THE WINSTON CHURCHILL MEMORIAL TRUST OF AUSTRALIA

Report by    -   Michael Mitchell    -   2008 Churchill Fellow

CHURCHILL FELLOWSHIP to study overseas

Preventing and resolving mental health crisis situations by working collaboratively

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Introduction

The awarding of a Winston Churchill Fellowship in 2009 allowed me to travel, meet, discuss and examine the responses provided by police services to crisis incidents involving persons with mental illness. My topic of research was investigating police responding to mental health crisis incidents. The opportunity to actually meet police officers from other countries who have the responsibility of improving the policing response was a unique opportunity.

I must acknowledge the work of the Memphis Police Department and Major Sam Cochrane who in 1988, joined in partnership with the Memphis Chapter of the National Alliance on Mental Illness (NAMI), mental health providers, and two local universities (the University of Memphis and the University of Tennessee) in organizing, training, and implementing a specialised response unit. The work has spread worldwide and been adapted to suit many different localities, communities and needs. I hoped the police agencies I selected would give me a broader look. I believe I was able to achieve this. The gift of the Fellowship from the Churchill Trust, made possible the greatest luxury, time to enable learning, consideration and to become networked internationally. For this, I truly thank the Churchill Trust.

Without the full support of the Queensland Police Service I would not have been able to take up my fellowship. I thank those who provided support, encouragement and assisted in providing approval for me to travel on the fellowship.

And finally thank you to those individuals and organisations who gave freely of their time, their professional and practical knowledge, who shared experiences with me, their generous hospitality and their frankness. This made my Fellowship a unique experience, such which I very quickly realised was a tremendous honour. Towards the end of my tour I saw the following quote of Winston Churchill “To build may have to be the slow and laborious task of years. To destroy can be the thoughtless act of a single day.” Each of the agencies I visited spoke of the similar thoughts, to improve the response provided to persons with mental illness will take time and understanding but the wrong approach can lead to a fatal incident.
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**Project Description**

Preventing and resolving mental health crisis situations by working collaboratively.

**Highlights**

It would be an injustice to mention any particular bits and pieces of the fellowship as a highlight. The entire journey was a wonderful and rewarding experience. It was refreshing to meet other people who share a similar level of passion towards assisting persons with mental illness in crisis. Every police agency in every country visited displayed the highest level of professionalism, cooperation, support, honesty, transparency and willingness to exchange information in the interest of value-adding to the police response to mental health crisis incidents. Even though I was seeking information from these agencies, the opportunity to sit and discuss also lead to sharing of policing practices from Queensland.

**Lessons learnt**

Three main issues were identified across the agencies which I visited. These were:

1. Tailored training Police first response officers, primarily focused on enhancing tactical communication skills through practical role-play scenarios. This training will provide personnel with enhanced skills to de-escalate situations involving people with a mental disorder.

2. Police and health agencies need to come together on a regular basis to identify issues, discuss complex cases, develop preventative interventions (such as pre-crisis plans) and identify alternative pathways of referral.

3. Government need to identify ways of having designated Emergency Mental Health Receiving Facility who have a no wrong door approach. All persons who police have detained for medical assessment need to be accepted.
Background
Since the advent of deinstitutionalisation and the movement of persons with mental illness into the community, the Queensland Police Service has played an increasingly important role in the management of persons who are experiencing mental health crises. The police are very often the first to be called to deal with persons with mental health emergencies. As a result, Queensland Police officers have assumed the role of “street-corner psychiatrist” by default. It would appear many officers have grown accustomed to this role and consider it one of their duties. A major problem with having to fulfil this role is that the police have had over the years little training in performing this kind of duty. This lack of training is one of the factors that have played a part in the criminalization of persons with mental illness.

I sought through the Winston Churchill Fellowship the opportunity to research on how to optimize the collaboration between the law enforcement and mental health systems to improve the care of persons with severe mental illness who are in crisis.

