POLICING INTERACTIONS WITH PERSONS WITH MENTAL ILLNESS IN RCMP JURISDICTIONS IN BRITISH COLUMBIA

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The Crime Reduction Research Program

The Crime Reduction Research Program (CRRP) is the joint-research model in British Columbia between academics, the provincial government, and police agencies operated by the Office of Crime Reduction – Gang Outreach. The CRRP is supported and informed by a Crime Reduction Research Working Group that includes representation from the Ministry of Public Safety Solicitor General (represented by Community Safety and Crime Prevention Branch and Police Services Branch), the Combined Forces Special Enforcement Unit of British Columbia, and the Royal Canadian Mounted Police "E" Division.

The CRRP focuses on investing in research that can be applied to support policing operations and informing evidence-based decisions on policies and programs related to public safety in British Columbia. Each year, the CRRP reviews submissions of research proposals in support of this mandate. The CRRP Working Group supports successful proposals by working with researchers to refine the study design as necessary, provide or acquire necessary data for projects, and advise on the validity of data interpretation and the practicality of recommendations.

The CRRP operates a $1M annual funding allocation in the form of grants that are dedicated to support university-led research at Canadian institutions. This project was supported through the 2021/22 CRRP funding allotment.

Executive Summary

Persons with mental illness are at increased likelihood of coming into contact with the police (Hartford et al., 2005; Livingstone, 2016). Between 5% and 20% of all police calls for service may involve mental health crises (Abramson, 2021; Balfour et al., 2022; Cotton & Coleman, 2010; Ghelani et al., 2023; Hodgkinson & Andresen, 2019; Koziarski et al., 2022; Langton et al., 2021; Langton et al., 2022; Ratcliffe, 2021). Yet, mental health training for police officers in Canada has historically been quite limited and lacking in practical relevance (Coleman & Cotton, 2010; Huey et al., 2021; Sanders & Lavoie, 2021). Consequently, police responses to mental health-related calls for service may involve the person in crisis being arrested (Watson & Wood, 2017) or apprehended and taken to hospital (Klein, 2010; Shore & Lavoie, 2018; Watson & Wood, 2017) where they may be promptly released back into the community by the examining physician (e.g., Shore & Lavoie, 2018). Many calls for service involving persons with a suspected mental illness involve non-criminal matters (e.g., Koziarski et al., 2022; Vaughan et al., 2015). These findings support that police officers are not best positioned as the primary response to mental health-related issues in the community. Increasingly, police agencies are implementing collaborative models, such as co-response teams that involve a police officer partnered with a mental health expert (Blais et al., 2020; Cohen et al., 2025; Huey et al., 2021; Koziarski et al., 2021; Park et al., 2019; Teti et al., 2025). Other approaches to improve police response to mental health-related calls for service have focused on training, for example, Crisis Intervention Team (CIT) training. Overall, while the research is still lacking in rigorous evaluation studies, preliminary data seems to demonstrate that the co-response team model is achieving the most success in improving the police response to mental health-related calls for service (Seo et al., 2021), though positive effects have also been demonstrated for the intensive in-person training provided by CIT (Bonfine et al., 2014; Borum et al., 1998; Bratina et al., 2020; Canada et al., 2012; Compton et al., 2011; Hanafi et al., 2008; Ritter et al., 2010; Tartaro et al., 2021; Willis et al., 2023).

The current study explored police officer responses to mental health-related calls for service by the Royal Canadian Mounted Police in British Columbia ('E' Division RCMP). The objectives of the study were to identify patterns in mental health-related calls for service, examine police officers' perceptions of interacting with persons with mental illness, and to explore the range of programs in place to manage mental health-related calls for service. The overarching goal was to identify recommendations to enhance 'E' Division management of mental health related calls for service. The research design involved three sources of data: police call for service data, surveys with frontline police officers, and interviews with police officers in specialized positions related to mental health.

The 'E' Division RCMP provided a dataset on mental health-related calls for service between 2018 and 2024. Mental health-related data was identified by the mental health field study flag, as well as mental health-related codes that were assigned to the file. This data was analyzed to identify the patterns in mental health-related calls for service, such as the time of day, day of week, day of month, offence type, clearance status, and the amount of time spent at the scene. A second database with the total number of calls for service for each detachment between 2018 and 2024 was provided to enable calculations of the proportion of calls that were mental health related.

Between 2018 and 2024, the 'E' Division RCMP identified 480,896 mental health-related calls for service, or 188 mental health-related calls for service per day for the British Columbia RCMP. This represented an average of 5.7% of the calls for service over this seven-year period. Overall, there was an increase of 8% in mental health-related calls for service between 2018 and 2024, with the growth in calls more pronounced in the Island (15.5 per cent increase), North (13.8 per cent increase), and Southeast (11.7 per cent) Districts. Across the province, a slightly higher proportion of mental health-related calls for service occurred between May and August, and mental health-related calls more commonly occurred on Mondays through Fridays. Mental health-related calls for service generally occurred during daytime hours, with the peak occurring in the afternoon around 3pm. Most mental health-related calls occurred in some form of housing, such as townhouses, single homes, apartments, or condos.

Over half of the mental health calls were related to provincial statutes, i.e., the provincial *Mental Health Act*, and most were information files, meaning no investigative action was taken. Consistent with the prior research, most mental health-related calls for service to the 'E' Division RCMP were not for criminal offences. Mental health calls for service were generally dispatched as either a suicidal person or a check wellbeing call. On average, 2.4 police officers were dispatched to the call for service, although this varied based on call type. On average, mental health-related calls for service were responded to in 23.6 minutes, though higher priority calls saw a faster response time. Response times also varied by district, with the North responding in an average of 21.7 minutes as compared to around 24-25 minutes in the Lower Mainland and Southeast districts. Police officers spent an average of 1.8 hours on mental health-related files; more time was spent on higher priority files, and by officers in the Lower Mainland District. Of note, service time on mental health-related calls for service has generally increased year-over-year. In 2018, police officers spent an average of 1.73 hours per mental health-related call for service while in 2024 they spent 1.81 hours on average.

Overall, around one-quarter of the mental health-related calls for service resulted in the individual being apprehended under the *Mental Health Act*. The proportion of files resulting in a *Mental Health Act* apprehension increased slightly but significantly between 2018 (23.8 per cent) and 2024 (25.1 per cent). Police officers in the Lower Mainland District were significantly more likely than police in the other three police districts to make a *Mental Health Act* apprehension. Apprehensions were significantly less likely to occur on weekends and were less likely to occur overnight. Police officers responded significantly faster (21.7 minutes versus 24.3 minutes) and spent significantly more time at (2.8 hours versus 1.4 hours) files that resulted in a *Mental Health Act* apprehension.

An anonymous online survey was distributed to frontline RCMP officers in the 25 detachments invited for participation from the four policing districts. The survey measured access to mental health training, comfort level in handling mental health-related calls for service, and common practices in responding to these files. There were 143 participants, most of whom were male with around 13.5 years of service. Nearly half of all the survey participants came from the Lower Mainland District. Overall, most (86.7 per cent) participants indicated that they had received training on mental health-related calls for service, which they primarily identified as online crisis intervention de-escalation training or incident management intervention training courses available online. Still, three-quarters also reported that they had completed in-person training at the Pacific

Regional Training Centre. Overall, less than one-third felt that their training had adequately prepared them to manage these kinds of files. They recommended having more specific mental health content in their future training, such as suicide intervention, recognition of symptoms, and the distinction between mental health and addictions. Police officers also wanted more scenario-based training, in-person training, training that provided more realistic examples, as well as cross-training with other agencies.

Relative to the finding that 5.7% of all RCMP calls for service involved mental health health-related issues, many police officers over-estimated the proportion of their calls that involved mental health. They also perceived that most of these files involved drug or alcohol intoxication, which relates to the aforementioned difficulty in distinguishing between mental health and substance-induced behaviours. On average, they felt that mental health related files took approximately three hours, which was consistent with the call for service data when apprehensions occurred. However, they overestimated the proportion of mental health-related calls for service that resulted in an apprehension, suggesting that nearly one-half of the files concluded this way.

Police officers felt that it was somewhat or very difficult to manage calls for service involving persons with a mental illness, to know how to access community-based resources for a person with mental illness, or how to distinguish between a mental health issue and substance-induced behaviour. On the other hand, they generally felt comfortable understanding when they could make an apprehension under the *Mental Health Act* and how to articulate their rationale for apprehension, they felt confident in their response to mental health files, and they were satisfied with their detachment's approaches to these files. Most participants reported having assertive outreach teams in their communities. Still, they recommended more access to mobile crisis response teams, such as the co-response partnership between a police and mental health clinician, which they reported using often or always when available. Other concerns focused on hospital wait times and the need for mental health assessments to be given a higher priority, lengthy waitlists for programs relevant to persons with mental health issues, and a lack of mental health professionals.

