VANCOUVER POLICE DEPARTMENT

LOST IN TRANSITION:

How a Lack of Capacity in the Mental Health System is Failing Vancouver's Mentally Ill and Draining Police Resources

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Special Investigation Section

For

The Vancouver Police Board and
Chief Constable Jim Chu
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Detective-Constable Fiona Wilson-Bates
Vancouver Police Department
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GLOSSARY OF TERMS

BET (Beat Enforcement Team):
Four squads of police officers who are responsible for working exclusively in the Downtown Eastside, conducting patrol of the area primarily on foot.

Car 87:
A Vancouver Police constable teamed with a Registered Nurse or a Registered Psychiatric Nurse to provide on-site assessments and intervention for people with psychiatric problems. The nurse and the police officer work as a team in assessing, managing and deciding about the most appropriate action.

CAD (Computer Aided Dispatch):
The primary tool used by call takers and dispatchers to electronically create and manage events, to dispatch police officers to incidents and to provide them with updated information.

Director's Warrant:
If a committed patient on leave is recalled and does not return, or leaves without having been discharged, or if extended leave conditions are breached, the Director may issue a warrant that requires police to apprehend the person and return him/her to the hospital.

ERT (Emergency Response Team):
A team of police officers who are specially trained and equipped to tactically respond to high risk incidents (often described as "SWAT"). The negotiator squad often works in concert with members of the ERT to resolve situations using effective communication skills.

NCRMD (Not Criminally Responsible by Reason of Mental Disorder):
A finding by the court that an individual accused of a criminal offence was incapable of understanding the nature and potential consequences of their actions at the time the crime was committed due to a mental disorder.

PRIME (Police Records Information Management Environment):
The electronic records management system for police in British Columbia.

Review Board:
Accused who are found not criminally responsible at the end of the trial, or unfit during the trial, are subject to the jurisdiction of the review board. The board is responsible for making orders to manage the risk posed by the accused.

EXECUTIVE SUMMARY

The purpose of this report is to provide a quantitative analysis of the prevalence of Vancouver Police Department (VPD) calls for service that involve mentally ill clients; to identify the significant factors that contribute to the frequency of these incidents, and the potential consequences for a mentally ill person who comes into contact with police; and to describe the capacity gaps in the mental health system's response to the mentally ill from a police perspective. This report is the official position of the VPD and the Vancouver Police Board.

Anecdotal observations of calls for police service in the City of Vancouver in the first eight months of 2007 suggested a marked increase in those involving people who were mentally ill. Specifically, a significant number of disturbances, minor property offences, aggressive panhandlers and similar incidents that contribute to disorder and perceptions of a lack of safety in some communities were believed to be attributable to mentally ill people. Additionally, there were a number of suicides and other tragic incidents involving mentally ill people that drew the attention of members of the VPD Executive, who were interested in knowing if this perceived increase was reality, what the causes were and what could be done about it.

This report is a summary of data collected over a sixteen-day period from September 9, 2007 to September 24, 2007 of police incidents that involved a person who was suffering from the effects of a mental illness. The calls were documented by patrol officers who indicated if they believed that the mental health of an involved person was a factor in police attendance. In total, 1,154 calls for service were recorded and, of those, 31% involved at least one mentally ill person; in some areas of the city this figure rose to almost half of all incidents where police contact was made with an individual.

Although the police members were not required to confirm any diagnosis of mental illness, the expectation of the patrol members to use their subjective judgement is consistent with the intent of the British Columbia *Mental Health Act*, whereby officers are afforded the power to apprehend a person based on their observations. In any case, generally speaking, when police identify that a mental health issue exists, the symptoms are readily apparent and would

likely be obvious to any layperson. The result is a probable underestimation of calls for service that involve a mentally ill person as opposed to an overestimation.

A conservative economic analysis suggests that police time spent dealing with incidents where a person's mental illness was a contributing factor in police attendance is equivalent to 90 full-time police officers, at an annual cost of $9 million. This would not include indirect policing costs, or the costs to other agencies such as the ambulance service, hospitals, or the court system.

There are several possible contributing factors to the excessive police interactions with mentally ill individuals. These include a mental health system that has not kept up with the loss of resources in the wake of deinstitutionalization; a profound absence of information sharing between mental health resources in the Lower Mainland; and an unwillingness on the part of service providers to fully utilize the provisions of the *Mental Health Act* due to a lack of available resources and/or personal ideology. These services are particularly sparse for people who are mentally ill and also addicted to illicit drugs or alcohol. Although patrol officers have become front line mental health responders, investigating over 1,744 incidents where an individual was arrested under the provisions of the *Mental Health Act* in 2007 alone, the options available to them when interacting with a person who is mentally ill are limited to institutions (jail, court, hospital) that are struggling to accommodate people for whom they lack capacity and/or were not designed to manage.

In particular, the Downtown Eastside is a predictable example of what happens when people who need various levels of community support are left to fend for themselves. Drawn by cheap accommodation and access to services, they are often the victims of predatory drug dealers, abusive pimps and unsavoury landlords who take advantage of their vulnerabilities. These people are consequently coming into frequent contact with VPD members who in turn rely on the provisions in the *Criminal Code* in the absence of an acceptable response from hospitals to admit mentally ill patients.

Patrol members in the VPD receive adequate training to manage the current reality that up to 49% of all calls they attend in which contact with an individual is made involves a mentally ill

person. In addition to police academy instruction, all new members are required to complete a comprehensive four-day “Crisis Intervention Training Course” within their first few years of service. Additionally, patrol officers can rely on the crisis negotiator team, Car 87, and the Police Records Information Management Environment (PRIME) for assistance.

Many of the problems described in this report are illustrated through “Corey’s Story”. Corey O’Brien was a young man who had the rare combination of both intellect and athletic prowess. Raised in a loving and supportive environment, Corey was a talented athlete, gifted artist and excellent student. After successfully graduating from High School, he thwarted university recruitment attempts to accept an enviable position at one of the country’s largest animation firms. Regrettably, with the onset of schizophrenia, Corey’s world changed dramatically. The story of his struggle and the tragic conclusion to this promising man’s life is documented to provide a real life illustration of the issues covered in this report.

The key finding of this research is that there is a profound lack of capacity in mental health resources in Vancouver. The result is an alarmingly high number of calls for police service to incidents that involve mentally ill people in crisis. VPD officers, along with the citizens with whom they come in contact, are bearing the burden of a mental health system that lacks resources and efficient information sharing practices, often with tragic consequences. In an effort to address the current situation, several recommendations are made that centre on the need to better serve people who are mentally ill in Vancouver.

PURPOSE

The purpose of this information report is to provide a quantitative analysis of the prevalence of Vancouver Police Department (VPD) calls for service that involve mentally ill clients; to identify the significant factors that contribute to the frequency of these incidents in the City of Vancouver, and the potential consequences for a mentally ill person who comes into contact with police; and to describe the capacity gaps in the mental health system's response to the mentally ill from a police perspective. This report is the official position of the VPD and the Vancouver Police Board.

BACKGROUND

Anecdotal observations of calls for police service in the City of Vancouver in the first eight months of 2007 suggested a marked increase in those that involved people who were mentally ill. A significant number of disturbances, minor property offences, aggressive panhandlers and similar incidents that contribute to disorder and perceptions of a lack of safety in communities were believed to be attributable to mentally ill people. Additionally, there were a number of suicides and other tragic incidents involving mentally ill people that drew the attention of members of the VPD Executive, who were interested in knowing if this perceived increase was, in fact, reality and what could be done about it.

A local Vancouver resident who often took her dog for a morning walk around the grounds of Lord Nelson School noticed a male dressed in odd clothing walking around the area mumbling to himself in the last few days of July 2007. Other local residents also saw the man, who many later described as looking "depressed", lying on a bench. In the early hours of July 31, 2007, a witness awoke to what he thought were a female's screams. He got out of bed and saw that there was a fire in the school grounds adjacent to his house. Thinking there was a pile of garbage alight, he watched as the flames died down. He called 911 when he realised that there was a shoe and the remnants of a person's body lying on the ground where the blaze had been. The deceased was a 36-year-old male suffering from depression who had doused himself with gasoline before lighting his body on fire.

RESEARCH DESIGN

Methodology

With the intention of comparing mental health calls from a given period in 2007 to the same time frame in 2006, the Computer Aided Dispatch (CAD) system was utilized. It was

discovered, however, that the current method of recording 911 calls involving people who were mentally ill is inadequate for the purpose of extracting details of these incidents.

When an individual calls 911, the call taker determines what “type” of “incident” to create for dispatch in the CAD system. There are over 100 options for the operator to choose from, the list being designed to cover every possible circumstance that would result in a call for police attendance. Although there are call types that are specific to mental health incidents, such as a suicidal person (SUIC) or a *Mental Health Act* arrest (MHES), there are also several general call types that often, but not always, include a person whose mental health is the reason for police attendance. An example of this is a 911 call in which a man is reported to be walking down the middle of a busy street during rush hour screaming obscenities. When the call is received by the call taker, it can be created as a person annoying (ANNOY), disturbance (DIST), noise complaint (NOISE) or suspicious person (SUSPER). When police officers arrive on scene, however, it may become apparent that the subject of the complaint is suffering from the effects of a mental illness. If the attending officers are able to calm the individual down, assist him home and connect with a family member, the call will be closed and a report submitted. The result is that a 911 call for police service that was clearly due to an individual’s poor mental health is not recorded as a mental health incident.

Due to these factors, it was not possible to compile a computer generated comparison of mental health related calls over two different time periods based purely on CAD data, so a different method of data collection was required. A shift was made in focus from trying to determine if there had been an increase in mental health calls to discovering the frequency of these incidents and the common factors that contribute to them. An attempt to manually extract mental health calls from CAD was next undertaken.

In Vancouver, patrol members submit a written report in approximately 47% of all completed calls. The alternative is to record (or “memo”) a few comments into the original CAD call via police computer and close the incident. This would typically be done in circumstances where there was no criminal act committed or attempted, no injuries to any involved parties, no transport to jail, a detoxification facility or hospital and no intelligence-gathering benefit to completing a report. Those situations that are informally resolved and are minor in nature

may result in the attending officer closing the incident in CAD with a few words that briefly indicate the outcome. It was many of these very events that could not be overlooked when considering mental health calls for police service, despite the absence of a written report.

In order to have complete results, CAD calls over two one-week periods were chosen: August 6 to 12, 2007 and September 3 to 9, 2007. Over these days, there were a total of 10,666 calls for police service. To make the task of analyzing the incidents manageable, the following call types were isolated and viewed:

ab911	**abandoned 911**
annoy	**annoying circumstances**
aslt	**assault**
aslti	**assault in progress**
assgp	**assist general public**
assmha	**assist mental health act**
assoa	**assist other agency**
asspfa	**assist police/fire/ambulance**
check	**check welfare**
distb	**disturbance**
domi	**domestic in progress**
domrpt	**domestic report**
foundp	**found person**
harass	**harassment**
hazard	**hazard**
missip	**missing person**
sudden	**sudden death**
suicide	**suicidal person**
suspc	**suspicious circumstance**
suspp	**suspicious person**

Figure 1

Recognising that the list of chosen CAD calls was not exhaustive, the intention was to include call types that could reasonably be seen as incidents that might involve mentally ill people and to capture as many of them as possible. Incidents such as motor vehicle accidents, found property and parking complaints were excluded. In all, over 4,000 original calls for service were analyzed; however, it became apparent that the emerging picture was an incomplete one. In several instances, it was not clear from the information if an involved person was in fact mentally ill or if they were high on drugs, intoxicated, or simply engaging in unusual behaviour. In addition to this, the limited call types proved to be exclusive of many incidents

involving mentally ill people such as thefts, frauds and break and enters. Consequently, although a count of mental health incidents was theoretically possible, the sheer volume of calls for service (on average 762 per day) coupled with the difficulties of determining what was a mental health related situation made this method of data collection flawed to such a degree that the results were unreliable.

Data Collection

In an attempt to move forward and determine the frequency of police attended incidents involving people who are apparently suffering from a mental illness, a new method of compiling data was created. Since it was not practicable to take a thorough look at previous mental health-related police calls for service, the new research method was designed to look forward.

The Patrol function of the VPD is staffed 24 hours a day, seven days a week throughout the city. In order to facilitate adequate coverage for this schedule, there are two groups of 22 squads that work opposing days in a four on, four off shift rotation. A research period was chosen to cover two blocks of four days from each of the 44 squads from September 9, 2007 to September 24, 2007. These days represented an even number of shifts and days of the week. The weather was average during the collection period and there were no major events that took place that could have reasonably been believed to have an affect on the data such as a natural disaster or a major change in VPD policy or provincial legislation.

