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Response to Mental Health Calls: The frontline perspectives of police officers,  
communicators and administrators

by

Sarah Dougall

MSc Kinesiology, Wilfrid Laurier University, 2014

THESIS

Submitted to the Faculty of Kinesiology and Physical Education

in partial fulfillment of the requirements for

Master of Science in Kinesiology

Wilfrid Laurier University

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## Abstract

**OBJECTIVES:** The purpose of this study was to examine the lived experiences of frontline police personnel of a mid-sized police service in Southern Ontario. As the prevalence of mental illness increases, so do the calls for assistance to police services. Police officers often find themselves on the frontline and are often the first responders to mental health calls when an individual is in crisis (Wells & Schafer, 2006). With the majority of current research being quantitative in nature, this qualitative study allowed the voice of frontline police personnel to be heard in order to provide a complete picture of police response to mental health calls for service. Furthermore, this study included communications personnel, which are an important group that has often been overlooked in previous studies, but are instrumental in police response to all calls for service. **METHODS:** The lived experiences of fourteen participants were examined using in-depth, semi-structured interviews with heuristic phenomenology as a guiding theoretical orientation. The participants were placed into one of three groups based on his/her current role within the police service with the total number of participants within the groups as follows: police officers (n = 7), administrators (n = 3) and communicators (n = 4). Four research questions were examined through fifteen interview questions. **RESULTS:** Upon detailed analysis of the interviews, several themes and subthemes emerged from the data across all groups of participants. Each theme was found to play an important role in responding to mental health calls. The themes included: (1) Interaction of roles on mental health calls; (2) Challenges relating to mental health calls; (3) Strategies for responding to mental health calls; and (4) Coping and

aftermath. Four subthemes emerged relating to challenges when responding to mental health calls: (i) Perceived increase in mental health calls for service; (ii) Lack of training; (iii) Type of training; (iv) The broken system. CONCLUSIONS: Officers and communicators often find themselves as the first responders to individuals suffering from a mental illness who are in crisis. Hopefully this study has created an increased awareness of the role that frontline police personnel play when responding to mental health calls for service, some of the challenges that they face, and their voices will continue to be heard as policy makers and stakeholders make improvements and adjustments to the current system in the future.

## Acknowledgements

I would like to thank my colleagues who went on this journey with me. You are all inspiring individuals who strive to make a positive difference serving your community every day. Thank you for sharing your experiences with me and know that I appreciate how much courage it can take to open up and talk about some of your most traumatic experiences in a very challenging and difficult profession. I thank my supervising professors, Dr. Paula Fletcher and Dr. Margaret Schneider for challenging me to be the very best I could be, for supporting and encouraging me every step of the way, and for believing in me and my quest to make a positive difference in the policing community. To retired Staff Sergeant Porter, thank you for your words of wisdom. Please know that your endless support and encouragement made me realize why I needed to commit to my education and follow what was important to me. Finally to my family and friends, thank you for all of your love and support that helped me persevere and complete my thesis.





## **CHAPTER I: INTRODUCTION**

The Canadian Mental Health Association [CMHA] (2011) defines mental illness as “a variety of psychiatric conditions which typically show thought, behavioral or emotional impairments as a result of genetic, environmental, biological or psychosocial factors” (CMHA Website). Mental illness does not discriminate by gender, race, age or socio-economic status. In Canada, one in five people will experience a mental illness in their lifetime (CMHA, 2011). According to the World Health Organization, it is predicted that by 2020, depression in particular, will be the single biggest burden on health worldwide (World Health Organization, 2011).

While signs and symptoms can range from mild to severe, mental illness can affect thinking, mood and/or behavior, and can be associated with distress or impairment of functioning (Health Canada, 2010; CMHA, 2003). Mental illness is the second leading cause of disability and premature death in Canada. It is estimated that mental illness costs the Canadian economy \$51 billion annually in terms of health care and lost productivity. In Ontario alone, mental illness and addictions cost the Ontario economy \$31 billion per year (Centre for Addiction and Mental Health, 2009).

As the prevalence of mental illness increases, so do the calls for assistance to police services. Police officers find themselves on the frontline and are often the first responders to mental health calls when an individual is in crisis (Wells & Schafer, 2006). Over 30% of people with serious mental illness have involvement with police while making, or attempting to make, their first contact with the mental health

system. It is estimated that between 10% to 40% of all police work involves dealing with people who are in crisis or have a mental illness (Canadian Mental Health Association, 2003).

Police officers are often referred to as the “gatekeepers” to the mental health care system and play a role in deciding the fate of individuals with mental illnesses (Demir et al. 2009; Patch et al., 1999). For example, officers must determine if the most effective means to deal with these individuals is through the justice system, the mental health system or both (Demir et al., 2008). During a review conducted in 2004 by the Canadian Mental Health Association, it was found that police are being forced to respond to these types of calls without the necessary resources or support to do so in an effective manner (British Columbia Schizophrenia Society, 2006). In addition, previous studies have revealed that officers feel they receive very little training concerning mental illness in general, and want more as they feel it would be beneficial to their work (Vermette et al. 2005; Wells & Schafer, 2006).

The following discussion will provide an overview of the responsibilities of police services relating to mental health calls for service as set out by governing bodies of policing in Ontario. Next the Ontario Mental Health Act will be reviewed with a specific focus on Sections 16, 17 and 33, which pertain to police powers of apprehension when responding to calls for service. Finally, this paper will review studies that have been conducted in the United States that evaluate the Crisis Intervention Team (CIT) model and other response models relating to mental health calls. Canadian-based research relating to police training provided to new police officers in police academies and colleges, and in-service training for experienced

police personnel will also be examined. I am currently a police officer and have almost seven years of combined experience between two police services, as well as a special constable working on a university campus in Ontario. My interest and passion for this topic stems from personal experiences that I have had responding to mental health calls for service.

### **Purpose**

My exploratory study is qualitative in nature and will address the lived experiences of frontline police personnel relating to mental health calls for service (see Appendix A for demographic information about the police service). The majority of studies, some of which will be reviewed in this paper, are quantitative in nature and focus on statistics relating to police, mental health calls and response models. Very few of the studies have included the communications perspective. In order to gain a complete picture of police response to mental health calls, the experience and role of the call takers and dispatchers must also be included as they play a pivotal role and are often times the first contact point for the individual calling for help. A qualitative study will allow the voice of frontline responders to be heard, and not be overshadowed by statistics alone. Results from my study may be important for policy makers and community partners, as it will help to develop a greater understanding of the frontline experience and their potential needs.

## **CHAPTER II – LITERATURE REVIEW**

### **Mental Disorder Defined**

The Criminal Code of Canada uses the term “mental disorder” as a paradigm for the criminal justice system and mental health diversion programs. The term “mental

disorder” is defined in the Criminal Code of Canada (1985) as “a disease of the mind” while the Ontario Mental Health Act (2001) goes one step further defining mental disorder as “any disease or disability of the mind”. Both definitions, however, encompass the following: “mental illness, developmental disability, addictions, concurrent disorders, dual diagnosis, acquired brain injuries and serious behavioral and anger management issues” (Ministry of Health and Long Term Care, 2006). (Please see Appendix B for definitions of the above terms.)

### **Mental Health Calls for Service and Police Involvement**

#### **Adequacy Standards – Ministry of the Solicitor General**

In Ontario, the Policing Standards Manual (2000) governs the expectations of the level of service and responsibilities of all police services. The manual provides guidelines that outline the structure used by every Chief of Police to implement policies and procedures relating to all aspects of policing, as established by the Ministry of the Solicitor General. While each police service is unique and distinct, the Policing Standards Manual (2000) assists in ensuring a high standard, which is expected to remain consistent across all police services in Ontario (Ministry of the Solicitor General, 2000).

Section 29 of the Adequacy Standards Regulation requires that all Police Services have a policy in place that dictates police response to persons who are emotionally disturbed (EDP) or have a mental illness or a developmental disability. In addition, Section 13(1)(g) requires the Chief of Police to establish procedures and processes with respect to police response to persons who are emotionally disturbed or have a mental illness or a developmental disability. The policies developed and

implemented by the Chief of Police should focus in the areas of local service coordination, protocol and procedures, and training (Ministry of the Solicitor General, 2000).

According to the Policing Standards Manual (2000), there are several required areas that need to be addressed by every police service relating to training and response. It is the responsibility of the Chief of each police service to ensure that its members focus on skill development and have a learning plan that addresses the training and sharing of information with officers, communications operators/dispatchers and supervisors. Training needs to include local protocols such as conflict resolution and use of force in situations involving persons who may be emotionally disturbed, or may have a mental illness or developmental disability. Training also needs to adhere to the relevant provisions of the Mental Health Act, Substitute Decisions Act and the Health Care Consent Act, outline how to recognize common mental illnesses and instruct on how to provide assistance to families of persons who have mental illness (Ministry of the Solicitor General, 2000).

## **Mental Health and the Law**

### **Ontario Mental Health Act**

Each province has its own provincial legislation, which outlines the law and the powers entrusted to police officers responding to mental health calls for service.

The Ontario Mental Health Act (2000) regulates the administration of mental health care for persons residing in Ontario. The Mental Health Act (MHA) provides authority to physicians, justices of the peace, police, and members of the general public to ensure that individuals who are suffering from a mental illness are brought

to an appropriate facility for protection, diagnosis, and treatment in order to protect themselves and others from serious bodily harm and to evaluate their mental well being. The Act also defines community treatment plans that permit patients who might otherwise be institutionalized to live within a community. There are three sections within the Ontario MHA that relate specifically to how officers manage a call that falls within the parameters of a mental health crisis, namely, Section 16, 17 and 33 (Mental Health Act, 2000). (Appendix C will provide Sections 16 and 17 in their entirety).

Under section 16 of the MHA, any citizen can appear in front of a justice of the peace and provide evidence, under oath, as to why he/she feels the person in question needs to be apprehended and taken in for psychiatric assessment. If the justice of the peace is satisfied with the evidence provided and the evidence meets the criteria listed in section 16 then a Form 2 will be issued, directing police to apprehend the person named in the form and take him/her to the closest psychiatric facility for assessment (Kitchener Human Services and Justice Coordinating Committee, 2010). Section 17 of the MHA outlines criteria, which allow a police officer to apprehend a person and take him/her to the closest psychiatric facility for an assessment. Officers encounter this situation when responding to a call for service or come across a person who is exhibiting certain characteristics and the officer feels it is too dangerous to proceed under section 16. If an officer believes that a person is a harm to him/herself or others the officer can involuntarily bring that person to the hospital for a psychiatric assessment (Kitchener Human Services and Justice Coordinating Committee, 2010).

Finally, Section 33 states that a police officer (or any other person who takes a person into custody to a psychiatric facility) shall remain at the facility and retain custody of the person until the facility takes custody of him or her in the prescribed manner (Mental Health Act, 2000). This section is significant, as it requires police officers to remain with the person until he or she is assessed by a medical doctor or psychiatrist. Due to emergency room wait times, it can take a significant amount of time for the person to see a doctor, which in turn prevents officers from returning to the road quickly to respond to other calls for service (Ontario Mental Health Act, 2000).

The government has clear expectations of the role of police officers when responding to and interacting with individuals suffering from a mental illness, as outlined in the Policing Standards Manual (2000) and the Ontario Mental Health Act. While this legislation differs slightly across Canada and throughout the United States, the range of police involvement remains consistent. Different services have come up with response models and strategies to arm officers with knowledge, skills and tools to better assist them in managing and responding to mental health calls for service. The next section of this paper will examine the Crisis Intervention Team (CIT) that has been a popular and well-documented response model used in the United States. Parts of this model have been adopted and incorporated into Canadian response models as well, but the outcome and evaluation of its impact has not been well documented in Canada.

## **PREVIOUS RESEARCH ON RESPONSE MODELS**

### **Crisis Intervention Team (CIT) Model**

In 2003, it was estimated that approximately 45% of police services in the United States reported having some form of specialized response to persons with a mental illness (PMI) in crisis. Of these services, 30% employed a mental-health based response with the Crisis Intervention Team (CIT) structure, while 12% of services used a police-based, specialized mental health model, whereby mental health professionals were employed by the police service to provide on-site and telephone consultations to officers in the field. Finally 3% used a model where police officers who had received advance mental health training served as frontline responders to mental health crises and acted as liaisons to the formal mental health system (Hails & Borum, 2003).

The CIT response model originated in Memphis, Tennessee in 1988 and previous research has supported positive effects as a result of this model in many areas concerning police response to mental health calls. Early research has revealed several benefits as a result of implementing this model, including fewer injuries for responding officers and lower arrest rates (Strauss et al., 2006). In Canada, the CIT model is the most replicated model and consequently, much more information is known about the details of this approach when compared to other models as a result of this U.S research (Canadian Mental Health Association, 2003). In Canada, Car 67, COAST and HELP are all mental health response models that incorporate some of the principles of the CIT in both their training and structure. The following section will review research from both the United States and Canada relating to the CIT model.



CIT programs are designed to educate and prepare law enforcement officers to recognize the signs and symptoms of mental illness and to respond effectively and appropriately to the individual in crisis (Ralph, 2009). The ultimate goal is to de-escalate crisis situations, thereby improving public safety, minimizing use of force, reducing unnecessary incarceration and providing individuals with appropriate treatment and services in the community. In addition to this, CIT also addresses stigma, attitudes and myths relating to mental illness, and focuses on understanding and support for these individuals. Currently there are over 400 CIT programs operating in the United States and CIT is considered to be the most rapidly expanding and promising partnership between policing and mental health professionals (Ralph, 2009).

Hanafi et al. (2008) conducted a qualitative study in the United States using focus groups to examine how officers were incorporating CIT knowledge and skills into their daily work. An invitation to participate was distributed via e-mail to all officers in the metropolitan of Atlanta, Georgia who had completed the 40-hour CIT training program within the previous 24 months. Four groups were composed of five to eight officers each (total n = 25), and discussed these issues for one to two hours on average. Researchers audio recorded the sessions and then transcribed them verbatim. Several themes emerged relating to the benefits that officers had gained through the CIT training they had received (Hanafi et al. 2008). The major themes included: increased knowledge and awareness of mental illnesses, reduced stereotyping and stigmatization, greater empathy towards consumers and their families, and increased redirection towards treatment. Officers reported practical

applications such as reducing unpredictability, reducing the risk of injury, and having a better grasp on how to assist the individual in de-escalating the situation (Hanafi et al., 2008). This study provided insights into the benefits of CIT training, and identified the need for further research to investigate the differences between CIT-trained officers and non-CIT trained officers relating to the above themes (Hanafi et al, 2008).