The rationale for the police to intervene in the lives of persons with mental illness derives from two common law principles: the power and authority of the police to protect the safety and welfare of the community, and the state’s authority, which dictates protection for citizens with disabilities who cannot care for themselves, such as those who are acutely mentally ill. Often both principles are involved when police are dealing with persons with mental illness who pose a threat of danger to the community or to themselves.

Police officers have a legal obligation to respond to calls and to provide services 24 hours a day, seven days a week. With respect to persons with mental illness, police in Queensland have the power to transport persons for evaluation and treatment when there is probable cause to think that they are a danger to themselves or to others because of their mental condition.

Queensland police are typically the first and often the sole community resource called on to respond to urgent situations involving persons with mental illness. They are responsible for either recognizing the need for
treatment for an individual with mental illness and connecting the person with the proper treatment resources, Queensland Health or making the determination that the individual’s illegal activity is the primary concern and the person should be arrested. This responsibility thrusts them into the role of primary gatekeepers who determine whether the mental health or the criminal justice system can best meet the needs of the individual with acute mental health problems.

Queensland police have a great deal of discretion in the exercise of their duties, including determining what to do when dealing with a person with acute mental illness in the community. In most cases, the police use informal tactics, such as trying to “calm” the person or taking the person home.

In situations that cannot be handled informally, the police may have to take persons with mental illness to hospitals or to jail. In some cases, however, public policy limits the police officer's discretionary ability. For instance, if the person with mental illness is alleged to have committed a major crime, the course of action is clear; the person is taken to jail because of the seriousness of the offence. In this situation, it is hoped mental health evaluation and treatment will take place while the person is in custody.

A number of factors have been proposed to explain why, when minor offences are involved, a police officer decides to arrest a person with mental illness rather than take the individual to a hospital. A person who seems to be mentally ill to a mental health professional may not seem so to police officers who, despite their practical experience, have not had sufficient training in dealing with this population. In some cases mental illness may seem to the police to be alcohol or drug intoxication, especially if at the time of arrest the person has been determined to have been using drugs or alcohol. Another factor is in the confusion that may accompany an encounter with the police and other citizens, in which the individual may be forcibly subdued, signs of mental illness may go unnoticed. It has also been shown that the occurrence of violence at the time of arrest increases the chances that the person with mental illness will be taken to jail.
In addition, police officers may be more inclined to charge persons with mental illness with a misdemeanor and take them to jail if they think that no appropriate alternatives are available and they have no other option. This could be regarded as a major cause of criminalization. The police are well aware that if they refer a person with mental illness to the criminal justice system, the individual will be dealt with in a more predictable way. He or she will be taken into custody, will probably be seen by a mental health professional attached to the court or the watch house, and will probably receive psychiatric evaluation and treatment. Thus arrest is a response with which the police are familiar, one over which they have more control and one that they think will lead to an appropriate disposition.

**Scope and objectives for the review**

The overall objective of my fellowship was to examine and discuss the policing response to persons suffering from mental health disorders.

My objectives of the fellowship were to:

1. Identify improvements in current services and facilities delivered by the police and other stakeholders to improve the safety, security and quality of care provided to people with mental illness;

2. Identify communication channels, information gathering and exchange processes between agencies including any established protocols with a view to assessing how they could be improved;

3. Explore lessons learned from recent cases, which may not have been handled appropriately, as well as examples of innovative practice to develop recommendations for improvement;

4. Identify areas in which changes in process or policy would benefit service users and eliminate discrimination;

5. Clarify the human rights issues relevant to both public protection and individual mental health service users; and

6. Elucidate the myths and realities around the predictability of behaviour and claims that a proportion of violent and related undesired events associated with mental health problems could be avoided proactively.
The operational components of policies and procedures for police officers in London detail:

- how to deal with a mental health crisis in a public place;
- how to deal with a mental health crisis in a private premises;
- how to respond to hospitals seeking police help to manage violent patients; and
- how to respond to requests from health agencies to transport detained patients.