Two police officers were randomly chosen from each squad and given instructions to fill out provided cards to track every call for service that they attended throughout a shift (see figure 2). These directions were given by the writer and were read aloud to the participating patrol officers[1] to avoid the possibility of faulty or inconsistent information being provided by multiple briefers affecting the reliability of the data gathered.

[1] With the exception of BET members, who were not briefed in person by the author for logistical reasons.

Date _____ PIN _____
District _____ Shift _____
Call Sign _____ Partner Y N

Incident Number	Mental Health?
07 –	YES NO N/A
07 –	YES NO N/A
07 –	YES NO N/A
07 –	YES NO N/A
07 –	YES NO N/A
07 –	YES NO N/A
07 –	YES NO N/A
07 –	YES NO N/A
07 –	YES NO N/A
07 –	YES NO N/A
07 –	YES NO N/A
07 –	YES NO N/A
07 –	YES NO N/A
07 –	YES NO N/A

Figure 2

The Patrol officers were asked to circle “yes” when an incident involved one or more people whose mental health was a contributing factor in police attendance, and “no” when this was not the case. They were further advised to circle “N/A” (not applicable) when they did not have contact with any people involved in the call.

There was no requirement that the police member confirm that an involved person was diagnosed with a mental illness and they were not asked to complete any paperwork in addition to the normal requirements and the provided card. The card was then placed in an envelope at the end of each day and a new one used the following shift. Ideally, one person on each squad completed one card for each of their four duty days; however, in some cases the same officer completed cards for the entire eight days during their reporting period.

Assumptions of Research

This research was conducted based on several guiding assumptions. The first was that there was a need for the VPD to understand the nature and extent of calls for service that involved people who were mentally ill. This was grounded in the belief that mental health calls were

pervasive to the extent that understanding them was of value, particularly to the VPD, but also to the community at large. It was further assumed that the officers who carried out the data collection had the personal and professional experience necessary to make accurate determinations of mental health involvement in the calls they attended. Additionally it was assumed, based on anecdotal observations, that many people who interacted with police did so because they were mentally ill and were not receiving appropriate mental health treatment to address their illnesses. A final guiding assumption was that police interactions with people who are mentally ill increase in the absence of appropriate mental health intervention. This is not to suggest that a policing response is not appropriate in mental health situations; however, it is to suggest that a policing response is only part of what is needed to effectively address the issue of service delivery for the mentally ill in Vancouver. It is hoped that the unique experience of police will illuminate the issues in a way that will bring additional attention and resources needed to better serve the mentally ill.

The Role of Subjectivity in the Research Design

At first glance the issue of subjectivity inherent in this research can be viewed as a methodological limitation because the reporting of incidents relies on the opinion of the participating police member. Lack of standardization in reporting was due to the fact that no preconceived criterion was provided for the officers to use to determine whether mental health was a factor in the call or not. They were not required to confirm any diagnoses, nor did they have to explain how they arrived at a determination that one or more mental health issues were part of the call. It was, however, precisely the subjective assessment of the involved police officer that was desired, as it was this opinion that would guide their actions. The benefit of utilizing the subjective experience of police officers in the data collection was two-fold. The data collection method was consistent with everyday practise and no further instruction was needed for patrol officers to complete the task. Further, the expectation of the involved police officers to use their subjective opinions in determining mental health involvement in an incident for the purpose of this study is congruent with the intent of the *Mental Health Act*, whereby officers are afforded the power to apprehend people based on their observations. It should also be noted that, generally speaking, when police identify that a mental health issue exists, the symptoms are readily apparent and would likely be obvious to any layperson.

RESULTS AND ANALYSIS

Of the 352 cards distributed, 233 were returned with a total of 1154 calls recorded. See Table 1.

District	Total Calls	**Yes** (mental health was a factor)	**No** (mental health was not a factor)	**N/A** (no contact made)	Total contact calls	**Yes** (when contact was made)
1	302	30%	51%	19%	245	37%
2	316	42%	43%	15%	269	49%
3	185	20%	64%	17%	154	23%
4	278	26%	64%	10%	249	29%
BET	73	34%	56%	10%	66	38%
TOTAL	1154	31%	55%	15%	983	36%

Table 1

Of all recorded police-attended calls for service in the City of Vancouver, 31% involved a person who the attending member believed was suffering from poor mental health to the extent that a police response was required. This figure rose to 36% when only those calls in which police made contact with an individual are considered.

The geographical distribution of mental health calls in Vancouver is also significant. The City of Vancouver, for the purposes of policing, is divided into four districts, as shown in Figure 3.

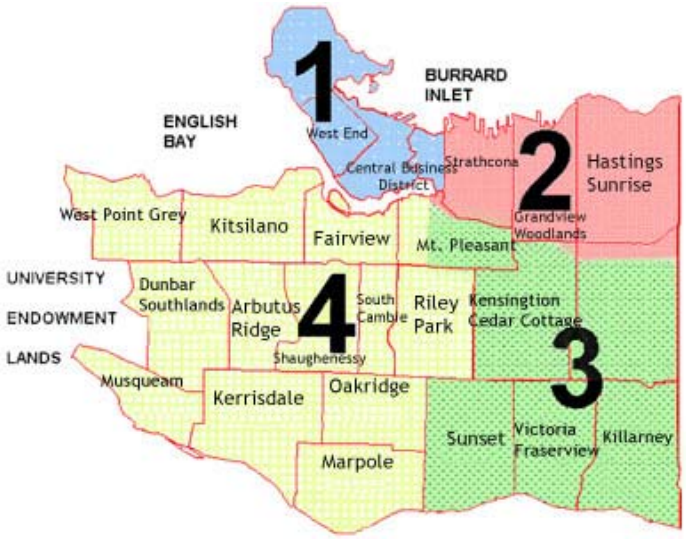

Figure 3

District One, an area comprised primarily of the West End and central business district, reported the second highest percentage of incidents involving mentally ill people, with a rate of 30% overall and 37% of contact calls.

In District Two, an area that includes Vancouver's Downtown Eastside, 42% of all police-involved incidents were mental health related and this rises to almost half of all calls when only those where contact was made are considered. From the patrol members who work in the Beat Enforcement Team ("BET") in the Downtown Eastside, 38% of all contact calls involved a person whose mental health was a factor in police attendance. The disparity between the percentage from BET member's and District Two officers could be attributed to the low reporting rate from BET (73 calls compared to 316 from District Two[2]).

Districts 3 and 4 reported rates of 20% and 26%, respectively, with these numbers jumping to 23% and 29% of all calls where contact with an involved person was made.

It is likely that the data collected represents an increase over time in calls for police service involving people who are mentally ill; however, this remains unverified. What is clear, however, is that an alarming percentage of all police calls that patrol officers currently attend

in the City of Vancouver are in response to people in mental health distress. This fact is supported in current literature where it is widely accepted that 'the police are, by default, becoming the informal "first responders" of our mental health systems' (Canadian Mental health Association BC division, 2003, p. 5). Factors that have contributed to this reality will now be explored.

RESOURCE IMPLICATIONS FOR THE VANCOUVER POLICE DEPARTMENT

As described earlier, in 2007, there were 1,743 cases where individuals were arrested under s. 28 of the *Mental Health Act*. According to the Computer-Aided Dispatch (CAD) data, this required a total of approximately 13,000 police officer hours. In addition, a total of 1,389 "disturbed person" cases required approximately 6,000 police officer hours. Therefore, *Mental Health Act* cases and "disturbed person" incidents alone required the equivalent of more than eleven full-time frontline police officers. Accordingly, the estimated direct annual cost associated strictly with *Mental Health Act* arrests and incidents coded as "disturbed persons" would be at least $1.1 million.

However, it is clear that these two types of incidents account for only a small percentage of the total number where a person's mental illness was a contributing factor to police attendance. The research demonstrated that approximately 31% of all police calls for service attended by a VPD unit involved a person suffering from mental health problems. This implies that approximately 58,900 out of the 190,000 calls for service attended by VPD units each year involve a person suffering from mental health problems. In 2007, each recorded call for service required an average of 2.6 officer hours. Assuming that calls involving mental health problems require roughly the same police resources as the average police call for service, 153,140 police officer hours would be required annually to deal with mental health-related calls. This is equivalent to approximately 90 full-time frontline officers. The direct annual cost associated with these police resources would be approximately $9 million.

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[2] The low reporting rate from BET was partially because there are a smaller number of police officers working in BET compared to District 2. Further, it was likely also because the BET members were the only group that, for logistical reasons, did not receive an in-person briefing from the author.

It should be noted that the direct costs associated with mental health calls are conservative because they do not include the costs associated with follow-up investigations by specialty squads or the costs incurred by the victims or the complainants (when a crime is committed). In addition, these direct costs also do not include the costs incurred by other agencies, such as the provincial ambulance service (responsible for transporting patients who are injured or arrested under the *Mental Health Act*), hospitals (responsible for assessing and treating mental health patients), or the justice system when criminal charges are involved. Finally, the direct costs fail to account for the loss in productivity associated with mental health problems.

The economic cost associated with mental health issues has become relevant because the emerging empirical evidence suggests that mental health problems have recently become both more prevalent and more complex. Further research in this area could potentially offer new insights towards improving the mental health system, particularly the services offered to Vancouver's mentally ill, thereby reducing the drain on police resources.

CONTRIBUTING FACTORS

Deinstitutionalisation in British Columbia

Riverview Hospital, B.C.'s only and Canada's largest remaining psychiatric hospital opened its doors in 1913 under the auspices of the *Hospitals for the Insane Act*. At its peak capacity in 1951, Riverview's patient population was 4,630 (BC Mental Health & Addiction Service, 2007, para. 27). In 1965, the *BC Mental Health Act* was introduced and Riverview's patient population began to decline.

In 1985, a nationwide trend to deinstitutionalize the mentally ill (and developmentally disabled) was evident as portions of Riverview were closed and patients moved into the community. The process of informal downsizing resulted in a gradual reduction in beds to 1,000 by the early 1990's (MacFarlane et al., 1997).

In 1992, a Provincial Government mental health initiative formally introduced a plan for the development of mental health services throughout the province. Its focus was on replacing Riverview with smaller, more specialized regional facilities. In 2001, the Provincial

Government announced a new administrative structure for health services, comprising five geographically-based regional health authorities plus the Provincial Health Services Authority (PHSA). Riverview and the Forensic Psychiatric Services Commission were among the agencies placed under the PHSA.

The following year, the Riverview Redevelopment Project was announced and plans to phase out the aging institutional buildings were developed. The few remaining Riverview patients were to be transferred to facilities within the various Health Authority regions on a "bed-for bed" transfer process. There were 209 beds slated to be transferred to the Vancouver Coastal Health Authority to replace those lost in the downsizing of Riverview. 200 of these transfers have yet to take place.[3]

One of the results of deinstitutionalization in BC was that people spent less time specifically in psychiatric hospitals (63.9% decrease in days of care per 1,000 population from 1985 to 1999) and more time in psychiatric units at general hospitals (20.9% increase in days of care per 1,000 population from 1985 to 1999) (Sealy and Whitehead, 2004, pp. 3-4).

For many individuals previously confined to mental institutions, deinstitutionalization has been a real success. They live normally in the community, in group homes or apartments. They are monitored, have supports available, and take medication. For a smaller proportion, however, deinstitutionalization has been a dramatic failure. They are homeless, or in very poor and dangerous accommodation. Social agencies, such as the Lookout Emergency Aid Society in Vancouver, "found increasing numbers of psychiatrically disabled needing assistance" (The Lookout Emergency Aid Society, 2007, our history, para. 2) with the

***On November 24, 2007 a male was arrested by VPD members under Section 28 of the* Mental Health Act, *taken to Vancouver General Hospital and subsequently transferred to Royal Columbian Hospital. Upon his release the following day, staff called New Westminster Police to remove him when he refused to vacate the premises. Attending officers placed him in a police wagon and drove him home to Vancouver. The following day, VPD members responded to reports that he was causing a disturbance; the situation was resolved informally. Later that afternoon, he was removed from the skytrain by Greater Vancouver Transit Authority Police on two separate occasions when citizens called 911 to report disruptive behaviour. The following day, another emergency call was made and this time the party was taken to the VPD jail, again for causing a disturbance. A few hours after his release, he was arrested yet again and charged with mischief. Seven interactions with police from three different agencies over three days began with an arrest under the* Mental Health Act.**

deinstitutionalization of the mentally ill. They also noted that "the seriously mentally ill were particularly unable to access housing, even when poverty was not a factor" (The Lookout Emergency Aid Society, 2007, our history, para. 6). The prevailing reason for this failure has been "the inadequate follow-up and the lack of social structures in the community at the time hospital beds were closed" (Arboleda-Florez, 2004, p. 377). The Canadian Mental Health Association states that, "unfortunately, community support systems have not received sufficient funding to grow proportionately to the increased need" (The Canadian Mental Health Association, 2005, para. 1). Further, "reductions in hospital beds and services result in hospital admission only for those in acute crisis, and, even then only for very short periods of time" (The Canadian Mental Health Association, 2005, para. 1).