Interviews were conducted with 18 specialized RCMP police officers working in positions related to mental health-related calls for service. The interviews explored training on mental health, the typical profile of mental health-related calls in their jurisdiction, specialized positions, units, or models to manage mental health-related calls for service, partnerships with other programs, and perceptions of the strengths and challenges of their detachment's responses to persons with mental illness. Interview participants came from a range of specialized positions, including as mental health liaison officers and members of Integrated Crisis Response Teams or co-response teams. These participants frequently worked in collaboration with mental health specialists. Many of the themes present in the interview data reflected the blurring of boundaries between policing and social/health services. For example, they described that their position required a deep understanding of their jurisdiction's social services in addition to strong crisis intervention skills. They saw their roles as facilitators initiating referrals, presenting cases to community teams, and advocating for follow-up care. Skills such as the ability to de-escalate crises, strong communication, emotional regulation, and relationship building were sought after for personnel assigned to mental health-related positions.

Despite their specialized positions in mental health-related units or teams, a recurring theme was the limited formal training provided on mental health. Participants explained that the mandatory courses tended to focus on general crisis intervention, de-escalation, operational skills, or cultural/unconscious bias and rarely addressed the complexity of mental health conditions or provided guidance on differentiating between mental health and substance-related behaviours. The training was often considered generic, limited in scope, and repetitive, providing foundational skills but lacking depth in understanding specific mental health conditions, neurodivergence, or culturally informed approaches. Many participants consequently sought additional training outside of their policing agency, for example, by attending conferences, seminars, or workshops on mental health-related topics. The participants felt that experiential learning opportunities, such as scenario-based exercises and rotations through mental health teams were important for all police officers, and they preferred in-person exercises to online ones, though they felt that virtual reality exercises could have potential value at providing access to training in a realistic environment where they could practice their decision making and crisis response skills.

Many of the interview participants described co-response teams as the primary model for managing mental health-related calls for service at their detachment. They wholeheartedly supported this model, emphasizing that it reduced common barriers to information sharing, increased police officer knowledge about mental health issues, reduced unnecessary apprehensions, and improved outcomes for people in mental health crisis. Generally, co-response teams provided a secondary response to files, arriving after police officers had already secured the scene. Having a co-response model meant that the responding police officer would be able to return to the road while the co-response team could dedicate more time to building rapport, conducting mental health assessments, and supporting their clients to access relevant resources. The main limitations identified with these partnerships were personnel shortages or funding constraints, meaning that some teams were not always fully operational, while other detachments did not yet have access to these teams. When co-response teams were present, they were typically deployed according to call for service volume, with peak activity during the afternoon and early evenings. Given the demand for their services, participants generally reported that they had limited time to conduct follow-ups on these files, and they referred to the role of community-based resources such as ACT teams or community mental health centres as the lead providers of ongoing support.

Collaboration with community partners was viewed as very important, though very few had established any formal partnerships beyond the police-health authority agreements for co-response models. Generally, any existing partnerships were built on informal relationships and ad hoc collaboration. While participants did not necessarily see the need to establish many formal partnerships, they commonly viewed hospitals as one of the resources they would like to build a more formal partnership with. Barriers to further collaborating with other community-based programs included a perceived lack of desire to work with the police, limited operational hours, and lengthy wait times. Given the province-wide scope of this study, there were a wide range of community resources available to different participants. However, consistently, participants identified a need for more low-barrier, trauma-informed, and culturally relevant programs and services. Generally, participants felt that the clients they dealt with were adult males, though this varied by community and by the mental health profile of the clients they were working with. Lack of housing and addictions commonly overlapped with mental health issues. Several participants also

observed that brain injuries were common among the clients they were working with. When violence was a concern, it was more often self-directed than directed towards others. About one-half of the mental health-related calls for service were estimated to involve some form of criminality, but this was generally very low-level nuisance type of offences, such as causing a disturbance. Most of the individuals with mental health issues who they interacted with were already known to the police, reflecting the revolving door dynamic of police interactions with persons with mental health issues. This underscores the need for more community resources to provide necessary supports to persons in mental health crisis, such as access to low-barrier housing, detox beds, inpatient recovery facilities, and long-term treatment and rehabilitation programs.

The results pointed to several areas of recommendations. Given the positive effects of co-response teams shared by participants in the current study, as well as the findings of previous research, recommendations regarding co-response teams focused on the need to expand these models more broadly throughout the province, potentially using regional or rotational units for smaller communities that may not otherwise be able to sustain a full-time deployment of a co-response team. Co-response teams could also be expanded in places where they are currently operating to provide better coverage of the call for service. These decisions should be made based on call for service patterns. Regardless of whether co-response teams are present, there was a clear need for more training for police officers, particularly training that involved experiential learning and scenario-based formats, and joint training exercises with mental health partners. Multiple levels of training should be offered according to whether the police officer is in a frontline or more specialized position. Regarding those working in specialized positions, recommendations were made around recruitment strategies and the need to emphasize soft skills, such as effective communication, emotional regulation, de-escalation, and collaboration. Recommendations also reflected on the need to create opportunities for follow-up work to be conducted with clients, together with community partners when possible. As hospital wait times continued to pose an issue, recommendations included building more formal partnerships and developing memorandums of understanding with hospitals and exploring options to facilitate quicker access to mental health assessments. Building other formal partnerships is also recommended to improve information sharing and collaboration.

From the analysis of the data collected for this report, it seems that mental health-related calls for service continue to increase, and current police and health approaches are often reactive rather than strategic. Call volumes related to mental health are unlikely to decrease, yet there has been limited planning for how police are to effectively address this increase in service demand. Broader systemic investments are required to address the gaps that leave the police as the default responder to persons with a mental illness. There is a need for more supportive housing, expanded access to long-term psychiatric care for individuals unable to live safely in the community, and specialized court or diversion mechanisms for low-level offences linked to mental illness across British Columbia. These approaches would provide alternatives to the criminal justice system, reduce the cycle of repeated police contact, and enable individuals with mental illness to be connected to appropriate medical and social supports.

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Introduction

Generally speaking, persons with mental illness are at an increased likelihood of coming into contact with the police. Whereas Gatens (2018) estimated that up to one in ten police calls for service involved a person with a mental health issue, a much higher prevalence rate was estimated by the Vancouver Police Department in their 2008 *Lost in Transition* report, where approximately one in every three calls for service involved a person with a mental health issue (Wilson-Bates, 2008). The wide range in prevalence depends upon the definition of mental illness, the location of study (e.g., urban versus rural, city centre versus city outskirts), and the source of the data used, such as police perceptions of mental illnesses versus official diagnoses.

Given the role of police as frontline responders in situations involving acute mental health issues and increased public scrutiny over police encounters with persons with a mental illness, police programs to more effectively respond to and manage persons with a mental illness have proliferated across North America. There are a wide range of programs already operating in British Columbia, including the mental health cars in Vancouver (Car 87), the Integrated Mobile Crisis Response Team (IMCRT) in Victoria, the Downtown Community Court in Vancouver, Assertive Community Treatment programs (e.g. in Kamloops, Nanaimo, Prince George), and mental health liaison officers. These programs typically have a focus on a collaborative system response with the goal of reducing the likelihood that a police call for service involving persons with a mental illness will result in injury or death, increasing service access amongst persons with a mental illness, reducing pressure on the criminal justice system, reducing wait times for mental health care services, enhancing the police-persons with a mental illness relationship, and serve to reduce calls for service over the long-term (Shapiro et al., 2015). While collaborative responses to persons with a mental illness are typically a goal of these programs, the extent to which these programs successfully and effectively integrate multi-systemic responses to persons with a mental illness remains unclear.

This report analyzes the patterns in police calls for service involving persons with a mental illness across British Columbia, provides an analysis of surveys conducted with frontline police officers regarding their experiences responding to mental health-related calls for service, summarizes the results of interviews conducted with specialized police officers regarding the various deployment models of mental health teams, police officers, or programs currently operating in police agencies across British Columbia, and makes recommendations to enhance the police response to persons with mental illness.

Project Methodology

The objectives of this report were achieved through a combination of quantitative and qualitative data. A comprehensive literature review on the various policing models for responding to and managing calls for service involving persons with a mental illness in North America, Europe, the United Kingdom (UK), New Zealand, and Australia were conducted with the goal of identifying promising and best practices. The literature review also included a scan of the specific programs and models operating in police agencies across British Columbia.