A vital aspect of the procedures is transportation of service users in a way that promotes wellbeing, safety and reduces stigma. To support this, an agreement was signed to ensure that ambulance transport will always be used to transport service users compulsorily detained under the Mental Health Act 1983. This is very clear evidence the procedures are being implemented.

Significant work was completed on addressing the problems of stigma towards service users who were mentally ill. As a result of a strong slant towards anti-stigma, various internal policies and procedures were revised and influenced. Since the mentally ill are part of the disabled community, this has a positive impact upon this community.

The emphasis of work completed by the Metropolitan Police Service seems to be in providing a policing service to an individual with a mental illness that treats all persons fairly and has regard both for their human rights and their individual needs. The Metropolitan Police Service seeks to ensure that its actions are proportionate, legal, accountable, and necessary and based on the best information available. They continue to develop and review, in partnership with other agencies and organisations, clear working practices that will enable the delivery of a high quality service to all those affected by mental health (including carers, family members, and the wider community).

The role of the Borough Mental Health Liaison Officers includes a mixture of partnerships working, problem solving and communication. Whilst the choice
of rank and unit is that of the Borough Commander, the recommended rank is Inspector.

The critical success factor for policing mental health at a local level is frequent communication between the Borough Commander and the Borough Mental Health Liaison Officers. Primary local partners include the Community Mental Health team, places of safety, A & E Department and any psychiatric units. Without these simple structures in place, problem solving is likely to be inefficient and the same difficulties will be repeated.

**Calgary**

Calgary has over a million citizens and approximately 20,000 people move there each year. This has resulted in an increase of the homeless population from a low of 461 people in 1994 to 3,436 in 2006.

Although the link between homelessness and crime is tenuous, the visible social issue prevalent on the streets where this population is concentrated impacts on citizens perceptions of safety.

The downtown core received over 32,000 “social disorder” police calls about minor crimes and nuisances in public places, during 2005-2007. These types of calls involve: unwanted guests, suspicious persons, disturbances, drunks and drugs. It is not uncommon for the Calgary Police Service to deal with a chronic offender 20-30 times a year.

An objective of Calgary Police was to reduce the number of social disorder calls reported to the Community Support Centre (CPS) in the downtown core. Currently the downtown core receives 25% of all social disorder calls city wide. Of these 25% over 80% involve: drugs, unwanted guests, suspicious persons, drunks and disturbance call codes which are repeatedly committed by these people who are experiencing physical, mental or social health issues.

The Calgary police target enforcement against those individuals that prey on the mentally and physically ill, the addicted and the homeless. They seek to increase perceptions of safety among people and businesses in the downtown area.
A great number of Calgarians that come into contact with the Calgary Police Service suffer from mental health issues and would be better served receiving treatment for these issues, rather then serving time behind bars.

The Calgary Police Service, The Crown Prosecutor’s Office and the Calgary Health Region have entered into a project called the Calgary Diversion Project. The objective of this initiative is to divert suitable candidates who have been charged with minor criminal offences that can be directly linked to a mental illness, from the criminal court forum to the health services field. This should help alleviate the current capacity issues experienced by the courts and legal system in general, as well as allowing these individuals to receive the medical care they require.

So far almost half of the people referred to this program have been deemed to be suitable clients and there is a 75% success rate being experienced by the client over a one-year period – meaning that the client is not accessing or re-entering the criminal or medical services system during that period.

Las Vegas

The Crisis Intervention Team (CIT) program is a group effort bringing the police and the community together for the common goals of safety, understanding, and service to mentally ill persons in emotional crisis situations, and their families.

CIT sets a standard of excellence for their officers with respect to treatment of individuals with mental illness, to respond to a crisis and work with the community to resolve each situation in a manner that shows concern for the citizen’s well being.

