician	n/a	n/a	157 (88.2%)
Support Nurse	n/a	186 (92.5%)	n/a

*Number represents the frequency of calls. **Number in brackets represents the percent. Note percentages in columns are not intended to add to 100 as calls may have involved more than one discipline.

Data analysis revealed that the Social Program Officer 67.8% of the time was involved in adult calls, and on other calls provided assistance to the SN or C&Y clinician. The adult nurse 75.6% of the time responded to adult calls, and on other calls provided assistance to the SN or C&Y clinician.

The police officer was utilized on 29.8% of adult calls, 4.5% of SN calls, and 3.4% of C&Y calls. Note, the police officer was only available to the team on a half-time basis during this phase of the evaluation.

A C&Y clinician 88.2% of the time attended to C&Y calls, and otherwise provided assistance to adult and support nurse calls. The support nurse 92.5% of the time attended to SN calls, and otherwise provided assistance to adult and C&Y calls.

The results suggest that the right combination of clinical/law enforcement expertise to each specific call is achieved the majority of the time.

6 CORONER’S INQUEST RECOMMENDATIONS/RESPONSE

During February, 2005 Devin Lynn, IMCRT coordinator and Matt Waterman, IMCRT police officer testified at an inquest investigating the police shooting of a mental health client, Majencio Camaso. In response to recommendations made by the inquest jury specific to mental health related matters, Devin Lynn addressed the recommendations as follows on July 13, 2005:

“We recommend that if the Emergency Mental Health Services pilot project meets its objectives that it be expanded to a 24 hour, 7 day a week program to service all police agencies within the jurisdiction of the Vancouver Island Health Authority’s Capital Health Region.”

The Integrated Mobile Crisis Response Team (IMCRT) project was conceptually developed in 2002 as an evolution of the existing Emergency Mental Health Services (EMHS) based on the award-winning COAST model from Hamilton Ontario, and entered a 6-month pilot project in November 2004. The project was extended to a 12-month pilot project ending in December 2005 and has functionally integrated plain-clothes Victoria Police Department officers and child & youth clinicians into the existing Emergency Mental Health Services (EMHS), creating an interdisciplinary team that responds to all ages of clients and families in crisis.

The initial 3-month evaluation highlighted several key qualitative and efficiency related service improvements suggestive that the project is meeting defined “best practices” objectives, and the project continues to be strongly supported by VIHA and the Victoria Police Department.

Outcomes included improved accessibility to the program, reduced proportion of cases involving hospital resources, significant increase in interventions with children/youth, increase in high acuity calls responded to, improved timeliness of response, and less intrusive interventions that help protect confidentiality of clients/families and provide a less overt police presence. Recommendations from this evaluation specific to police included continued attendance by EMHS officers/clinicians at police watch briefings, relief coverage for police officers on vacation, and protocols for dispatch to inform EMHS officers of any pending or active mental health related calls.

A 6-month evaluation is currently being completed, with plans to forward the findings to the Area Chiefs of Police and VIHA leadership in September 2005. Current funding allows for a team that operates between 1300 hours and midnight every day, and pilot project funding for police officer salaries was shared equally between the Victoria Police Department and VIHA Child, Youth and Family Mental Health Services. Ongoing operational funding beyond 2005 would require service agreements with the area police forces, and expansion of hours would require additional funding for both clinical and police components of the team.

“We recommend formalization of communications within Greater Victoria police jurisdictions, to include Municipal and RCMP, in order to ensure increased awareness of mental health issues and the services and benefits provided by the Emergency Mental Health Services team.”

Emergency Mental Health Services (EMHS) has engaged in ongoing liaison with regional police forces, and these activities to assist police in awareness of mental health issues and the services of the team have on occasion facilitated discussion between municipal and RCMP police forces. Liaison activities have included the following:

- Victoria Police liaison with designated officer – Sgt. Derek Chow and more recently Inspector Darrell McLean.
- Saanich Police liaison with designated officer – Sgt. Bob Wall, Sgt. Mike Irwin, and recently Sgt. Gary Schenk.
- Intermittent contact with other police forces (e.g. 2003 stats collaboration on identifying number of mental health calls by jurisdiction, presentation to area Police Chiefs on the concept of an Integrated Mobile Crisis Response Team in 2004, Pilot Project announcement in November 2004 initiated by Victoria

- Police Inspector McLean to counterparts in other jurisdictions and to communications staff).
- 2004/2005 attendance at police shift changes. EMHS Constables Matt Waterman and Greg Holmes have facilitated team attendance at several police shift changes, including Victoria Police, Saanich Police, Westshore RCMP, and Central Saanich Police. Constables Waterman and Holmes have also set-up liaison contacts with other police forces with ongoing efforts to attend watch briefings for all police departments. Feedback on our new pilot project is being actively solicited from patrol officers making use of the team.
 - 2005 Presentation to area Police Chiefs. Victoria Police Inspector Darrell McLean, EMHS Coordinator Devin Lynn, and EMHS Const. Matt Waterman presented to the area Police Chiefs on the progress of the integrated team, securing an extension of support for EMHS police officers to operate regionally until Dec. 31st 2005.
 - Designation of EMHS on police radio as "Sierra 28" and as such accessible directly to all first responders.
 - July 2005 Presentation to Regional Diversity Committee, consisting of several police representatives from various jurisdictions.
 - June 2005 presentation to Saanich police communications staff by EMHS Coordinator Devin Lynn on access to the integrated team.