Premier Gordon Campbell recently referred to deinstitutionalisation as a "failed experiment" and said "the government over the years left too many mentally ill people to fend for themselves without the community support and affordable housing they require" (Schultz, 2007, para. 3). It seems the reduction in beds at Riverview and the lack of support services in the community to replace those lost are significant contributing factors to the current crisis. Those individuals with serious mental illness, and frequently with addictions, create considerable demands for police services, and destabilize communities.

It is not surprising that the Downtown Eastside in particular has a high concentration of mentally ill people in the wake of deinstitutionalization. The Strathcona Mental Health Team that serviced 325 clients in 1978 now has a caseload of 1,200, and it is estimated by some that there are three times that number of mentally ill people living in the neighborhood (Zacharias, 2004). The highest concentration of affordable housing in the province coupled with the prevalence of social service resources attracts mentally ill people, many of whom rely exclusively on the $786.00/month disability payment for income (Bula, 2004). The same neighborhood is also home to B.C.'s largest street level drug market. The temptation to self medicate together with the predatory nature of drug dealers finds many of the city's mentally ill becoming addicted to illicit drugs such as crack cocaine or heroin. Further, those with psychiatric problems are more likely to become chronically homeless and the wait list for supported housing is years long (Zacharias, 2004). As Jane Duval of the BC Schizophrenia

[3] L. Howes, Vancouver Coastal Health, personal communication, January 10, 2007

Society states, “it’s going to be considered a scandal that people were allowed to be just neglected and abandoned in the street. I know that some people will say they choose to live under the bridge or they choose to live in the back lane. I don't believe that. I don't believe any of us would choose that if we had all of our faculties" (Bula, 2004, para. 8).

Current Legislation

Mental Health Act of BC

British Columbia’s current *Mental Health Act* contains a provision for police when they come into contact with a mentally ill person. Section 28 of the *Act* states:

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.
2) A person apprehended under section (1) must be released if a physician does not complete a medical certificate in accordance with section [22] (3) (4) (involuntary admissions criteria).

The BC *Mental Health Act* contains some of the broadest, least restrictive language and regulations in Canada (Zoffman, 1999). Once arrested, an individual can be involuntarily admitted to a designated facility and detained for examination and treatment with one medical certificate from one doctor for whom the criteria is one of “protection”. The Supreme Court of Canada has interpreted this to mean more than just physical harm (*McCorkell v. Riverview Hospital*); it also relates to the social, family, work, or financial life of the patient as well as physical conditions. Once admitted, a second doctor must sign a committal certificate within 48 hours. After that, an individual may have their involuntary admission extended for up to six months at a time, depending on their initial certification date (*Mental Health Act of BC*).

Application of the *Mental Health Act*

The *Mental Health Act* is not being used or enforced to its full potential in Vancouver for three main reasons.

i) ***Politics of public opinion***: Physicians and mental health care professionals are under significant pressure to ensure that the treatment they provide is as minimally intrusive as possible. While laudable, it seems that there is a lack of balance between a patient's right to refuse care and their protection, to the point that it is not in the patient's best interest, nor the public's. After decades of forced psychiatric care resulting in horrific examples of institutional abuse as documented in various lawsuits in British Columbia, there is a widespread reluctance to engage in compulsory treatment.

ii) ***Review panels***: Every patient who is involuntarily admitted can request a hearing before a review panel to appeal their committal. Within each of the first two months, a hearing must occur within 14 days of the patient requesting it; after that it must happen within 28 days of the request (*Mental Health Act of BC*). One senior psychiatrist who works at a Vancouver hospital expressed frustration with these panels, describing them as often being barriers to care for the mentally ill.[4] The panel itself consists of three people: a chair appointed by the Minister of Health, a doctor who is appointed by the hospital (but is not the patient's doctor), and a person appointed by the patient who has not had recent contact with them. In addition to the aforementioned three panel members, the individual may also choose anyone they wish to advocate on their behalf at the hearing, such as a friend, family member or paid advocate.

When certifying a patient, physicians use the protection standard previously mentioned; however, the review panel often applies the strict dangerousness criteria, i.e., is the patient a danger to him/herself or others (Zoffmann, 1999, p. 383). Although the patient's current psychiatrist attends and contributes to the hearing, the panel members (a majority of whom may not be medical professionals themselves) often override their medical recommendations.[5]

[4] Confidential personal communication, September 4, 2007
[5] Confidential personal communication, October 15, 2007

iii) ***Lack of Resources***: The final and perhaps most significant issue affecting the enforcement of current legislation is the lack of resources for people who are mentally ill. This is such a profound contributing factor to the current situation in Vancouver that a more in depth explanation will be detailed.

Criminal Code of Canada

There are provisions in the *Criminal Code of Canada* (*CCC)* that apply to those who commit criminal offences but who are suffering from mental health problems that result in psychosis. If a person is arrested and taken to jail a psychiatric evaluation can be requested, and when the accused goes to court, their mental state can be considered.

Section 16(1) of the *CCC* (1985) contains provisions for the defence of mental disorder:

> No person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing it was wrong.

The statue has been upheld in the Supreme Court of Canada (for example, in *R v. Chaulk,* 1990*)*. There are four ways in which the issue of criminal responsibility may arise in court proceedings:

1) The accused raises the issue by stating that he/she lacked criminal responsibility on account of mental disorder immediately following arraignment;
2) The accused pleads not guilty but is found guilty and raises the issue of being not criminally responsible by reason of mental disorder (NCRMD) following the finding of guilt but before a conviction is entered;
3) The accused is found guilty or pleads guilty and NCRMD is raised by the Crown;
4) The accused, in the conduct of the defence, puts his/her mental capacity for criminal intent in issue and the Crown raises NCRMD (Cavalluzzo, Hayes, Shilton, McIntyre & Cornish, 2004, p. 5).

Once a verdict of NCRMD has been delivered, a disposition hearing is conducted and the accused is referred to a review board, an independent tribunal established under the *Criminal Code*. The review board's mandate is to protect public safety while also safeguarding the rights and freedoms of mentally disordered persons who are alleged to have committed an offence (British Columbia Review Board, 2007). The review board conducts a hearing and makes one of the following dispositions:

1) An absolute discharge (similar to a pardon);
2) A conditional discharge (e.g., supervision, counselling);
3) Custody or detention in a designated psychiatric hospital (British Columbia Review Board, 2007).

At first glance it appears that section 16(1) may be a useful option to compel mentally ill repeat offenders who find themselves in court for relatively minor offences into a treatment facility. The above legislation, however, was designed as a defence and as one member of the review panel pointed out, even if an NCRMD application was brought forward in relation to a minor charge, the accused would likely get an absolute discharge because the panel's primary consideration is whether or not he/she is a significant threat to the public.[6] In short, it does not adequately address the issue of the chronic, mentally ill offender who commits nuisance offences, but it is a useful tool for those who are severely mentally ill and commit a serious offence.

MENTAL HEALTH RESOURCES

Introduction

As previously detailed, despite the promise of replacement facilities for the mentally ill in the wake of deinstitutionalization, these beds have not materialized. Currently in Vancouver there are no treatment facilities to accommodate people who require a moderate to long stay (i.e., over three months).[7] Moreover, there are no options for long term care in the Lower Mainland outside of Vancouver's city limits. Compounding this is the fact that hospitals in Vancouver

[6] Confidential personal communication, January 3, 2008
[7] L. Howes, personal communication, December 19, 2007

are simply not equipped to handle long term psychiatric patients and primarily take a "crisis care" approach.[8]

One result of this profound lack of resources for people who are mentally ill is physicians who have little motivation to certify an individual when there are no treatment beds available. Instead, doctors triage patients and only the most ill that are in need of immediate attention are accommodated. Consider this in the context of the Downtown Eastside, where over one third of the approximately 16,000 residents are estimated to live marginal lives by Vancouver Coastal Health Authority (Vancouver Coastal Health Authority, 2007). Given these numbers, it is not difficult to imagine why the threshold for mental health care in Vancouver is so high.

VPD members come to understand this reality and the result is the criminalization of people who are mentally ill. When patrol members respond to reports of a person who is known to be mentally ill screaming obscenities and being physically aggressive with pedestrians, they are more inclined to take an offender to jail in the absence of reasonable access to mental health services. This reality is supported in current literature that states that police are more likely to arrest an offender using provisions in the *Criminal Code* if they think that no appropriate alternatives are available (Lamb, R., Weinberger, L., & DeCuir, W., 2002, p.4). According to the Canadian Mental Health Association's *Study in Blue and Grey* (Adelman, J., 2003, p. 8) the following accessibility issues are said to make police reluctant to go the mental health route:

- Having to wait long periods in hospital emergency wards
- Having patients that were transported and initially admitted quickly discharged
- Having admission denied because the person had committed a crime
- Believing the person would likely be deemed not to meet the committal criteria.

Knowing that the assessment standard of being "a danger to himself or others" is inordinately high, the officers look to the *Criminal Code* to address the immediate problem of getting the individual off the street.

[8] L. Howes, personal communication, December 19, 2007

This lack of options for the mentally ill is further exacerbated when an individual has the additional burden of an addiction.

Dual Diagnosis

Vancouver is home to Canada's largest open drug market (Buxton, 2005). Moreover, studies show that over 50% of people with a mental illness abuse illegal drugs and alcohol, compared to about 15% of the general population (Canadian Mental Health Association, 2005). Dr. Bill MacEwan, a clinical psychiatrist who is also the director of the schizophrenia program at the University of British Columbia, estimates 60 to 70 per cent of the mentally ill treated at St. Paul's Hospital have multiple addictions (MacLean's, 2007, para. 7). Clearly the issue of "dual diagnosis" must be included in any discussion on the subject of resources for people who are mentally ill.

Despite the prevalence of people who require both mental health and addictions assistance, there is a disturbing lack of available resources for such individuals. Vancouver Coastal Health Authority operates one designated concurrent disorder program for people who are actively addicted and mentally ill. Ironically, the brochure for the Centre for Concurrent Disorders states that "you can begin the program by attending an information session. Come to this session clean and sober" (Vancouver Coastal Health Authority, 2007, p. 2). In addition to this, they operate eight mental health teams throughout the city. According to their website, the teams are "multidisciplinary and may include nurses, occupational therapists, physicians, psychiatrists, psychologists, rehabilitation therapists, social workers and support staff…each team is unique, with the mix of staff and services reflecting the needs of each community health area population" (Vancouver Coastal Health Authority, 2007, p. 2). An official at Vancouver Coastal Health Authority asserts that the clinics will treat people who are also drug and/or alcohol addicted as long as their primary diagnosis is a mental illness and the received services are voluntary.[9] However, a phone call to the West End clinic suggests that this is simply not the case.[10] With the exception of the Strathcona clinic, case workers do not take a concurrent approach to clients, insisting that they receive addictions treatment before engaging mental health resources. Further, they do not follow-up to ensure that this treatment is received and will not see clients who are "difficult" (i.e., refuse to take their medication or

[9] L. Howes, personal communication, December 19, 2007

are volatile). The result is that people who are drug addicted and severely mentally ill, a particularly disproportionate population in the Downtown Eastside, fall through the cracks.

An example of a completely concurrent approach to care can be found in Nanaimo, BC. Under the umbrella of the Vancouver Island Health Authority, Nanaimo Mental Health began taking this progressive approach when they received funding for a pilot project sponsored by the Provincial Government in 2000. The Concurrent Disorder Program identified 30 severely mentally ill, drug addicted offenders and responded to their police interactions with a "wrap-around" approach to their care. This included addressing issues such as their mental health, addiction and housing upon being arrested by Nanaimo RCMP. A multi-agency effort was made that included police, mental health workers and addictions counsellors who shared information with the sole purpose of assisting the involved person to improve their quality of life and reduce police interactions. With the inception of the program came a change in philosophy: that people who are mentally ill should not be turned away from service delivery for their illness because they are also drug addicted and vice versa.[11] An acceptance that these two afflictions often go hand-in-hand is apparent when mental health workers no longer believe, as they appear to at Vancouver's west end mental Health clinic, that it is not their mandate to provide service to these individuals.

In short, resources for people who are suffering from both a mental illness and a drug addiction are lacking, a fact that is most apparent for mentally ill women in Vancouver.

Women and Mental Illness in Vancouver

Although there is an absence of empirical data about women who are mentally ill in Vancouver, a look to the streets of the Downtown Eastside is all that's required to understand the gravity of the problem. Constable Linda Malcolm, a 26-year veteran of the VPD, knows this reality well. Linda has a wealth of policing experience, having worked in a variety of positions during her time as a police officer. Recently, she spent four and a half years working on the infamous Robert Pickton investigation. Pickton, charged with murdering twenty-six women, chose his victims from the countless drug addicted prostitutes in the Downtown Eastside.