There are numerous US quantitative studies that support these qualitative findings. For example, Demir et al., (2009) conducted a survey to determine if CIT training changed officer perceptions and beliefs relating to the causes of schizophrenia. Officers (n = 159) completed the same survey before the CIT training and again after completion of the course. The results demonstrated that officers' understanding of the possible causes of schizophrenia were significantly improved after the completion of the training week, with an increased acceptance that schizophrenia is not caused by the individual and that it is not just an excuse for poor behavior. Demir et al (2009) suggest that this change in perspective may lead to increased rapport-building skills, de-escalation abilities, increased communication between officers and family members, and ultimately better outcomes in terms of referrals to mental health care services, thereby reducing unnecessary incarcerations resulting from interactions between officers and individuals with schizophrenia. From their findings, they concluded that further research is necessary to investigate if certain personality traits contribute to identifying which officers are ideally suited for CIT training, and whether officers

with exposure to mental illnesses beyond their professional duties are more likely to respond to CIT training with attitudinal changes (Demir et al., 2009).

Strauss et al. (2005) conducted a study to examine the psychiatric disposition (or state) of individuals brought to emergency departments by CIT officers of the Louisville Metro Police Department. Data collection began six months after the CIT program was implemented and included data obtained from the clinical charts in the ER (n = 485), primarily noting demographics, diagnosis and disposition. From the data, three groups were identified: (1) subjects brought in on a mental inquest warrant (MIW) (similar to Section 16 of the Ontario Mental Health Act); (2) subjects referred by CIT; and (3) subjects who were self-referred.

Some charts were missing data, for example, toxicology reports and disposition. A significant number of CIT-referred patients suffered from schizophrenia (43.0%,  $p = 0.002$ ), compared to MIW (24.7%) and self-referrals (21.3%). Mood disorders were less common among CIT-referred patients (15.2%) compared to MIW (22.2%) and self-referrals (30.9%). Where toxicology reports were available (n = 279), screenings revealed a positive test for ethanol or drugs in 47.1% of CIT subjects, 34.8% of MIWs and 46.2% of self-referrals. In evaluating disposition, MIWs were significantly different from CIT and self-referral groups and were significantly more likely to be hospitalized. They were also less likely to be referred to outpatient follow up. The data collected in this study suggests the CIT trained police officers are able to identify psychiatric emergencies efficiently and refer patients to emergency psychiatric services where required for evaluation and treatment. While this study had some limitations, such as the one-month period in

which data was collected, the results demonstrate that CIT training provides officers with the tools to assist in making referrals for psychiatric assessment to those who are in need of care (Strauss et al, 2005).

While CIT is not the only model employed by police services across the United States, it has been the focus of the majority of research because it has addressed several key areas that challenge police officers when responding to mental health calls for service. Some common findings remain consistent across the studies that have been conducted. CIT training has shown its effectiveness in educating officers as to the potential causes of mental illnesses, which reduces stigma and better aligns officer attitudes with those of mental health professionals. In addition, prior research suggests that CIT programs have the potential to reduce unnecessary arrests, minimize injuries, minimize use of force and increase referrals to psychiatric facilities (Demir et al., 2008; Hanafi et al., 2008; Steadman et al., 2000).

Gaps in the CIT research include determining which police officers are ideally suited for CIT training, based on personal characteristics and experience. It is possible that personal and family history of psychiatric treatment may impact officer response and beliefs relating to mental illness (Demir et al., 2009). In addition, investigation into how personal characteristics of CIT-trained officers differ from non-CIT officers could be helpful to include in future studies (Hanafi et al., 2006).

### **Research from Canada**

The majority of the Canadian-based literature in this area revolves around reviewing the challenges that are faced by frontline police officers when responding to mental health calls for service and the current intervention strategies being used. Some of these challenges include intrinsic qualities like officer attitude (Cotton, 2004), while others have examined current training requirements for new recruits and experienced officers (Cotton & Coleman, 2008; Cotton & Coleman, 2010). In addition, McAndrew and Sutton (2004) conducted a mixed methods study to document the experiences of frontline officers in dealing with mental health calls in Simcoe County. The purpose of this study was to identify partnerships between police and the community and to identify mental health training and education priorities compared to the needs that are identified by the frontline. Most of the studies that will be discussed are quantitative in nature, while a few include a small qualitative component.

Cotton (2004) conducted a study to identify and quantify attitudes that may influence discretionary behavior of police. More specifically, the purpose was to seek information regarding attitudes of police officers towards the maintenance of people suffering from mental illness in the community. Questions such as how much control the mentally ill should be subjected to, the extent to which the community should tolerate or interact with those who are mentally ill, the need for public resources and funding, and the role of the police in the care of these individuals were addressed. To accomplish these goals, officers were recruited from three police forces: Kingston City Police, Port Moody Police Department (British

Columbia), and selected detachments of the OPP within Eastern Ontario. Officers were asked to complete the Community Attitudes Towards Mental Illness (CAMI) Scale to assess their attitudes and perspectives on four leadership-style dimensions: authoritarian, socially benevolent, socially restrictive or oriented toward community integration. The scale is comprised of 40 questions, 10 questions for each dimension. In addition to the CAMI scale, the researchers devised six open-ended questions relating to police officers views on their role in the mental health system. These questions were strictly exploratory in nature.

The overall response rate for this study was 34%, with approximately equal participation from all three police services, and there were no significant differences between them. The low response rate was highlighted as a limitation to this study. The results from the CAMI scale were compared to the results taken in 1981 from the general Canadian population. Based on these results, Cotton found that officers have a more positive attitude towards the mentally ill than the general population. Very few officers felt that individuals with a mental illness should be isolated from society and most felt that as a society, mental illness should be better tolerated. In addition, it did not appear that the attitude of police officers was the problem when it came to criminalization of the mentally ill. The findings do reflect a common dilemma that officers' face and that is being placed in a position where society expects them to do something, while at the same time having no clear reason to arrest or apprehend the person with the mental illness (PMI). Most officers felt that dealing with PMI was a part of a police officer's role and that they needed special training to fulfill this part of their role (Cotton, 2004).

By providing more information about working with this population, it might be possible to identify and re-educate officers who do not readily accept dealing with the mentally ill as part of their duties as a police officer. In this study, 11% of the respondents felt that dealing with PMI was outside their role as a police officer (Cotton, 2004). This study was a positive starting point in exploring officer attitudes towards working with the mentally ill and concluded that there does not appear to be cause for general concern about police attitudes toward PMI.

Hoch et al. (2009) conducted a study that examined the quantity and nature of police interactions of PMI in London, Ontario from January to December 2001. To accomplish this, researchers used the administrative database, which is maintained by London Police Service and contains all recorded police interactions with citizens (N > 111, 000). For a more in-depth look, an intensive text-based search of 100 randomly selected computerized records was also completed by one of the authors. To identify PMI, the algorithm search sorted people based on address, key word search, and caution flags (identifies PMI) (Hoch et al, 2009). In addition, complaints, occurrences, and tickets also identified the most common type of police interactions. The outcome of the interaction was recorded, so researchers could keep track of whether a charge or arrest occurred as a result of the interaction. Results were analyzed using t-tests and Wilcoxon rank sum tests to explore statistical differences between the two groups: PMI and NPMI (not persons with a mental illness) (Hoch et al, 2009).

In this study, the researchers speculated that 23% of PMI and 31% of NPMI had police interactions. There was no clarification to address whether or not these

numbers included calls involving the same PMI as a repeat offender. One limitation to this study is that no psychiatric diagnosis was used to identify PMI, and substance abuse and drug use were not accounted for. Officers determined whether or not an individual suffered from a mental illness either by their observations and interaction with the individual, or based on what the PMI or his/her family members told the officer during the interaction. No formal psychiatric evaluation was available, due to patient confidentiality. It is therefore possible that there was an under-representation of PMI in the numbers (Hoch et al, 2009).

Despite this limitation, this study presented some key findings. Frequently the first indication of a mental illness occurs when a person's behavior attracts police attention. The police become an entry point into the mental health system, either directly through a Mental Health Act apprehension or indirectly when asking for a psychiatric remand (psychiatric assessment before trial can continue). People identified as mentally ill were higher users of police services than people who were not. The nature of police interactions was also different for PMI than the general population. The elevated arrest rate for these individuals did not appear to be linked solely to crimes or actions that warranted arrests in the general population. This could be linked to the limited options that police have when encountering a PMI (Hoch et al., 2009). Some key recommendations that were proposed as a result of this study included increased access to community-based services and case management services, enhanced police training, mobile mental health crisis services and pre-arrest diversion program to better support individuals in the community



who are living with a mental illness, while decreasing frontline police involvement (Hoch et al., 2009).

McAndrew and Sutton (2004) conducted a study to gain insight into frontline police perspectives on mental health interventions in Simcoe County, Ontario. A census survey was conducted with 460 frontline officers who are employed by Simcoe's eleven Police Services. The survey was made available to the participants through paper and web formats. The response rate for this survey was 54%. The quantitative portion of the study was analyzed using SPSS and the results of the eight open-ended questions were coded manually for themes. It was observed that the themes corresponded strongly to the quantitative results. Officers responded to questions in the following areas: (1) trends in the number of calls to which they respond; (2) the details of the most recent incident they responded to; (3) general perspectives on managing mental health incidents including community partnerships, and (4) education and training. This study found that approximately 85% of officers had responded to at least one mental health call in the previous month with over 40% reporting to have responded to at least three or more calls. Of the respondents with five or more years of service, 68% thought the number of mental health calls had increased and 81% thought the time spent per call had increased compared to when they first started policing (McAndrew & Sutton, 2004).

Key findings determined that the most common outcome of a mental health call is the PMI is apprehended under the Mental Health Act or agrees to go to the hospital with officers voluntarily. Officers typically spend about two and a half hours at the hospital, followed by an hour of paperwork or follow up activities. Officers

would like to see a faster response rate at the hospital, an alternative to the hospital that is available 24 hours a day, and clear protocols for diversion and consultations with support resources and follow up. To build a better relationship with doctors and mental health professionals, officers suggested joint training, designated liaison officers, and upper-level management being involved to resolve issues together. Officers identified several areas of training they felt would contribute to their efficiency in managing mental health calls. These areas included: de-escalating strategies; information on mental health resources; mental disorders and community treatment orders; and substance abuse and stress management techniques for police officers to help them achieve better mental health (McAndrew & Sutton, 2004).

Several recommendations were proposed based on the results of this study. First, a better arrangement needs to be established between police officers and the hospital to allow for improved hand-off and shorter wait times. In addition, the development of partnerships would assist in decision-making and in determining the best course of action to take with the PMI. An exploration into the development of a 24-hour alternative to the hospital would also be beneficial. It is clear from this study that frontline officers are interested in additional education and training related to mental illness. When training sessions are planned, instructors should recognize that police officers are confident in their abilities to effectively manage an incident, but see their main challenge as being within the health care system both during and following the incident. Finally (whenever possible), training should offer the opportunity to build relationships and a shared understanding between police,

mental health providers, and emergency room staff and physicians (McAndrew & Sutton, 2004).

### **Canadian Studies – Training for new and experienced police personnel**

Cotton and Coleman (2008) conducted a quantitative study to determine the training relating to mental illness, if any, that police academies and colleges in Canada provide to new recruits. In order to accomplish this, questionnaires were sent to all 13 academies/colleges in Canada responsible for training new recruits. Questions relating to the number of hours, nature and content of topics, teaching modalities, personnel involved, and which parts of the curriculum address mental illness, were included in the questionnaires (Cotton & Coleman, 2008).

The results of this study showed that all new police officers in Canada currently receive at least minimal training relating to mental health, as this topic is covered at all academies and colleges. Time spent in training varies from one hour in Lethbridge, seven hours in Ontario, up to twenty-four hours in Edmonton, with too much variation to get a true mean number of hours across Canada. Training programs are designed differently from one organization to another, and what is included in one academy or college might not be included in another program. Mental health training was covered across a number of different subjects such as provincial statutes, use of force and officer safety to name a few (Cotton & Coleman, 2008).

Cotton & Coleman (2008) identified that the most challenging limitation to this study was that there was not enough data collected to warrant any further statistical analyses and it was difficult to draw conclusions from the data that was

collected. What was clear was that police academies, and thus police services, have very different ideas about what is adequate and important to address when preparing police officers for their interactions with PMIs. While this study possessed several limitations, it did provide insight into topics that are generally recognized by all academies as essential, such as the necessity for verbal strategies, dealing with aggression and suicide, excited delirium, mental health law, unique dangers associated with this particular population, and use of force options. The data also indicated that there is limited coverage, and thus understanding, of some issues, as it is simply not possible to cover all of these topics in the number of hours dedicated to training in some academies. This study did not look at in-service training for experienced officers (Cotton & Coleman, 2008). More research is needed to determine what the essential areas are that need to be covered in training, and how long it would take to adequately cover them (Cotton & Coleman, 2008).

Cotton and Coleman (2010) followed up their initial study to gain insight into existing Canadian in-service learning programs used by police services across Canada. To achieve the goals of this study, the Police/Mental Health and Liaison (PMHL) Listserv managed through [www.pmhl.ca](http://www.pmhl.ca) was used to ask approximately 500 Canadian police agencies, Canadian police colleges and academies, and mental health agencies to describe the police/mental health education and training in their respective jurisdictions. Twenty-six responses were received from across Canada, predominately from police agencies but some from police/mental health partnerships, as well as mental health agencies (Cotton & Coleman, 2010). After an extensive literature review to gain insight into training relating to police education

and training and an evaluation of the nature of police contact with PMI, Cotton and Coleman proposed a model to address the needs of all personnel involved in responding to and assisting PMI including call-takers, dispatchers, victim services and front-desk personnel (Cotton & Coleman, 2010).

Cotton and Coleman (2010) constructed a comprehensive, multilevel yet flexible model for police personnel based on the identified Learning Spectrum that they called TEMPO (**T**rainning and **E**ducation about **M**ental Health for **P**olice **O**rganizations). TEMPO consists of ten modules that are broken down into five levels with each module crafted towards a specific audience. The levels build on one another with TEMPO 100-104 providing baseline training to allow the learning of the skills and knowledge necessary to take modules in the next level. Appendix D provides a breakdown and description of each level and module within the TEMPO program.

### **Summary**

Most of the research from Canada (although limited) has looked at the amount of time dedicated to training police officers related to mental illness and police response to calls for service. The results of Cotton and Coleman's study (2008) has demonstrated that while all police colleges and academies provide training, time spent varies significantly across police services and academies throughout Canada. While the total amount of training and time spent in various subject areas are very different, there are several main topics that emerge from all of the programs suggesting an acknowledgement of their importance regardless of where a police officer is trained. These topics include: dealing with aggression and suicide, excited

delirium, mental health law, unique dangers associated to this population and use of force options (Cotton and Coleman, 2008). One area that the research has not addressed is what topics are essential to cover relating to this area and how much time is sufficient to adequately train new recruits.