An anonymous online survey with frontline RCMP police officers was distributed to selected police agencies from across British Columbia. The purpose of this survey was to identify pressure points where mental health-related calls for service occurred, the nature and common practices in managing calls for service with persons with a mental illness, and awareness and use of community level mental health resources and programs. This survey also measured access to training in mental health (e.g., Crisis Intervention Training), officers' comfort level in handling mental health-related calls for service, and their level of understanding of the signs and symptoms of mental illness.

Moreover, a dataset on calls for service to RCMP police agencies from all four policing districts in British Columbia involving persons with a mental illness between 2018 and 2024 was received from 'E' Division RCMP. This data was analyzed to identify the patterns in mental health-related calls for service, such as time of day, day of week, day of month, UCR code, CCJS status, and the amount of time spent at the scene with persons with a mental illness. Analyses were conducted for all 'E' Division RCMP detachments. A second database with the total number of calls for service for all 'E' Division RCMP detachments annually between 2018 and 2024 was also provided, which permitted the researchers to calculate the proportion of calls for service that appeared to be mental health-related.

Finally, interviews were conducted with RCMP police officers specifically assigned to work with or oversee teams assigned to working with persons with a mental illness. All interviews were conducted by University of the Fraser Valley researchers using online conference software (Microsoft Teams). The ethics of the research project, including the interview schedule and project methodology, was reviewed by the University's Human Research Ethics Board prior to any data being collected. Participation in an interview was voluntary and those willing to participate were provided with an information sheet prior to the interview that included a detailed overview of the purpose of the interview. Immediately before the interview began, the participant was asked to verbally confirm that they had read the information sheet and that they gave their informed consent to participate. Student research assistants attended the interviews and took notes in a word document. Interviews were not recorded using video or audio recording and all information provided by participants was anonymized prior to analysis. The analyses focused on themes emerging from the specific content provided by participants during their interviews, in addition to latent content illustrating any underlying themes.

Literature Review

The role of police officers is to maintain law and order, protect the public and their property, and prevent, detect, and investigate crime (Charman, 2018). Yet, in practice, policing extends beyond law enforcement to include responsibilities that overlap with health and social care (De Jager, 2021; Langton et al., 2022; Ratcliffe, 2021). One of the most prominent examples is the frequent role of police as first responders during mental health crises (Huey et al., 2021). Police officers are often tasked with de-escalating volatile situations, determining whether criminal activity has occurred, and facilitating access to health or community services. As such, scholars describe mental health work as 'core police business' (Kirubarajan et al., 2018), reflecting the reality that people living with mental illness face an elevated risk of contact with the criminal justice system (Costigan et al., 2021). People with mental illness experience two to three times as many police interactions as compared to people without a mental illness, become re-involved with the police more quickly following their initial encounter, and are more likely to be criminalized for their behaviour through an arrest and/or criminal charge, often for nuisance type behaviours (Hartford et al., 2005; Livingstone, 2016). Yet, mental health training for police in Canada has historically been quite limited, ranging from one to 20 hours, far short of the standard 40-hour training provided through empirically supported programs, such as the US-based Crisis Intervention Training (Coleman & Cotton, 2010; Sanders & Lavoie, 2021).

The intersection between policing and mental health is substantial. Research indicates that between 5% and 20% of emergency calls for service to police in Western countries involve mental health crises (Abramson, 2021; Balfour et al., 2022; Cotton & Coleman, 2010; Ghelani et al., 2023; Hodgkinson & Andresen, 2019; Koziarski et al., 2022; Langton et al., 2021; Langton et al., 2022; Ratcliffe, 2021). In one US-based study using approximately 260,000 calls for service to the police in Detroit in 2019, Langton et al. (2022) reported that police officers spent an average of 40.9 minutes on scene per health-related call (defined as mental health, suicide/suicidal threat, overdoses, or wellbeing checks). Presumably, this did not account for the time spent in a hospital emergency room awaiting a mental health assessment. This is critical because police officers have been found to be responsible for approximately 25% to 30% of emergency psychiatric admissions to hospital for people with mental illness (Klein, 2010). In a study with the Chicago Police, Watson and Wood (2017) found that the most common response to a mental health-related call for service was to transport the individual to hospital (44.9 per cent). Similarly, in a study examining mental health-related calls for service to police at an Ontario police agency, Shore and Lavoie (2018) found that police officers made apprehensions under the *Mental Health Act* in over one-half (55 per cent) of the calls, while one-half of these apprehensions (49 per cent) resulted in the individual being admitted to hospital. Apprehensions were more likely to occur when the individual was self-harming or expressing thoughts of self-harming, when the call to police came from a family member, friend, civilian, or service provider, and when the individual was reported to have abruptly ceased taking their medication. These complex and time-sensitive cases can account for as much as 40% of officers' workloads (Fisher et al., 2024; Kyprianides & Bradford, 2025; Shore & Lavoie, 2018; Short et al., 2014).

Several Canadian studies have identified that mental health-related calls for service to the police tend to cluster in particular areas of the city (Hodgkinson & Andresen, 2019; Koziarski, 2020;

Vaughan et al., 2015). In one study in Barrie, Ontario, Koziarski (2020) found that calls for service involving persons with mental illness were clustered in two hot spots areas. One was around the downtown core in an area where many social services and public health units were located, while the second was around the local hospital. Furthermore, Koziarski (2020) found that one-half of all the calls for service involving persons with a suspected mental health issue originated from just 4% of the streets in Barrie. Similarly, in a study examining Canadian police data, Vaughan et al. (2015) identified that calls for service involving "emotionally disturbed persons" clustered in areas where hospitals and other medical services were located. The researchers analyzed 140,748 calls for service received by the Royal Canadian Mounted Police (RCMP) over a one-year period in 2006, of which 2,847 (2.0%) involved suspected mental health issues. Over one-half (56.6 per cent) of these calls for service were classified as *Mental Health Act* related, while the next most common call for service classification was for disturbing the peace, threats, harassment, or breach of conditions (13.7 per cent). In other words, most of the police calls for service that involved persons with suspected mental health issues concerned non-criminal events (Vaughan et al., 2015; see also Koziarski et al., 2022). This suggests that a non-policing-based response could be a viable option to reduce some of the demand on police officers, such as a mobile mental health team that responds or does outreach activities separately from the police (Curry et al., 2023). However, in another study, Hodgkinson and Andresen (2019) analyzed approximately 250,000 calls for service received by one city in 2014 and found that, while those involving mental health were concentrated in the areas of the city where a homeless shelter was located, there were also some overlaps with areas where violent crimes were being reported. Hartford et al. (2005) also found an overrepresentation of flags for violence in calls for service involving persons with mental health issues, while Koziarski et al. (2022) identified that persons with suspected mental illness were more prevalent than expected in weapons-related calls for service. Shore and Lavoie (2018) also reported that 16% of mental health-related calls to police at one police agency in Ontario involved the presence of weapons. Both Hartford et al. (2005) and Koziarski et al. (2022) also found that family violence or domestic disturbance calls had a higher concentration of persons with suspected mental illness. These findings suggest that while police officers may not need to be the primary response to mental health calls, their presence may still be required to ensure the safety of non-police officers responding to the call for service (Koziarski et al., 2022; Lum et al., 2021), such as in co-response models involving police and mental health partners who jointly respond to mental health-related calls for service (Cohen et al., 2025; Curry et al., 2023).

Prioritizing a response to calls for service concerning persons with mental health issues that does not primarily assign responsibility to the police is an important consideration given that interactions between the police and persons with mental illness can carry profound consequences. Research suggests that police officers are more likely to use force in calls for service where the individual is displaying signs of mental illness (Kesic et al., 2013; Rossler & Terrill, 2016). In Canada, nearly 70% of police encounters resulting in death involve individuals experiencing a mental illness (Deveau, 2021; Singh, 2020). This highlights why police-mental health interactions have become a pressing policy and public health issue. Police officers are called upon to manage complex crises for which they may lack specialized training while systemic gaps in community mental health services place law enforcement as the default response to behavioural health emergencies (Cotton & Coleman, 2010; Marcus & Stergiopoulos, 2022; Morgan & Miles-Johnson,

2022; Sanders & Lavoie, 2021). The consequences of this misalignment are visible not only in police call for service and crime statistics but also in widely publicized tragedies. Numerous cases of people with mental illness dying or experiencing use of force during encounters with police officers have sparked public outrage, generated criticism of law enforcement practices, and strained police-community relations (Aghasi & Beaudoin, 2021; Baker & Pillinger, 2019; Saleh et al., 2018; Thomas, 2020). While a death during a police interaction is universally regarded as unacceptable, they cannot be fully understood without acknowledging the difficult and challenging circumstances involved in interactions between the police and persons with mental health issues. Police decisions are made in rapidly evolving, high-stakes environments where perceptions of threat, stress, and uncertainty commonly shape responses (Aghasi & Beaudoin, 2021).