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[10] Personal communication, December 19, 2007

In 2004, in an effort to gather information relevant to the investigation, Linda began attending the Women's Information Safe House (WISH) every Tuesday for "Safety night". Operated by women for the exclusive use of female "survival sex workers", WISH is a non-profit society located in the heart of the Downtown Eastside. Meals, showers and clothing are available along with nursing care and shelter referrals for people who are arguably the most marginalised in our society.

Although her presence at WISH did offer valuable insight into the investigation, over several months Linda found her motivation for attending the drop in center shifting. When her tenure came to an end with the Missing Women's Task Force, she was transferred to the VPD Elder Abuse Unit. Believing that the relationships she had developed and the impact she was able to have on the lives of women at WISH was too important to abandon, Linda maintained her presence at the drop in centre. What began as an unwelcome presence in a world where police are not typically appreciated became a line-up of sex trade workers waiting to speak to Linda. Offering help with what she perceived as small tasks such as reference letters for access to services or phone calls to landlords, Linda could see the dramatic impact this assistance had in the lives of these females. Moreover, she discovered underneath layers of mental illness and addiction were "articulate, intelligent women who were beautiful in spirit and appearance."[12]

When asked to estimate how many of these women appear to be suffering from a mental illness, Linda pauses in thought, and then replies "85 to 90 per cent". She goes on to say:

> I don't believe they come down here necessarily because they are addicted to drugs or want to work the streets. I know the majority of these women gravitated to the Downtown Eastside because of abuse and the break down of a spousal relationship. Failed relationships often result in the apprehension of children and soon after the woman finds herself living in an apartment that she simply can not afford. She ends up looking for cheap housing and gravitates to the Downtown Eastside. Once here, she lives in constant fear.

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[11] N. Winsper, mental health worker, personal communication, August 9, 2007
[12] Personal communication, January 9, 2008

Linda believes that housing is the single most critical concern for the women that she speaks with, many of whom are homeless. "If women don't have a safe place, and few SRO (single room occupancy) hotels can be considered safe, they are up all night worrying about being victimized. They start their day on alert wondering how they are going to survive. Not only are these women victims of the local drug dealers, pimps and sex trade consumers, but also of reprehensible landlords."

When Linda recently mentioned to one WISH client that she was looking tired, she replied that she was desperate for sleep. A few more questions revealed that "Jane"[13] had been avoiding going home. She explained to Linda that a few months ago she found a hole in the corner of her room and discovered that mice had burrowed into the mattress that she sleeps on which lies on the floor of the 100 square space that she pays $375.00 a month to rent. Being unable to cope with rodents crawling over her head at night and keeping her awake, she asked the manager for assistance. Reluctant to get involved, he provided her with saran wrap and a can of Raid. The "in-house" mechanism to rid rooms of these vermin was to wrap the mattress in plastic and then spray it with repellent. While lying in bed, Jane could feel the mice moving inside the wrapped mattress while others were still running around the room. With no further help from the landlord and afraid to spend time in her room, Jane began to abuse prescription medication to maintain an uninterrupted night's sleep. Longer periods of time outside also meant more exposure to the dangers of the street and less mental stability. The last time they met, she told Linda, "I sweep and wash my floors to keep the mouse droppings down and make sure my dirty dishes are never left out. I'm going out of my mind with the infestation of mice. I'm scared to eat at home; all my neighbours have cockroaches and mice."

Linda has several examples of mentally ill women who came to the Downtown Eastside and fell prey to the street. Susan,[14] a female who often comes into WISH, has frequented the Downtown Eastside for the past several years. Since 2001, according to police records, she has shown clear signs of being mentally ill. She is now drug addicted, homeless and works the street to support herself. Although she is prescribed medication for her illness, without any supervision or structure in her life, she rarely takes her pills. Susan has recently been

[13] Name has been changed to protect identity
[14] Name has been changed to protect identity

criminally arrested and taken to jail by VPD members for the first time after several failed attempts to get her the psychiatric help she clearly requires.

In 2007, Susan had 15 documented contacts with VPD members. Her file was referred by officers to Mental Health Emergency Services (MHES) seven times during this same period and she was taken to hospital on two separate occasions. During one such incident, she was involuntarily taken to St. Paul's by two members after she stated that she was desperate and wanted to kill herself. The trio arrived at the hospital at 2:23 pm. Susan was administered anti-psychotic medication and released 50 minutes later.

When Linda made efforts to connect with Susan's advocate and mental health worker to provide collateral information about her increasingly odd behaviour, she was told that due to confidentiality, Susan's situation could not be discussed without speaking to her first. Weeks later, although Linda has had numerous contacts with Susan, a meeting with her worker has yet to happen.

Linda finds herself frustrated with the apparent lack of reasonable help for people such as Susan and watches in horror as the women around her predictably spiral further into the depths of chronic mental illness and addiction, with seemingly little intervention. She recognises that the assistance she can provide many of these mentally ill women is limited by her role as a police officer. Linda's new assignment as a member of the District 2 Neighbourhood Policing Team has afforded her the opportunity to continue her presence at WISH. "What has been identified is a clear need for support for these marginalized women. There is a profound need for advocacy; I only regret that there are not more available mental health and addiction services to improve their lives."

How the VPD is currently addressing the fact that up to half of all calls for service in which contact with a person is made are mental health-related will now be described.

TRAINING

Recruit Training

Fortunately, in Vancouver, Patrol officers are trained to deal with the fact that during some shifts almost half of all incidents they attend in which they make contact with a person involves a mentally ill individual.

When a person is hired by a municipal police agency in British Columbia, they attend the Justice Institute's Police Academy for the first three months of a total eight month training program. This segment of recruit training is referred to as "Block I" and is completed prior to working with a field trainer in a patrol squad. During Block I, recruits are given three hours of mental health instruction. This is taught by a Vancouver Coastal mental health nurse and one of the police members from Vancouver's Car 87. The intent of the presentation is to facilitate a working understanding of assessing risk and determining outcome followed by an explanation of what resources are available in the community. The material provides the constables with the knowledge required to assess the needs of people who are mentally ill and determine when it is appropriate to leave a person in their own care, make an arrest using the provisions of the *Mental Health Act,* or ask for further assistance. The focus is broad, however, as there are constables from various municipalities around the province being trained.

It should be noted that according to the current Justice Institute Police Academy director Axel Hovbrender, the topic of mental health and police is otherwise pervasive throughout academy training.[15] In final simulated incidents, for example, recruits are assessed on their ability to effectively deal with a mentally ill person in crisis. They are expected to recognize that the situation is the result of an individual's poor mental health, apply appropriate techniques to communicate with that person, and determine what the best course of action is. These simulations are observed by a senior police member along with a mental health nurse. Specific feedback is then provided for the trainee and documentation is completed to ensure any necessary follow-up training is carried out.

[15] Personal communication, November 13, 2007

Crisis Intervention Training Course

In addition to the training received at the Police Academy, newly hired VPD members are required to complete a four-day crisis intervention training (CIT) program within their first few years of service. This mandatory program, which started in March 2002, is designed to enhance the working skills of patrol officers when dealing with mental health related crises in the community. The course objectives are:

- *To familiarize participants with the most common apparent mental disorders and psychiatric illnesses such as:*
    - *general concept of mental illness*
    - *early psychosis*
    - *bipolar disorder*
    - *schizophrenia*
    - *drug psychosis*
    - *age-related mental illness*
    - *developmental disorder*
- *To provide participants with the basic tools to assess behaviors and risk associated with these illnesses*
- *To educate participants about services available in Vancouver for this clientele and how to access these services*
- *To provide participants with an overview of police tactical considerations when dealing with people in crisis*
- *To educate participants about victim-initiated homicide(also known as "suicide by cop")*
- *To educate participants of the effects of critical incidents on the officers and the importance of self care*
- *To provide participants with the opportunity to practically apply their skills through simulations.*[16]

[16] Inspector S. Thompson, personal communication, November 6, 2007

The goals of the training are essentially to minimize the use of force by police when dealing with mentally ill people in crisis, reduce the risk of injury to involved parties, and develop a stronger partnership between police and the mental health community. The VPD have met their initial internal goal of having 25% of all members trained in crisis intervention.

Unfortunately, VPD members quickly become experienced at dealing with the mentally ill and make full use of their training. For example, in 2007 alone, police in Vancouver attended 48 suicides. Patrol members, along with Car 87, investigated 1,743 incidents where an individual was arrested under the provisions of the *Mental Health Act*, up from 360 incidents in 1999 (LePard, D., 2000). These are in addition to the countless incidents involving suicidal behaviour that patrol members attend every day, most of which are resolve peacefully.

INTERNAL RESOURCES

Car 87

The Car 87 program is a partnership between the VPD and the Vancouver Coastal Health Authority – Mental Health Emergency Services (MHES). The car is staffed 20 hours a day, seven days a week, with a plainclothes police constable teamed with a registered nurse or a registered psychiatric nurse to provide on-site assessments and intervention for people with psychiatric problems. The nurse and the police officer work as a team assessing, managing, and deciding on the most appropriate course of action. The team is supported by psychiatric nurses on a mental health crisis line which vets calls for police response (Vancouver Police Department, 2007, p. 1). If necessary, the team can call on a psychiatrist who will attend for assessment and, when appropriate, certification of an individual. Further, they represent a valuable source of information for patrol members who often call for advice and direction when responding to incidents that involve a mentally ill person.

Car 87 has been in operation for almost 30 years in Vancouver and is a vital part of the police response to mentally ill people in need of assistance.

Crisis Negotiator Unit

For incidents that require an in-depth knowledge of crisis intervention, the VPD also has a Crisis Negotiator Team of 20 highly trained officers. These police members are chosen through a rigorous selection process that includes the requirement of over five years of police service and the successful completion of a panel interview. Once selected, new team members attend a 10-day Crisis Negotiator Course, typically held at the Canadian Police College in Ottawa, Ontario. The course focuses on how best to defuse high risk incidents such as attempted suicides, barricaded suspects or hostage takings using effective communication skills. The team meets several times a year to discuss incidents where significant lessons have been learned in order to integrate and improve operations and service to the community. After three years, each member re-attends the Canadian Police College and completes a "refresher" course to update the negotiator on current philosophies and techniques in addition to the review of basic skills.

The Negotiator Squad typically works in conjunction with the Emergency Response Team (ERT). Incidents that would otherwise be managed from a tactical perspective, given their level of risk, are often resolved through effective communication. Although the exact numbers are not known, it is believed that the vast majority of situations that require the use of a negotiator involve a person who is experiencing a mental health crisis.

Car 87 was alerted that a male who was diagnosed with bipolar disorder and off his medication was threatening to kidnap his young son. In one day, he went from home to his child's school and then to work, crossing into three jurisdictions as he went: New Westminster, Burnaby and Vancouver, respectively. In each city, he engaged in criminal behaviour related to the kidnapping of his child but managed to elude police before they arrived. Once in Vancouver, he was located and arrested by members of Car 87. The arrest was the result of three police agencies using the information in PRIME to track the suspect and ultimately arrest him for a variety of offences. The grounds for his arrest along with collateral information for his certification under the Mental Health Act all came from PRIME. None of this information was available to the male's mental health worker in Burnaby, nor would it have come available, until police shared it.

PRIME

The Police Records Information Management Environment (PRIME) is the electronic records management system for police in the Province of BC. If an individual has had contact with police and a report was submitted, it is available for reference should it be required. Electronic access to these records is immediate, so PRIME is a valuable tool in responding to critical incidents. Additionally, the nature of previous documented situations may include

collateral information about an individual's diagnosis, family contacts and baseline behaviour. These details, coupled with the particulars of how previous events were successfully resolved, can prove invaluable when attempting to peacefully interact with a mentally ill person.

Because of successful information sharing using PRIME, police in BC often have the most complete and accessible detail about a person's mental health history when compared to that of the various health resources in the community that are limited by region (i.e., Fraser Health, Vancouver Coastal Health Authority, Provincial Health Services Authority) and type (i.e., hospital, mental health clinic, psychiatric institution). None of the health authorities have a common, electronic records management system.

CURRENT OPTIONS: POLICE AND THE MENTALLY ILL

Jail

Recent literature indicates that mentally ill people comprise up to 40% of the prison population in Canada (Canadian mental health association, 2005) and the number of people with mental disorders coming into contact with the justice system is estimated to be increasing at a rate of about 10% a year (Canadian Mental Health Association, 2004). Anecdotally, Sgt. Anne Drennan, who worked in the VPD jail, estimated that the number of mentally ill people in the City jail could be as high as 60% and states that it is typical to be involved with several "significantly mentally ill people" in a 12-hour shift.[17]

In the Vancouver jail there is a Registered Nurse (RN) who works in company of a Licensed Practical Nurse (LPN) for the purpose of assessing the health needs of prisoners. These nurses work 12-hour shifts that are scheduled to provide 24-hour coverage, seven days a week.

