Mental Health Systems, the Police and the Justice System

Presentation to the Standing Senate Committee on Social Issues, Science and Technology

In response to

Mental Health, Mental Illness and Addiction: Issues and Options for Canada

Dorothy Cotton, Ph.D., C. Psych.

Canadian National Committee for Police/Mental Health Liaison

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Dorothy Cotton, Ph.D., C. Psych, presenting to the committee,

Canadian National Committee for Police/Mental Health Liaison
www.pmhl.ca

WHO ARE WE???

This organization, composed jointly of police officers and mental health professionals, provides information, contacts and support to police officers and services to aid in their work with individuals experiencing mental illnesses. Its primary goal is to ensure that individuals who suffer from mental illnesses are not "criminalized" inappropriately but rather are directed toward the system which is most appropriate for them in their circumstances. It may be that this means entry into the criminal justice system if indeed a crime has been committed—but equally, it may mean that they are directed to the mental health system, or—if it is their choice and they do not represent a danger—no system at all. Obvious as this goal may be, it has often fallen to police organizations in recent years to take the lead role in directing these individuals to services. Lack of easily assessable community mental health services combined with the comfortable public expectation that the police fix all things means that calls to assist a person with a mental illness who appears to be in trouble go to the police.

A secondary goal of this committee is to ensure that both the police and mental health resources dedicated to this type of work are used efficiently and effectively. Many police departments are spending significant amounts of money in responding to calls involving mentally ill individuals. Is this a reasonable and effective expenditure? Would these problems best be handled in some other fashion?

The CNCPMHL is comprised of representatives from police services and mental health agencies, dedicated to finding solutions to issues related to police involvement with persons who suffer from mental illnesses. Issues of concern to the group include (but are not limited to):

- First responder interaction and responsibilities
- Training for police in understanding mental illnesses
- Training for mental health professionals in working with the criminal justice system
- Effective liaison models
- Partnerships between correctional facilities, mental health facilities and the police
- Research and data collection mechanisms to support the development of "best practices"
- Less than lethal use of force methods
- Effective mental health legislation

Primary Activities:

The primary activities of the committee include:

- An annual conference
- An informative website
- A listserv
- Providing resources and direction for research
- Acting as a forum for exchange of information and ideas

The current leadership comes from the steering committee comprised of:

Co-Chairs:

Chief Terry Coleman, Moose Jaw Police Service, Member Board of Directors, Canadian Association of Chiefs of Police
Dr. Dorothy Cotton, Psychologist, Correctional Service Canada and Queen's University

Members:

Inspector Sean Ryan, Royal Newfoundland Constabulary
Agent Michael Arruda, Service de Police de la Ville de Montreal
Ms. Louise Riopel, Coordinator, l'Urgence psychosociale-justice de CLSC des Faubourgs (Montreal)
Maureen Fedorus - Division Manager Psychosocial and Spiritual Services Division Canadian Forces Health Care Centre (Ottawa)
Sharron Gould, Manager of Human Resources, Winnipeg Police Service
Supt Ken Cenzura, Toronto Police Service
Devin Lynn, Program Coordinator, Mental Health Access and Crisis Response Services Vancouver Island Health Authority

The current membership is about 250, but services and support are provided to all interested police officers in Canada, as well as mental health service providers who work with the police.

CNCPMHL is a sub-committee of the of the Canadian Association of Chiefs of Police

For further information, please contact….

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Mental Health Systems, the Police and the Justice System

In an ideal world, mental health care would be client centered and client driven. People with complex mental illnesses, beyond what could be handled in a primary care setting, would work with a case manager to pick and choose from a variety of resources that would create a supportive road to recovery suited specifically to that individual. But there are a number of services that people with mental illnesses become engaged in that are never going to be chosen by clients and never recommended by the case manager. These include the police, the courts, the jails and prisons, and the other aspects of the justice system. People with mental illnesses and addiction problems do not (in most cases) elect to use these services—but they do become engaged with them nonetheless, and they are represented in these systems at a much higher rate than are the general public. . We do not have Canadian data but information from other countries, particularly the US and the UK suggests that people with mental illnesses have a higher arrest rate than the general population, and the amount of police contact with people with mental illnesses is much higher than the prevalence of mental illness in the population. People with mental illnesses are arrested and jailed for relatively minor offenses at a higher rate than their non-mentally ill counterparts. The result is the criminalization of the mentally ill.

The Standing Committee has heard from representatives of the federal correctional system, and from the police directly. It has also heard from a wide variety of service providers, government agencies and academic institutions. My intent here is to provide only that information that is unique and not redundant with what others have said. I will also point out that I speak only for myself and for the Canadian National Committee for Police/Mental Health Liaison. I do not speak for Correctional Service Canada or Queen's University or the College of Psychologists.