It is essential to examine the systemic and situational factors that contribute to negative interactions between the police and persons with mental health issues. This includes evaluating the adequacy of police training, the accessibility of community-based and police-based crisis services, and the broader structural contexts that position law enforcement as the primary responder to mental health crises. Shifting the focus towards a trauma-informed understanding can contribute to constructive dialogues about prevention and identify opportunities for collaboration between police and mental health systems. Within this context, the following literature review provides an overview of British Columbia's (BC) current policies guiding police responses to persons with mental health issues, as well as some current international models. In doing so, this review aims to contribute to ongoing policy discussions and support the development of practices that reduce harm and improve outcomes for persons with mental health issues and strengthen collaboration between law enforcement and mental health services.

CURRENT POLICIES AND RESPONSE MODELS IN CANADA

BRITISH COLUMBIA'S MENTAL HEALTH ACT

The British Columbia *Mental Health Act* provides police officers with the power to apprehend individuals under certain conditions. In particular, Section 28(1) of the *Mental Health Act* permits a police officer to apprehend a person for a mental health assessment if two conditions are present: (a) if the person is acting in a manner that is likely to pose a threat to their own safety or the safety of others, and (b) the person appears to have a mental disorder.[1] When a police officer apprehends an individual under Section 28(1), they must immediately take them to a physician or nurse practitioner for a mental health examination, who may then issue a Form 4.1 to certify them for admission into the hospital to allow for further assessment or treatment over a 48-hour period, or who may order their release back to the community.[2] Two separate medical certificates from physicians or nurse practitioners who have assessed the patient are required to admit a patient for longer than 48 hours.[3]

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[1] https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96288_01

[2] https://www2.gov.bc.ca/assets/gov/health/forms/3504_1_form4_1_fil.pdf

[3] While nurse practitioners can issue the first Form 4.1, Form 4.2 which authorizes involuntary hospitalization beyond 48 hours can only be signed by a physician.

Additionally, police officers can be directed by a judge or justice to locate and apprehend a person under Section 28(3) via a Form 10 warrant.[4] This may occur if a person, such as a family member, has applied to the court for the individual to be detained, providing sufficient evidence to the judge or justice of the peace that there are reasonable grounds that the individual in question likely has a mental disorder and requires care or supervision to prevent substantial mental or physical deterioration or to protect themselves or others. Finally, a Form 21 can be issued by hospitals, which is a Director's Warrant for a police officer to locate and apprehend the patient.[5] For example, the individual may be absent without leave from the hospital or may not have attended a required treatment. In these cases, the hospital can issue a Form 21 where police will locate and apprehend the person to bring them to the hospital for treatment.

TRAINING

Limited research has been conducted on police officer training on persons with mental illness in Canada. Cotton and Coleman (2010) identified that some police agencies have committed to providing advanced training in mental health education for all frontline police officers, although they observed that this is particularly expensive and difficult to deliver in police agencies with large numbers of frontline police officers. An alternative approach to reach more police officers at a lower cost is to offer training online. One online training program available through the Canadian Police Knowledge Network for the RCMP is the Crisis Intervention and De-escalation training, which is not specific to interactions with persons with mental illness but can include some mental health scenarios (Huey et al., 2021). As an example of this type of training, the Decision Model (Andersen et al., 2018a as cited in Huey et al., 2021) trains police officers on five domains: Approach (gather information ahead of time or at the scene and use this to inform the approach that will be taken); Position (strategically choose where to stand with respect to distance from the individual and the use of cover as needed); Communication (respectful and calm verbal and non-verbal communication with the individual and other personnel in attendance, active listening); Containment (when the situation has escalated, strategies to keep the individual isolated for safety); and Assistance (anticipate the need for backup from other police officers as well as other teams, such as mental health or paramedics). This model is not specific to interactions with persons with mental illness but is designed to reduce the need to revert to use of force by approaching the initial call for service in a calm and prepared manner.

Unfortunately, there are no existing evaluations of Crisis Intervention and De-escalation training (Huey et al., 2021). Huey et al. (2021) recommended establishing national standards for mental health training, as well as de-escalation training and conducting rigorous evaluations to ensure that the training is achieving its stated goals. Of relevance to this, Krameddine and Silverstone (2015) found that providing realistic training scenarios was effective at achieving behavioural change. In their training model, police officers received direct feedback on how they handled each of the six mental health scenarios they engaged in, providing opportunities for learning and correction, which

[4] https://www2.gov.bc.ca/assets/gov/health/forms/3510fil.pdf

[5] https://www2.gov.bc.ca/assets/gov/health/forms/3521fil.pdf

is something not typically offered in online training programs (Krameddine et al., 2013; Krameddine & Silverstone, 2015). Realistic scenario-based training resulted in statistically significant behavioural changes, improved identification of mental health-related calls for service, and reduced the amount of time spent handling mental health-related calls for service. Although there were no observed changes in police officer attitudes, it was reported that police officers felt more confident in managing mental health-related calls for service post-training and there was a reduction in use of force post-training (Krameddine et al., 2013; Krameddine & Silverstone, 2015). The authors recommended that training be repeated every three years to protect against a reduction in skills and knowledge. Given these findings, further expansion of mental health training that provides opportunities for hands-on engagement and instructor feedback should be explored, although it is recognized that the costs of offering such training may be prohibitive for some police agencies.

As will be discussed below in this report, an e-learning curriculum implemented in New Zealand (Davey et al., 2021) was largely viewed very positively by participants, particularly with respect to the inclusion of persons with lived experience, which appeared to increase empathy and understanding. However, research in the United States with instructors who delivered mental health first aid programming identified that, as a group, police officers were very difficult to train and that certain characteristics, including being mandated as opposed to volunteering, and having more years of service, made participants more resistant to the training (Soderstrom & Bumgarner, 2024). While Davey et al. (2021) found that participants valued the inclusion of persons with lived experience, Soderstrom and Bumgarner (2024) reported that police officers preferred training where the trainers were viewed as credible based on having personal and direct policing experience. Finally, while police officers tend to prefer in-person training, geographic and staffing challenges can limit this option (Davey et al., 2021; Soderstrom & Bumgarner, 2024). Overall, training that is specific to recognizing and managing mental health calls for service for police officers in Canada appears to still be quite limited. Instead, the focus largely appears to have been on the development of specialized teams.

Blais and Leclerc (2023) offer a constructive perspective on police interactions with persons with mental health issues by applying Script Theory, which suggests that people develop “scripts” through repeated experiences that guide how they anticipate, interpret, and respond to future situations. Scripts can be developed by anyone with the responsibility or willingness to maintain safety in public spaces, making them particularly useful in professions that require rapid, high-stakes decision-making (Leclerc & Reynald, 2017). In the policing context, Intervention Scripts are shaped through both training and field experience, enabling police officers to rely on structured, practiced strategies when responding to calls for service involving persons with suspected mental illness. Rather than reacting impulsively, police officers can draw on these scripts to navigate complex and emotionally charged situations more effectively, with the aim of minimizing conflict and avoiding escalation (Blais & Leclerc, 2023).

Based on their analysis of 100 detailed Canadian police reports, Blais and Leclerc (2023) identify a six-step intervention script that underpins successful interactions with persons with mental illness. These steps are receiving the emergency call for service, arriving at the scene, assessing the situation, engaging with the person in crisis, managing the situation, and completing the

intervention. While these stages may superficially resemble those used in other types of calls, Blais and Leclerc's (2023) findings highlight that the specific actions and communication techniques embedded in each step are uniquely adapted for interactions with persons with suspected mental illness. This structured approach provides police officers with a clear framework for action and promotes consistency and professionalism in interactions that can often be unpredictable. By relying on scripts, police officers may be better equipped to anticipate potential risks, apply de-escalation strategies, and engage empathetically with persons with suspected mental illness. Over time, the accumulation of positive experiences reinforces these scripts, strengthening police officers' confidence and improving outcomes for both police and community members. Importantly, the use of scripts can reduce officers' reliance on force, foster trust with vulnerable populations, and ultimately contribute to safer, more compassionate responses to mental health crises.[6]

The value of Script Theory lies in providing a framework for developing situation-specific scripts that emphasize non-coercive, collaborative strategies. By training officers to internalize and apply scripts tailored to mental health crises, police services can promote more consistent, compassionate, and effective responses that reduce reliance on force, foster trust, and improve safety for both officers and community members. As discussed above with respect to approaches to training, Script Theory may be best accomplished through the provision of in-person training that allows for hands-on engagement in the skills and instructor feedback.