[17] Personal communication, November 6, 2007

The role of the jail nurse in identifying prisoners who are mentally ill is significant. Despite officer training and "on the job" experience, patrol officers are not experts in health-related issues, nor could they reasonably be expected to be. Further, many people who are brought to jail are less likely to speak to a law enforcement member than a medical professional about their mental health, simply by virtue of the role that police embody. All prisoners brought into the jail facing criminal charges are interviewed by nursing staff. During this discussion, the nurse asks about possible thoughts of suicide and/or harm to others. If the nurse feels that there is a risk to the offender or those around them, the jail sergeant and the guard supervisor are advised. Decisions are then made about the individual's need to be checked more frequently and/or segregated. Sgt. Drennan described the interview with nursing staff as "critical" because often it is the only opportunity to assess a prisoner's mental state.[18]

Although on occasion there are nursing shifts that go unstaffed due to a shortage of RNs, this issue has drastically improved in 2007. Regrettably the jail doctor will not attend and complete "rounds" if there is no nurse on duty due to safety concerns.

Unfortunately, people who are brought into the jail for being intoxicated in a public place or for a breach of the peace are not seen by nursing staff. Although neither of these circumstances result in a criminal charge, they may often involve a person who is mentally ill.

There is a well known, regular occupant of the VPD jail who typically gets arrested for minor offences on a weekly basis. He is diagnosed with schizophrenia, often fails to take his medication, and subsequently presents as a very ill individual. Once in jail, it is not uncommon for him to smear feces all over himself and the cell that he is in. He then masturbates to the camera, yells profanities, and bangs his head against the walls. Jail guards wash him down, move him to a new cell, and bleach the old one clean. Once relocated, he repeats this behaviour, often requiring several moves. This male has had 112 documented contacts with police in 2007 alone. He was taken to hospital under the provisions of the **Mental Health Act** ***nine times during this same period.***

As previously mentioned, if police officers in Vancouver feel it is necessary, they are able to request a psychiatric assessment for an individual upon arrest. The officer may spend considerable time detailing the reasons for this request in the Report to Crown Counsel. This will include not only relevant details of the incident but perhaps mental health history from police records, family, and/or friends. Given that police records are contributed to and accessible by all police officers in BC through PRIME, this

collateral information can be extensive. Once the accused is lodged in jail, however, neither the jail nurse nor the doctor has access to this report. This is significant because it is the doctor who, in the absence of a court imposed assessment, may decide to certify the offender under provisions in the *Mental Health Act*.

Court

If an accused person is recognised as being mentally ill prior to going before a judge for their first appearance (by the jail doctor, Crown, or defence for example), a forensic liaison nurse or social worker may become involved. The liaison will speak to the individual's community situation, provides a brief overview of their psychiatric and medical history and comments on their current mental status. Unfortunately, the flow of information to the liaison is somewhat informal and often relies on their personal knowledge of the accused person. The court may release the individual with conditions to attend the Forensic Psychiatric Services Clinic where their mental status can be monitored while on bail.

In September 2007 a man attempted to kill his six-year-old daughter as she lay sleeping on a couch in the family home. When the child awoke to her father strangling her, she struggled until he released his hold on her neck. Police were called and the suspect was arrested and taken to jail. It became apparent based on collateral information from family and in speaking to the suspect that he was suffering from a significant mental illness. Relying on details from the investigating members, Crown Counsel requested that the accused be remanded in custody pending a psychiatric evaluation. The judge agreed and ordered an assessment to determine if he was fit to stand trial on the attempt murder charge. He was transported to North Fraser Regional Correction Centre where he sat waiting for a bed at the forensic psychiatric facility. No space became available and the assessment was completed in jail. When he went back into court a month later his lawyer, frustrated at the time his client spent in jail, requested that the judge order that the next evaluation take place in a designated psychiatric facility. The presiding judge stated that he was apprehensive to get involved in what was essentially a provincial resource issue. The accused went back to prison to await room at a designated facility.

Alternatively, the judge may order a "fitness to stand trial" assessment. The threshold for this test is very low and although an offender may be extremely mentally ill, if they are able to understand the possible consequences of the proceedings and communicate with counsel, they will be deemed fit to stand trial. There are only sixteen individuals in the province who are currently deemed chronically unfit[19].

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[18] Personal communication, November 6, 2007

[19] These are people who are likely to remain unfit to stand trial due to a permanent condition (brain injury for example).

In the event that a fitness assessment is ordered, the accused may be transferred to North Fraser Pre-trial Center or the Surrey Pre-trial Center pending completion of the assessment. The judge allows up to 30 days for this assessment to be done and, although it only takes approximately one hour to complete, the next hearing for the accused is typically scheduled 30 days from the original order to allow time for the evaluation to occur.

There is a profound lack of space at the Forensic Psychiatric Hospital in Port Coquitlam, the only secure forensic facility in British Columbia. Many of the fitness assessments are conducted in jail and, when necessary, some offenders often wait weeks to be transferred. The hospital is typically at capacity with a waiting list.

If medication is refused by a mentally ill offender in jail, they sit untreated in a cell because forced medical treatment is not permitted in a prison (*Corrections and Conditional Release Act*, 1992). According to Dr. E. Russel, who often works in the Vancouver jail, individuals often become so sick that when their time comes to be transferred, either back to court or to the forensic facility, the guards are apprehensive to go in to their cell to retrieve them due to health and safety concerns.[20]

If an individual agrees to accept medication while in prison, when they go back before the judge, their symptoms may have abated and they may appear to be mentally well. Since there is therefore no longer justification for further incarceration, the judge will often release the accused on an undertaking with conditions. Therefore, a person who was suffering from a mental illness endured incarceration for 30 days simply to receive medication. There is no reason to believe that the individual has any more insight or understanding of their illness than they did upon entering the justice system. Further, this period of imprisonment would clearly not have occurred had the individual not been mentally ill, since it stands to reason that if the judge releases the accused once they present as “well”, the same would have occurred in the first instance in the absence of a mental illness. Finally, when they are released, the individual is no further ahead in regards to treatment of their condition. The end result is that they are back on the street and likely back in court a few days or weeks later.

One senior Crown lawyer stated that there was "general exasperation at the pressure to approve charges against people who could otherwise be served by civil resources" and the courts have recently acknowledged the lack of community resources for people who are mentally ill.[21] In an extraordinary comment from the B.C. Court of Appeal in November 2007, three Justices concluded that a lower court judge had difficulty sentencing a 27-year-old mentally ill repeat offender because there was no medical help available. Justice Catherine Anne Ryan wrote that, "this court can do no more than to acknowledge the lack of resources and urge our legislators to respond to the need" in the unanimous decision. Justice Ryan went on to say that the case "demonstrated the difficulty of sentencing the mentally ill offender, especially those who are also addicted to alcohol and/or drugs" (*R v. Donato, 2007*).

Hospitals

There are two circumstances under which a police officer would accompany an individual to hospital for mental health assessment and treatment. The first is a voluntary admission at the client's request. The second is an involuntary admission when a police officer arrests an individual using the provisions of the *Mental Health Act* or when executing a "Director's warrant". In both cases the mentally ill adult person is usually taken to either St. Paul's hospital or Vancouver General Hospital (VGH) via ambulance.

St. Paul's Hospital is run by Providence Health Care. Upon arriving at the emergency department, hospital protocol requires that the patient is initially seen by the emergency room physician. If the person is deemed to be in need of mental health care, they remain in the emergency department until a psychiatrist is available or they are admitted to an inpatient unit, depending on the circumstances. The mental health program at St. Paul's has 48 general beds, seven eating disorder beds and four pain program beds (Canadian Mental Health Association, 2006, p. 13).

Vancouver General Hospital is run by Vancouver Coastal Health Authority. As with St. Paul's, a patient must be assessed by the emergency room physician prior to admission to the Psychiatric Assessment Unit (PAU). The PAU is a short term holding and assessment unit of

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[20] Personal Communication, September 27, 2007

20 beds. VGH also has an additional 40 beds in various psychiatric units (Canadian Mental Health Association, 2006, p. 13).

There are several concerns for the VPD with respect to taking a mentally ill person to hospital. Given the patient must first be seen by the emergency room physician, wait times are often significant for a patrol officer who is required to stay with a person until they are seen by a doctor. These wait times are currently being recorded by the VPD in an effort to clearly quantify police resources that are being used to accommodate this requirement; police typically can wait from several hours to an entire shift to have the patient seen.

Additionally, there is a perception that an individual must meet specific, narrow criteria that is much higher than the legislated threshold of being a danger to themselves or others in order to be admitted. Former coroner Kathleen Stephany conducted PhD research on recorded cases of subjects who had committed suicide within 72 hours of meeting with a health professional. While investigating 118 cases over 11 years, she found that "…physicians aren't very well trained in suicide prevention….interns might get an hour or two of lecture time on suicide risk assessment during their residency" (McMartin, 2007). Further "out of a sense of frustration and expediency, physicians and staff sometimes fall back on what she calls the one-sentence suicide risk assessment – that is they ask the patient, are you suicidal now?" (McMartin, 2007). If the person responds "no" they are often deemed to be no longer a danger to themselves and are released.

Vancouver Coastal Health Authority estimates there are about 4,000 people in the Downtown Eastside alone who require more support in terms of health and addiction services. Of those, they further assert that approximately 2,100 individuals from that group have visible problems, no permanent housing and "exhibit behaviour that is outside the norm" (Vancouver Coastal Health Authority, 2007). It is this group of people who frequently come into contact with police and for whom there appears to be little in the way of mental health intervention. An example of one such person is Bill Taylor.[22]

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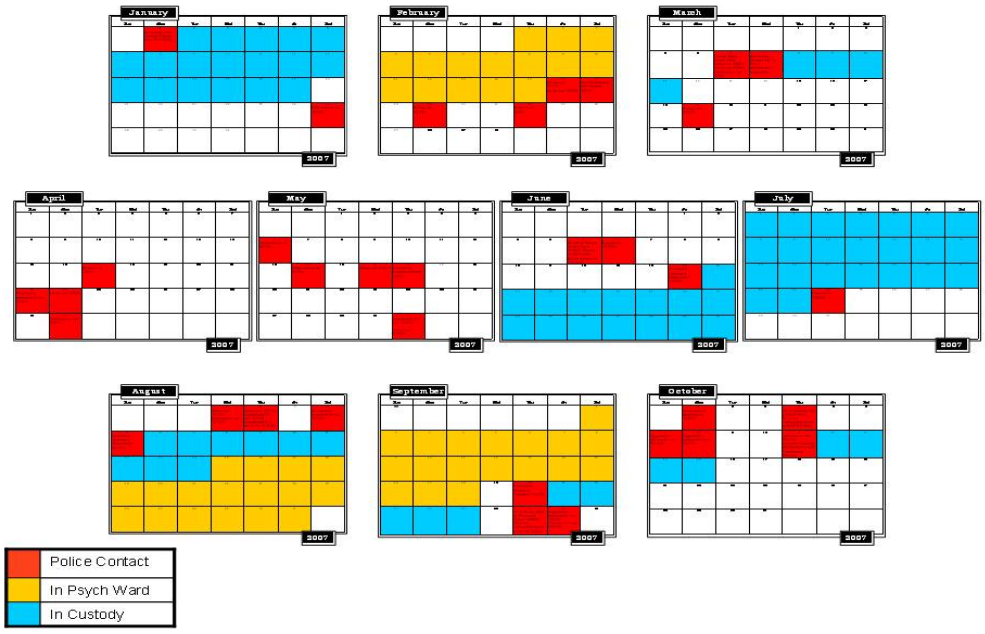
[21] Confidential personal communication, January 3, 2008
[22] Name has been changed to protect identity.

Bill lives in the Downtown Eastside. He is a crack cocaine addict and is diagnosed with both schizophrenia and bi-polar disorder. In the 1970's Bill was found not guilty by reason of insanity for attempting to kill someone in BC. He spent ten years in a psychiatric facility as a result of this incident and was then released onto the streets of New Westminster where he wreaked havoc until 2003 when he moved to Vancouver.

Bill is a daily challenge for the VPD and has had 145 documented incidents with police between 2003 and 2007. In addition to being mentally ill, addicted and physically disabled, he has a personality disorder and engages in attention-seeking behaviour, often waiting outside of the VPD jail and assaulting a passersby in an effort to get arrested and gain entry. During a recent incident, Bill told the involved police officer that he was going to pour gasoline on her home and watch it burn. This type of behaviour is not the exception for Bill, it is the norm. He has been known to approach vehicles that are stopped at a light, thump on the driver's side window, scream outrageous obscenities at the driver despite the presence of small children in the car, expose himself, and demand money. Bill frequently urinates on the lobby floor of the building in which he lives and is often a victim himself given his behaviour towards others coupled with his physical disability.

