POLICE ACT REVIEW COMMITTEE
BC SCHIZOPHRENIA SOCIETY
JOHN GRAY, PHD.

Introduction

Good morning. I am John Gray, Vice President of the British Columbia Schizophrenia Society (BCSS), a provincial non-profit organization. BCSS very much appreciates the opportunity to provide input into the work of this important committee. The police are very important in our mission to improve services for those with schizophrenia and psychosis, especially in applying the Mental Health Act (MHA). An influential member of our board was former Chief of Police Jamie Graham and we currently have a member of a local police department on our Public Policy Committee.

The police have been called by many family members to help with a loved one whose behaviour caused by serious mental illness is also causing safety concerns. Attached is a survey of over 50 family members who had police involvement.[i] Most responses are positive especially when the officer was accompanied by a nurse.

During this presentation, I will address:

- Why the police are involved with people with serious mental illness
- Why BCSS is interested in this Police Act Review
- Current roles and challenges of police under the MHA.
- Improving wellness checks (joint police/mental health worker)
- Reducing police time waiting and escorting
- Other issues – eg training, case finding, MHA changes
- Planning, coordination of services

1. Why the police are involved with people with serious mental illness

Police, at times, need to be directly involved with people with serious mental illnesses, such as schizophrenia and bi-polar, because their psychotic symptoms can cause the person to act out, act bizarrely and/or endanger their own safety or those of others. That is when police must be called in. If the person cannot be persuaded to obtain help voluntarily a police officer can apprehend the person if they meet the MHA criteria, and take them to a physician for an examination under the MHA.

Even when the threat of safety is not present, police are called to deal with individuals in a crisis because they are the only ones who will respond 24/7. This is at the heart of what needs to be addressed.

2. Why BCSS is interested in this Police Act Review

BCSS is interested in the Police Act Review for the following key reasons. BCSS wants to:

- Support the current MHA police powers, such as wellness checks
- Support police and mental health teams, and other means of reducing police involvement
- Suggest changes to help reduce the time police spend in escorting patients, thus freeing them up for other police duties.

3. Police apprehension under the MHA

Police officers can apprehend an individual when a physician or judge is not available. The criteria are:

s. 28(1) *"A police officer or constable may apprehend and immediately take a person to a physician for examination if satisfied from personal observations, or information received, that the person:*

(a) is acting in a manner likely to endanger that person's own safety or the safety of others, and

(b) is apparently a person with a mental disorder."

Comment: The safety criterion the police officer must use is narrower than the criteria a physician uses, as demonstrated below:

s. 22(3)(c)(ii)*..to prevent his/her substantial mental or physical deterioration or for the protection of the person or for the protection of others.."*

"Safety" has been interpreted by some police officers to mean only physical safety, but some clinicians and family members have reported that this definition is too narrowly focused.

There appears to be two approaches to the interpretation of "*endangering that person's own safety or the safety of others: "*

(1) Define "safety" broadly so the meaning is as similar as possible to the 'protection concept' used by physicians. This would not require a change in the MHA. As the BC McCorkell court states: "*In this context the word "safety" goes beyond mere protection from the infliction of physical injury."*

(2) Police and physicians use the same criteria except the physician requires more certainty, as used in Newfoundland and Labrador (s. 20). This would require a change to the MHA. Exploring the limits of "safety" is recommended.

4. Improving wellness checks (s. 28) (joint police/mental health worker)

BCSS advocates for more police and mental health worker teams modelled after Car 87 in Vancouver for "wellness checks." You may ask why not use two mental health workers? There are often safety concerns in these calls, and if the person needs to be examined under the MHA, they would have to call a police officer or a physician to attend so it makes sense to pair a mental health professional with a police officer.

Police receive very sizable numbers of "mental health calls". For example, in the Kelowna area with a population of 760,000, over 15,000 calls in 2019 were related to mental health concerns. Most were diverted to voluntary services, but 17% were apprehended under the MHA. Recently, the Chief Superintendent of the RCMP in southern BC issued a statement in support of police/mental health professional teams. He wrote:

> *"I want to commend Interior Health and our Detachments for creating the program [police/nurse], which has proven to be very effective in the response to mental health calls, de-escalating persons in crisis, and when treatment is necessary, easing their referral into the health care system to obtain the best possible care. My goal is to greatly expand this needed service at existing locations as it is not always available, and introduce it into as many of our communities as possible.*
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> *….If there is an inability to provide a dedicated Interior Health nurse for every call, then I want to implement a real-time information sharing model that provides our members important health information that will ensure a wholesome assessment of the person in crisis before attending the call. I want to build a sustained corporate-based infrastructure for all mental health related calls."*

BCSS supports the Superintendent's intentions.

BCSS recently asked families about their experiences of police and mental health teams (see attached). Most communities do not have such a service available, resulting in police being the only alternative when a loved one is in a mental health crisis. Despite this, the majority of respondents expressed their gratitude for police.

This service which has been in place for many years does not require a change in the MHA to be expanded.

Recommendation: Expand the police/mental health response model to all BC communities and create a data base of information and resource sharing.

5. Reducing police time waiting and escorting.

Police spend a considerable amount of time transporting people and waiting with them in hospitals. This section offers suggestions to reduce times and release the officer for their police duties.

A. Transportation from a first certificate to a facility for an examination.

s. 22(6) *A medical certificate … is authority for anyone to apprehend the person to be admitted, and for the transportation, admission and detention for treatment of that person in or through a designated facility*.

Comment. This allows mental health staff or sheriffs, relatives, ambulance personnel or anyone to apprehend and transport. If is not safe, police would be involved. The advantage is a reduction in police resources, less anxiety for the person, less stigma etc.