The University of Alberta has partnered with the Edmonton Police Service to develop a training program in which Canadian police officers engage with professional actors to practice responding to mental health scenarios (Krameddine & Silverstone, 2015). These scenarios are intentionally designed to be emotionally intense, allowing police officers to build practical skills in de-escalation, enhance empathy, and better understand the perspectives and needs of individuals in crisis. The outcomes of this training have been highly positive. After training over 650 police officers, significant behavioural improvements were observed even six months later (Krameddine et al., 2013). Marked enhancements were noticed in communication, empathy, and de-escalation techniques among patrol officers. Additionally, police officers demonstrated an increased ability to recognize mental health issues, with the average number of mental health calls handled rising by more than 40% (Krameddine & Silverstone, 2015). Time spent on each mental health call for service decreased by nearly 20%, reflecting more effective and efficient interactions. Supporting these observations, police officers self-reported a 23% increase in confidence when responding to individuals in psychiatric distress (Krameddine & Silverstone, 2015), underscoring the lasting impact of this experiential, scenario-based training. Lavoie and colleagues (2023) conducted further research on scenario-based training among Ontario police officers, utilizing virtual reality technology to simulate first-person perspectives in realistic environments. This approach provides a safe and controlled setting in which officers can practice responding to complex situations. In particular, virtual reality simulations are frequently used to help officers develop skills for managing encounters involving persons with mental health issues, thereby enhancing

[6] It should be noted that scripts are used in most western countries.

preparedness for real-world interactions (Lavoie et al., 2023). Training approaches that combine virtual reality with hands-on skill development and instructor feedback may be the most feasible at generating behaviour change in a cost-effective manner.

POLICE-BASED MENTAL HEALTH SCREENING TOOLS

The interRAI Brief Mental Health Screener was designed for use by police officers as a screening tool to identify persons with serious mental disorders (Hoffman et al., 2016). The screening tool guides police officers to complete information about the individual and incident, signs and symptoms of potential mental health issues, and the time spent on the call. In one evaluation of the tool with two police agencies in Ontario, Hoffman et al. (2016) compared the screening tool data collected by police officers with health records to measure the accuracy of the tool at identifying individuals with mental illness. They concluded that the screening tool was able to predict individuals more likely to be apprehended and those who were more likely to be admitted into psychiatric care at the hospital. They also found that when the person had self-injured within the past 30 days or other individuals had expressed concerns over potential self-injury, police officers were more likely to take the individual to the hospital for a mental health exam. This coincided with the criteria for police apprehension of persons suspected to have a mental health issue under the provincial mental health legislation, namely, that there was a suspected mental health issue and that the individual posed a threat of violence to themselves or others. In contrast, factors that were associated with the person being admitted to the hospital included hallucinations, delusions, and abnormal thought processes (Hoffman et al., 2016). The authors concluded that use of the interRAI Brief Mental Health Screener assisted police officers in forming and articulating the rationale for apprehension and admission to hospital for mental health-related concerns. However, a subsequent study by Sanders and Lavoie (2021) identified that police officers felt burdened by having to complete the screening tool and did so more as a way of confirming their decisions about whether to apprehend rather than as a guide to more proactively inform their decision making. Police officers preferred being able to have a discussion with a mental health expert, particularly in cases that were perceived as more "borderline" with respect to the criteria for apprehension. While police administrators felt that the tool improved police officers' "mental health lingo" (p. 973), Sanders and Lavoie (2021) concluded that the tool generated a shared language that could help police officers to articulate their rationale but that it did not improve their understanding of how to manage the interaction. Of note, when Hoffman et al. (2016) implemented the screening tool, the training provided to police officers focused on demonstrating how the tool could help them to articulate their observations of the individual rather than training them on understanding the mental health issues they were facing or how best to manage mental health-related issues during an interaction. Still, the observations made by Sanders and Lavoie (2021) were that many police officers were confused by the intent and content of the tool.

Further, as police officers were making apprehension decisions under the criterion of personal or public safety while hospital admissions were based on the presence of delusions, hallucinations, or disordered thought processes (Hoffman et al., 2016), it was unclear whether use of the interRAI by police officers resulted in their making more informed decisions about who would likely be admitted upon exam. This is an important limitation, as prior research by Shore and Lavoie (2018) in Canada found that only one-half of individuals apprehended by police for a mental health

assessment were admitted for hospital care. While the screening tool may support police officers in deciding when to apprehend and how to articulate the rationale for apprehension in the absence of more empirically supported models, such as co-response teams, further research is necessary to establish the benefits of its use by police.

ASSERTIVE COMMUNITY TREATMENT (ACT)

Assertive Community Treatment (ACT) is a well-established, evidence-based model that uses integrated, multidisciplinary teams to provide intensive outreach and support to persons with mental health issues, with the goal of promoting community living, rehabilitation, and recovery (Costigan et al., 2021). These teams are comprised of psychiatrists, nurses, social workers, and community outreach workers who work together to create tailored treatment plans for clients (Costigan et al., 2021). In some jurisdictions in BC, ACT was adapted into Assertive Community Treatment - Police Integrated (ACT-PI) that incorporates police officers directly into ACT teams. This adaptation was designed to address the complex needs of individuals with varying degrees of involvement in the criminal justice system, including those who have committed offences, those who have been victimized, and those with minimal or no prior criminal justice system involvement (Costigan et al., 2021). ACT-PI fosters stronger and more positive relationships between police officers and persons with mental illness. Unlike traditional policing interactions, officers within ACT-PI are often perceived as trustworthy, empathetic, humane, and less stigmatizing (Costigan et al., 2021). People with mental illness report valuing these relationships, as they feel more comfortable relying on ACT-PI members for assistance in navigating the criminal justice system and accessing supports (Costigan et al., 2021; DeLuca et al., 2018). Furthermore, ACT-PI emphasizes collaborative problem-solving and early intervention rather than punitive responses, helping to align law enforcement more closely with healthcare and social services (Parker et al., 2018). This integrative approach not only enhances coordination across sectors but also prioritizes de-escalation and tailored interventions that reduce the likelihood of criminalization.

Nevertheless, challenges remain. Some community members expressed concerns about the stigma associated with increased police involvement in mental health care, which may discourage participation (Stuart & Arboleda-Flórez, 2012). Additionally, there is a risk of overreliance on police officers for de-escalation and guidance, potentially overshadowing the roles of healthcare professionals or reinforcing perceptions of policing as central to mental health management (Costigan et al., 2021). These limitations highlight the importance of the careful balance in ACT-PI models, ensuring that while police involvement can build trust and improve access to services, it does not inadvertently perpetuate stigma or dependency.

SITUATION TABLES AND INTERVENTION CIRCLES

Situation Tables are community-led initiatives that bring together frontline professionals from public safety, health, and social service sectors to collaboratively address situations involving individuals or families at acutely elevated risk (Government of British Columbia, 2025). The first Canadian Situation Table was established in Saskatchewan in 2011, and the model has since expanded to more than 115 communities nationwide (Cohen et al., 2022). British Columbia has been a leader in this expansion, with over 50 Situation Tables now operating across the province

(Government of British Columbia, 2025). These multi-agency teams work to identify and support those facing complex and intersecting risks, such as victimization, homelessness, unemployment, or mental health challenges, with the goal of preventing crises before they occur. Referrals may originate from any participating community agency, after which partners coordinate rapid, cross-sector interventions to reduce immediate harms. While each organization remains accountable for its own services, the Situation Table framework enables timely, holistic responses that enhance community safety and well-being while maintaining client confidentiality (Cohen et al., 2022; Government of British Columbia, 2025). When a case is presented, participating agencies use structured risk assessment tools and organizational databases to determine whether it meets the threshold for acutely elevated risk. If so, members share relevant information, develop coordinated intervention strategies, and connect individuals to appropriate supports, typically within 24 to 48 hours (Cohen et al., 2022). Although criminal involvement may sometimes trigger a referral, police generally play a supportive rather than leading role, while community-based organizations spearhead service delivery (Cohen et al., 2022; Taylor, 2021).

In addition to Situation Tables, Intervention Circles developed and led by Indigenous communities reflect a similar collaborative philosophy grounded in culturally safe and community-driven practices (Government of British Columbia, 2025). Each Circle is designed by the community it serves, ensuring that participating service providers and supports align with local values, traditions, and needs. Rather than directing individuals toward policing or the justice system, Intervention Circles connect people with appropriate health, social, or cultural supports, thereby reducing harm and promoting healing through locally guided solutions (Government of British Columbia, 2025). This model is particularly valuable in remote or rural areas where police presence is limited and where community and cultural continuity are central to effective intervention.