A calendar showing Bill's contacts with police, the time he has spent in a psychiatric facility and the time he has spent inside jail from January 2007 to October 2007 is provided.



The police contacts are in red, the jail time in blue and the psychiatric facility time in yellow. On some days, there were multiple contacts with police. This calendar does not include any incidents in which Bill's name was not referenced or an incident number was not generated by the involved police member, so it is likely there are additional incidents. In fact, Bill's housing worker was asked if it was possible that he had stayed out of trouble for the first few weeks of April, when Bill's whereabouts were unknown. His response was, "unless Bill was inside [in custody], it is impossible that he went 24 hours without having police contact."

As can be seen, there are significant police and other resources being used to manage this man. One thing that people involved in Bill's life, such as his mental health worker and staff at his residence, agree on is that he is not successful living in the community. They believe that he requires a lengthy stay in an institution where his medication could be stabilized, his drug addiction addressed, his physical needs evaluated and his future considered. While none of these individuals philosophically support institutionalization of the mentally ill, they do recognize that Bill's current situation is not working for anyone, particularly for Bill himself.

Through the examination of hundreds of reports, it became apparent that there were two distinct groups of individuals who represented the majority in mental health related police incidents in Vancouver. There were the severely drug addicted, mentally ill, hard to house, chronic offenders like Bill Taylor. But there were also those people who often came into contact with police for relatively minor offences and, although the police members could see the person was mentally ill and made note of it, they did not meet the threshold for being a danger to themselves or others. These people were unlikely to have ever come into contact with police were it not for their illness.

THE ROLE OF PROPER HOUSING AND SUPPORTS

As noted earlier, many individuals with mental illness live successfully within the community, but there are significant numbers living in inadequate housing and are vulnerable to predatory drug dealers and others who victimize them. One of the Vancouver's problems related to the

mental health issue is homelessness; in fact, a high proportion of the homeless suffer from mental illness and addictions. These individuals are a major draw on police resources. It is noteworthy that the increase in homelessness over the last decade is strongly correlated to the increase in problems associated to the mentally ill on Vancouver's streets.

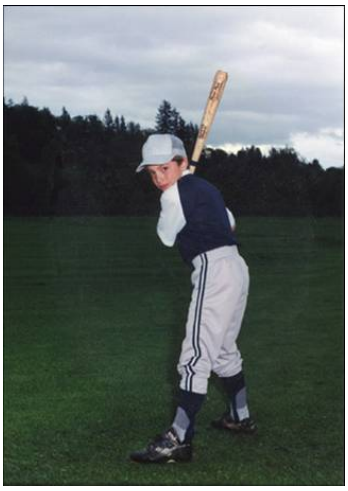
There are successful housing facilities in Vancouver that provide housing and support services for the mentally ill and dual-diagnosed population; however, there are not enough such units, and more support services are required. The City of Vancouver has argued (unsuccessfully) for a number of years for increased supportive housing to address the problems of homelessness, mental illness, and addictions. Most recently, the City has considered the concept of enhanced tax breaks for private investors for the construction of supportive housing. A more aggressive program for the provision of housing and appropriate supports is necessary to address the homeless and those living in inadequate housing.

Even this will not address the problems associated with the small number of highly disruptive mentally ill people currently in the community. A mental health care facility for moderate to long term stays is required for chronically mentally ill individuals with extreme behaviours and disabling addictions.

The following true story is documented in an effort to illustrate many of the issues that have been covered in this paper.

COREY'S STORY

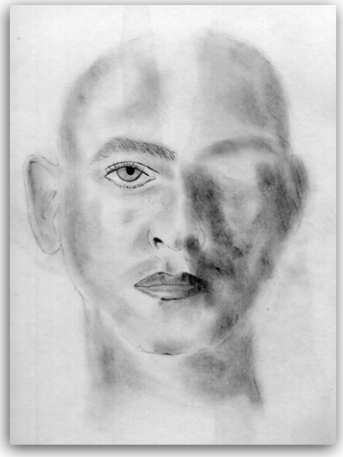
Corey O'Brien, the only child of Kate O'Brien, was born in Moncton, New Brunswick on November 16, 1981. Kate describes Corey as a "dream to raise", an easy baby and a calm, thoughtful and polite child. Summers would find the two at Grandma's cottage, playing with cousins and neighbors and swimming in the warm waters of Northumberland Strait. Corey spent winters going to French immersion elementary school and hitting the ski slopes with his mom on the weekends.



A new career, better weather, and great slopes drew Kate and Corey to BC where they settled in Mission in 1989. Corey continued to thrive. He began to develop what would be a lifelong love of sports and it became apparent, even at this young age, that he was a gifted athlete. Starting with soccer, he played all over the Lower Mainland, barely ending the season before donning a baseball glove. Summer brought swimming at Cultus Lake and with the first decent snowfall, out came the skis.

When Corey was nine years old Kate was thrilled to watch her son develop a more creative side. When he received the gift of a keyboard, Corey not only taught himself how to play it without the benefit of lessons, but also how to read notes and later compose music. He went on to reveal a talent for drawing that was impressive for one so young.

In preparation for the start of high school, Kate and Corey moved to Abbottsford in 1993 and Corey attended Bateman High, where he flourished. Corey became part of a close circle of friends and enjoyed the social activities of a typical teenager. He went on to excel not only as an athlete, but also as an artist.



Corey embraced technology during these years and it became his passion in life, winning numerous national Skills Canada Awards for animation. By age 14, Corey had developed his own web site and went on to form a web development business while still in high school. He passed his knowledge and interest on by teaching seniors how to navigate the internet at a summer job he was awarded through the government program “Youth and the Internet”. One of the managers at the Clearbrook library where he worked remembered Corey’s time there and years later wrote to Kate, “I remember one time Corey did an internet training session for senior library system staff, and he didn’t break a sweat. He was funny and entertaining and I remember I was so proud of this young Abbotsford kid because he worked at my library in Clearbrook. I still hear people from time to time talk about that kid from the library that helped them to learn about computers – he mattered, he made a difference.”

In addition to being creatively gifted, Corey had the rare combination of both intellect and athletic prowess. He continued to pursue his love of sports and, much to Kate's concern, switched from the relatively safe sport of soccer to the hard hitting game of rugby.

Twice Corey went overseas to play the sports he excelled at, first with his soccer team and then with the Bateman High rugby team, having a fantastic time as much for his love of sports as for the camaraderie that each trip brought.

Corey successfully completed high school with impressive grades and having often made the honor roll. He participated in graduation celebrations with his friends, including his longtime girlfriend. His grandmother came from the east coast to attend along with his aunt and uncle and many family friends. During his final year, Corey received a recruitment letter from UBC inviting him to enroll and play for the Thunderbird Rugby Team. At the same time the animation industry had its eye on this gifted, award-winning young animator and Corey was offered a job with Electronic Arts (EA), one of the largest and most prestigious animation firms in the world. It was his dream, what he had worked so hard for all though high school.

Yet another success story in this impressive young man's life, Corey was only 17 years old when he was nominated "Rookie of the Year" at work. One of Corey's coworkers at EA wrote this about their impression of the new kid at EA. "I knew Corey when he first started at EA in the motion capture department. I was amazed at how bright and enthusiastic Corey was from his very first day. I recall myself and other co-workers commenting on his amazing potential and passion. He had this aura of ability that surrounded him; it's something I'll never forget."

Corey moved out of the family home into an apartment in Burnaby and then into Vancouver with a friend, working at Electronic Arts during the day and also teaching animation at VanArts College at night. Kate was very proud that Corey was well on his way into successful adulthood. He had a wealth of opportunity in front of him and an admirable history of achievements for a person so young. Corey was doing the work he loved, earning a very good wage, giving back to his community by teaching others, and enjoying the life of an intelligent,

good-looking young man with a solid family and close friends. It was not long, however, before Corey's world began to unravel when, without explanation, he quit both jobs and came back to the family home to live in September 2001.

Once the confusion of Corey's decisions about work dissipated, Kate and her partner Craig encouraged him to see a doctor for what they believed was depression. Corey refused to go and continued to live with them in Langley for several months. After moving out with friends, then into his own suite and back home again, it became apparent that Corey was not the same young man who had been happy and successfully navigating his way through life only 12 months earlier.

Kate, who focused on ensuring that Corey had a safe place to live regardless of his lack of income, arranged for him to rent an apartment in Abbottsford. In November 2002 she was stunned by a phone call from the owner of the suite who stated that Corey had been arrested for mischief in relation to damaging the premises. Upon arrival at her son's home, Kate was horrified to "walk into a nightmare", and see how sick Corey really was. There were disturbing drawings all over the walls, window coverings torn down, walls kicked in, mirrors smashed and food smeared on the floor. It was inconceivable that Corey – the gentle, thoughtful, intelligent young man they knew and loved – had done this: what proved to be over $6,000 worth of damage to the suite, a bill that Kate and Craig paid.

Desperate to find help for Corey, Kate begged the police in Abbotsford to have a mental health assessment done; however, they were either unable or unwilling to do so. Corey was released from police custody the following day and his situation was dire. He was seriously ill, evicted from his home, and isolated from his friends and family due to increasingly aggressive behaviour.

Knowing that it was critical to keep Corey housed but unable to bring him home to live due to his behaviour, Kate moved him into a hotel first in Langley, then Surrey, and finally in Vancouver, each resulting in a brief stay and subsequent eviction. While living in a hotel on Granville Street in January 2003, Corey had his first incident with the VPD in relation to eating a meal at a local restaurant and then refusing to pay for it. Recognizing that Corey was ill, the attending police members resolved the situation informally by phoning Kate, who agreed to

pay the outstanding bill. They then escorted Corey home to his room and, after a brief conversation, requested the assistance of the mental health worker on duty (Car 87).

Car 87 attended and for the first time in his life Corey spoke to a mental health professional about his condition. Determining that he was not a danger to himself or anyone else, but clearly recognizing that he was suffering from a mental illness, the mental health nurse secured Corey's commitment to check in with the West End Mental Health Clinic the following day. A detailed report was then completed and forwarded to the clinic with a request that "they contact the client should he make no inquiry re: appointment".

Seven days later, in the absence of contact from Corey, staff from the clinic determined that he had been evicted and his file was closed. This missed opportunity for intervention would prove devastating for Corey, and his family, as he fell further into the confusion of living with an untreated mental disorder.

Later that January, Corey travelled to New Brunswick to visit family. He had still not seen a doctor, nor had he been diagnosed with a mental illness. After a disastrous brief stay with relatives, Corey found himself homeless in Moncton before returning to BC in September of that year. Despite Kate's best efforts, he remained on the streets in Vancouver and had three incidents involving police when he ate meals in Vancouver restaurants and then failed to pay for them.

In the first incident, Corey was charged and released on an appearance notice. On the second occasion, although it was clear he was ill, he did not meet the threshold of being a danger to himself or others and was released without charges or an arrest under the *Mental Health Act*. In the final incident he was taken to jail on an outstanding warrant in relation to the first fraud, but no additional charges were pursued. By October, Corey managed to find a room to rent on Abbott Street in the Downtown Eastside. In his confused state he couldn't understand the rental application, nor was he able to figure out how to acquire new identification to replace what he had lost; he was a far cry from the highly functioning young man of only a few short years prior. Corey angrily allowed Kate to help him put this most basic roof over his head.

One month later, distraught and terrified by the intense psychotic symptoms he was experiencing, Corey finally took himself to hospital. On the first visit, he was turned away and told that it was not necessary for him to be admitted. Knowing that he was very ill, he went back to hospital and was seen by a doctor who agreed to help him.

On December 17, 2003 Corey was admitted into the Psychiatric Unit at St. Paul's, committed, then transferred to St. Vincent's Hospital. Just after Christmas, however, he fled and went home to his room on Abbott Street. A Director's warrant was issued to have him returned. When police picked him up Corey was taken first to jail in relation to one of the previous fraud charges and then back to St. Vincent's. He was then transferred to St. Paul's for what would prove to be his longest stay in hospital: 28 days. At the time he was admitted, Corey denied the use of any illicit drugs and his negative toxicology screen supported this assertion. While in the hospital, staff from the psychiatric ward phoned Kate who met with them and provided details of Corey's struggles over the previous two years. It was in the first weeks of 2004 that Corey was diagnosed with schizophrenia before being discharged on January 14, 2004.

While in hospital, Corey's psychiatrist reported that he had "shown a steady and gratifying remission of his active psychotic symptoms", and that "the auditory hallucinations" had completely stopped. Discharge issues were discussed with Corey, along with Kate, and disability was applied for. Corey himself described his mood as reasonably good and stated that he was relieved to be no longer having the auditory hallucinations or other confusing symptoms he had been experiencing.