This study led to the follow up study by Cotton and Coleman (2010) geared towards an understanding of in-service training for experienced personnel and the development of a flexible training model designed to be used by all police personnel who have contact with PMI, including dispatchers, call takers and police officers. Through this study, the TEMPO model emerged with a focus on ensuring that new police officers have basic education and knowledge relating to mental illness and more advanced levels for officers and personnel responsible in a “specialized area” of policing.

These Canadian studies clearly have a different focus than those studies conducted in the United States. Cotton (2004) focused on how intrinsic characteristics of police officers can influence the way they respond to and interact with individuals suffering from a mental illness. McAndrew and Sutton (2004) added to the literature with a mixed methods study to document the experiences of frontline officers in Simcoe County. Finally, Cotton and Coleman have conducted a two-part study to gain insight into training relating to mental health for new recruits (2008) and experienced police personnel (2010). Research from the United States has evaluated current models in place to assist officers in responding to mental health calls with the main focus being on the CIT model, where research from Canada has evaluated response to mental health calls using more of a systems

approach, looking at policy and procedures and the training that officers receive to assist them.

### **CONCLUDING THOUGHTS**

As the prevalence of mental illness increases in society, so does the demand for police services and calls for service involving PMI. Police officers are often the gatekeepers to the mental health care system and encounter many individuals who are using them as a stepping-stone into psychiatric treatment. In order to properly address the needs of this unique population, the governing bodies of policing standards and the Ontario Mental Health Act have outlined what is expected of each police service and Chief of Police in the province relating to mental health calls for service. In order to manage mental health calls for service and to better assist individuals suffering from a mental illness, best practices have emerged throughout Canada and the United States. In the United States, CIT has been implemented and evaluated on the programs' effectiveness in different areas including officer perception, use of force, minimizing unnecessary arrests, and referrals into psychiatric treatment. The majority of the research focuses on the CIT program and various aspects of this program have been adopted in Canada, although not assessed.

Police training has been a central topic in Canadian research relating to mental health calls. Cotton and Coleman have focused their research on police personnel and their interactions with PMI. Their recent research has focused on what training is offered to new recruits at police colleges and academies throughout Canada, and the training that is provided to experienced police personnel through

in-service programs. This research has led to the development of the TEMPO model, which is a comprehensive and flexible training module designed to provide the necessary baseline information for new recruits and to address the specific needs of police personnel depending on their specialized roles within the police service (Cotton & Coleman, 2008; 2010).

Many of the previous studies have identified low response rates as a limitation. These studies also identify that it is challenging to generalize findings to all police services for a number of reasons. First, it is unknown whether the perspectives of the officers or services who did not respond are very different from the ones who did, making any sort of generalization impossible. Secondly, the needs of police services often reflect the needs and demographics of the communities in which they serve, so what may work for one service will not necessarily work for another in a different city, province or country. This highlights the need for further research to occur within individual police services, to increase the reliability and validity of the research and allow for a comparison of the similarities and differences across services.

While the majority of the research has focused on quantitative data in an attempt to measure different aspects of training and changes as a result of these response models, there are a few qualitative studies that have been conducted in this area. Further qualitative research would greatly contribute to the existing literature as it addresses the area of study in a way that provides some insight into the experiences of the individuals. In previous research, numbers and statistics have



overshadowed the voice of the frontline responders. Policies and procedures have been implemented with the best of intentions, but are not always optimally fulfilled.

By providing frontline officers with a voice and asking them what they need to better serve this unique population, their concerns can be addressed and training and response models can be modified accordingly. This would result in a more efficient way to respond to mental health calls for service while identifying the specific needs of the community in which the police service patrols. This would provide an opportunity for the police service to understand the specific needs and challenges faced by frontline police personnel and the opportunity for mental health service providers and the community to have a voice in an attempt to come together for an optimal response strategy.

## **CHAPTER III: METHODOLOGY**

### **Purpose and Research Questions**

The purpose of this exploratory study was to gain insight into the lived experiences of frontline police personnel of the police service who have responded to mental health calls for service. To accomplish this, four specific research questions were explored, including: (1) What role do frontline personnel play when responding to mental health calls for service? (2) What training have frontline personnel received to prepare them for this role? (3) What challenges do they face when responding to mental health calls for service and (4) What strategies or training would better prepare police personnel when responding to mental health calls for service? These research questions were examined through the use of face sheets, semi-structured interviews, journal entries, member checks and field notes.

## **Participants**

In order to successfully fulfill the purpose and goals of this study, it was necessary for me to connect on a personal level with those “who have directly experienced the phenomenon of interest” (Patton, 2002, p. 104). In total, fourteen frontline personnel participated in this study. This allowed for the examination of the experiences of police personnel involved in the response to mental health calls for service from the initial call-taker, through to the dispatchers and finally, police contact with the person with the mental illness. The study was advertised to all members of the police service through the use of the bulletin board on the internal website, as well as through the distribution of posters in each division asking for interested individuals to contact me. Once interested individuals identified themselves to me, several sampling strategies were used to select participants within the scope of purposeful sampling.

Criterion sampling was important for this study, as it aims to “review and study all cases that meet some predetermined criterion of importance” (Patton, 2002, p. 238). Once the participants were chosen, stratified purposeful sampling was used to place them into groups based on their role. A total of three groups were assigned: police officers (n = 7), communicators (n= 4) and administrators (n = 3). All three of the administrators are also police officers with previous experience responding to calls for service on the frontline. One administrator is currently assigned to the communications branch supervising the dispatchers and call takers in the communications call center. The purpose of stratified purposeful sampling is to place individuals into groups based on a set of similarities, which in this study,

was his/her role on mental health calls. The goal of a stratified purposeful sampling is to “capture major variations rather than to identify a common core, although the latter may also emerge in analysis” (Patton, 2002, p. 240). Stratified purposeful sampling allowed me to understand the experiences of police officers, communicators and administrators and understand variations between these three groups, as well as identify a common core between the groups in several themes that emerged. Additionally, opportunistic or emergent sampling was used allowing me to follow new leads as they presented themselves during fieldwork and to take advantage of the unexpected.

I followed up on leads two times during the research where a participant provided contact information for a member of the police service who he/she felt could contribute to the study. The participants were placed into one of three groups: administrators, communicators or police officers, which was the predetermined criterion for participants.

Table 1: Information about participants

| <b>Participant Code</b> | <b>Pseudonym</b> | <b>Male/Female</b> | <b>Years of Service</b> | <b>Work Title</b>                                      |
|-------------------------|------------------|--------------------|-------------------------|--|
| A1                      | Matt             | M                  | 23                      | Administrator/Police officer (Staff Sergeant)          |
| A2                      | Tyler            | M                  | 15                      | Administrator/Police officer/Communications (Sergeant) |
| A3                      | Rhonda           | F                  | 16                      | Administrator/Police officer (Sergeant)                |
| C1                      | Clara            | F                  | 27                      | Communicator   |
| C2                      | Martha           | F                  | 26                      | Communicator   |
| C3                      | Ben              | M                  | 1                       | Communicator   |
| C4                      | Christina        | F                  | 8                       | Communicator   |
| P1                      | Mark             | M                  | 1                       | Police officer (Constable)                             |
| P2                      | Rob              | M                  | 12                      | Police officer (Constable)                             |
| P3                      | Travis           | M                  | 9                       | Police officer (Constable)                             |
| P4                      | Curtis           | M                  | 27                      | Police officer (Constable)                             |
| P5                      | Greg             | M                  | 8.5                     | Police officer (Constable)                             |
| P6                      | Tom              | M                  | 5.5                     | Police officer (Constable)                             |
| P7                      | Beth             | F                  | 12.5                    | Police officer (Constable)                             |

All participants were assigned a pseudonym to protect his/her identity throughout the results section.

## **Research Tools & Procedure**

### **The Qualitative Method**

In order to address the goals of this study, a qualitative method of inquiry was selected, as it lends itself to understanding and representing the views and lived experiences of the participants. Semi-structured interviews were chosen as the main method for data collection, as it allowed me to connect on a personal level with the participants to truly understand and appreciate how he/she has experienced the phenomenon. Along with the interview, several other methods, including facesheets, field notes and member checks, were used in order to gain further insight into the essence of this experience for the participants. I also used journal entries to capture my thoughts, feelings and opinions relating to mental health calls.

### **Ethics**

Ethics approval was obtained through the Wilfrid Laurier University Ethics Board prior to data collection. Once ethics approval was obtained, informed consent was sought from all participants prior to the commencement of data collection. In addition, participants were provided the opportunity to ask me questions either in person or via phone or e-mail prior to participation in the study (see Appendix E).

### **Facesheet**

All interested participants were asked to complete a facesheet consisting of items pertaining to demographics such as age, gender, years of service and what capacity he/she serves in the police service. The content of the facesheet was used to provide me with context for the semi-structured interviews. The information provided insight into each interviewee's work experience, personal experience and training (See Appendix F).

**Interviews**

Each individual participated in a one-on-one semi-structured interview. The interviews were conducted at a time that was convenient for the participants and all were completed in person at a mutually agreed upon place. Every interview was audiotaped and transcribed verbatim. I reviewed every interview four times in order to ensure the accuracy of the transcription. I transcribed the interviews as soon as possible, following the conclusion of the interview. The length of the interviews varies between 18 and 56 minutes with the average length of the interviews being 35 minutes. The lengths of the interviews are consistent with the experience of the officer or communicator with the more experienced personnel offering more examples and experiences than the personnel just starting out in his/her career. The interviews consisted of fifteen open-ended questions designed to obtain information about the lived experiences of the participants. The interview questions focused on training, experience responding to mental health calls, resources and community supports. (See Appendix G for the Interview Guide).

**Field Notes**

Data collection was enhanced through the use of field notes. I took field notes before, during and immediately after the interview in an attempt to capture the essence of the interview and any significant thoughts or findings resulting from interaction with the participants. Patton (2002) suggests that field notes should contain “everything that the observer believes is worth noting” (Patton, 2002, p. 302). These descriptive notes can include but are not limited to distractions during the interview, the comfort level of the interviewer and the participant, the setting, and any concluding thoughts resulting from the interview. Field notes can also help

the researcher recall specific thoughts, feelings and opinions that he/she had during the interview and can alert the researcher to any biases that he/she has (Patton, 2002). These field notes became very useful as a couple of the participants shared personal information and experiences with me prior to the audiotape being turned on. This discussion prior to the interview was important for building rapport and connecting with participants on a meaningful level. Field notes provided me with a place to record the context of information that was shared, as some participants referred to the “earlier conversation” in the actual interview itself. In addition, during one interview the recording device had some technical difficulties. Field notes were very useful to help me recall information disclosed during that interview, and a follow up interview was conducted in order to ensure that the participant’s experience was properly recorded.

### **Journal Entries**

I kept a journal containing my thoughts, feelings and perspectives throughout the research process. The purpose of the journal was to ensure that my own personal reflections and opinions did not interfere with or overshadow the perspectives and experiences that the participants described through the interview process. These journals were analyzed to identify themes and findings to see if there were similarities between my experiences and those of the participants who shared the phenomenon under study. This added further credibility to the findings as a whole and assisted with the analytical process that will be described in the *qualitative analysis* section. These journal entries were different from the field notes as they only contained my thoughts, emotions and feelings regarding mental health calls

and did not contain anything regarding the interviews or the experiences of the participants.

### **Member Checks**

Member checks were conducted in order to ensure that the essence of what the participants were trying to convey through the interviews was accurate.

Participants were e-mailed a copy of the transcript to provide them with the opportunity to read it and add, clarify, or remove any information that they did not wish to be analyzed (Lincoln & Guba, 1985). I requested that transcripts be reviewed and that participants respond within two weeks of receiving the transcript. Eight participants acknowledged reviewing their transcript and one participant added clarifying points to her transcript to ensure her experience was more accurately captured. Another participant requested that one experience that she described not be used in the results section, as she felt her identity could be compromised as a result. I ensured her that no information that could compromise anonymity would be disclosed in the results section or any other section of the findings and the experience she was concerned about was removed. She was satisfied with this response. I did not attempt to contact the remaining six participants who did not respond to my e-mail. For ethical reasons, I was only allowed one attempt to send the transcript to my participants for their review. In the initial e-mail that I sent I stated that if the participant did not respond to the e-mail, that this would indicate that he/she acknowledged that they accepted the transcript as is, and that nothing needed to be changed or redressed, and that his/her experience was properly captured in the interview.



**Triangulation**

Triangulation is a method that provides strength to the data by using multiple sources to ensure they support each other. Two forms of triangulation were used to enhance the findings and credibility of this study. The face sheet, background questionnaire, field notes, one-on-one interviews and journal entries that were completed all contribute to data triangulation. Furthermore, all participants had the opportunity to review and comment on the general summary of the preliminary themes found across all interviews through member checks, although only eight participants acknowledged reviewing his/her transcript. In addition, investigator triangulation was used as my supervisors and I reviewed the data individually and provided our own interpretations and feedback on the findings (Patton, 2002).

**Credibility**

Rigorous methods were used in every aspect of the study to obtain significant findings. Informed consent and member checks were used in order to make sure that the essence of the experience of the participants was accurately recorded. Additionally, credibility was enhanced through obtaining quality data. Using information-rich cases was more important than focusing solely on sample size for the purposes of this study, and the concentration was on achieving theoretical saturation of the information collected.

The researcher is an integral tool in the research process and must be qualified to carry out the study. In order to ensure that this was the case, a number of steps were employed. An extensive literature review was carried out relating to research on police response to mental health calls in both Canada and the United States. I completed field notes, ensuring that all information worth noting was

recorded and be supplemental for other data sources. As a police officer myself, I have experience and an intense interest in the topic under study and I have my own opinions and feelings regarding this topic. While it is impossible to eliminate my bias completely, I followed specific steps in my data analysis, as outlined by Patton (2002), to become self-aware and to understand my experiences and opinions so that I could focus on my participants and understand the similarities and differences in their experiences when responding to mental health calls for service. The details of this method will be discussed in the next section.

### **Data Analysis**

A phenomenological approach was the theoretical orientation used to guide this study relating to the lived experiences of police personnel who have responded to mental health calls. Phenomenology is the “explication of phenomena as they present themselves to consciousness,” as “consciousness is the only access human beings have to the world” (Van Manon, 1990, p. 9.). While there are many different phenomenological approaches, they all share “a focus on exploring how human beings make sense of experience and transform experience into consciousness, both individually and as a shared meaning” (Patton, 2002, p. 104). This study aimed to gain a deeper understanding of the experiences of police personnel who have responded to mental health calls either as a call-taker or dispatcher, or as a frontline officer responding to the scene. A phenomenological approach seemed to be the most appropriate method of analysis.

“Heuristics is a form of phenomenological inquiry that brings to the fore the personal experience and insights of the researcher” (Patton, 2002, p. 107). There are two elements of heuristic inquiry within the larger framework of phenomenology.