CO-RESPONSE MODEL

The co-response model represents a partnership approach in which police officers and mental health professionals (generally nurses or social workers) collaborate to respond as a secondary response team to calls for service involving mental health or individuals with complex needs (Blais et al., 2020; Cohen et al., 2025; Huey et al., 2021; Koziarski et al., 2021; Park et al., 2019; Teti et al., 2025). Co-response teams depend on strong information sharing and collaboration among police agencies, hospitals, community services, psychiatric nurses, and social workers to provide effective support to individuals in crisis (Bailey et al., 2018; Cohen et al., 2025; Ghelani et al., 2023). Within this model, police officers are primarily responsible for securing the scene and ensuring public safety, while mental health professionals focus on assessment, de-escalation, and developing an appropriate action plan for the individual in crisis (Cohen et al., 2025; Park et al., 2019). Mental health professionals fulfill these responsibilities through ride-alongs or by offering telephone or radio support during calls for service involving persons with suspected mental illness. Studies have found that co-response models reduce hospital wait times and result in more relevant connections with services (Baess, 2005, as cited in Cotton & Coleman, 2010; Blais et al., 2020; Cohen et al., 2025; Every-Palmer et al., 2023; Fahim et al., 2016; Semple et al., 2021). Positive findings have even been found in smaller more rural Canadian communities that typically lack access to relevant services, though long wait lists and lack of available programming do appear to somewhat limit the

effectiveness of these models (Koziarski et al., 2021; Zitars & Scharf, 2024). Studies have also found a reduction in the amount of time spent on scene by police officers, as well as an increase in the number of calls for service these specialized teams are able to respond to (Allen Consulting Group, 2012; Every-Palmer et al., 2023; Kisely et al., 2010; Semple et al., 2021). Additionally, a study by Blais et al. (2020) in Québec identified reductions in use of force for calls for service handled by the co-response team in comparison to the control sample. Both Blais et al. (2020) in Québec and Semple et al. (2021) in Ontario found that the co-response model resulted in reductions in apprehensions under provincial mental health legislation. While Fahim et al. (2016) also found reductions in hospital visits with the co-response team, when the individual was taken to the hospital, they were more likely to be admitted, suggesting more accurate discernment of mental health needs. In contrast, a recent study in Indiana did not find any influence of co-responder models over police-as-usual responses in terms of reducing future emergency medical services events, reducing jail bookings, reducing hospital visits, or improving behavioural health outcomes (Lowder et al., 2024). Their study involved a random control design which is a more rigorous evaluation approach. Their model involved a police-mental health clinician model operating between 10am and 5pm where the team/officer self-dispatched to 911 calls they thought may involve mental health based on what they heard over the dispatch radio. The authors acknowledged that all police officers had received mental health training, which may have elevated the effectiveness of the police-as-usual response, thus negating any effects of the co-response model. In contrast to the findings of this study, while both Crisis Intervention Training and co-response teams have shown positive outcomes in the available research evidence, a recent meta-analysis of 42 prior studies by Seo et al. (2021) found stronger effects for co-response teams. In some cases, Crisis Intervention Team training is provided to co-response team members (Fahim et al., 2016; Zitars & Scharf, 2024), thus combining what to date appear to be the two most effective models in police responses to policing persons with mental health issues.

Co-response teams also appear to generate higher levels of confidence and trust among police officers. In a study on co-response models operating in British Columbia, participants generally held positive views of the co-response teams, noting that these models enhanced client care through information sharing, trust building, and interagency collaboration (Cohen et al., 2025). They emphasized that co-response initiatives improved client well-being by assisting persons with mental health issues in transitioning from crisis situations to appropriate care (Cohen et al., 2025). Moreover, individuals in crisis who interacted with police officers accompanied by mental health professionals tended to perceive the police more favourably, which enhanced perceptions of legitimacy and procedural justice (Teti et al., 2025). Despite these benefits, respondents identified several challenges including limited hospital resources, staffing shortages, and inconsistent procedures, in addition to the need for greater outreach, follow-up, and resource allocation (Cohen et al., 2025).

Police officers have also provided positive feedback after working in co-response teams and noted that collaboration with mental health professionals increased their knowledge of community resources and improved their capacity to support persons with mental health issues (Cohen et al., 2025). These partnerships appeared to foster officers' confidence, decision-making abilities, and willingness to engage effectively with individuals experiencing mental health crises (Bailey et al., 2023; Teti et al., 2025). Given these and other benefits, Cohen et al. (2025) recommended

expanding the use of co-response teams to more police agencies and providing more opportunities for police officers to participate in the co-response model. While there is some demand to expand co-response teams to 24/7 scheduling (Koziarski et al., 2021), expanding the hours is not necessarily recommended given low call volume as well as the lack of available services to connect clients to overnight (Cohen et al., 2025; Shore & Lavoie, 2018; Zitars & Scharf, 2024).

MOBILE CRISIS RESPONSE TEAMS

In response to the increasing demand for alternative crisis intervention methods, numerous police services in Canada have implemented a community-based crisis response strategy. This strategy was developed to provide timely support for people in crisis, improve service user experiences, and reduce the pressure on justice and health systems through de-escalation, the prevention of injuries, and the safe assistance of people with mental health and substance use concerns in the community (Bailey et al., 2018; Bailey et al., 2022; Cohen et al., 2025; Park et al., 2019; Shapiro et al., 2015). Crisis response team approaches rely on collaborations between police departments, hospitals, community services, and psychiatric nurses or social workers who specialize in behavioural health problems (Bailey et al., 2018; Ghelani et al., 2023; Lamanna et al., 2018). The model is the collaborative, coordinated response from police officers and mental health practitioners to mental health-related calls for service to the police (Cohen et al., 2025). In this model, the police officer secures the scene and provides general safety, while the mental health professional assesses, de-escalates, and develops an appropriate action plan for the subject of the call for service (Cohen et al., 2025). Typically, the team members share information during the triage response, including mental health and criminal justice history, as well as the level of risk the subject poses to themselves and others to ensure the most appropriate response (Cohen et al., 2025; Park et al., 2019).

Nova Scotia's Mental Health Mobile Crisis Team (MHMCT) provides 24-hour telephone support from mental health clinicians to assist police officers responding to mental health crises (Kisely et al., 2010). Compared to a nearby region without the program, implementation of the MHMCT led to more frequent contact between clinicians, police officers, and individuals with mental illness. This collaboration reduced police officers' on-scene time from 165 minutes to 136 minutes on average, increased outpatient service use among individuals supported by the program, and improved police officers' knowledge and confidence in handling situations involving persons with mental illness (Kisely et al., 2010).

Ontario has adopted a slightly different model through the Toronto Mobile Crisis Intervention Team (MCIT), which pairs a psychiatric nurse with a specially trained police officer to respond to mental health calls for service (Kirst et al., 2015). Unlike the telephone-based model, the MCIT provides an in-person, co-response approach. Teams are dispatched as a secondary response when requested by the primary responding police officers. MCITs have been widely regarded as effective for addressing community needs, diverting individuals from hospital emergency departments and the criminal justice system, and allowing patrol officers to return to other calls for service more quickly. Service users frequently emphasize the compassionate and non-criminalizing approach of MCITs, describing these encounters as more supportive and less stigmatizing than interactions with police-only responses (Kirst et al., 2015).

Despite these benefits, challenges remain. Some concerns have been raised about unclear role definitions between health professionals and police officers, as well as broader systemic issues, including the limited availability of non-police crisis services and the need for better coordination within the mental health system (Kirst et al., 2015). There can also be delayed response times when the mental health specialists do not travel directly with the police to the scene (Zitars & Scharf, 2024), potentially leaving police to de-escalate the situation without the benefit of the mental health insights and skilled provided by clinicians. There are also challenges associated with offering this type of programing in rural or remote areas. Nonetheless, the research on mobile crisis response teams speaks to the value of training all police officers on mental health, regardless of whether they are part of a specialized team.

INTERNATIONAL COMPARISONS

AUSTRALIA

Research in Australia identified that police officers receive approximately two days of training (approximately 11 hours) on mental health during their initial recruit training, which many felt was insufficient (Morgan & Miles-Johnson, 2022). Interviews conducted with recruits suggested that the training, which was largely theoretical in nature, would benefit from the integration of role-playing opportunities, as well as exposure to mental health professionals and individuals with lived experience. The recruits observed that, while they were exposed to a mental health scenario during their Operational Skills Training where they encountered a suicidal individual threatening self-harm, this training occurred prior to the two-day mental health response training, which limited their appreciation for the mental health aspects of the scenario and how to appropriately respond, such as through the use of effective communication tactics to de-escalate the scenario (Morgan & Miles-Johnson, 2022). They also observed that some of the skills taught during their Operational Skills Training, such as to draw their gun in response to the danger posed by the situation, conflicted with the emphasis on verbal de-escalation that they were taught during their mental health response training. These findings point to the importance of weaving mental health considerations throughout the training provided to recruits and ensuring that recruits have sufficient opportunities to engage in scenario-based training where they can attempt different approaches to resolve a scenario and receive feedback on their efforts. The recruits desired opportunities to role play in a larger variety of mental health contexts that were more reflective of the type of interactions they were likely to experience once deployed, including with respect to the types of situations they might experience working with Indigenous or remote communities where there may be a lack of available resources. Still, while they desired more opportunities for role playing and for more training time to be spent on managing mental health-related calls for service, overall, the recruits did feel as though the training they received resulted in a greater understanding of the extent and range of mental health issues in society, more appreciation for the challenges experienced by persons with mental health-related issues, and greater compassion towards these individuals (Morgan & Miles-Johnson, 2022).