For the first 10 days out of hospital, Corey appeared to be coping well. He was referred to the Strathcona Mental Health Team and met with a doctor for an assessment, along with Kate. One evening Corey began to feel unwell again and took himself back to St Paul's to ask for help. He spent one night in the psychiatric ward and when staff called Kate, she was waiting for him upon release the following day to take him home with her.

At the end of January 2004, with the assistance of a lawyer hired by Kate and Craig, Corey began attending court in relation to the mischief charge from Abbotsford. The process dragged on for months until the charge was dropped when the judge did not believe that Corey had the mental capacity at the time of the incident to form the required intent necessary

for conviction. The constant worry about the outcome and concern about the cost his family had incurred weighed heavily on Corey's mind and health.

Corey lived with Kate and Craig for several months, a time described as one of great hope. Corey attended an early psychosis intervention (EPI) program in Vancouver to help him identify, understand, and manage his illness. He also continued to meet with a mental health worker at the Strathcona Mental Health Team and successfully attended court in relation to the fraud incident at the Vancouver restaurant. Kate and Craig educated themselves and went to seminars to learn about schizophrenia. There was a strong belief that with Corey's diagnosis would come help from within the mental health profession and some relief from the horrors of the past two years. Corey was moody and anxious, but continued to take the medication prescribed to him during his hospital stay.

Although Corey maintained his room on Abbott Street and occasionally stayed overnight to attend meetings in Vancouver, he primarily lived at his family home over the next few months and through the summer. In May 2004, with the help of Kate and Craig, Corey rented a suite in New Westminster and began classes at Douglas College. He was eager to get his life back and tried valiantly to focus on his studies and manage his stress and anxiety. It was not to be. Finding it difficult to concentrate, Corey withdrew from college after a few weeks, deciding instead to focus on trying again in the Fall 2004 semester. Corey continued taking his medication while attending the EPI program and his file was transferred from Strathcona Mental Health to New Westminster Mental health where he began to meet with a new worker and see a different psychiatrist on a routine basis. When meeting with his doctor, there were no signs of illicit drug use and Corey kept regular appointments, often going home to stay with Kate and Craig for prolonged periods.

In September 2004 Corey again enrolled in a course, this time at Emily Carr Institute of Art and Design. Kate stood painfully by as she watched her son, for whom academics and artistic endeavors had come so easy in previous years, struggle with basic entry level material. It was not long before the challenges of living with schizophrenia proved too much for Corey and he withdrew from class again. At his February 9, 2005 psychiatric appointment, it was noted that Corey's current quality of life was "slipping away from him." Kate continued to be involved and kept in contact with Corey's psychiatrist, updating him regularly on how she believed her son was doing.

At some point in February Corey stopped taking his medication and his mental health began to rapidly decline. He attended his appointments, however, and was able to convince mental health professionals involved in his care that he was doing fine and still complying with his medication schedule. Kate, on the other hand, became alarmed at Corey's state as did the manager of the building in which he lived. Always advocating on behalf of her son, Kate tried repeatedly to convince Corey's worker that he needed help and that a visit to his residence would show how ill he really was.

Finally, at the end of March 2005, that visit took place and Corey was immediately involuntarily admitted under Section 28 of the *Mental Health Act* to Royal Columbian Hospital. After a 10-day stay in hospital, Corey was certified and then released on a 10-day pass. The following weeks were spent going in to Royal Columbian Hospital for a few days, being released briefly, then being re-admitted for non compliance with medication.

A shift was apparent in Corey's behaviour during this time and he was noted to be "very hostile and argumentative". This was a "dramatic change as previously Corey had been a very polite reasonable fellow with whom rapport was not a difficult thing to attain". Corey remained certified and was in and out of the psychiatric ward in New Westminster until June 21, 2005 when he was released for the final time from Royal Columbian Hospital.

During the month of June, Corey managed to secure a low level job at a call centre in Vancouver, soliciting donations mostly from senior citizens. The job lasted only four days but it was long enough for Corey's confused mind to rationalize moving from the quiet New Westminster neighborhood, which he now perceived as a negative and frightening place, into a rooming house in Vancouver's Gastown. Kate was horrified to see Corey's new home, later describing the conditions as "disgusting", with water leaking throughout the building and dirty communal bathrooms. The 100-square-foot room contained little more than a mattress on the floor.

Although Corey was still "committed," he was on leave. His file was transferred from New Westminster back to Strathcona, which assumed responsibility for monitoring his mental health. Corey continued to deny the use of illicit drugs and attended scheduled meetings with his worker and psychiatrist. Kate made contact with Corey's new doctor and began the search

for new housing for her son, believing that he had to get out of the Downtown Eastside to be able to live independently in peace and safety.

During this period Corey was erratic in his demeanor with Kate. He demanded she not interfere with his life or health care and insisted she not do or say anything that would result in him being committed to hospital against his will. He desperately wanted his independence back and was very frustrated and resentful when he had to ask for help. Kate played a balancing act in order to help Corey while trying not to alienate him.

Then suddenly Corey seemed to find some clarity and began his own search for better housing. He found a City-run building on Granville Street that was newly renovated and appeared cared for. As had happened before Corey was unable to navigate the application process. Thankfully he shared enough information with Kate that she was able to advocate for him with the building manager, and while there was a huge list of applicants, Corey was accepted. Kate was thrilled. There were compassionate staff on site who agreed to monitor Corey and alert Kate and his health workers if he appeared unwell.

In September 2005 Corey moved in and Kate and Craig both went to work getting him settled yet again. Corey's few belongings were left at his previous residence because neither Kate nor Craig could bring themselves to venture back into the building given its appalling state.

Just prior to moving from Gastown, Corey took himself back to St. Paul's Hospital as he was having feelings that were similar to those that he'd experienced when he last had auditory hallucinations. He stayed at St. Paul's for three days, telling staff that he had a "sense of comfort from his previous inpatient stay" there. The attending psychiatrist noted that Corey "slept well over the three nights of his stay and his mood improved. He was able to focus on his drawing and do a number of pieces while he was here. He was in daily contact with his mother, who was reassured by his improvement and felt that he was more organized and calm after his hospital stay." With a slight change in medication, Corey reported feeling better by the time he saw his mental health worker on September 14, 2004.

In December 2005, Corey was reported to be having difficulty in his new home. The building manager phoned Corey's mental health worker and stated that he was accusing other tenants

of bizarre behaviour, was sleeping all day, and had shaved his head. On December 15 a mental health worker attended Corey's home but he was not in. According to interview notes, at his next scheduled appointment he seemed relatively well and a follow up phone call to the manager confirmed this.

That Christmas when Corey stayed with Kate and Craig, he was clearly suffering from hallucinations and paranoid thoughts, believing that military aircraft were surveilling him and that mathematical equations would help him get better. He spent considerable time writing and drawing "formulas" and Kate was so concerned that she called and relayed this information to his doctor at the end of December. Despite this information, when Corey had his next appointment, it was noted that he "was neatly dressed and groomed and was wearing stylish casual clothing". Further "he denied any paranoid thoughts" and stated that "he had had a pleasant time over the Christmas holidays staying at his mother's." Finally "he cheerfully accepted an appointment." The follow up meeting with the doctor also contradicted what Kate had reported and it was recorded that Corey "was fairly cooperative and pleasant through the interview" and "denied having any belief that he could solve his problems through mathematical equation." Corey continued to deny the use of any illicit drugs.

Despite several apparently successful appointments with both his mental health worker and the doctor, Corey's mother continued to notice and report her son's mental decline. Kate phoned Strathcona Mental Health on January 25, 2006 and expressed her frustration because she believed Corey was very ill and not taking his medication. In yet another phone call on the 26th, she stated that Corey appeared "irritable, demanding and verbally hostile." She was advised that "when he presents here, he is keeping everything intact" and the possibility of Corey having medication administered to him was discussed. A phone call to the manager of Corey's building by his mental health worker revealed that she believed Corey was using drugs and was refusing to allow staff to enter his room. Further, she stated that in her opinion, Corey was paranoid and some staff felt intimidated by him.

Kate called again on January 30 and reported that her son had threatened her and, although she was not at all concerned for her safety, she asked that he be hospitalized to get some help. On January 31, 2006 a Director's warrant was finally issued for Corey's return to hospital from Extended Leave. The warrant was executed later in the day and Corey was returned to St. Paul's by the members of Car 87. Despite the collateral information from both Kate and the

manager of his building, upon admission to St. Paul's a nurse advised that "he may be kept overnight, however there is a chance he may be discharged this evening." As it turned out, Corey stayed in hospital for one night and was released the following day. During his brief stay he continued to deny any illicit drug use; however, for the first time since his diagnosis, a toxicology screen revealed cocaine and cannabis in his urine.

When confronted about the illicit drugs in his system, Corey continued to deny that he had consumed any cocaine. He went on to miss several scheduled appointments in the days following his release from hospital. Kate phoned, arranged and drove Corey to a scheduled appointment on February 14. Corey's certification was renewed for six months given his lack of insight and the additional problem of drug use.

In February 2006, Corey was arrested by VPD members in the first of 4 incidents over 12 weeks. Every situation was minor in nature, however, and it is clear that his behaviour could be directly attributed to the symptoms of his illness.

At the end of February, Corey phoned 911 to report that people were following him and that they had a magnetic attraction that was hurting his biorhythm. Police attended his suite and determined that he was not a danger to himself or anyone else, appeared physically healthy, and had food in the fridge. They had a brief conversation and completed a detailed report that was forwarded to Corey's mental health team. Corey's meetings with his psychiatrist became more confrontational through March, and he requested that his file be transferred to the West End clinic as it was closer to home. In May, this transfer took place.

With the move, Kate attempted to make phone contact with his new worker several times to provide collateral information about Corey's history and introduce herself. More than two weeks later, in the absence of a return phone call, Kate faxed through a letter in which she stated, "I just wanted to introduce myself and share some background information about Corey with you. Wanted you to know he has a family that cares a lot about him and give you some insight into who your new patient is and what he has been through. I hope you find this helpful. Please feel free to contact me if you wish." The three page document then went on to

clearly detail Corey's history and his struggles with schizophrenia.

Corey continued to be certified and on extended leave under the provisions of the *Mental Health Act*. He made 11 regular visits to the clinic from May 26 to October 26, 2006. In June, he agreed to scheduled injections that began to be administered every two weeks at the clinic. Despite this, there were several recorded contacts from Kate or others to report that Corey was doing poorly. Specifically, on October 27, Kate phoned to advise Corey's worker that her son was not coping well. She explained that she believed much of his anxiety and apprehension in public places was due to his paranoia and exaggeration of real experiences. Kate was assured that Corey's medication would be reviewed the following week. At his next visit on November 2, 2006, despite the warning sign of "lost" prescriptions and further details from Kate that Corey continued to be "anxious and paranoid about being in public", this review did not happen. The case worker noted that "it may be that his anxiety and paranoia are a result of his being under medicated" but went on to write "we will address this issue at Corey's next appt." A visit the following day and then another on November 9, however, came with the suggestion that the "patient continue on his current medications."

On November 17, 2006 Corey stabbed himself in the stomach in an apparent suicide attempt and then called police, reportedly regretting his actions. He was taken to St. Paul's hospital with what proved to be non-life-threatening injuries. A toxicology screen confirmed the presence of cocaine in his urine. Corey admitted that he had consumed illicit drugs on his birthday. Despite pleas from Kate to keep Corey in hospital and a request for the same from his psychiatrist at the clinic, he was released after a four-night stay.

This pattern of deterioration and lack of meaningful intervention culminated on November 25, 2006. Only four days after being released from hospital, at 8:26 a.m., Corey was seen jumping from the west side of the Granville Street Bridge. He landed on the roadway below, was transported to Vancouver General Hospital, and died a short time later from his injuries with his mother at his side.

The final case note audit report stated that "street drugs are suspected as a contributing factor in Corey's death" and "it is likely his use of street drugs had a contributing role in his suicide." This conclusion may have been accurate; however, it is unknown and somewhat troubling, since a toxicology test was never completed by the coroner. The report further reads "this was

an apparent suicide attempt, but no note was left". There was in fact a suicide note that Corey left; it wasn't discovered until Kate went into her son's room and found it herself.

During the last several months of Corey's life it was clear to Kate and others around him, such as the manager in the building that he lived, that his mental health was in decline and he needed assistance. Pleas were made to change his medication, admit him to hospital and conduct home visits. Kate was a tireless advocate, not only taking Corey to appointments, but repeatedly contacting the involved mental health professionals to advise them of her son's condition. Frustrated at the lack of action, she worked on maintaining a positive relationship with staff so as not to isolate herself or Corey from them in any way.