Heuristic inquiry focuses on intense human experiences, intense from the point of view of the investigator and co-researchers. It is the combination of personal experience and intensity that yields an understanding of the essence of the phenomenon (Patton, 2002, p. 107).

I am currently a frontline police officer have experienced responding to mental health calls for service, therefore this study fulfilled both elements required to use heuristics inquiry. Data analysis was approached using a number of steps as outlined in Moustakas's *Phenomenological Research Methods* (1994) and as cited in Patton (2002). First, I went through the process known as *epoche*. It was important for me to reflect upon my own experiences and identify my own opinion and judgments relating to responding to mental health calls for service. This was established through the process of self-reflection and making notes on thoughts, feelings and pre-existing perceptions. I completed journal entries prior to commencing and throughout the study that remained available for review through all stages of analysis. These personal reflections are shared in “Reflections of the Researcher” at the end of this section.

The next step is *phenomenological reduction* whereby the preconceptions that were identified in the first step were set aside, allowing for the data to be analyzed without the influence of extraneous factors. Once I recorded and processed these preconceptions, I was able to clearly identify my thoughts, opinions or reflections and separate them from those of my participants as to not overshadow

or influence the experiences of my participants. This step was accomplished by containing my personal experiences in the results section, which separated mine from the data that was collected. The third step involved *horizontalization* and *delimitation*. Horizontalization allowed for the data to be considered as a whole and to organize information into clusters. This was accomplished by reviewing each interview a total of four times to ensure accuracy of the transcription and begin to identify some of the key points in the participants' experience. By focusing on the key points, I then continued on into delimitation, which allowed for repetitive and redundant information to be eliminated making it possible to identify enduring themes. Next is the development of a *textural portrayal* of the experience, which entails a description of the experience, not the essence of the experience. This is accomplished by identifying the common themes that emerged across all of the participants, including my experiences. It can describe for example, what generally occurs when frontline personnel respond to a mental health call without focusing on the essence of his/her experience, but focusing more on the process. The fifth and final step is the establishment of a *structural description*. During this step, I sought to find the deeper meaning of the experience in order to put myself there with the participant and truly appreciate his/her perspective. This step also allowed me to see how my experiences were similar and different to those of my participants. After these five steps were accomplished, the essence of the experience of the participant allowed for a true representation of their perspective and insight to be integrated (Moustakas, 1994; Patton, 2002).

### **Reflections of the researcher**

Mental health calls are often times the most challenging, frustrating and time consuming calls that communicators and officers deal with on a daily basis. They can also be some of the most rewarding calls to respond to if you can make a positive difference to an individual who is suffering from a mental illness. My journey in policing started in December 2006. I began my career with Peel Regional Police, and it became clear to me after a short time that calls involving mental illness were a common occurrence. Even if the call was not specifically classified as a mental health call, mental illness was an underlying issue of many neighbor disputes, domestic disputes, disturbances and conflicts between parents and children. My eyes were also opened to the overwhelming amount of people who are addicted to drugs and alcohol. It made me reflect on whether this was representative of our entire population or whether individuals with a mental illness or addiction just have more interaction with the police.

While I attended the OPC, I received training that was to prepare me for all areas of policing: how to drive fast in a police car, how to fight and how to shoot a gun. I was pepper sprayed to see how it felt and understand that as an officer you still can fight through it if you get sprayed on a call by a fellow officer amidst the chaos. I learned about the textbook material and provincial and federal law. There was so much packed into three months that by the end of it, my head was spinning. After OPC I headed back to Peel for additional training by the training branch and by the end of it all I felt somewhat prepared to head out into the real world with my coach officer. Of course the first time I suited up and hit the road I felt like I forgot it

all, which I was told was normal. I was fortunate to have amazing coach officers who all jumped on the “big calls” to get me as much experience as possible before I was set free on my own.

One thing that I do not recall was any training or discussion about how to manage the tragedy, loss and stress that one experiences on the job. Maybe it is impossible to do that, but no one explains or provides strategies on how to cope with feelings and emotions after tough calls, or even touches on what ‘normal’ or ‘common’ reactions might be. As a new officer, I was so overwhelmed with trying to learn how to be a police officer, how to complete paperwork and court documents and how to manage my time to get everything done that I think part of me compartmentalized my feelings as a coping mechanism.

One of the toughest days on the job for me was when I responded to a homicide call where a mother had killed her autistic son \*Ben\*. I saw the call pop up on my computer in my cruiser. I arrived at the family residence and spoke to the father \*John\* for hours while the other officers conducted the investigation at the scene which was at a hotel down the street. I learned about how police and ambulance had attended previously as his son who was a teenager, often lost control and caused damage in the house. I looked around and saw holes in the walls and doorframes that were damaged. I saw family pictures of a happy, healthy boy until he received his booster shots around the age of two, according to dad.

\*John\* told me that his wife would take their son to Niagara Falls as this often calmed him down when he was upset. He said that his wife had left with \*Ben\* the evening before and he had a bad feeling. If they were not home by noon he was

going to call police to report them as missing. \*John\* said he felt that either she was going to return home or police would show up at his door - he was not sure which one would happen. During our conversation, I heard the other officers on the scene confirm that \*Ben\* was dead over my police radio. His mother was in the process of trying to kill herself when officers arrived. I sat and talked to \*John\* some more, knowing that his son was dead and his life would never be the same, but I could not tell him any of this. When instructed to do so, I drove \*John\* up to the homicide office where detectives would tell him the awful news and interview him. I remember escorting him to the office, into an interview room. I remember listening to the sound of his grief when detectives broke the news.

The drive back to the division seemed surreal to me. I do not remember much of it. I completed my notes and went home. The next day I needed to complete some paperwork for the investigation and then it was a scramble to get back out there and deal with the workday. One thing that I have learned is that the calls do not stop. They do not wait for you to be okay, or slow down when you need a breather. I did not talk about the call with any of the other officers who were on it. There was not a de-brief or anything of that nature. I went through a range of emotions and I was not sure how to cope. It was in that moment that I wanted to try to make a positive difference, and the only way I knew how to try was by going back to school.

There seems to be more attention and focus surrounding post-traumatic stress disorder and the devastating effects that it can have. Officers are at a high risk for developing this due to the nature of our work, as we try to “normalize the

abnormal” after responding to awful calls. There is such a stigma, whether it is perceived or real, that officers should not need help dealing with calls, even the tough ones; that if an officer asks for help than he/she is weak and is in the wrong career. I have watched colleagues suffer in silence from the internal wounds that are not tangible, while their personal lives fall apart. It almost seems easier to lose it all than to speak out and reach for a helping hand for fear of the judgment and stigma that might come from it.

I was enlightened through my interviews that I am not alone in thinking that this attitude towards stigma needs to change and that we all need to support each other through the tough calls to look after both our professional and personal lives. I spoke to some amazing officers and communicators who reinforced the fact that we are all humans who have chosen a rewarding profession with a unique set of challenges and stresses from other career choices, and that in order to adapt to greater demands, higher call volumes, and everyday work stress, we need to look after each other and transform the way we prepare for work through training, and re-examining the way we help our members cope with the tough calls. I also learned of some valuable resources that are available such as the “Badge for Life” website, which was established by police personnel and serves as a forum to raise awareness about mental health and to provide support and advice to officers and communicators who reach out for help.



## **CHAPTER IV: RESULTS**

Responding to mental health calls for service is a daily occurrence for police personnel. Mental health calls pose a set of challenges that are unique from other types of calls for service, and previous studies have discussed the need for more training relating to these calls (Cotton, 2004; Cotton & Coleman, 2008; McAndrew and Sutton, 2004). It is important to acknowledge the unique experiences of personnel when responding to these types of calls, as it allows the reader to gain an appreciation for the participants' individual viewpoints. The first part of this section will look at the background information of the participants and why he/she chose a career in policing. Upon detailed analysis of the interviews, several themes and subthemes emerged from the data across all groups of participants. Each theme was found to play an important role in responding to mental health calls. The themes included: (1) Interaction of roles on mental health calls (2) Challenges relating to mental health calls; (3) Strategies for responding to mental health calls; and (4) Coping and aftermath. Each theme will be discussed in turn.

Due to the phenomenological nature of this study, the findings were examined based on each participant's perceptions. While the roles of police officers, communicators and administrators are different, these three groups work together toward a common goal, which is essentially the safe resolution of each and every call for service. In order to appreciate the experience of the participants, the above themes will be explored as told through the eyes of the participants.

## **Background information about participants**

Frontline police officers respond to all emergency and non-emergency calls for service. Calls originate either from the communications center or are initiated by the officer himself/herself. Most of the officers and administrators that were interviewed in this study started a career in policing primarily because they wanted to help people and/or make a positive difference in their community.

*I just wanted to get involved in helping people (Matt, administrator, police officer).*

*I enjoy helping people (Tyler, administrator, police officer, communications).*

*I enjoy, you know, what policing stands for and what we do every day. There is no one reason, other than I just love coming to work every day (Curtis, police officer).*

*I decided to become a police officer because I wanted to help people and give back to my community (Greg, police officer)*

One officer went on to discuss what it means to her to protect people in her community.

*It's always been something I had been thinking about since I was quite a young girl apparently, my parents tell me. So um, it's just always been a desire, I think to help people in the community. I just believe that we are all entitled to the same opportunities in life, and that when someone commits some sort of a crime against someone else, it's more of just a violation to them. It's, you know, bigger than that. So I like the idea of protecting that (Beth, police officer).*

Likewise the communications personnel choose this career for similar reasons as the

police officers.

*Um, right out of school I didn't think I wanted to go into the policing field, but I did finish. I worked for about a year in different jobs, and kind of decided I did want to get back into the field and you know, help people (Ben, communicator).*

*Well I actually enjoy both (referring to both call taking and dispatching) cause call taking you get to talk to people, and you can*

*help them out, because you've been through experiences they are going through. So I mean that part I like, being able to give them advice, who to go to for help et cetera (Christina, communicator).*

One police officer described mental health calls as an important and demanding call involving people who often require the most help.

*Our job is to help people, and people with mental health illness are people who definitely require some of the most help. So definitely I think it falls into the expectations of our job for sure (Mark, police officer).*

One communicator also mentioned that she felt that mental health calls can be rewarding and that she can provide advice to help guide the caller to the right resources.

*I like when I get those calls (mental health calls) cause I feel like I'm giving them good advice. I'm putting them to the right place that they need to go (Christina, communicator).*

While police officers, communicators and administrators reported a wide range of reasons for getting into the profession, the majority of participants in this study described a strong desire to help people and make a positive difference in the communities that they serve and protect.

### **(1) Interaction on the roles on mental health calls**

The communications branch (also referred to as the 911 call center) is made up of call takers, dispatchers, a police constable and a sergeant. The call takers are responsible for answering all calls placed to 911 and the non-emergency line, and based on the information they receive from the caller they generate a call for service. The dispatchers see the information that is entered by the call taker and dispatch officers to attend as needed. The police constable and sergeant in the communications center answer 911 calls when the call takers are busy, assist with

calling out additional resources (depending on the type of call), and deal with administration details within the communications branch. In the 911 call center, the call takers are essentially the lifelines for the people on the other end of the phone. The dispatchers are the lifelines for the patrol officers who respond to calls. When it comes to mental health calls for service, it is up to the call taker to make an initial determination of whether or not the person calling in may be in crisis:

*Ah I guess right off the bat it's gauging the situation. I mean you're talking to them first, and it's more so gauging if they're a harm to themselves, or if they just are kind of manic or off medication, you can just tell. I guess it's just gauging the severity, if they are a harm to themselves or they're a harm to others (Ben, communicator).*

The call taker has the extra role of determining whether or not ambulance or fire are also required for the call, and the dispatcher will see if a mental health nurse is working, at the police officer's request.

*I would say it plays a bigger role when you're the complaint handler, because you're actually talking directly to the people as opposed to ah when you're dispatching the call. (Clara, communicator)*

*Well I guess bottom line is you need to determine, do they need an officer to come see them? Do they need an ambulance? Do they need to go to the hospital? You've got to figure out what it is they need. If it's someone that they just need to talk, you can sometimes transfer to the crisis line or CMHA. Other times we have to put a call in. (Christina, communicator)*

For situations that are more involved, such as when the crisis line is concerned about a client who was threatening suicide to them over the phone, or a call that might include a weapon or person with a weapon, the sergeant makes arrangements for the tactical team, or other resources such as negotiators to be called out to the scene.

*I have had numerous calls in the 4 months that I've been in there (communications) and approximately say, 15-20 calls from crisis, which says "I've just got off the phone with so and so, they are threatening to kill themselves. I can't help them any further over the phone, we need officers to attend because this person is threatening to kill themselves, or is a threat to themselves or others". Um, and then we have to start a call and dispatch officers, and then if it's an emergency where there is an imminent threat to life, or safety to either the person or someone else, then it's a call that I immediately look at and determine what additional resources should be dispatched. (Tyler, administrator, communications)*

In summary, when a call comes into communications, a call taker assesses it and if it meets the criteria, a call for service is generated by the call taker and passed on to the dispatcher and an officer is dispatched. The call taker continues to add information to the call and the dispatcher updates the officer.

*So, once the call is entered by the call taker, which they will just start with the basic, our code to say that this is mental health or attempt suicide. The address ah, a blurb of what is, what's taking place, um, that immediately goes on the dispatcher screen um, for them to see and dispatch officers to. And from that point on, anytime that call taker, or if the Sergeant is adding anything to that call, it ah, it automatically pops up as an update to the dispatcher, as well as the officer going to the call on the road (Tyler, administrator, communications).*

This last quote nicely summarizes the process of what happens when a person calls in to

the communications center for assistance and a call for service is generated. The process

of response from the police officer, communicator and administrator perspectives will be

described next.

When responding to a mental health call, the officers said it is up to them to determine the appropriate course of action to take depending on his/her observations and the information received from the individual, as well as potentially

friends and family members (if they are available). Essentially, their main role is to make an apprehension under the Mental Health Act if a person is refusing to seek treatment but are a harm to themselves or others, or if the person is not apprehendable, the officer tries to direct the individual and his/her family to the appropriate community resource for further support or assistance.

*Generally, our role is just to sort of make some sort of an assessment on that person, and see if there's a safety issue at the time. If there is then, um, you know, you may need to look at an apprehension, or you know, hopefully the person will go willingly or voluntarily to get some help at the local hospital or something like that. So usually we're just there to obviously protect the person, and anyone in the situation with them, and then try and get them help really. (Beth, police officer)*

Another officer described his experience of being the first responder to the scene of a mental health call and what this means relating to the role or roles that officers can take on.