Australia's Operational Procedures Manual (OPM) emphasizes the importance of treating persons with mental health issues with dignity and respect, noting that transport in police vehicles can be stressful and stigmatizing for individuals experiencing a mental health crisis (QPS, 2020). In response, Queensland police have increasingly adopted ambulances as an alternative mode of

transport for persons with mental health issues (QPS, 2020). Although ambulances provide a more supportive and less intimidating environment, this approach faces practical limitations. In rural and remote areas, ambulance availability is often limited, creating challenges for timely transport. In situations where a person is severely agitated or violent, ambulance staff may also be placed at risk, raising concerns about safety and the broader feasibility of this approach (Morgan, 2021).

Australia has also developed a co-responder model known as PACER (Police and Clinician Emergency Response). A PACER team consists of a police officer and a clinician who provide secondary response after police determine that an individual requires assessment by a mental health professional (Allen Consulting Group, 2012; Watson et al., 2019). PACER teams deliver assessment, behavioural de-escalation, emergency department diversion, and referrals to community care (Watson et al., 2019). An evaluation of the PACER model in Queensland over a 16-week period showed that of 137 persons with mental health issues encountered, only 28.7% required transport to an emergency department. Without the clinician present, police officers reported that 81.9% would have been transported, suggesting that PACER diverted 67% of cases away from hospitals (Meehan et al., 2018). Other reported benefits included enhanced police officer safety due to the presence of mental health staff, stronger collaboration between police, mental health teams, and hospitals, and positive client feedback that their needs were met and their crises effectively de-escalated (Evangelista et al., 2016; Watson et al., 2019).

Despite these benefits, PACER is restricted to daytime and evening hours, leaving a gap in support during night shifts (Lee et al., 2015). Some individuals expressed discomfort in the presence of a police officer, noting that a clinician-only response might have been more effective (Lee et al., 2015). In addition, assessments were often conducted in public at the scene rather than in private settings, such as hospitals or offices, which could compromise privacy (Watson et al., 2019).

NEW ZEALAND

Between 2009 and 2016, police officer calls for service involving a mental health issue increased by an average of 9% per year in New Zealand (Li et al., 2020). Approximately two-thirds (64 per cent) of these files were initially considered priority level 2, requiring a police officer to attend within a target timeframe of 30 minutes from the time the call for service was received by dispatch; however, 40% of these calls for service were subsequently downgraded to priority 4, indicating that no police attendance was required. Li et al. (2020) concluded that the year over year changes largely reflected an increasing trend towards lower priority calls for service that were mental health-related. Given the increases in mental health-related calls for service to the police, the New Zealand Police introduced a new mental health training program to address stigma and provide skills to better manage these calls for service (Davey et al., 2021). The training was delivered nationally online as part of an e-learning training intervention. In total, three half-hour modules were created that were designed for completion over a three-week period. The first module focused on recognizing mental distress, the second addressed engaging with people experiencing mental distress, while the third more specifically concerned suicide awareness (Davey et al., 2021). The program content included direct participation of persons with lived experience, and was composed of written text, video recordings, and practical exercises, including the use of case studies and self-reflection exercises. Approximately 25% of the police force volunteered to complete the training.

Davey et al. (2021) conducted post-implementation interviews with 24 police officers who completed the training.

Overall, the training curriculum was viewed very positively by participants, who appreciated the inclusion of persons with lived experience, although they felt that it would have been better to do the training in person, and that more real-life scenarios were important to include. There were self-reported reductions in stigma and increases in empathy and understanding towards people experiencing mental distress. Some participants also reported changes in how they conversed with clients, where they used more of a direct communication style. However, the study findings should be interpreted with caution due to selection bias and the small sample size. Approximately 3,000 of the 12,000 police personnel elected to complete the training, and then only 24 of the 3,000 participated in the study (0.8 per cent). While the authors continued to collect data until they experienced saturation, those who were motivated to participate in the training and then the subsequent interview may differ in important ways from those who neither partook of the training or the interviews. In other words, the findings of the research should be not attributed more broadly to the entire police agency (Davey et al., 2021). Moreover, the results were based on self-reported changes in attitudes and behaviours and did not integrate the use of validated scales or quantitative data. Still, the findings supported that police officers felt that the provision of mental health training, particularly when it included persons with lived experience, can provide valuable insights that reduced stigma towards people experiencing mental illness. This might result in behavioural changes, particularly when combined with training that models how to interact in these scenarios.

One of the findings from Davey et al. (2021) was that police officers largely viewed that working with other agencies on mental health calls for service was very challenging, due to the lack of available resources at the community level. A few years later, Every-Palmer et al. (2023) and Kuehl et al. (2024) described the implementation of a co-response model in New Zealand. Unique elements to this model compared to those already described in this report included that they utilized two different co-response teams. One team described as the “home” team consisted of a police officer partnered with a mental health clinician who provided in-office support, such as compiling information about the individual and providing phone-based support or referrals (CRT liaison response), while the “field” team, which consisted of a police officer, mental health clinician, and a paramedic, responded to crisis calls for service in the field (CRT response). The teams were deployed between 08:00 and 18:00 Tuesdays through Fridays. The teams screened incoming emergency calls for service for potential mental health or suicide and could also be called or deployed for field support. Quantitative analysis of the program identified reductions in the number of apprehensions and visits to the emergency room for assessment, quicker resolution of calls for service, reductions in hospital waiting time, and reductions in future attendance at the emergency hospital room or mental health unit over the one-month follow up period when compared to the usual police response (Every-Palmer et al., 2023).

Qualitative analysis found that program users, their families, and their support workers largely saw the program as very positive, with 91% stating that they felt very or extremely satisfied with their program experience. They felt that the co-response team was more likely to see the situation from a position of empathy rather than dangerousness, they felt listened to and supported, they believed

that the team response streamlined their access to services, and they felt that more holistic care was provided, including attention to their physical health and mental distress (Kuehl et al., 2024). While there were ongoing challenges post-response with accessing community-based resources, these were outside of the mandate of a crisis-focused co-response team. More directly relevant to the co-response approach, some of the participants felt that there could have been a more culturally-informed responses, while others remained hesitant about the involvement of police, feeling that their presence heightened the distress that they felt. The inclusion of a paramedic on this team was unusual compared to many other co-response models but was viewed very positively by participants. For example, the paramedic was able to help distinguish between individuals who were experiencing mental health distress versus a physical health issue (e.g., a panic attack versus a seizure) and helped program users understand what happens to the body when someone has a panic attack. Kuehl et al. (2024) concluded that "participants viewed the paramedic as a crucial part of the CRT" (p. 573).

UNITED KINGDOM

Similar to British Columbia, under the 2007 *Mental Health Act*, police officers in the United Kingdom are authorized to detain individuals experiencing a mental health crisis and who present a risk to themselves or others. However, this approach is often criticized as being distressing for those detained, costly to the system, and resource-intensive for the police (Kirubarajan et al., 2018; Riley et al., 2011). In addition, police officers report feeling a lack of training to appropriately support those in a mental health crisis (Kirubarajan et al., 2018; Wells & Schafer, 2006). As a result, the United Kingdom has implemented street triage services and changes to their 2017 *Policing and Crime Act* making it a legal requirement to consult with a mental health professional before detaining an individual experiencing a mental crisis (Policing & Crime Act, 2017).

Rather than using ride along techniques, like in Australia or Canada, police departments across England implemented street triage services. In one example, the Cleveland Police Department in England placed a mental health nurse at police headquarters from noon to midnight to monitor calls and respond on-scene if an officer made a request (Dyer et al., 2015; Horspool et al., 2016). Another form of street triage involved 24/7 telephone support to police officers where they could seek advice from mental health professionals when interacting with persons with mental health issues (Kirubarajan et al., 2018). Street triage has received mostly positive feedback from the community, who stated that having both police officers and mental health professionals led to timely on-scene support that resulted in better outcomes for persons with mental health issues and fewer mental health detentions (Dyer et al., 2015). Those who have experienced triage services stated that this approach was less stigmatizing and traumatic than traditional policing approaches (Kirubarajan et al., 2018). A couple of issues arose, however, when officers took the person with a mental health issue directly to the hospital because nurses were unavailable or if they did not agree with nurse assessments (Dyer et al., 2015). Still, in a survey measuring the effectiveness of street triage services in the UK, results indicated that police officers overwhelmingly supported street triage and had a strong preference for services providing 24/7 support (Kirubarajan et al., 2018). One officer reported that "mental health is a specialist area and police officers are not mental health specialists", highlighting their reliance on this service (Kirubarajan et al., 2018).