The CIT objectives are to teach law enforcement personnel how to respond to any request; to provide assistance to persons who have a diagnosed mental illness or who are in a volatile emotional crisis; provide referrals to the proper social agencies; diversion of certain persons away from the criminal justice system and toward treatment, whenever available and appropriate.
Las Vegas Metropolitan Police Department’s CIT was introduced in 2002. The department researched different law enforcement models that assisted persons with mental illness. The one chosen was the Memphis CIT model which has been successful since 1988. This model had been chosen by other major law enforcement agencies throughout the United States as the best protocol for handling calls involving emotionally disturbed persons.

**Ventura County**

Ventura County is a county in the southern part of the U.S. state of California (Southern California). It is located on California’s Pacific coast, and forms the north-western part of the Greater Los Angeles Area. It has a reputation of being one of the safest populated places and one of the most affluent places in the country. It is ranked as one of the top 100 highest-income counties in the country and as the 6th wealthiest county in California by per capita income.

As of the 2000 census, the county had a population of 753,197. A more current California Department of Finance estimate places the population at 813,052. The county seat is the city of Ventura (formally known as San Buenaventura). Ventura County’s largest city is Oxnard, with a population of about 200,000.

The mission of the Ventura County CIT program is to develop partnerships with mental health consumers and their family members, and other agencies and organizations. CIT officers will respond to individuals who are in crisis as a result of a mental disorder, and shall assess and assist those individuals in the most effective and compassionate manner possible.

The goals of the Ventura County C.I.T. are to:

- Reduce the necessity for the use-of-force;
- De-escalate crisis situations;
- Reduce the use of jail;
- Decrease recidivism; and
- Increase lawful self-reliance and health enhancing behaviours.
The objectives are to:

- Train and maintain at least 20% of patrol officers and dispatchers in 40-hour mental health training;
- Increase the percentage of individuals linked with treatment through interagency meetings;
- Conduct ongoing update trainings;
- Conduct ongoing CIT stakeholder/advisory meetings; and
- Conduct 8 hour "Police Response to People with Mental Illness or Developmental Disability" trainings to all non-CIT officers.

The strategy for accomplishing this mission is to facilitate the safe and secure assessment and transportation of an individual in crisis, who meets the criteria established in Welfare and Instructions Code (WIC) Section 5150, to an appropriate mental health facility. CIT program staff act as a law enforcement liaison with the Behavioural Health Department (BHD), and other agencies and organizations.

The current status is 40% of patrol officer’s trained countywide and 25% of dispatchers trained countywide.

For six decades, one of the largest employers in Ventura County was the local locked State Mental Hospital. Over time, as the State Mental Hospital phased out its services and eventually closed in 1997, the demographics of Ventura County were affected, as people with mental illnesses were released to the community. Adequate provisions were not made to housing and treatment for many of these displaced individuals, often leaving them to fend for themselves. It is estimated that 11,960 mentally ill adults currently reside in Ventura County.

As a result of shootings that occurred in the late 1990’s and in 2001, the CIT program was brought to Ventura County through the efforts of Ventura Police Department (VPD), the Ventura County Behavioural Health Department (BHD), and Oxnard Police Department (OPD). In December 2001, the first 40-hour C.I.T. training was conducted in Ventura County. In early 2002, a mutual aid protocol was signed in order to coordinate this countywide effort - which
includes five Police Departments and a Sheriff's Department with six substations. Three more 40-hour CIT trainings were conducted during 2002. During 2002, CIT trained officers began to fill out CIT Event Summary forms. By the end of the year 2002, both VPD and ODP had 20% of patrol officers trained. During 2003, six CIT trainings were conducted. In the beginning of 2003, non-CIT trained officers began to fill out CIT Event Summary forms. By the end of 2003, the Sheriff's Department had 20% of patrol officers trained.

In 2004, CIT field interview (FI) cards were introduced, as a more user-friendly option to the CIT Event Summary Forms. During mid-2004, a Memorandum of Agreement was signed by all of the Ventura County law enforcement agencies in order to continue funding the program administrator and program assistant positions through June, 2006.