*Um, well, we're typically the first responders that arrive on scene. The roles that we take can be quite extreme. Sometimes it's just responding and listening to somebody that needs to vent. Quite often, we also need to mediate neighbor disputes, or family disputes, because one person has mental health issues, and that's sometimes a little bit difficult to deal with. Uhhh, and we also sometimes need to apprehend people with mental health issues under the Mental Health Act, because they are causing harm to themselves or others, and actually take them down for an assessment. So it's quite broad what our involvement is and our roles. (Greg, police officer)*

An administrator goes on to describe the role or roles that an officer will take on after dealing with the initial situation and the additional role that officers' can play at the hospital.

*Well frontline first of all, you have to decide if, if there's grounds to get them to the hospital or not, and that's under your powers of apprehension. But then you transition very quickly to being a social worker, and you have to babysit the people at the hospital, and you have to get them into the hospital, and be the social worker with the doctor,*

*and the social worker with the family, to get all the pieces to come together before they actually get the medical attention that they need or deserve, which is very time consuming, and takes up a lot of staff hours for the police (Matt, administrator, police officer).*

While the quotes above provide insight into the process of responding to mental health calls for service, the next section will explore some of the experiences that both communicators and officers have actually had responding to calls.

On the surface, it appears that the role of the communicators is simple: take the call, determine the nature of the call, and then dispatch officers and additional resources as necessary or as requested by the responding officer, but this is just the beginning. The following quotes provide some specific examples of what the communicators actually deal with on a typical day at work:

*Um the suicidal ones are very hard. Um very hard you know, I've had to, you know, I ended up speaking to parents who have just found their child has killed themselves, and that's always been very difficult. And ah talking to someone that's contemplating it. A couple weeks ago I had you know "911 emergency" He goes "You wanna hear something really funny?" and I'm going, "First tell me what your emergency is". He goes "No never mind. Just forget it." I said, "Oh no no no. You called 911 for a reason." And you know his voice just broke down, and you know, he wanted to turn the car on and gas himself in the garage. Then I found out that he his wife wanted to leave him and that. So it's like I had to talk to him while putting in the call and waiting for officers to go. (Martha, communicator)*

*I remember um a father calling in and his 8 year old daughter had just passed away of cancer. Her name was [Rebecca] and at that time the McDonalds commercials had a [Rebecca] and we talked about that and he said "ya [Rebecca] loved McDonalds French fries" and we talked for a bit until the ambulance got there. I remember that, and went out crying afterwards thinking you know how horrible that would be. And just hoping that just talking to him for those few minutes helped. (Clara, communicator)*

*Oh all kinds. I've had from kids to adults. I've had actually, one time I was dealing with somebody that I didn't realize, he actually had a gun right on him as we were talking and at one point he had it in his*

*mouth and I was like “you have what in you’re mouth?” and it was a gun, and I was like oh my god. (Christina, communicator)*

Most officers have also responded to a wide range of mental health calls.

*I have had jumpers; I have had suicides; I’ve had self-talkers; I’ve had violent people. I’ve had people that just didn’t want to go to the hospital even though they were living in their filth. You name it after 25 years I have been fortunate to see it all, and I’ve seen every range. People who have been so enraged lethal force had to have been used, to just grandma who doesn’t want to go to the hospital anymore, and she’s just talking to herself, and everything in between. (Curtis, police officer)*

*Everything from neighbor disputes, I’ve had some calls because somebody with mental health issues didn’t want a mailbox sitting up on the side of their semi. I’ve had some attempt suicides and some actual suicides. Um, and then everything kind of in between. (Greg, police officer)*

One administrator reflects on the time he spent on patrol and describes some examples of

the wide range of mental health calls to which he responded.

*I’ve gone to jumpers where people have jumped off buildings, and they’ve hurt themselves, or they’ve killed themselves; I’ve had a guy have a shotgun to his head and pull the trigger and kill himself. Ummm I’ve had a guy jump off an overpass on the 401 try and kill himself. I’ve had a guy in a car drive in front of a transport truck and try and kill himself. Pills, well that’s old stuff now, I mean pills and alcohol, everyone tries that. Ummmm there’s just been so many over 23 years that; Razor blade to the arm. Cutting (pause 3 seconds). I’ve probably seen everything (Matt, administrator, police officer).*

It is evident from the quotes above that all participants responded to a wide variety of calls involving individuals suffering from mental illness, ranging from a calm situation where someone has ingested pills and/or alcohol in a suicide attempt, to completed acts of suicide through different means. The next section will look at the challenges that the participants face when responding to mental health calls.



## **(2) Challenges relating to mental health calls**

The participants experienced a variety of challenges relating to mental health calls that have been broken down into the subthemes: (i) Perceived increase in mental health calls for service; (ii) Lack of training; (iii) Type of training and (iv) The broken system. The subthemes will be discussed in turn.

### **(i) Perceived increase in mental health calls for service**

Many officers, communicators and administrators have noticed an increased number of mental health calls for service. While the focus of this study was not to analyze the statistics regarding the number of mental health calls that come through the communication center, the perception of the participants was that the numbers of calls relating to mental health are on the rise for a variety of reasons.

*Actually the calls did increase, and I can tell you when they increased. They increased when the provincial hospitals closed, and they downloaded the responsibility of mental health to the region or local jurisdictions. All those really sick people were put back into the community, so eventually they get sick, and then they need help. Then all your other people who maybe aren't as sick as they were; it just backed up the whole system and when the hospital closed, the municipality wasn't prepared to take on the mental health cases. So they got behind and they're just maybe now starting to get caught up since they opened Freeport. And Freeport hospital, which used to be for the old age people, now is basically a psychiatric hospital for varying degrees of mental health. (Matt, administrator, police officer)*

With more individuals living in the community without the assistance of the services described above, it seems that police officers have greater expectations to intervene and assist individuals who are unsure of other resources to call.

*Well, as far as the expectation that's sometimes it becomes because we are 24/7 we are the automatic response team for anything. So um it's, it's kind of a piecemeal set up to, you know, where we are always available to deal with a crisis, even though we may not be the most appropriate, but we are the most available. So sometimes that gets overused, um, for a "Band-Aid" sort of solution. Which is fine for an*

*initial crisis, but um, sometimes it gets used as a constant process, which isn't effective at all because we are doing the same thing, managing a crisis that's just continuing. (Travis, Police Officer)*

The increased popularity of texting and using social media such as Facebook and Twitter

has also impacted the perceived increase in calls.

*We've been talking about how many suicide calls there's been lately. And you know I think that's with the coming of text and Facebook and things like that too. (Clara, Communicator)*

Officers, administrators and communicators have the perception that the number of calls involving a person suffering from a mental illness is increasing based on the type of calls that he/she is responding to on a daily basis. Despite this perception, this study did not collect any data to support this with call volume statistics.

**(ii) Lack of training**

All police officers in Ontario, with the exception of the Royal Canadian Mounted Police, are required to attend the Ontario Police College (OPC) for the Basic Constable Training Course. Mental health training is one topic that is covered during this comprehensive three-month course. Some officers described the training they received at OPC.

*You get a minimal amount of training, like scenario-based training at OPC but from what I can recall that long ago there's not a lot. (Rhonda, administrator, police officer)*

*At Police College Basic Constable program there's a section, a module there on mental health, or they'll have people come in and talk about different mental health issues, and some of it is about using proper terminology; the differences between hallucination and delusion and so forth. (Travis, police officer)*

*They're basically reading off what they need to read. They probably don't have that much first-hand experience or a high level of training, they're just basically giving you the OPC "this is what we need to*

*teach you” and it sometimes comes across that way. And then sometimes when they bring in guest speakers, they don’t have the police aspect and it doesn’t involve our safety, and it is viewed purely as us trying to give them hugs and kisses and warm fuzzy feelings and things like that. However they don’t always realize the line that we need to stay on, and what we need to do for safety and everything else. So there’s that disconnect. (Greg, police officer)*

One officer describes his views on why he felt OPC did not provide more training

on mental health specifically.

*There are a couple classes at OPC umm I just find that at OPC there’s so much they have to teach you up there that they can’t really get too specific with any one item. There’s a number of classes or seminars that they do and even some of the scenarios based stuff that we did up in the simulation area were directly related to some mental health calls. So there was some training but nothing very specific. (Mark, police officer)*

One of the biggest challenges that officers identified was the lack of training relating specifically to communicating strategies to assist in de-escalating calls that involve individuals who are suffering from a mental illness.

*I think sometimes people struggle to know, um, like communication skills. Like how to speak, we don’t really teach you, so how would you know unless you’ve had that kind of experience once and it went well? Then you’re probably going to copy what you did before. Um and that’s a really poor way to figure it out (laughter) and some people as you know are good communicators and some people just aren’t and don’t have those skills, so I think we kind of lack um giving our people those kinds of skills. (Beth, police officer)*

*I don’t recall any training at OPC with different scenarios of how to communicate effectively with someone um with a mental health, suffering from a mental health related symptoms probably isn’t the right word but probably along those lines. (Rob, police officer)*

Similarly, when asked about the training that goes into preparing our communicators for their role in responding to mental health calls for service, the

response was consistent across all of the participants: there is not enough training relating to mental health calls for service to prepare them to deal with these type of calls. Participants also identified mental health calls as one of the most challenging and demanding call types.

*I don't think they give you nearly enough training to deal with calls of mental health. (Clara, communicator)*

*There's definitely a lack of training on how to effectively communicate with ah people suffering with mental illness. It's one of our most demanding calls that we deal with, and not on a daily basis but on an hourly basis. (Tyler, administrator, communications)*

*Knowing what questions are ok to ask and what's gonna agitate somebody. I know it's different for everybody but there's probably some standard type questions. What questions are ok to ask and what's gonna agitate somebody. (Clara, communicator)*

One communicator described some training she received that covered some topics related to mental health.

*We've had um crisis worker come in and do a presentation for 2 hours. Ah it dealt a lot more with DVU (Domestic Violence Unit) than anything actually, and the hostage negotiation one had a suicide component. (Clara, communicator)*

Another communicator brought up the fact that a lot of calls that may not be classed directly as a mental health call may still have mental illness as a root of the call:

*I just think it's important for there to be more training geared towards them (mental health calls) for everybody in the call center. Ya I mean it's surprising because it is such a big part of the job, like the whole field now is so much geared towards that because that's what you're responding to a lot of the time. I think a lot of the 933s (domestic disputes) and 993s (other family disputes) you see also have mental health undertones. (Rhonda, communicator)*

Some officers recalled quick refreshers on training days or in meetings at the start of his/her shift, but nothing of significance that has stood out as being adequate training.

*I think we've had one, maybe two mental health refreshers at training days, nothing really I would say overly useful. All I remember from that was at briefing one day "so there's this new program and here's what they do. It was about a 5-minute schpiel and that was that. It was for Lutherwood saying "Hey Lutherwood is dealing with young people now with mental health issues. Call this number on Mon, Wed and Fri between these hours". That's about the extent of what you get, there's not a whole lot more than that other than there's a new program here's the number. (Tom, police officer)*

*I don't know in 30 years I've probably got, not 30 years, 25 years (3 second pause) 30 hours total, maybe. An hour per year would be about right to average it out. (Curtis, police officer)*

*Periodically there's been ah training days, there's been some mental health awareness type training. (Travis, police officer)*

One training tool that was implemented in 2013 was an online course offered through the Canadian Police Knowledge Network that was mandatory for all frontline officers of the police service to complete within a certain time frame relating to mental illness and how to communicate with a person in crisis. While officers agree that any training is good training, there were a few thoughts regarding the effectiveness of online training.

*I just clicked through it to be honest. Like, you look at the first screen, and it's not interactive or anything. It's just like any other online course, and then again it's different; younger guys may pay more attention to it, and the older guys might just breeze right over it, so I didn't find it very effective because again people are just doing it, and then especially on our shift or other shifts, you've gotta get it done by Friday because everyone forgot about it, so they are just clicking on it to get the stupid thing out of the way. (Curtis, police officer)*

*It wasn't a bad thing, but I think getting it directly from um a professional rather than a video you know, where you just sit there at*

*computer, and people are walking in and out of the room distracting you, and you're not necessarily paying attention to stuff, you know, I think it's good, but I think it would be better to get it in person from a trained professional, rather than you know, from officers making a video. (Rob, police officer)*

*They have come along with a digital online program through police, Canadian Police Knowledge Network, ahh which goes through some scenarios, which I thought was pretty good for patrol officers response. (Travis, police officer)*

While he did not find the online training meaningful, one officer did recognize that the online training is a good way to cover the Police Service when it comes to liability as they can say that all of their frontline officers received and passed mental health training.

*If you want to make it meaningful, at least do something, either do it or don't do it this half ass thing is really not supporting anyone else, other than covering the services department saying that "Hey we gave him mental health training and he passed." That's all they can say. (Curtis, police officer)*

Based on participant responses to the training that they have received so far in their careers, training seems to occur through experience both on the job and in a previous career or with a friend or family member suffering from a mental illness, rather than in a classroom setting.

*Umm I think working at a psychiatric hospital, I mean I've seen people under treatment that are like zombies walking through the hall, and it's scary to see but I've dealt with that kind of person. I've dealt with the people who are brain injured for life. I've dealt with the people who are on and off their medications. I've reasoned with different people and so because I have that and, that was a very big eye opener for me and I go back to that and I find as a police officer that was invaluable for me working at a psych hospital for 2 years. (Matt, administrator, police officer)*

*I found that working with young offenders and working with behavioral treatment kids before, kids who were actively suicidal,*

*that helped me more than any of the OPC training would have. It's very different when you work in that for 2.5, 3 years and it seems like every other week you've got a kid on suicide watch, and trying to ask certain questions, and looking for various responses. (Tom, police officer)*

*My experience education wise has really helped with some of the calls that I've had to deal with. (Mark, police officer)*

*So it's just what you've learned through the years. And a lot of them (communicators) do have friends or family who work with ambulance, or who are nurses, and they get knowledge from them too, so it's just basically a big room of knowledge sharing with each other on how to deal with things. (Christina, communicator)*

Police officers, administrators and communicators find that their personal experiences and their educational backgrounds help to assist them on mental health calls.

### **(iii) Type of training**

All officers, communicators and administrators were open to more in-service training and provided insight into what they felt would benefit them the most when responding to these types of calls. First, an officer from the training branch provided some insight on how to improve training for new recruits.

*We do a little bit of a piece now with the recruits, and it's very basic and to be honest with you, I hate the module because it's simply a Powerpoint, and ya ramble through what their authorities are. Um, and you describe a little bit about you know, maybe some symptoms, you know, some of the things that you shouldn't do, um, especially if somebody's paranoid, like we'll talk about personal space, and stuff like that, so it's very, very, very basic. (Laughter) So to do it properly, I would like to see the agency that deals with mental health perhaps actually do the training. Because we're not qualified as far as I'm concerned. (Beth, police officer)*

When considering who to bring in to train officers, it is important to understand what teaching approaches will help the frontline personnel to get the most out of

training days by making it relevant to their work and realizing the perspective of the presenter.