B. Return from Unauthorized Absence or Extended leave

Form 21 is used to bring someone back to hospital if they have left without permission or to return a person from extended leave (s. 39 and s. 41). Form 21 is directed only to "To all Peace Officers". It is completed by the director of the psychiatric unit.

We recommend that Form 21 be modified to include "all peace officers and others designated by the director" s. 41(2). This would reduce the need for police.

Other provinces like Saskatchewan allow this. 24.6(1) *(b) is sufficient authority for any peace officer or other person named or described in the order to apprehend."*

C. Long waits for a police officer with a person in emergency waiting to be admitted (or not)

Once at the hospital, the officer or other person must maintain control until the physician has examined the person. This can take hours. BCSS and the BC Psychiatric Association have completed a report calling for more acute and longer term beds[ii]. If implemented that would help. Referenced is a project that resulted in a 57% decrease in police wait times.[iii]

6. Other issues

A. Training: BCSS has a training program that has been used by some police departments to illustrate how a psychotic illness can affect the person and how approaches by police officers can be modified to address the symptoms of the illness.

B. Police case finding: Police case finding of seriously ill but treatable people needs to be recognized. It occurs in homeless shelters, tent cities, arrests, and in police cells.

C. Untreated involuntary patients discharged. If a Charter challenge to the MHA is successful involuntary patients will be allowed to refuse the treatment necessary for their recovery and release. This may put more pressure on police departments. A paper is available from Ontario called Treatment Delayed-Liberty Delayed.[iv]

7. Planning and Coordination

Planning and coordination of services with others starts with the health authority developing programs like ACT, beds and selecting and training staff who can work with people with psychosis.

Joint planning and coordination between police, community and hospital mental health staff is essential in developing efficient and effective services. The Vancouver Police Board, Vancouver Coastal Health Board and Providence Health Board, for example, developed Project Link. Teams developed "have greatly reduced negative contacts with police, emergency room visits, victimization, and criminal justice involvement for those living with mental health and substance use issues".[v]

An excellent Ministries document for planning and coordination is "*Interfaces between mental health and substance use services and police.*[vi]

At the provincial level, BCSS' echoes the comments made to this Special Committee by the Assistant Deputy Minister of Public Safety when he expressed the need for *"cross-ministerial strategies…"*[vii]

Conclusion

BCSS is committed to the families and our loved ones who live every day with brain illnesses that sometimes require police support. Our hope is that your efforts as a Special Committee will find ways to support and expand coordinated services, as well as retain mental health legislation that is essential to the wellbeing of the most vulnerable, seriously mentally ill and addicted individuals in our province.

Thank you. That concludes our presentation and I'm happy to take any questions.

Relevant Materials & Reports:

[i] Family Survey: Police/Mental Health Calls. BC Schizophrenia Society.
[ii] Inadequate Access to Acute Psychiatric Beds in British Columbia, 2019, BCSS and BC Psychiatric Association, https://www.bcss.org/wp-content/uploads/2019/12/Psychiatric-Beds-Report-.pdf

[iii] .. *A protocol to reduce police wait times in the emergency department* by Barb Pizzingrilli, RN, BN, MN, CPMHN (C), MBA1 ; Ron Hoffman, PhD2 ; and Daniel Pearson Hirdes, *This article describes the development, implementation, and outcomes of a collaborative protocol between the Niagara Health System and the Niagara Regional Police Service that resulted in a 57% reduction in police wait times in the ED. Six critical success factors contributed to the outcomes that were achieved and are detailed for those organizations interested in engaging in a similar change initiative.*
Healthcare Management Forum 2015, Vol. 28(4) 134-138 ª2015 The Canadian College of Health Leaders. All rights reserved. Reprints and permission: sagepub.com/journalsPermissions.nav DOI: 10.1177/0840470415581257

[iv] Treatment Denied-Liberty Denied, Faculty of Law & Psychiatry Department, University of Western Ontario, https://cbr.cba.org/index.php/cbr/article/view/4117/4110

[v] Awards associated with Project Link:

1. International Association of Chiefs of Police 2015 Webber Seavey Award for quality and innovation in policing: *"Vancouver, British Columbia, Canada Police Department: Assertive Outreach Team. In part of the city's downtown area, 3 percent of the population accounted for 25 percent of all reported mental health calls to the department. Both health and police data highlighted that residents with repeated admission to hospital emergency departments also had increased interactions with police prior to obtaining treatment. To address these issues, police officers teamed up with nurses and other healthcare professionals to transition residents from local emergency departments to appropriate community services. As a result of their efforts, there has been a 77 percent reduction in violent offences by these residents."*
*(*https://www.businesswire.com/news/home/20151026005225/en/Police-Go-Above-and-Beyond-to-Serve-Communities*)*

2.Canadian Mental Health Association BC: 2016 Mental Health Voices Award: For cross-sector consultation to inform the 2016 VPD Mental Health Strategy
(https://vancouver.ca/police/assets/pdf/reports-policies/mental-health-strategy.pdf

[vi] *Interfaces between mental health and substance use services and police*
https://www2.gov.bc.ca/assets/gov/health/managing-your-health/men…

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Assistant Deputy of Public Safety, Minister Rideout, when he expressed the need for *"cross-ministerial strategies that align and look towards that all-of-government approach to the problem at the municipal and provincial levels and leveraging the resources that are there, not only to expand our expertise but to coordinate a response and to ensure that the police are not tasked with managing situations that, really, they're not equipped to handle and perhaps will not be as effective as they could be if they were supported by health care professionals and experts."*