**Riverside**

Riverside is a large city located in the Inland Empire in Southern California. It is also the county seat of Riverside County, California, United States. The city is named for the nearby Santa Ana River, and is the birthplace of the California citrus industry. As of 2008, Riverside has an estimated population of 311,575. Riverside is the 61st-largest city in the United States, 12th largest city in California, the largest city in California's Inland Empire region, the fourth largest inland city in California, the 14th-largest metropolitan area in the nation and part of the 2nd largest Combined Statistical Area in the country. The city anticipates that the population of Riverside will surpass 320,000 by 2010. Riverside is one of the fastest growing cities in the U.S.

Compared with other cities in Southern California, real estate prices in Riverside are significantly lower than those in adjacent counties. This has led to steady growth in Riverside. Consequently, this has also contributed to heavy traffic as residents from Riverside commute to job centres in Orange County and Los Angeles.

Riverside Police investigated the 2 primary approaches to developing a mental health intervention program. The first approach, the Memphis Model, is based on a completely voluntary program. The goal is to train a certain percentage of your first response officers, recommended 25%, with all
volunteers. The second approach is to train all first response personnel. There are arguments for and against each approach. Riverside has adopted the second model similar to a significant number of other police agencies in the United States. This is also based on a one week curriculum. The 40-hour comprehensive training emphasizes mental health-related topics, crisis resolutions skills and de-escalation training, and access to community-based services. The format of a 40-hour course consists of didactics/lecture, onsite visitation and exposure to several mental health facilities, intensive interaction with individuals with a mental illness and scenario based de-escalation skill training. USA experience has shown this is a minimum level of training hours. The material covered is complex. The desired learning outcomes go beyond simple cognitive retention of material. The outcome desired is the retention of behavioural changes learned as part of the training.

**Intended dissemination and implementation**

In Queensland a blended approach to training has been successful in developing the skills of police officers. From recruit training to operational duties, police officers in Queensland can access training throughout their service both in face to face, classroom, distance education and on-line learning.

Mandatory mental health training is provided to recruits and first year constable. As a police officer in Queensland develops their career, mental health training is provided as required.

Training issues identified in the overseas visits which can be brought into Queensland are:

- Greater understanding in the difference between a mood and a thought disorder;
- Provision of resource documents to be supplied to mental health trained officer for use at incidents;
• Medications, in particular the impact of both taking and non compliance with treatment plans;

• Interviewing techniques for persons with mental illness and how to assess them; and

• All call centre dispatchers in the agencies visited receive a specialised course. The training course also addresses how to properly receive and dispatch calls involving individuals with a mental illness and crisis situations. Additional and advances in-service training courses are also provided.

A number of police agencies I visited identified that the detention of a person for a mandatory mental health examination could be classified as an arrest. The person with mental illness may have not done anything wrong criminally however the person is detained and made to undergo involuntary assessment. The issues raised were a person could be considered in the same light as an offender. Ambulance services in the United Kingdom and United States are used for transport only and do not have the authority to detain persons as in Queensland.

A number of agencies visited discussed the need for a designated Emergency Mental Health Receiving Facility which is a critical aspect of their model. They provide a source of emergency entry for consumers in to the Mental Health System. To ensure success, the Emergency Mental Health Receiving Facility must provide police officers with minimal turnaround time comparable to the criminal justice system. The facility should accept all referral regardless of diagnosis or financial status. Additionally the facility will need access to a wide range of emergency health care services and disposition options, as well as, alcohol and drug emergency services.

I have identified these issues are important to the continued development of the Queensland Police Services response to persons with mental illness who are in crisis.

Conclusion
The Queensland Police Service is continuing to improve the service provided to persons with mental illness and I consider the following quote from Winston Churchill to be very appropriate, ‘Attitude is a little thing that makes a big difference.’