What are the barriers that prevent us from serving the needs of people with mental illnesses who come into contact with the police in particular, and the criminal justice system in general? I will refrain from making the obvious points that you have heard

many times before about lack of integration within the mental health system, need for increased services and funding and the need to involve and be responsive to client wishes.

<u>The role of the police:</u> The police are de facto the front line extension of the mental health system. When someone in the community is acting oddly and the public feels uneasy, it is not the local hospital they phone. When their son with schizophrenia threatens to burn down the house to rid it of demons, they don't phone the fire department. When someone thinks there are aliens invading their apartment, they don't phone the exterminator. When an eccentric woman living under a bridge is beaten and has her blanket and shopping cart stolen, it is not her lawyer who comes to her aid. When life no longer seems like living and an adolescent is perched atop that bridge, it is not the school guidance counselor who talks him down. In all these cases, it is the police who are called and the police who respond.

Yet, surprisingly, there is no formal connection between the police and the mental health system. If there is only one piece of advice I can give this Committee, it is to acknowledge the police role by integrating them into the mental health system, to include them in the blueprint for care—for their role is significant. The police are not funded by a health ministry and they aren't officially members of multidisciplinary health care teams, but they are involved just the same. They are part of the solution, not part of the problem.

As has been indicated elsewhere, the number of people entering the correctional system with mental health problems has increased by a staggering amount in the past few years. While not all of these people have had previous contacts with the mental health system, all have had prior contact with the police. What happens in that initial contact may well determine the course of that person's life . If the police have no options, no connections, and no one wants to listen to them, then the visit to the emergency department of the local hospital becomes a waste of time, and a stint in the cells becomes the only alternative. Once the person with mental illness is branded as a "forensic" case, or as dangerous, his chances of obtaining services from mainstream mental health agencies decreases

dramatically. However, if the police are able to facilitate connections with appropriate mental health services, then the individual's contact with the justice system may be short lived and the appropriate diversion to mental health care will have been made.

It is not easy for the mental health workers and the police to work together. It is not easy for them to agree about what their roles are, and how they should interact. To some extent, that is because there really are no role definitions. While police responsibility for people with mental illnesses is certainly consistent with both the duty to ensure the safety and welfare of the public, as well as the principle of parens patriae, which involves the protection of disadvantaged citizens, neither of these two principles was ever intended to suggest that the police were intended to be therapeutic.

Police and mental health workers represent very different worlds and very different cultures. Police often feel that their job is made more difficult by the failure of the mental health system to provide appropriate services. Mental health practitioners often feel that the police do not appreciate the limitations of the health care system and the constraints (and legal limitations) they work under. Police are oriented toward public safety, whereas mental health workers are concerned with individual rights and freedoms. Police officers are concerned with immediate crisis response whereas the mental health system is slow, cumbersome and looks for longer term solutions. Whereas the motto of the medical profession might be "Above all, do no harm," the public expectation of the police is more likely "Above all, do something!"

Exchange of information: In order to work together, police and mental health workers have to be able to speak to each other. There are simply too many laws restricting who mental health professionals can talk to . In my position, for example, I am bound by federal privacy legislation, provincial privacy legislation, the Regulated Health Professions Act, the Psychology Act, the Mental Health Act, the Corrections and Conditional Release Act. And they all say slightly different things about release of information. I am also bound by common law and professional guidelines.. Precedents such as the Tarasoff Decision are always foremost in a clinician's mind, but we have no

law to back us up when we break confidentiality. We have not a clue what we can tell the police without losing our licenses. We are at a loss as to where to begin in developing any memoranda of agreement about information sharing. If there is a crisis and we need to communicate with the police, we are in a quandary about what to do. As a result, your average health practitioner does not tell anyone, anything, ever. While this may the safe route for the health practitioner, it often does not serve the needs of the client.

Education: It is popular--and easy—to suggest that the police need educating. It is the most common recommendation in inquest reports when there have been fatal encounters between the police and individuals with mental illnesses. Indeed, if you ask any police chief, he will tell you that there are a line of people at his door ready to provide education—CMHA, the Schizophrenia Society, organizations representing people with autism, fetal alcohol spectrum disorders, Alzheimer disease, developmental disability, Asperger's Syndrome, bipolar and other mood disorders, learning disabilities, attention deficit disorder, brain injuries…the list goes on. I have a PhD in psychology and I do not have training in all these areas. I cannot tease out a differential diagnosis between autism and Asperger's Syndrome without consultation. Is it reasonable to expect the police to do so? While there is no doubt a place for education in the police curriculum and there is a definite need for training, the answer is more complex. Yes, it would be a good idea to develop standardized curriculum so every police service would not have to reinvent the wheel and so that police officers would not have to go back to school fulltime to achieve this working knowledge. But equally important, mental health workers need to be educated about the criminal justice system. There should be standardized medical school curriculum to introduce physicians to the role of the police. It might help to reduce some of the animosity between emergency room personnel and police officers if each had an understanding of the other. Members of all mental health professions would benefit early on in their careers to exposure to forensic issues. It might help decrease some of the stigma and fear that mental health providers feel about potential clients that have been involved in the criminal justice system.