*It would probably be more meaningful if it came from a police officer that did care about the material that is being taught. Ah, instead of ah, an instructor, a police officer that is presenting it because that's what they need to do, or a social worker that is coming in and doesn't have the police aspect, because I think there is a huge disconnect when those ah, people are presenting the material. When you have someone who has a good understanding of both, that would be much more meaningful. (Greg, police officer)*

*I know in one of our training days, I believe the goal was to speak with somebody that had mental health issues. Ah however, I think the point of the topic was greatly lost ah, one from the actual presenter, and two from the officers' perception of what they should be learning. And it ended up turning more into a "this was something really cool that I did when I was having a mental health issue." Alright, and it ended up into more of a bragging session of them running over, or trying to run police officers off the road, and trying to get shot by police, and a number of things like that. And I found that extremely bad. (Travis, police officer)*

Participants had different ideas on what might be beneficially when it came to inviting guest speakers in to present on different training topics.

*I think it would be beneficial for the nurses from the ummm, Grand River Hospital, or even from the CAIP unit (dealing with children under 16 years of age) would be huge, because I think there's a huge difference in understanding between mental illness and behavior issues. . I know I have a difficult time because you think, you know "you can't control a 7 year old!? C'mon!" you know umm, so maybe even having one of them speak. Just from a personal interest point, I would love to see a psychiatrist speak um, there because when we take people to the hospital you know, I often wonder when you and I, you more so, but you sit there for six hours and they're like "no they're ok." And you know, I don't understand the reasoning behind that so. I want them to explain to us what they're looking for for forming people and that type of thing. Um, So I guess ah maybe even people from the Mental Health Association could be helpful. (Clara, communicator)*



*I think it would be great for us to sit with someone in crisis. One on one with these people, just to see is there some other tips they can give us, is there something else we should be saying? Like are there any other resources out there that we don't know about, that kind of thing. I think that would be great. (Christina, communicator)*

*I would say CMH for sure. Um, let's see a lot of organizations we already work with like mobile crisis. And I would say for youth stuff, bring in more people from Lutherwood. Because I mean they're in it every day. And I know we have had things like that in the past, and I know that a lot of what it comes down to is the service just doesn't have the time to give us the extra training. But ah I think those people; Lutherwood for the younger kids, getting into CMH for more the adult stuff, coming out and explaining, how their procedures work, all that stuff. And just ah just with them, giving us more of an idea of these are some of the really dangerous signs you should look for. (Tom, police officer)*

Participants felt that guest speakers could address all frontline personnel but specific parts of training should be geared towards the specific needs of communicators and officers as the role that each plays on mental health calls is different.

*I think probably the dispatchers and communicators should received a little more training, oh sorry, a little different training because they are on the phone, and they're not face to face with these people, so for them to solicit some information, they may have to ask some different questions or ask them in different ways. But for us officers and like Constables and Sergeants, I think we should all receive the same training. (Rhonda, administrator, police officer)*

*Our call takers should have similar type training to the people working in crisis, right, the crisis hotline. Whatever training they're getting should be the training that a call taker is getting, because they are the lifeline just like the crisis worker on the crisis hotline is a life line there, um the same goes for our call takers. (Tyler, administrator, communications)*

*What questions are ok to ask and what's gonna agitate somebody. I know it's different for everybody, but there's probably some standard-type questions. And um, having someone from the field come in would*

*make more sense to me from somebody teaching from a police point of view. (Clara, communicator)*

Two communicators felt that refresher courses on mental health would be helpful on a regular basis.

*It's not something you go to a two-hour class and, you know once a year. I think there should be workshops on it; things like that, that people are sent to on a regular basis. (Clara, communicator)*

*So I think ya it would be great to have something in play so that say every 6 months you're gonna have this session to go to or what have you. (Christina, communicator)*

As for trying to figure out who should be responsible for deciding what training is essential for officer and communicators to have as new recruits and throughout his/her career, one administrator offered his opinion based on his personal experiences:

*It would be easier for everybody, if everyone got the same training, and I'm really surprised that the province hasn't mandated it because they have mandated everything else. Why the province hasn't mandated mental health training for frontline police officers, I can't believe they haven't done it up until now. (Matt, administrator, police officer)*

All participants were open to more in-service training, although opinions about the amount and type of training varied. For officers, training should focus on mental health scenarios similar to what is done for use of force training with coaching from mental health professionals. For communicators, information on what questions to ask and scenario training over the phone would be helpful. The administrators echoed the needs of the police officers and communicators relating to training (see Figure 2). Finally, with respect to responding to the calls themselves, there was a

suggestion on what might be a more efficient response to certain types of mental health calls.

*Ya I kinda think we'd be better off if we could kinda make it so we could send both the officer and the CMH at the same time. I think that would be a lot better cause then, there's no briefing to be done on the subject, and I just think "why are we not allowed to send them together?" Like put a criterion in place and say if it's this and this you know, send the officers and CMH, then there is no wait. (Martha, communicator)*

This type of response is already used in several police services across the province, for example Peel and Hamilton with the COAST model and Chatham-Kent with the HELP model.

**(iv) The broken system**

Officers identified that they sometimes struggled with knowing which community resource would be best to call in specific situations. For example, if a person needs help or community support but is not apprehendable under the Mental Health Act, which support would be the best one to call to get the PMI the help that he/she needs.

*Umm, knowing who to call, I think so far has been the biggest challenge, there's a lot of different services that we can provide to the people, so its' just knowing who to call that could best help the person that I'm dealing with. (Mark, police officer)*

*It's mainly knowing what resources are out there. and what resources we are able to direct them (person with the mental illness) to, and have a better understanding of what these services actually do. Because sometimes they have a lot of these token responses, well we'll deal with this and this and this however, in reality it isn't that same level of care or meeting their (person with the mental illness) criteria. (Greg, police officer)*

One final challenge that was expressed by participants is that essentially police are a “Band-Aid” solution within the mental health system. Once the initial crisis is managed and the individual was either apprehended and taken to hospital or provided with information regarding community resources, technically the role of police involvement is complete.

*I believe that once you get to the hospital, it's no longer our problem and that's when the social system should take over, and the hospital should do their thing to get the person help, and to meet with the family and what not. Often we are called upon to do more than that.  
(Matt, administrator, police officer)*

Sometimes the societal expectations that are placed upon officers relating to mental health calls fall outside of the role that the officer plays when responding.

*Well it's becoming a hot topic obviously, and how to deal with them, and here again it's a matter of the public's or the organization's perception of what our role in mental health is. We are still a “band-aid” solution, I know they don't like using that, I know we are an integral part of the bigger scheme of trying to help; but when I'm there at the side of the road with a guy with a knife or a guy who wants to jump off a bridge or a guy that just sees the devil come out of the walls it's a stop gap. I don't have time to solve his problems you know, to figure out how he grew up as a child, you know lead him to that way. So I think it's gone negative in that the public expects things that we aren't really equipped for, nor are we trained, but it's positive because I think the way we do handle the things are far superior, but we're just not getting recognized for it. Like I said 99.9% of the time, the public doesn't even hear anything about what our people deal with. They only hear about the situations that I wouldn't even say gone bad, they turn into a, you know, public either a tasing or a shooting or whatever. Was it an appropriate way to deal with it? I still think in many cases it is because there were no other options.  
(Curtis, police officer)*

There also appears to be a real disconnect between the initial situation requiring police involvement to the transition and follow up from community support services. An example of this is when a person is apprehended by police under the

Mental Health Act and immediately released from hospital after being seen by the Emergency doctor. Officers are often frustrated because it is not uncommon to be dealing with the same individual again either later on that same day or later on in the week or month.

*If that attending physician in the ER decides “No, this guy is not a problem” then the person is out the door as fast as they came in the door, and nothing changes. (Travis, police officer)*

One officer described a situation where a little girl found her mom unconscious on the floor of their apartment with superficial cuts to her wrists, and empty pill bottle next to her and open alcohol around. Mom told the doctor it was an accident and was sent home, despite the situation leading to her apprehension.

*[Nurse] “But she has been talking about taking her daughter out to a play the next day, or future events showing that she didn’t really want to kill herself.” [Officer] And um, she spoke with the doctor, I don’t even think I had an opportunity to speak with the actual doctor, and basically I was told that she wasn’t going to be formed. And I needed to drive her back home to her house, and I was like, ok I guess we will be back next week or next month or whatever the case was. (Greg, police officer)*

It becomes frustrating when a person is discharged by the emergency room doctor after being brought in by police, and then continues to require assistance after being discharged. A lot of the issues that officers have difficulty with stem from the lack of resources to assist these individuals after he/she has been released from the hospital, not the initial police response to the mental health call.

*People with mental health ah, issues ah, live in the community all around us, and most of them don’t come to police attention, but the ones that do often come repeatedly to the attention of the police. (Travis, police officer)*

*I think we actually really care about helping people, because we understand that it’s such a societal problem, and it takes up so many hours and person hours, and not just for the police; that we try and*

*incorporate those people, and to divert them to the hospital where they can get care, because we know that it helps everybody. The only problem with that is the hospitals now are being bogged down. There are a lot of sick people out there and we're seeing the hospitals can't keep up and can't cope, and people are being rotated out the door, and then we as police officers are dealing with these people over and over and over again. And really it isn't until they get really sick and are a danger to themselves, those are the ones, it's the squeaky wheel gets the grease. (Matt, administrator, police officer)*

*There's a big gap between uh, the services available for those individuals who have addiction issues, and mental health issues together. The two streams of healthcare in those areas are pointing the finger at each other; that the client needs to get help there first. So even a person that's willing to get help finds themselves um, caught between two systems that are fighting each other rather than working together. (Travis, police officer)*

There is often a great disconnect between the role that officers play when responding to mental health calls and the mental health system, as is evident by the quotes above. With limited community resources available, police are often the ones who pick up the pieces and respond to the individual when they feel that no one else is helping him/her. The majority of challenges that officers and communicators face when it comes to responding to mental health calls are a result of the mental health care system and not the response itself.

### **(3) Strategies for responding to mental health calls**

Participants are hopeful that the introduction of the Canadian Mental Health workers who were brought in to assist on non-violent mental health calls will be an excellent resource when it comes to supporting individuals who are suffering from a mental illness. They have knowledge of all community resources and can assist officers in shedding some light into borderline cases where an officer is not sure what the best course of action is to take with the individual.

*I really applaud this Canadian Mental Health, all these professionals getting involved, because that's been a huge weight off where you can have somebody who's trained, and it's their job to come in and say "yup I agree with you we don't have grounds to apprehend, that way we can say "look we did everything we could, we have this extra resource, and we did everything we could, so if something else happens later you know you're covered". (Tom, police officer)*

*I mean um we do have, and you know the new program that's just started, with the CMH people. Um I think that's a great step in the right direction. Just from our point of view of sending them um, I don't know if it's a great step in the right direction only an officer can tell you that. (Clara, communicator)*

*Well what we're trying to do is let the CMH worker know of every like 937 call. (Well that would be good) Trying to, I think it's too much though, because I mean there will be 3 on the go at one time so. And if he's at one he can't go to the other ones too. (Martha, communicator)*

*Well that's where the CMH is in now, that it's an awesome thing to put into play because you can call them directly on their cell phone, and say this is the situation if they're available they will come out and talk. Or they can say "bring them to the hospital" and they will meet them at the hospital. So those guys, like I know I keep saying it but they're new and its been really great having them. If we could have 2 on it'd be awesome. But they are making a big difference and they really are helping. (Christina, communicator)*

Currently the police service has two mental health workers from the Canadian Mental Health Association who work from 11:00am to 11:00pm and are available to respond to mental health calls with officers at their request. Overall, officers, communicators and administrators have seen this addition as a positive step in the right direction and they would like to see more workers available to attend calls, as there is only one available per day. Officers and communicators shared some other strategies that have worked for them in the past when responding to an individual suffering from a mental illness.

*Be open and honest, don't lie to someone with a mental health issue. And because as soon as you lie to them, they are not gonna trust you again because, they already have trust issues as it is. And a lot of them are paranoid, so don't lie to them. (Matt, administrator, police officer)*

*If you speak in a calm manner and be empathetic to them and, you know, try and communicate what they are going through, and try and show an understanding and be a good listener, quite often that will assist in communicating with them. It doesn't mean that this will happen every time, but from what I've seen, it's much more effective obviously than a short fused or impatient officer that's dealing with the situation. (Tyler, administrator, communications)*

*Um I think you have to be empathetic. I mean you can't be sympathetic because I don't think that's helpful. But I mean, you have to be empathetic and kind of understand. You probably don't understand what they're going through. So that would be the big one. (Ben, communicator)*

*I think just the patience right, the level of patience, and I think a level of maturity as well. Those two things they definitely help, and some officers who have lived with persons with mental health issues, or have worked in that field prior, they are leaps and bounds ahead of the other officers in how to deal with it. (Rhonda, administrator, police officer)*

The next two quotes address the fact that mental health calls often times take longer to deal with than other types of calls. If proper time is invested it can help to de-escalate the situation and possibly prevent future calls in the future:

*So, the officer that you want on a call like that is someone who has an even tone of voice, can control the tone of their voice, can speak softly to someone or um not sternly is what I mean. Not soft as in can't hear but that's approachable and open and non-judgmental, willing to talk. You're gonna be there for hours, so you know, just put everything else aside and you know, someone that isn't rushing onto the next call. (Beth, police officer)*

*Taking time. If you take the extra 5, 10, 15 minutes with them, usually that will help calm the situation. Because a lot of the time, with mental health situation they need to vent or have somebody to talk to. A lot of the times with mental health situations ah, they become*



*very isolated right, so they just need that person to talk to. Ah and then know the resources that are currently available, and actually make sure that you do get them in touch with those services and there is some level of follow up, if possible. (Greg, police officer)*

Communicating with the person suffering from a mental illness is one of the most important strategies that can help to de-escalate a situation as identified by the participants. Interestingly, police personnel also identified communication skills as an area that is overlooked in training.

#### **(4) Coping and aftermath**

While it was not the intention of this study to investigate the supports in place for frontline responders, employee wellness was an area identified by the participants as requiring attention. Participants brought up several concerns regarding employee assistance and current support services, such as the Employee Assistance Plan (EAP) and the Critical Incident Trauma Team.

*Um, there is the employee assistance plan our EAP program. Ah however there really isn't a culture awareness of it, and there's a very negative stigma that I think goes along with it. (Greg, police officer)*

*I don't feel that the people at EAP are very qualified as to what an officer may need in other situations" (relating to traumatic incidents in the workplace). Um, and like I said I mean I personally have gone to an EAP counselor and I found them inadequate. And no offence to them, but um you definitely feel more comfortable with your own counselor, and I think that if we really wanna help our officers with anything going on in their life, whether it's personal or professional, we should allow them to go to their own counselor. (Rhonda, administrator, police officer)*

*Just because someone has a Masters of social work doesn't make them qualified to be a counselor. And we have people in this region that are police specific trained and we don't recognize them. So um I think that's a huge gap. There's people that are specifically trained in certain techniques to deal with those exact issues, to deal with a sudden death or some sort of traumatic event for any EMS personnel,*

*and we do not recognize them. So I think there's some change that needs to be there. (Beth, police officer)*

One officer had a good experience through the EAP and was happy with the services that were provided to him.