"We recommend every municipal police recruit spend one shift during Block 2 field training with Emergency Mental Health Services Team and that this opportunity be extended to members of the Greater Victoria RCMP."

Although this recommendation is not formally addressed to VIHA, it does have implications for impact on EMHS shifts and it does relate to ongoing training initiatives involving police and EMHS.

Ride-along agreements have been forged between EMHS and Saanich/Victoria Police Departments, allowing for new recruits to spend a shift with the team and for new EMHS staff to spend a shift with police patrol officers. Further to this agreement, police have requested the following:

- 2002 Increment training to Victoria Police officers, provided by EMHS Coordinator Devin Lynn and Forensics nurse Randy Puetz. This training focused on understanding community resources and an overview of mental illness.
- 2004 ERT Tabletop exercise. EMHS Coordinator Devin Lynn, EMHS clinician Ned Baess, and Forensics nurse Randy Puetz collaborated with the regional ERT and negotiators in simulating several situations involving a mentally ill person.
- May 2005 ERT Negotiator training. EMHS Clinician Dr. Ned Baess provided a training session on mental disorders and implications for verbal engagement.
- June 2005 discussions with Saanich and Victoria Police training divisions related to EMHS officer/clinician providing a two hour in-service to new recruits, and a four hour training session to officers during increment training. Development of these training packages is ongoing, and would ideally be presented by the EMHS assigned police officer and an EMHS clinician. Funding is required to backfill EMHS staff providing these training sessions.

“We recommend that all 911 operators and dispatchers be oriented in the services provided by the Emergency Mental Health Services Team.”

Although this recommendation is not formally addressed to VIHA, it should be mentioned that the EMHS Coordinator Devin Lynn was invited to brief the Saanich Police communications staff on access to the integrated team in June 2005, and Victoria Police Inspector Darrell McLean has circulated correspondence to the various police departments for circulation to communications staff.

During the Saanich Police Department’s bi-weekly media conference on Wednesday, March 2, 2005 Chief Constable Derek Egan issued a statement in support of the jury’s verdict.

“The recommendations of the coroner’s jury seem very well considered and are very good. I will be considering them very carefully with my staff and discussing them with my colleagues in other police departments where they touch on regional issues.”

“The six recommendations appear to focus on the need for alternate and early intervention strategies and resources, and ensuring awareness and training of police. I am strongly supportive of any strategy that sees early intervention in treating persons suffering from a mental illness before the condition deteriorates to a point where emergency police intervention becomes necessary in the interest of public safety.”

7 RECOMMENDATIONS

7.1 Staffing

The data from this study suggests that the availability of an IMCRT officer is having a significant positive impact for consumers, mental health professionals, and police agencies in the realm of mental health crisis intervention and public safety. However, the IMCRT officers, due to the officer being on holidays or away training, did not staff a significant number of days during the pilot study. For example, during May and June 2005 25% of the officer’s shifts were not filled.

It is recommended that the integrated mobile crisis response team continue to be staffed as it is currently on an operational basis, including child & youth clinicians and plain-clothes police officers, with a reserve pool of child & youth clinicians and CRD police officers that are interviewed and interested in the opportunity of working with the team. These officers would receive mental health training and could fill in for the team when the full time EMHS officer is on holidays or away training.

7.2 Vehicle

IMCRT requires a vehicle that is more suitable for transporting clients. This would ensure the safety of both the client as well as IMCRT members. It would also eliminate the need for patrol officers to provide transportation to hospital in some situations.

7.3 Education

It is recommended that IMCRT staff provide future educational opportunities to the CRD police agencies and their members. This could be encapsulated in programs designed to teach officers how to best respond to individuals experiencing a psychiatric crisis by using lecture and experiential teaching formats.

It may be beneficial to have discussions with area chiefs and police management to educate them with regards to liability issues when dealing with persons experiencing psychiatric crisis.

Provide continuing educational opportunities and funding for same, for all IMCRT members.

It is recommended that the IMCRT officer have more involvement with community care plans with various mental health agencies to ensure the CRD police are well represented in the round table discussions.

7.4 Office Location

It is recommended that the IMCRT office be relocated from the current limited space in the Archie Courtnall Centre. EMHS requires more privacy and a secure office for the sensitive information that is out in the open and the police equipment that is present in the office.

7.5 Information Access

It is recommended that IMCRT police officers be able to have desktop access to email and other information related to law enforcement duties, situated in a secure location.

7.6 Police Radio

It is recommended that IMCRT mental health professionals be trained to use police radios in order to communicate with dispatch staff regarding potential referrals, safety in terms of informing dispatch of the teams whereabouts when providing assessments in the community, and accessing immediate assistance should an officer become disabled as the result of an accident/incident.

8 FUTURE ACTIVITIES

- 1) Present findings of evaluation at Area Chief's Meeting on September 15, 2005.
- 2) Present findings of evaluation to Victoria Inner City Health Initiative (VICHI).

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