Integrated Systems: As noted, education will never suffice, as long as police are viewed as outside the system (or not viewed at all). They need to be at the table. The lesson of deinstitutionalization and the failure to involve or prepare the police and the justice system should not be overlooked.

Prisons need mental health services: Earlier in your consultation process, you heard about the types and frequency of mental health problems in the offender population. Canada does not really have a "champion" of forensic mental health. We are world leaders in the field of risk assessment, but we have no one advocating for the needs of the person so disparagingly called the MDO (mentally disordered offender). Since, provincial jails offer very little for these troubled offenders, it is not unusual for some individuals who are convicted to actually request sentences of two years or more so that they can go to a federal institution where programming and treatment is at least sometimes offered. Community integration as far as mental health care is concerned is extremely problematic. Mental health agencies have exclusionary criteria. They are unable or unwilling to provide services to people who might be dangerous or who might abuse substances. Their exclusionary criteria eliminate almost the entire correctional population.

Stigma is a huge problem: The issue of stigma has been mentioned by many groups and while it is a difficult and challenging problem, it must be addressed. While stigma affects all people who experience mental health problems, it is particularly destructive for people who are not only have a mental health problem but also have encountered the criminal justice system. They are discriminated against in both systems. As noted above, a criminal history often excludes people from mental health services—and having a mental health problem in prison carries with it a very significant risk if it were to become known in the population.

Ironically, it is partly stigma that leads to the involvement of people with mental illnesses in the justice system. As is the case for any citizen, alienation and rejection from the dominant society increase the probability of engaging in criminal acts.

One cannot overlook the fact that police are also consumers, much as it is difficult for them to admit that – and that too speaks to stigma. Given the nature of their work and the personality characteristics that are necessary to do the job, police officers are prone to substance abuse, interpersonal difficulties, depression and posttraumatic stress disorder, suicide and other mental health difficulties. It is telling that the section on the mental health issues of the RCMP in an earlier report of this Committee simply says "information was not available."

Stigma is not only a problem for the consumer but it is a problem for the people who work in this field whether police or mental health workers. This often leads to human resourcing issues and staffing problems.

There need to be alternative forms of justice— Having a mental illness does not absolve one of the obligation to observe the laws of society. In rare cases it does prevent one from following the rules, but in most cases it is more of a mitigating factor. With rights come responsibilities. If a person with a mental illness wants to live in the community and be like everyone else, then they also have to follow the rules. But when that does not happen—and we know if does happen at a greater frequency with this population than with others—they need to be held accountable in a way that increases the likelihood that they will in the long term be welcome as members of that society. Serving time does not increase that likelihood; however, there are other more appropriate options that can be used – conditional sentences, restorative justice, mental health courts, and appropriate diversion.

Research: There is essentially no funding for police research in Canada. It is not within anyone's mandate. A large part of the problem is that virtually all research funding is tied to either industry or universities—and typically the police are not, so they can't access research money. There are many areas we know nothing about, as related to the police/mental illness interaction. We do not know:

- The nature, role and extent of police interactions with the mentally ill

- What number or percentage of people with mental illnesses come in contact with the police and why
- Effectiveness and issues re tasers
- Effects of normal police procedures on the mentally ill
- What constitutes effective training
- Relative effectiveness of different models of police/mental health liaison
- Attitudes and viewpoints of consumers toward police
- Effects of diversion and other nontraditional justice programs
- The effects of mental health courts
- How decisions in regard to arrest versus apprehension decisions are made

We do not even have basic descriptive data about the frequency or outcomes of police interventions. A few police services keep some data, but there is no standardization of such data across the country. There are many police officers with university degrees, and a significant number with masters and doctoral degrees as well as law degrees. Yet there is no way for these people to access research funds. In many cases, very small amounts of funding would suffice. Even if police were eligible under the current research schemes, or if they were able to team up with an eligible researcher, the current methods of dispensing funds limit their distribution to large research projects. A great deal of research can be done for the cost of photocopying, postage and a part-time research assistant. Yet there are virtually no funding agencies that offer small grants. The person who needs $5,000 has no place to go.