When asked what could have been done to prevent her son's death, Kate O'Brien first starts by explaining that she does not hold any anger or resentment towards anyone who was involved in Corey's care. She does, however, believe that her son was failed by the mental health services in Vancouver for a variety of reasons and wonders what happens to those people who do not have the support of family, as Corey did. Despite her unrelenting advocacy on Corey's behalf, many of those people involved in his care were simply unable to adequately provide for his needs. She attributes this to mental health professionals who were overworked, lacked practical resources and were generally frustrated trying to function in a dysfunctional system that is unrealistic in regards to institutionalization and the sharing of information.

Further, Kate feels that the threshold of being "a danger to himself or others" was a major negative factor in Corey getting the treatment he desperately needed. She believes that this is an unrealistically extreme and vague benchmark with which to gauge treatment options and a completely impractical measure for the acceptable quality of life for people with mental illness.

Kate believes that if Corey had been institutionalized for a number of months his medication could have been stabilized and he could have spent time learning how to cope with his illness. Further, a program of reintegration that started with housing and involved closely monitored care along with administered medication may have resulted in Corey again becoming a functioning, contributing member of society.

CONCLUSION

This report has endeavoured to demonstrate the extraordinarily high number of mental health related calls that police in the City of Vancouver attend, and to identify significant factors that contribute to their prevalence. It was discovered that patrol members of the VPD are essentially the vanguard of mental health service response with up to 49% of all calls in which contact is made with an individual involving a mentally ill person. The direct police workload is equivalent to approximately 90 full-time officers, at a cost of about $9 million per year; other agencies such as the ambulance service, hospitals and the court system also bear costs.

Throughout the exploration of potential causes for these alarming statistics, the theme that consistently emerged was one of a lack of resources for the mentally ill. At the heart of this crisis is a mental health system that has not kept pace with the loss of resources in the wake of deinstitutionalisation; an unwillingness on the part of service providers to fully utilize the provisions of the *Mental Health Act* due to a lack of available resources and/or personal ideology; and a profound absence of information sharing between mental health resources in the Lower Mainland.

Although VPD members are trained to successfully interact with people in mental health crisis and have internal resources such as Car 87 and the negotiator team to call on, the current situation is unacceptable for both police and the community at large. Corey's story is simply one example of what can happen when a mentally ill person does not get adequate mental health support. Tragically, there are countless others whose lives, and deaths, chronicle similar accounts. Police in the City of Vancouver attended 48 suicides in 2007. Patrol members, along with Car 87, investigated 1,743 incidents where an individual was arrested under the provisions of the *Mental Health Act.* In particular, the Downtown Eastside, an area that has the city's highest concentration of marginalized people, is a predictable example of what happens when people who need various levels of community support are left to fend for themselves. Drawn by cheap accommodation and access to services, they are often the victims of predatory drug dealers, abusive pimps and unsavoury landlords who take advantage of their vulnerabilities. Unable to access reasonable mental health and/or addiction services, people are frequently coming into contact with VPD officers who in turn

rely on provisions in the *Criminal Code* in the absence of an acceptable response from hospitals to admit mentally ill patients.

Half of all police-involved fatal shootings in the City of Vancouver since 1980 involved some sort of mental illness or depression on the part of the deceased person; this is the most tragic and extreme manifestations of a mental health system that is failing. Without exception, these incidents are devastating for all parties concerned and take a significant toll on the officer involved whose judgement is typically criticised in the media. Considering that up to half of all calls for service that police in Vancouver attend involve a mentally ill person, it is a testament to the skill, training and compassion of patrol members that relatively few situations result in serious injury or death.

In conclusion, it is clear that many Vancouverites with mental health issues are poorly served by a system that is failing. VPD officers, along with the mentally ill citizens with whom they come in contact, are bearing the burden of a mental health system that lacks sufficient and effective resources and adequate information sharing, often with tragic consequences.

RECOMMENDATIONS

The following recommendations are made in an effort to address the gap in mental health service for people in the City of Vancouver; decrease the percentage of VPD calls for service that involve a mentally ill person; and improve information sharing among mental health care providers. It is important to note that these recommendations are complementary. While some can be implemented independently, it is the "package" of recommendations that can make a significant difference in support for the mentally ill, and reduce the draw on police resources. For example, the Urgent Response Centre (recommendation 2) can refer to the medical health care facility (recommendation 1). Improved services for dual diagnosis individuals (recommendation 3) would permit more of those individuals to function acceptably in the community. Supportive housing (recommendation 4) would draw on these improved services, and reduce the demand for police services from the homeless

What's needed:

1) A mental health care facility that can accommodate moderate to long term stays for individuals who are chronically mentally ill. Of the 2,100 people that Vancouver Coastal Health Authority estimates are not adequately served in the Downtown Eastside, up to 500 are most at risk. These are people who are chronically mentally ill with disabling addictions, extreme behaviours, no permanent housing and regular police contact. This resource should be readily accessible and available for those who are both mentally ill and addicted.

2) What has been termed an "Urgent Response Center" by Vancouver Coastal Health Authority, where individuals can be assessed and triaged according to their needs along with additional resources to support the facility. VPD members have contact with mentally ill people at an alarming rate (up to almost half of all contact calls in some areas of the city). This is an opportunity for people who are mentally ill to receive treatment. A facility does not currently exist that is readily accessible and available for police to take a mentally ill person in the absence of jail or hospital. This would be a location accessible to police that would provide mental health, addictions and housing

support for individuals who came in contact with officers and for whom jail was not appropriate. **This initiative is only recommended in conjunction with additional resources to support the facility (i.e. beds for a short term stay, addictions and mental health counsellors, access to a long term care facility, etc.).**

3) Increased services for people who are dually diagnosed. It is estimated that up to 70% of all psychiatric admissions at St. Paul's Hospital involve a person who has multiple addictions and that over 50% of people with a mental illness abuse illegal drugs and alcohol. These statistics indicate, particularly in the context of the Downtown Eastside, which is home to Canada's largest open drug market, that treatment for concurrent disorders is essential. This includes mandating the existing mental health clinics to provide service to people who are mentally ill *and* drug addicted, regardless of which affliction is most prevalent.

4) A continued increase in supportive housing in Vancouver. An estimated 70% of Vancouver's inner city population who are either homeless or living in single room occupancy hotels have mental health issues and 23% have a diagnosed mental illness (City of Vancouver, 2007).

5) For St. Paul's Hospital and Vancouver General Hospital to speed up the admission process for police who have arrested an individual under the provisions of the *Mental Health Act* (by negating the need for the emergency physician to initially examine the patient, for example). One of the contributing factors to patrol members being less likely to arrest an individual under the provisions of the *Mental Health Act* is the lengthy time delay at both St. Paul's Hospital and Vancouver General Hospital in admitting a mentally ill individual.

6) Enhanced ability to gather data on all calls for service that are mental health related to facilitate further research on this matter and to establish benchmarks to track change for police in British Columbia. The VPD does not currently gather details about police calls for service that involve people who are mentally ill that is readily accessible for extraction and analysis via police computer.

7) A system, much like PRIME, that has readily accessible details of an individual's mental health history and addresses privacy concerns, for British Columbia mental health service providers. Vancouver Coastal Health Authority is one of several regional health authorities in British Columbia. Internal information sharing practices are a barrier to mental health care within Vancouver Coastal Health Authority and this problem is greater when an individual crosses health authority boundaries.

REFERENCES

Arboleda-Florez, J. (2004, September). Editorial review: on the evolution of mental health systems. *Current Opinion in Psychiatry, 17(5)*, 377-390.

BC Mental Health & Addiction Service. (2007*). BC mental health time line.* Retrieved December 3, 2007, from http://www.bcmhas.ca/AboutUs/History.htm

British Columbia Review Board (2007). *Welcome to the web site of the British Columbia review board*. Retrieved on January 3, 2008, from http://www.bcrb.bc.ca

British Columbia Review Board (2007). *Mandate and overview of the British Columbia review board*. Retrieved on January 3, 2008, from http://www.bcrb.bc.ca/overview.html

Bula, F (2004, January 26). Mentally ill hit hardest by homelessness Series: No Fixed Address. *The Vancouver Sun*, p. A1. Retrieved December 27, 2007, from Canadian Newsstand Complete database. (Document ID: 535743071).

Buxton, J. (2005). *Vancouver site report for the Canadian community epidemiology network on drug use*. Retrieved December 27, 2007, from http://www.vancouver.ca/fourpillars/pdf/report_vancouver_2005.pdf

Canadian Mental Health Association (2004, January). *Citizens for mental health backgrounder justice and mental health*. Retrieved on September 10, 2007, from http://www.cmha.ca/citizens/justice.pdf

Canadian Mental Health Association (2006, January). *Building capacity: mental health & police project Vancouver site report compiled by Canadian Mental Health Association Vancouver/Burnaby branch*. Retrieved on September 10, 2007, from http://modena.intergate.ca/cmha-vb/test/Pages/polproj.pdf

Canadian Mental Health Association (2005). *Mental illness and substance use disorders: key issues*. (1-16). Retrieved September 19, 2007, from http://www.cmha.bc.ca/files/policesheets_all.pdf

Canadian Mental Health Association (2005). *Police and mental illness: increased interactions* (1-16). Retrieved September 19, 2007, from http://www.cmha.bc.ca/files/policesheets_all.pdf

Canadian Mental Health Association BC Division. (2003). *Study in blue and grey: police interventions with people with mental illness: a review of challenges and responses*. Vancouver, BC: Adelman, J.

Cavalluzzo, Hayes, Shilton, McIntyre & Cornish barristers & solicitors (May 2004). *Not criminally responsible trial of the issues* (ppt). Retrieved on January 3, 2008, from http://www.cavalluzzo.com/publications/Reference%20documents/Not%20Criminally%20Responsible%20May%202004.ppt

Dobell, K., and Fairbain, D. (2007, March). *Vancouver Homelessness Funding Model: More than Just a Warm Bed*. Retrieved on January 23, 2008, from http://www.city.vancouver.bc.ca/commsvcs/housing/supportivehousingstrategy/index.htm

Corrections and Conditional Release Act, S.C. 1992, c. 20

Criminal Code, R.S.C. 1985, c. 46, s. 231(6)

Lamb, R., Weinberger, L., & DeCuir, W. (2002, October). The Police and Mental Health [Electronic version]. *Psychiatric Services a journal of the American psychiatric association*, 53, 1266-1271.

LePard, D., Status Report: Workload Changes: 1993-2000. Vancouver Police Department 2000.

The lookout emergency aid society. (2007). *Our History*. Retrieved September 19, 2007, from http://www.lookoutsociety.bc.ca/Our-History.html

MacFarlane, D., Fortin, P., Fox, J., Gundry, S., Oshry, J., & Warren, E. (1997, April). Clinical and human resource planning for the downsizing of psychiatric hospitals: the British Columbia experience. *Psychiatric Quarterly, 68 (1), abstract.*

MacQueen, Ken (2007, June). *Reinventing the asylum* (1-2). Retrieved on January 9, 2008 from http://www.macleans.ca/article.jsp?content=20070618_106208_106206&source=srch

McCorkell v. Riverview Hospital, [1993] 8 W.W.R. 169 (B.C.S.C.).

McMartin, P. (2007, July 5). Suicide risk assessment often a one-sentence question: [Final Edition]. *The Vancouver Sun*, p B2.

Mental Health Act, R.S.B.C 1996, c 288

R. v. Chaulk, [1990] 3 S.C.R. 1303

R. v. Donato, [2007] B.C.J. No. 2480

R. v. Oomen, [1994] 2 S.C.R. 507

R. v. Swain, [1991] 1 S.C.R. 933

Sealy, P. & Whitehead, P. (2004, April). Forty years of deinstitutionalization of psychiatric services in Canada: an empirical assessment. *Canadian Journal of Psychiatry, 49 (4)*, 249-257.

Vancouver Coastal Health Authority (2007). *Centre for Concurrent Disorders*. [Brochure]. Retrieved December 27, 2007, from http://vch.eduhealth.ca/PDF's/CA/HED.1070.pdf

Vancouver Coastal Health Authority (2007). *Vancouver Community Mental Health.* Retrieved December 27, 2007, from http://www.vch.ca/community/mental_health.htm

Vancouver Coastal Health Authority (2007, January). *Improving health strengthening communities: an integrated action plan for the downtown eastside.*

Vancouver Coastal Health Authority (2007). *A Population Health Approach.*

Vancouver Police Department (2007, May 29). *Car 87 – Mental Health Car* (1). Retrieved December 19, 2007, from http://www.city.vancouver.bc.ca/police/OpsSupp/youth/car87.htm

Zacharias, Y. (2004, August 18). Desperately seeking asylum: Evils of the institution replaced by brutality of the street :[Final Edition]. The Vancouver Sun, p. B2. Retrieved December 27, 2007, from Canadian Newsstand Complete database. (Document ID: 682736111).

Zoffmann, E. (1999, September 8). Criminalization of the mentally ill. *BC medical journal, 41(8), 382-385.*