*I went through the post-traumatic stress counseling, and I think I went to 3 or 4 sessions and it was perfect, it worked great. So at least where I went I think they were fantastic and I would recommend it to anybody. They were great. I think they (the police service) just need to educate the officers more that it's out there and it helps, and that um, they're not going to be looked down upon, or looked at as weak if they go to counseling for whatever reasons it is, because we see a lot of horrible stuff and it's great to go and talk to these people. (Rob, police officer)*

The Critical Incident Trauma Team is made up of both police officers and civilian members of the police service and they can be called out to assist both officers and communicators after a traumatic call.

*If it's a major call for them then the members of our critical incident trauma team would respond, and they would be assigned a specific time to go in and actually speak to someone from our critical incident trauma team. I don't think our critical incident trauma team is used enough, and I think a lot of times it's not even considered. (Greg, police officer)*

*I think that if it's a peer support that it would be better talking to somebody that you don't directly know, cause often times you don't feel comfortable talking to somebody that you know because you don't want to be vulnerable. (Clara, communicator)*

*We have the critical incident trauma team but I think that's difficult for some officers because some of the responders from that are people of rank, and some officers may not feel comfortable going to somebody that's a Sergeant or above. (Rhonda, administrator, police officer)*

Finally, the procedure defining what a critical incident should include and the police services response to traumatic calls that fulfill the critical incident threshold needs

to be addressed. First of all, broadening the scope of the definition of a critical incident to include a non-fatal shooting would be a step in the right direction to ensure that officers do not slip through the cracks when it comes to receiving support:

*The procedure was sort of written wrong... because it says in there, and I would have to look at the procedure now but it says that if an officer is involved in a fatal um situation then x, y, z. Well it doesn't have to be fatal...so it should be anything that potentially could be deemed as a fatal scenario, so they have to broaden their scope, because you're gonna get guys caught in that middle road that are either going to be procedurally wrong or left in the lurch by that little clause alone.  
(Travis, police officer)*

While not the focus of this study, employee wellness was a theme that emerged throughout every interview that was conducted. It is easy to neglect the individuals on the frontlines who are supposed to be able to handle the tough stuff and be there for the families and victims in the face of tragedy and destruction. One officer stated: “We’re still human we just choose to do a very unique role and I think that is forgotten” (Beth, police officer). This quote sums up what so many officers struggle to say.

One question that arose from the interviews is who specifically is responsible for employee wellness? Perhaps the best response to that is sharing the responsibility to look after one-self and each other.

*As a Sergeant, I took a personal interest in it, because those are in my opinion my people. Um, I think that it does come down to the supervision and management team as a whole, I think everybody from the sergeant to the staff sergeant and the superintendent and inspector, I think that they all need to have a vested interest in what's going on in that aspect with employee wellness. (Rhonda, administrator, police officer)*

*Well I think the Sergeant is in the room for a reason, and he monitors the calls, so I think he's the one that needs to pick up on uh, initiating the support um. They call victim services out regularly for the family, so what about the person dealing with the call? I mean yes you didn't know the person, but to think I just talked to someone and then a few minutes later they are no longer, you know um, or I knew this person and so I think the Sergeant possibly is the one who should initiate it. (Clara, communicator)*

*Basically, it used to be the Sergeants were supposed to watch to see if you need anything. Now we all watch each other. But if you see somebody's really having a tough time dealing with something, you usually tell Sarge and they send someone out to speak to them. (Christina, communicator)*

*There's the EAP program, and there's people that we work with that have more specialized training to deal with these programs, ah the events that happen. Um a lot of the times, it's really up to the person to open up about it as well. Um and sometimes that's easier for some people than others. (Travis, police officer)*

Employee wellness should be a top priority for the police service. While the responsibility falls on everyone to look out for themselves and one another, certain strategies could be used to reduce stigma and take a proactive approach in looking after the mental health of frontline responders.

## **CHAPTER VI: DISCUSSION AND CONCLUSION**

Previous studies have shown that responding to individuals suffering from mental illness is an integral part of police work and officers are usually the first responders to crisis situations involving persons with mental illness (Price, 2005; Wells & Schafer, 2006). Police officers are often referred to as the “gatekeepers” to the mental health care system and play a key role in deciding if the most effective means to deal with these individuals is through the mental health system, the criminal justice system or both (Demir et al., 2009; Patch et al., 1999). Officers play such a

key role when responding to mental health calls for service and carry out this role typically with very little training (Cotton, 2004; Cotton & Coleman, 2008; McAndrew & Sutton, 2004).

Communicators are often overlooked, with the focus being primarily on officers. Communicators are often the first contact and lifeline of the individual in need of assistance and ensure that the necessary information is passed on to the police officers who are responding to the call for service. Once on the call, the dispatcher is the lifeline for the officers and continues to assist the officer on the call as required. It is therefore necessary and important to include the experience of communicators to truly understand and appreciate how frontline police personnel respond to mental health calls for service. This study provided communicators with a chance to share their experiences of responding to mental health calls which addressed this gap in the literature.

Through phenomenological inquiry, the lived experiences of police officers, communicators and administrators who have responded to mental health calls for service were shared. By understanding the different perspectives of police officers, communicators and administrators and the experiences that they shared created a holistic picture on responses to mental health calls from the time the call for service is answered on the phone, to the end of police involvement with the individual in need of assistance. While other studies have included small components of qualitative examination in the research, this is one of the only studies that have focused solely on the personal experiences of front line responders. Overall, the responses and feedback regarding this study were very positive and the participants

were happy to share their experiences. Results focused on the roles one assumes when responding to calls, challenges when responding to these specific calls, the current practices in place to look after the mental health of frontline personnel, and finally, recommendations on what our frontline needs to be more efficient and confident when responding, as was described through their experiences.

Officers and communicators have a solid understanding of what role they play when responding to mental health calls for service. Officers identified their role according to the Ontario Mental Health Act (2000) and how they describe their role on these types of calls is consistent with what is laid out in the Act. While the Ontario Mental Health Act does not apply specifically to communicators, the results of this study has described very clearly the role that communicators play when responding to these types of calls. In addition, officers and communicators perceive that the number of calls relating to mental illness is increasing. This is consistent with the officer perception in McAndrew and Sutton (2004) where 68% of officers thought there had been an increased number of mental health calls since they started policing.

Police officers are often the first, and often times the only, community resource that respond to mental health calls for service. Officers first try to determine whether or not the person needs to go to the hospital for a psychiatric assessment. This was consistent with the results of Wells & Schafer (2006) who found that police officers are often the first responders to mental health calls where a person is in crisis. If the person is not apprehendable under the Mental Health Act, officers are very limited when it comes to assisting the person. Officers will try to

refer the person to community resources but there is no guarantee that the person will reach out to the resources or that the resources will reach out to him or her. Hoch et al (2009) found that officers had the same concerns and suggested the need for increased access to community-based services, case management services, enhanced police training and increased mobile health crisis services. Officers often become a “Band-aid” solution for the person with the mental illness and provide a short-term resolution without any long-term plan.

Both officers and communicators identified training as an area that they lack; however, they feel that it is necessary and valuable to assist them in their work. This echoed the results of numerous studies suggesting that officers feel they receive very little training concerning mental health in general, and feel that more training would be beneficial to their work [(Cotton, (2004); McAndrew & Sutton, (2004); Vermette et al, 2005 and Wells & Schafer, 2006)]. Officers and communicators in this study went on to say that training should be meaningful and practical by professionals in the field who can address the specific challenges that officers and communicators face when it comes to responding to mental health calls for service. Officers and communicators were open to the idea of more training and felt that ongoing training sessions would be more beneficial than a single session. I think that the roots of training should occur with new recruits who have just completed their Basic Constable Training at the Ontario Police College, and newly hired communicators and should occur through the police service itself. Refresher sessions for experienced officers and communicators could contain a shortened

version of this course and scenario-based training using examples of real life challenging calls from the previous year to encourage discussion and strategies.

While it was not the intention of this study to examine the mental health of our frontline responders, many officers and communicators spoke about the lack of or inadequate resources to assist in dealing with the toll that responding to traumatic incidents can have for first responders. Participants commented on their perceptions of the amount of support available and the quality of strategies offered when working through post-traumatic stress from a call at work. Many recommendations were provided on how the current services and assistance programs may be changed to be more accessible and effective while reducing the fear of stigma associated with a police officer or communicator expressing difficulty in dealing with a stressful or traumatic call. This was consistent with research by McAndrew & Sutton (2004) who found that officers wanted more training relating to substance abuse and stress management techniques to help them achieve better mental health. One participant in this study suggested a change to current procedure to address the definition of what a critical incident may include to broaden the scope and prevent oversights in the future.

### **Implications**

With few published studies on the experience of frontline police personnel responses to mental health calls, the combined perceptions and insight of participants contributes to understanding the experiences of officers and communicators when managing mental health calls for service. My study will be beneficial for policy makers and administrators as the voice of frontline responder's



experiences is provided, especially the challenges and recommendations on what would be helpful to be more efficient and safe when responding to mental health calls and individuals in crisis. With respect to training, it might be helpful for the province of Ontario to develop and implement a curriculum for all police services for new recruits returning from the Ontario Police College and newly hired communicators, and experienced police personnel. Officers and communicators provided numerous suggestions as to what would assist them in better dealing with mental health calls for service and it is my hope that the stakeholders will take these into consideration when developing future training frameworks. In addition, suggestions on how to improve the current resources available for officers in need of assistance after a traumatic or critical incident were discussed. It is important for policy makers to remember that police personnel are human beings and are not immune to the development of mental illness or post-traumatic stress. In addition, compounded fear of stigma and judgment of their peers and society when they do come forward and ask for help must also be acknowledged.

### **Future Directions**

Since this is one of few qualitative studies examining the experiences of frontline police personnel who respond to mental health calls for service, the results provide a stepping- stone for further research in this area. The inclusion of call takers and dispatchers is important in research relating to police response as the information they obtain from the caller tends to shape the experiences of all personnel that are involved in the call. It is important for researchers to recognize how police personnel work together and not to forget our communicators. Due to the small

sample size and range of experience, future studies might consider focusing on a particular grouping, such as new recruits or experienced personnel. Additionally, a case study approach with officers, communicators and administrators who have responded to a traumatic call involving a critical injury or fatality would be interesting to compare differences and similarities in post-traumatic stress effects and support.

While this study focused on frontline responders, the time constraints and scope of this study did not allow for the inclusion of University Special Constables or Security Guards at area colleges. It is important that these responders not be overlooked, as the roles that they play are often similar if not the same as an officer responding to a call. It would be interesting to hear about their experiences and compare the findings to that of police personnel. To the best of my knowledge, there are no qualitative studies that have examined the experience of guards and Special Constables who patrol campuses.

Lastly, it would be beneficial and interesting to conduct a case study on all first responders and community partners involved on these calls. This would provide insight into understanding the unique experiences of the responders and the person who has had dealings with police, fire, paramedics and other services like mobile crisis and/or the Canadian Mental Health teams. This holistic view would assist in putting all the pieces of the puzzle together and will address the need for a collaborative approach in assisting individuals who suffer from a mental illness. A lot of the frustration associated with police response to mental health calls is the silo effect that is currently experienced when the system breaks down and

community services work independently from one another instead of in partnership. One issue with this would be confidentiality of all parties; however with consent, it would be interesting to gain perspectives through the eyes of all who were involved.

### **Researcher as a tool**

Being a police officer in the service where I conducted my study provided me with a unique opportunity and gave me access to a population that is difficult to connect with as an outsider. I think that being an officer helped me to better relate to my participants, and that my position in the service created a baseline level of trust and understanding between my participants and myself. I feel that this enhanced sense of trust and understanding allowed my participants to be more open with their responses. On the other hand, it may have caused a potential barrier in that my participants may not have gone into great detail about an experience because they felt that I “just knew” what they meant and they did not have to explain. I attempted to probe further into the responses of my participants to get them to verbalize their perspectives, however if I was not knowledgeable about this topic, I may have asked more clarifying questions and probed a little deeper into the essence of their experiences.

### **Limitations**

One limitation that needs to be addressed is the low number of communicators and administrators that participated. As a result, theoretical saturation is questionable within these groups of participants. The participants in this study were all aware that the researcher is also a member of the police service. While I encouraged the

participants to answer the questions as openly as possible, the participant's biases must be recognized. Even though I assured confidentiality to the participants, it is still possible that some held back out of fear for repercussions if their identity was discovered. Overall, benefits of this study outweighed the limitations, as it provided insight into the experiences of frontline personnel when responding to mental health calls for service.

### **Conclusion**

Officers and communicators often find themselves as the first responders to individuals suffering from mental illness who are in crisis. The call takers are the lifelines to the individual calling in for assistance and the dispatchers are the officer's lifelines while he/she is dealing with the call. Once on scene, the police officer must make a determination based on his/her observations and knowledge of the situation and decide whether or not the person is an immediate risk to him/herself or others and if he/she appears to be suffering from a mental illness. If the criterion is met, the officer can apprehend the person under the Mental Health Act and transport them to the hospital to be assessed by a psychiatrist. If the person is not in any immediate danger and is not posing a threat to anyone else, the officer tries to connect with the appropriate community resources available to support the person with the mental illness and assist him/her with coping and recovery.

In summary, frontline police officers and communicators have voiced their experiences and thoughts relating to mental health calls and their own mental health needs. Hopefully this study has created an increased awareness of the role that frontline police personnel play when responding to mental health calls for

service, some of the challenges that they face, and their voices will continue to be heard as policy makers and stakeholders continue to make improvements and adjustments to the current system. The reality is that police work will continue to include responding to mental health calls and individuals in crisis, and these demanding calls require a unique approach and additional training to keep officers safe and to provide the best services possible to the community.

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## **Appendix A – Demographics of Police Service**

- For confidentiality reasons, the police service used in my study cannot be identified. Alternatively, I have provided some demographic details about this particular service, to provide some contextual information that may be useful when reading and interpreting my findings:
- Consists of approximately 739 police officers and 271 civilian members
- The service covers 1382 square kilometers and serves a population of 510 000 people
- The service covers both rural and urban areas
- There are currently policies in place and protocol relating to response to mental health calls for service and these materials are available for all members to review at any time. Part of this policy is that there are currently two Canadian Mental Health workers with one available from 11am-11pm who can respond to mental health calls for service, at the request of the responding officers.