The need for an academic presence: There is currently one PhD program in police studies in Canada. This is a unique initiative, to be applauded. But policing is a complex and multifaceted field and this program is not directed toward issues related to mental illness. Academic interest needs to be generated to examine how the police might best meet the needs of those individuals with mental illnesses, because we don't know at this time. Academia largely does not concern itself with practical problems and as a result, does not research police issues. The young academic

seeking tenure cannot take the risk of getting involved in a line of research for which there is no funding, and no previous research, an area in which the level of analysis which is currently needed is simply nose-counting.

Similarly, there is no such field as "police psychology" in Canada. We do not have any active research into any of the topics listed above (under Research), we do not train psychologists in particular and mental health professionals in general about how to work with the police, how to meet their mental health needs, how to contribute to effective recruitment and hiring or any other psychological aspect of policing. To the best of my knowledge there is not even a single professional level course in police psychology offered anywhere in the country. While this may appear on the surface to be a bit far afield from the topic of mental illness in Canada, it is in fact closely related. How are the police and mental health practitioners to work together effectively to ensure that people with mental illnesses are not criminalized, are not denied services, and are treated fairly, constructively and compassionately both inside and outside the criminal justice system, if there is no education, no research and no leadership to suggest that this might be the case?

The role of the federal government: Two of the areas in which the federal government has direct responsibility for mental health services are the RCMP and CSC. In both organizations, large numbers of psychologists are employed. It is telling that the salaries offered by the federal government are dramatically lower than community standards so recruitment and hiring are very difficult. In addition, the federal government has traditionally chosen to ignore provincial health professions legislation and has hired people who are not and would not be licensed to practice otherwise. While there has been significant improvement into the last few years in some areas, recruitment and salaries remain very problematic.

In summary…

Perhaps I have raised more issued than I have answered. The good news is that many of these issues (but not all) can be addressed simply by statements of policy rather

than by increased funding or major structural changes. An official statement that any of these areas were actually important would go a long way. One thing that is sorely lacking is simple leadership.

- A simple instruction (from a credible source) to hospitals and emergency room physicians to include the police in their deliberations and establish procedures for effective collaboration
- Incentives to universities and professional schools to develop police-related curriculum
- Direction to police colleges to ensure that mental health/mental illness education is part of the core curriculum
- Adjustment of research funding criteria to include those outside formal academe—with both large and small grants
- Symbolic leadership on the part of the federal government, in hiring the best people, honouring provincial standards, and paying a competitive wage
- Creation of "champion" positions—in CSC, in the forensic system, through research funding and academic chairs

The first step in finding solutions is to ask the right question, and give a name to the problem. For this part of the problem—the problem of the justice system and the mental health system trying to work together—we are still at the stage of trying to ask the question.

Dorothy Cotton, Ph.D., C. Psych.

Dr. Cotton is a registered psychologist, holding degrees from McGill University, Purdue University and Queen's University. She is currently the neuropsychologist for the Ontario Region of Correctional Service Canada. Her work with CSC involves the assessment and diagnosis of offenders who are experiencing cognitive difficulties, including those with mental illnesses, developmental and learning disorders, brain injuries, dementia, Fetal Alcohol Spectrum Disorder and other neuropsychological impairments. Prior to her current job, Dr. Cotton spent over 25 years working at a provincial psychiatric hospital, providing frontline clinical care on a variety of programs including the acute admissions, geriatrics and forensics programs. When she left that institution in 2002, she was Chief Psychologist and Administrative Director of the Forensic Program. It was in conjunction with the latter position that she became aware of the pivotal role that police officers play in the community support of people with mental illnesses, and thus began the Canadian National Committee for Police/Mental Health Liaison (CNCPMHL), now a subcommittee of the Canadian Association of Chiefs of Police. She co-chairs this committee with Chief Terry Coleman of the Moose Jaw Police. For her work in this area, Dr. Cotton was nominated for the Ron Wiebe Restorative Justice Award in 2001, and is a nominee this year for the Significant Contribution Award of the Criminal Justice Division of the Canadian Psychological Association.

Aside from providing direct service within CSC, Dr. Cotton is noted for her popular psychology writing and dedication to bringing psychological knowledge to the public, particularly as it pertains to mental illness. She writes columns for three very different publications. Her "Kitchen Sink Psychology," a syndicated newspaper column, addresses the psychology of everyday life; her column in Blue *Line* Magazine speaks to psychology for police officers; her column in a publication of the Canadian Psychological Association addresses clinical correctional psychology. She has authored a number of professional publications, including a book on stress management, and the only two published Canadian studies about police interaction with people with mental illnesses.

Dr. Cotton is an adjunct faculty member with the Departments of Psychology and Psychiatry at Queen's University, and serves on the executive of the College of Psychologists of Ontario (the regulatory body for the profession). For many years, she taught part-time at St. Lawrence College. She was a co-founder of the first workplace daycare centre in an Ontario Government facility, in 1982