First Contact with the Justice System:

Providing Police Services for Persons with Mental Health Problems

Deputy Chief William Moore, Halifax Regional Police
CST. Mike Alford, Royal Canadian Mounted Police
CST. David Fairfax, Royal Canadian Mounted Police

February 1, 2013
Halifax
Front Line Officer Reality Check

- Observations of a criminal lawyer turned police officer

- Surprising frequency of police interaction with clients in Mental Health Crisis

- Carrying the load in the Criminal Courts – Legal Aid, Crown Attorneys & Provincial Court Judges
Nova Scotia rural policing and mental health in 2007: Challenges and room for change

- Officer to citizen ratios – rural v. urban
- Geography and accessibility to police clients
- Smaller or non-existent mental health care resources
- Low officer confidence with respect to mentally ill clients
- Lack of formal training with respect to recognition of mental illness and appropriate alternatives for police response
- Officer frustration with mental health care and social services
- Working within our professional silos
- Barriers to communication – real and perceived
- Hospital wait times and inefficient use of police resources
Historical Discussion Points

- Psychologists in blue
- Impact of de-institutionalization of mental health services and the corresponding increase in calls for police assistance
- Criminalization of the mentally ill
Looking Forward . . .

- Adapt and grow with the resources you have – push for more where you can
- Dedicated resources – CSRO (RCMP), MHMCT (HRP)
- Training initiatives – Crisis Intervention Team (CIT), “Hyde” Training, Mental Health First Aid, Online Course Material
- Climbing out of the silos – committee work – forming a team
- Great strides in 5+ years – still moving in the right direction
- Where possible – trying to keep persons with mental illness out of the criminal justice system - Court as last resort
Nova Scotia
RCMP Detachments
Police, Mental Health and Addiction Services Liaison Committee

History to Date

- Committee started in Fall 2007
- Concerns expressed by police
  - Long ER wait times
  - Taxi service
  - Lack of communication between ER and police
  - Inappropriate police response for MH consumer
- Lack of understanding about each others services
Police, Mental Health and Addiction Services Liaison Committee

Terms of Reference

- Co-ordinating services for people living with mental illness and addictions
- Improve our crisis response
- Plan and implement strategies that will avoid crisis
- Enhance continuity of care and services for the individual across systems and service providers
Police, Mental Health and Addiction Services Liaison Committee

Collaborative Group

- Police EHS Services
- Canadian Mental Health Association
- Schizophrenia Society Family Representation
- Annapolis Valley Regional School Board
- AVH Quality and Risk Director
- AVH Mental Health Inpatient
- AVH Emergency Departments
- AVH Community Mental Health
- AVH Addictions
- Parole Services
Police, Mental Health and Addiction Services Liaison Committee

Highlights of Accomplishments

- **A Process Map**
  Clarifies expectations, roles, responsibilities of both law enforcements and AVH emergency services.

- **Communication Form (EDP)**
  Documents police observations for review by healthcare staff.

- **Pocket Information Card for Officers**
Police, Mental Health and Addiction Services Liaison Committee

Highlights of Accomplishments

- **Assertive Outreach**
  Police and MH representatives working together to reach out to people in the community prior to crisis.

- **Case Conference**
  Processes for consultation and service planning involving CIT, and Mental Health professionals; clients, families and other partners where possible.
Police, Mental Health and Addiction Services Liaison Committee

Early Results Indicate:

- Appropriate and proactive response for the mental health consumer

- Increased efficiencies through:
  - reduced number of emergency department visits
  - reduced wait times in emergency departments
  - decreased police role “transporting” clients
Police, Mental Health and Addiction Services Liaison Committee

Results Continued

- Decreased crisis calls
- Improved continuity of care
- Smoother transitions between services
Training

- Intro to the Recognition to Emotionally Disturbed Persons

- Crisis Intervention Team (CIT) Training
  - Memphis Model
  - 40 Hours – Police Directed

- Emergency Department Training

- Understanding and Responding to Mental Illness
Priorities for Future:

- Expand the representation and involvement of clients and families as partners
- Expand our work with addictions and youth
- Establish structures, policies and protocols to maintain our Crisis Intervention Team
- Develop and implement evaluation of work
Halifax Regional Police

- History

- What is working:
  - MHMCT
  - Training Continuum

- Hot button topics
  - Violent patients
  - Arrest in Care
  - Upstream diversion
MHMCT – Mental Health Mobile Crisis Team

- Creation ~ 2005
  - Partnership: CDHA, IWK, EHS, HRP

- Structure and Services
  - 24/7 Crisis Line
  - Mobile Operation

- Community Links
MHMCT – Who we serve
## MHMCT – Annual Snapshot

<table>
<thead>
<tr>
<th>MONTH</th>
<th>ADULT</th>
<th>YOUTH</th>
<th>TOTAL # INTERVENTIONS</th>
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<tr>
<td>JANUARY/12</td>
<td>72.7%</td>
<td>27.3%</td>
<td>1040</td>
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<tr>
<td>FEBRUARY/12</td>
<td>78.5%</td>
<td>21.5%</td>
<td>1097</td>
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<tr>
<td>MARCH/12</td>
<td>79.8%</td>
<td>20.2%</td>
<td>1097</td>
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<tr>
<td>APRIL/12</td>
<td>78.1%</td>
<td>21.9%</td>
<td>970</td>
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<tr>
<td>MAY/12</td>
<td>84.1%</td>
<td>15.9%</td>
<td>1002</td>
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<tr>
<td>JUNE/12</td>
<td>80.3%</td>
<td>19.7%</td>
<td>1025</td>
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<td>JULY/12</td>
<td>88.5%</td>
<td>11.5%</td>
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<td>15.0%</td>
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<td>20.2%</td>
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<td>21%</td>
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<td>NOVEMBER/12</td>
<td>73.0%</td>
<td>27%</td>
<td>936</td>
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<tr>
<td>DECEMBER/12</td>
<td>82%</td>
<td>18%</td>
<td>955</td>
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Monthly average interventions for 12 months 1029
Training Continuum

- Why?
- Approach
- Present
## HRP Training Continuum

<table>
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<tr>
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<th>Training Description</th>
<th>Target Audience</th>
<th>Pre-requisites</th>
<th>Duration</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Emotionally Disturbed Persons and In-custody Death/ Autonomic Hyperarousal State Recognition &amp; Response</td>
<td>All HRP Staff</td>
<td>None</td>
<td>Introduction to Mental Health issues, stigma, dealing with MHMCT, and hyperarousal awareness. 4 hours total delivered in 2010 Block Training</td>
</tr>
<tr>
<td>2</td>
<td>Recognizing Emotionally Disturbed Persons</td>
<td>All HRP Staff</td>
<td>None</td>
<td>CPKN On Line</td>
</tr>
<tr>
<td>3</td>
<td>Introduction to Mental Health</td>
<td>New Recuits, Lateralis, Civilian Staff, Commissionaires, Calltakers. All staff with interaction with public.</td>
<td>None</td>
<td>Introduction to Mental Health issues, stigma, dealing with and resources &amp; MHMCT</td>
</tr>
<tr>
<td>4</td>
<td>Crisis Intervention Team Member</td>
<td>Patrol, booking and front-line staff dealing with EDP on a regular basis and in crisis.</td>
<td>Introduction 3 Years police experience, willingness to act as an CIT</td>
<td>CIT Program (Hamilton)</td>
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<tr>
<td>5</td>
<td>MHMCT Officer Training</td>
<td>New Members of MHMCT</td>
<td>Patrol CIT, successful selection to MHMCT</td>
<td>Working with MHMCT, policy procedures and additional issues</td>
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<td>6</td>
<td>CIT Trainer</td>
<td>CIT and MHMCT Members</td>
<td>CIT Trained</td>
<td>Capable of teaching the CIT Program and Introduction</td>
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</table>
Hot button topics…

Outstanding

- Violent Patients and PICU
- Arrest In Care
- Upstream Diversion
Questions??
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