## **Appendix B – Definitions**

### ***Form 1***

An order made under section 15 of the Mental Health Act. Under section 15 a physician can commit a person to a psychiatric hospital for observation for up to 72 hours. There are specific criteria that must be met, as the order can force him/her to attend and remain at the hospital against his/her will.

### ***Form 2***

An order made under section 16 of the Mental Health Act. Under section 16 a Judicial Officer can order a person to go to the closest psychiatric hospital for an examination, at which point the physician who examines her may choose to issue a Form 1. The Judicial Officer must hear evidence under oath that satisfies certain criteria, as the order allows the police to apprehend the person named in the Form and bring him/her to the hospital without consent if necessary.

### ***Form 9***

If a person is an involuntary patient and flees from a psychiatric hospital the hospital will call the police and a Form 9 under the Mental Health Act will be issued directing the police to search for and apprehend him/her. A form 9 remains in effect for up to 30 days.

***Dual Diagnosis*** – Individual has a developmental delay and diagnosed mental illness

***Concurrent Disorder*** – Individual has an addiction and diagnosed mental illness

***Mental Disorder*** – Any disease of the mind

Adapted from “Mental Health, the Justice System, and You: Understanding the process, and the people that can help.” Kitchener Human Services and Justice Coordinating Committee. 2010.

## **Appendix C – Mental Health Act**

### **Section 16 MHA**

An order under this section shall direct, and, for a period not to exceed seven days from and including the day that it is made, is sufficiently authority for any police officer to whom it is addressed to take the person named or described therein in custody forthwith to an appropriate place where he or she may be detained for examination by a physician (Ontario Mental Health Act, 2000).

### **Section 17 MHA**

Where a police officer has reasonable and probable grounds to believe that a person:

is acting or has acted in a disorderly manner and has reasonable cause to believe that the person

a) has threatened or attempted or is threatening to cause bodily harm to himself or herself;

b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her or;

c) has shown or is showing a lack of competence to care for himself or herself, and in addition the police officer is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in:

d) serious bodily harm to the person;

e) serious bodily harm to another person; or serious physical impairment of the person, and that it would be dangerous to proceed under Section 16, the police officer may take the person in custody to an appropriate place for examination by a physician (Ontario Mental Health Act, 2000).

### **Section 33 MHA - Duty to remain and retain custody**

A police officer or other person who takes a person in custody to a psychiatric facility shall remain at the facility and retain custody of the person until the facility takes custody of him or her in the prescribed manner.

## **Appendix D – TEMPO Model**

### **TEMPO – Adapted from Cotton and Coleman, 2010**

Training and Education about **Mental Health for Police Organizations**

#### **Tempo 100:**

**Focus:** ensure that police first responders have sufficient knowledge and skills to be able to manage the types of encounters that police personnel have on a regular basis and to know when to seek additional support or, when available, more skilled intervention.

#### **Tempo 101 – Police Basic Training:**

**Focus:**

- 4-day module for ‘new police officers/police cadets’ in police college
- Should cover the entire recommended Learning Spectrum
- Some subject matter to be reinforced through other course work (use of force)

#### **Tempo 102 – Lateral-Hire Police Officers**

**Focus:**

- 2-day module for lateral hire
- Ensure that all officers are on the same page with training and have reviewed the material in Tempo 101

#### **Tempo 103 – Police Personnel/Support Staff**

**Focus:**

- Call-takers, dispatchers, front desk personnel and victim services workers
- Training geared toward role-play simulation based on work environments
- Example – telephone simulations for communications center staff

#### **Tempo 104 – Offender Transport/Prisoner Care Personnel**

**Focus:**

- 1-day module covering Learning Spectrum for personnel responsible for prisoners
- Emphasis is on signs and symptoms of mental illnesses and suicide awareness with both youth and adults

**Tempo 200:**

**Focus:** Assumes a pre-existing basic level of competence, and builds on it but the focus is still on the first police responder

**Tempo 201 – In-Service Training for Police First Responders****Focus:**

- 1-day module
- Refresher every 3 years
- Combined classroom and online resources
- Case study critique of recent police/PMI encounters to generate discussion about positive and negative points of each situation
- Change in legislation to be addressed
- Police agencies with mental health response teams should include team members as facilitators

**Tempo 202 – Field Training Officers/Coach Officers/New Supervisors****Focus:**

- 1-day program – review Learning Spectrum
- Assist FTOs to re-enforce their learning so they are confident in passing on his/her knowledge to new recruits
- Subject emphasis is on understanding mental illness, police attitudes and stigma related to MI and de-escalation techniques

**Tempo 300**

**Focus:** Designed for police personnel with specialized assignments that require a more in-depth knowledge

**Tempo 301: Specialized Assignments****Focus:**

- One week 40 hour learning module for personnel such as police negotiators, incident commanders, use of force instructors, ERT/Tactical teams and search and rescue managers
- Covers the Learning Spectrum and case studies
- Emphasis is on working with mental health professionals to plan and implement tactics for a satisfactory resolution

## **Tempo 400**

Focus: Specialist officers who will be providing expert or consultative services with regard to Police and PMI contact

## **Tempo 401 – Advance learning for police personnel assigned to joint police/mental health response team and/or police specialists**

### ***Focus:***

- 40 hour intense module which covers the entire Learning Spectrum
- Improve proficiency in reporting observations both verbally and in writing
- Addition 40 hour formal learning, four job shadow shifts with police/mental health response team
- If possible minimum 40 hour job shadow with a mental health facility
- Exam component with TEMPO pin to be worn on their uniform or jacket issued upon successful completion

## **Tempo 500**

### **Focus: Use of Force**

- 1-day module is the use of force continuum before progression to physical contact
- Emphasis on the following parts of the Learning Spectrum:
  - Understanding symptoms such as hallucinations, delusions, thought disorder etc.
  - Understanding of how much control the individual is likely to have on his/her behavior, including their ability to follow police direction
  - Communication skills and de-escalation techniques
  - Understanding of the relationship between dangerousness and mental illness
  - Being able to reasonably assess suicide risk and how to contain the situation and/or when to intervene accordingly
  - Ethical decision making and police discretion
  - Knowing how to apply problem-solving in the police/mental health environment

## **Appendix E – Informed Consent**

### ***INFORMED CONSENT STATEMENT***

WILFRID LAURIER UNIVERSITY  
INFORMED CONSENT STATEMENT  
Mental Health Calls: Experiences and Challenges of the Frontline  
S. Dougall, MSc Candidate, Department of Kinesiology  
Supervised By: Dr. P. Fletcher and Dr. M. Schneider

You are invited to participate in a research study. The purpose of this study is to explore the lived experiences of frontline responders of a police service in responding to mental health calls for service.

#### **INFORMATION**

This research study will consist of two components. Interested participants will be asked to fill out a form concerning demographic information and current position at work, as well as questions pertaining to experience responding to mental health calls for service. Researchers will then select approximately 20-24 individuals based on a predetermined set of criteria for semi-structured one-on-one interviews to better understand the frontline experience and response to mental health calls for service. Forms will be sorted according to the number of years of service of the member and his/her current assignment (e.g. patrol, administrator, communicator) and individuals will be selected after their form is reviewed by the researcher and her two supervisors. Upon consent, all participants will be audio-recorded. Recordings will then be transcribed verbatim and with the participant's consent, quotations may be used when research findings are presented. Interviews will take approximately one to three hours in length but this is ultimately determined by the participant's discretion. Prior to any findings being presented, participants will have the opportunity to review a copy of the transcript of his/her interview by e-mail or a hard copy if necessary, and will be able to make additions or changes to the data at his/her discretion. This will help to clarify any information that was not captured correctly in the interview and a chance for him/her to ensure that their perspective was captured accurately and provide an opportunity to identify data, which he/she may wish to omit from the results of the study. In total, the total time commitment required by the participant will be approximately five hours.

All direct quotations used will be identified using pseudonyms. Participants' identities will remain anonymous.

## **RISKS**

Participants have the potential to experience psychological or emotional risks regarding this research. Participants may regret the revelation of personal information to the interviewer and may experience emotional distress when recalling traumatic or stressful situations. Participants experiencing emotional distress will be provided information for the employee assistance program of the police service.

## **BENEFITS**

This research will allow frontline responders to voice their experiences and challenges relating to response to mental health calls for service in a confidential, anonymous environment. This study has the potential to improve police response to mental health calls in the community and to help frontline responders gain resources and support to better assist them in performing their duties and serving the community in which they work.

## **CONFIDENTIALITY**

Information collected will be locked in filing cabinets at Wilfrid Laurier University (232 King Street Building and/or Bricker Academic Building) and electronic data (such as audio-recorded interviews) will be password protected and stored on the researchers' personal computer. Once transcripts are typed they will be copied onto a USB stick and deleted from the computer. This USB stick will be stored in the locked filing cabinets at Wilfrid Laurier University. Only the researcher and her two supervisors will be able to access the data. The identity of the participation will be documented only via pseudonyms in the research findings. In addition, any incidental information that could lead to identifying a participant will be removed from the findings to protect his/her identity. This is important, as the findings of this study will be presented to Senior Management at the police service to make them aware of and help them to better understand the frontline perspective in this matter.

## **CONTACT INFORMATION**

If participants have questions at any time about the study or the procedures, he/she may contact the student investigator, Sarah Dougall at [doug5260@mylaurier.ca](mailto:doug5260@mylaurier.ca), or the supervisor, Dr. Paula Fletcher at [pfletcher@wlu.ca](mailto:pfletcher@wlu.ca) or 519-884-0710 ext. 4159. This project has been reviewed and approved by the University Research Ethics Board. If the participant feels he/she has not been treated according to the descriptions in this form, or his/her rights as a participant in research have been violated during the course of this project, he/she may contact Dr. Robert Basso, Chair, University Research Ethics Board, Wilfrid Laurier University, (519) 884-1970, extension 5225 or [rbasso@wlu.ca](mailto:rbasso@wlu.ca).



**PARTICIPATION**

Participation in this study is voluntary; participants may decline at any stage without penalty. If participants withdraw from the study, his/her data will be removed from the study and destroyed. Each participant has the right to omit any question(s)/procedure(s) he/she chooses.

**FEEDBACK AND PUBLICATION**

The results uncovered by this research will be presented in a thesis, journal articles and/or conference presentations. If participants wish to receive feedback, please contact the researcher Sarah Dougall at doug5260@wlu.ca. Additional feedback is available through the attendance of conferences whereby the collected data will be presented.

**PARTICIPANT CONSENT**

By signing this consent form, I agree to be a participant for the "Mental Health Calls: Experiences and Challenges from the Frontline" study. I have read the attached information and understand that I can withdraw from this study at any time.

I have read and understand the above information. I have received a copy of this form. I agree to participate in this study. I am aware that that I will be audio-recorded and that the audio recorded interviews will be transcribed verbatim.

Participant's signature \_\_\_\_\_ Date \_\_\_\_\_

Investigator's signature \_\_\_\_\_ Date \_\_\_\_\_

I am also aware that my quotations may be included in the results and that a pseudonym will be used in the results to protect my identity.

Participant's signature \_\_\_\_\_ Date \_\_\_\_\_

Investigator's signature \_\_\_\_\_ Date \_\_\_\_\_

**Contact Information:**

Participant's Name (print): \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## Appendix F: Face Sheet

### *Police Involvement and Mental Health Calls: Tales and Challenges from the Front Line*

The following questions deal with your background. Personal information collected from this sheet will be kept confidential. Information will be used to assist the researcher in learning more about you and will help to determine the criteria that will be used to recruit participants for semi-structured interviews. Participation in completing these questions is voluntary and by providing your name and e-mail you are indicating an interest in participating in the next stage of research, which will be the semi-structured interviews. These interviews will take between one and two hours of your time to complete. Thank you very much for your interest in this study.

Name:

E-mail:

Gender:

Date Of Birth: (yy/mm/dd):

- Male  
 Female

Have you ever been involved in the response for a call for service where mental illness is suspected?

- Yes  
 No

If yes, when was the most recent incident that you responded to?: (yy/mm)

Please complete the chart below relating to your experiences (Please use back of sheet if you need more room):

| <b>Police Service</b> | <b>Years of Service</b> | <b>Rank (i.e. Constable, Sergeant)</b> | <b>Assignment (i.e. General Patrol, Bureaus, Specialty Units, Communications, Records etc.)</b> | <b>List any training you have received relating to responding to MHA calls (Course/# of Hrs.)</b> |
|-----------------------|-------------------------|--|---|---|
|                       |                         |  |   |   |
|                       |                         |  |   |   |
|                       |                         |  |   |   |

## Appendix G: Semi-Structured Interview Guide

- 1) Tell me a little bit about you. Why did you become a police officer?
- 2) I can see from your response on the background sheet that you have \_\_\_ years in policing, what role/bureau has been the most memorable for you so far in your career?
- 3) I would like to know more about the experience of police officers when responding to mental health calls. What role, if any, do you feel police personnel are expected to play when it comes to mental health calls for service?  
Probe: Do you feel these expectations are realistic? Why or why not?  
Probe: Do you feel these expectations fall within your job requirements?
- 4) What type of mental health calls have you responded to?
- 5) Approximately how many mental health calls, if any, do you/did you respond to personally during a shift cycle? Over the past year? Over the course of your career?  
Probe: Have you noticed an increase in these types of calls since you started until now?
- 6) Can you think of a mental health call that you have responded to that has been personally significant for you (rewarding, stressful etc.)? If yes, can you describe every detail about it for me so I can try and put myself there at the scene with you?
- 7) How confident do you feel to take a course of action based on your observations and knowledge when you arrive on scene at a mental health call?  
  
Probe: What challenges, if any, do you face relating to these types of calls?
- 8) I can see from the background that you have receive “X” amount of training relating to mental health. Do you feel this training has influenced your response to mental health calls for service?
- 9) In your opinion what components contribute to and should be included in an effective mental health-training program for response to these calls (guest speakers, classroom, scenarios)?
- 10) Do you feel that training should be tailored specifically to different roles, for example, general patrol vs. road sergeant, patrol vs. communications?
- 11) If I responded to a MHA call and asked you for resources to guide me, do you know of any resources that you could refer to me that would assist me?

Probe: If yes, how did you learn about them?

Probe: If yes, how do you access them?

Probe: If no, what would you suggest I do?

12) Throughout your career, have you noticed any changes either positive or negative relating to policy, procedure or attitudes relating to mental health calls?

Probe: If yes, please explain how things have changed

Probe: If no, do you feel that policy, procedure and attitudes will remain consistent over the next five years? Ten years? Why or why not.

13) In your experience have you noted any specific personality traits that make some officers more effective at responding to mental health calls than others?

Probe: Please explain what traits you feel are effective and why?

Probe: Do you feel you have specific traits that you feel make you effective on these type of calls? why or why not?

13) Is there anything else you would like to add or tell me relating to your experiences in responding to mental health calls for service?

14) Do you have any questions for me?