UNITED STATES

Ruiz and Miller (2004) examined police interactions with persons with mental health issues in Pennsylvania and found that 43% of police officers immediately perceived persons with mental health issues as dangerous, while 49% reported feeling uneasy, nervous, or threatened when responding to mental health-related calls for service. These findings highlight a lack of preparedness and the need for enhanced training. The study also revealed that only half of the calls for service involving persons with mental health issues were managed using any formal policy, and most departments acknowledged they lacked clear guidelines and specialized training for responding to these situations (Ruiz & Miller, 2004). However, since then, the United States has implemented mental health training and programs, most commonly in the form of Crisis Intervention Teams.

The Crisis Intervention Team (CIT) model is one of the most widely used responses to persons with mental health issues in the United States. CIT takes a collaborative approach that equips police officers with the knowledge and tools to respond more effectively to individuals in mental health crisis. Central to the model is a 40-hour specialized in-person training program that builds officers' skills in de-escalation, crisis communication, and connecting individuals to appropriate mental health services (Watson et al., 2019). The program emphasizes partnerships between law enforcement, emergency dispatch, substance abuse and mental health providers, advocacy groups, and those with lived experience, as well as their family members. It is designed to be adaptable, allowing communities to tailor implementation to their specific resources and needs (Bratina et al., 2020).

A substantial body of research has evaluated the effectiveness of CIT (Huey et al., 2021; Rogers et al., 2019). For example, Ritter et al. (2010) found that CIT participation appeared to reduce stigmatic attitudes towards people with mental health issues and increased police officers' confidence in handling these types of calls for service (Ritter et al., 2010). Tartaro et al. (2021) similarly found that CIT-trained police officers felt better prepared to handle mental health-related calls for service, though surprisingly they were more likely to hold negative opinions towards persons with mental health issues than non-CIT trained officers. Unfortunately, Tartaro et al. (2021) did not study police officer attitudes towards persons with mental health issues prior to the CIT training, nor did they measure whether police officers volunteered for the training or were assigned to it. While feeling prepared does not necessarily translate to more effective behaviours in the field, Compton et al. (2011) examined the behavioural responses of CIT-trained versus non-CIT officers when presented with scenarios involving a subject with schizophrenia who displayed escalating behaviour. CIT-trained officers consistently demonstrated a lower preference for the use of force and were less likely to view physical force as effective compared to their non-CIT trained counterparts. Additional studies have found that CIT officers regard the model as highly effective in addressing the needs of persons with mental health issues, reducing unnecessary incarceration, minimizing officers' time on mental health calls, and enhancing their confidence in managing crisis situations while maintaining community safety (Borum et al., 1998; Hanafi et al., 2008). Furthermore, CIT-trained officers report using more complex assessment strategies, alongside de-escalation techniques, to resolve calls and display greater understanding of symptomatic behaviours in persons with mental health issues (Bonfine et al., 2014; Canada et al., 2012). Consequently, CIT police officers were less likely to use force and when they did use force, were

likely to use lower levels of force when compared to non-CIT trained police officers (Willis et al., 2023). Moreover, calls for service involving persons with mental illness were more likely to result in the individual being diverted by the police to relevant mental health services (Bratina et al., 2020). CIT appears to be one of the most promising programs to reduce negative interactions between police officers and persons with mental illness and to increase diversions to supportive programs. However, the 40-hour in-person training model may be a deterrent to more widespread use of this program in Canada. Further, Rogers et al. (2019) argued that more empirical research evaluating outcomes, such as reductions in arrest and lethal interactions between police officers and persons with mental illness, is still needed.

A range of diversion initiatives have been developed to redirect persons with mental health issues away from the criminal justice system and toward appropriate treatment and support services in the United States. These programs aim to reduce criminalization, alleviate pressure on correctional facilities, and improve outcomes for individuals experiencing mental health challenges (Lange et al., 2011; Sirotich, 2009). Diversion can occur at different stages of criminal justice involvement. For example, pre-booking diversion takes place at the first point of contact with law enforcement, before any charges are laid, and often involves police officers connecting individuals directly to community-based mental health services. By intervening early, these initiatives can prevent unnecessary arrests, reduce stigma, and promote treatment engagement. Diversion programs represent a critical step in addressing the overrepresentation of persons with mental health issues in the justice system and promoting recovery-oriented alternatives to incarceration.

In a study with the Chicago Police, Watson and Wood (2017) found that approximately one-in-ten mental health-related calls for service involved a referral to a mental health or social service (7.9 per cent of all files) or some other action being taken at the scene (10.7 per cent). An additional one-third (35 per cent) were resolved at the scene with no further action. Given this, while nearly one-half of all files (44.9 per cent) involved the person being transported to hospital and 5.8% resulted in the individual being arrested, police officers used diversion tactics more commonly than expected in these files. Qualitative interviews conducted with the police officers revealed high levels of empathy and compassion and attempts to de-escalate the situation to allow for informal resolutions when possible. Still, the shortage of available community resources meant that many of these individuals ended up in a revolving door situation with repeated interactions with the police.

EUROPE

Litzcke (2006) conducted a study in Germany to observe the attitudes of police officers and other civil servants towards persons with mental health issues. All participants reported that persons with mental health issues were seen as less intelligent, less trustworthy, and less employable than the rest of the population (Litzcke, 2006). At the time, German police interacted with persons with mental health issues in 25% of all calls for service, yet training and awareness were not standardized (Litzcke, 2006). Similarly in Portugal, a study identified that police officers with minimal education perceived persons with mental health issues as unpredictable and dangerous (Soares & Pinto da Costa, 2019). These police officers also reported feeling that they were unable to identify symptoms of a mental illness and were not properly trained to appropriately deal with

individuals experiencing a mental crisis. These findings point to the importance of providing training for police officers on mental health and crisis intervention.

Several European countries, including Portugal and Germany, use compulsory admissions to manage criminal behaviours among persons with mental health issues. A compulsory admission involves admitting an individual to a psychiatric hospital without their consent (Wasserman et al., 2020). The aim is not to punish the individual, but to ensure they receive appropriate treatment and stabilization while also protecting public safety (Salize et al., 2005). In Portugal, this process is governed by the Mental Health Law, and in Germany by the Penal Code, both of which grant police officers the authority to transport persons with mental health issues to emergency psychiatric services for urgent evaluation and care (Salize et al., 2005; Soares & Pinto da Costa, 2019). These measures are intended to serve as preventive interventions, applied when there is a foreseeable risk that the individual will continue committing offences (Salize et al., 2005). While police officers acknowledged that such laws deprived individuals of their freedom, they also emphasized their necessity, given that some persons with mental health issues were unable to make informed health-related decisions on their own. Police officers reported approaching these situations with sensitivity and empathy, though they also noted challenges, such as limited training and the unpredictability of patient behaviour (Soares & Pinto da Costa, 2019). Despite these safeguards, compulsory admissions remain controversial, as many critics view them as ethically problematic due to the infringement on patient rights (Wasserman et al., 2020).

Following an influx of research indicating the need for law enforcement officers to improve their handling of persons with mental health issues (Rohrer, 2021; Wells & Schafer, 2006), Lorey and Fegert (2021) piloted an education-based training program for police officers in Germany aimed at improving their interactions with persons with mental health issues. The intervention was delivered over a two-day program integrating lectures, case vignettes, role play scenarios with trained actors, and group discussion. The program's curriculum covered the recognition of common psychiatric symptoms, techniques for verbal de-escalation, legal frameworks, and strategies to reduce stigma and increase empathy toward persons with mental health issues (Lorey & Fegert, 2021). An exam evaluation following content delivery demonstrated significant improvements in officers' psychiatric knowledge and in their reported confidence to manage crisis situations, including de-escalation and handling compulsory admissions (Lorey & Fegert, 2021). Officers highlighted that role playing scenarios and case-based learning were particularly helpful in preparing them for real-life encounters and improving their attitudes towards persons with mental health issues (Lorey & Fegert, 2021).

SUMMARY OF APPROACHES TO POLICING MENTAL HEALTH-RELATED CALLS FOR SERVICE

As the demand for police involvement in mental health crises continues to grow, jurisdictions are exploring innovative models that move beyond co-response teams. These approaches emphasize early intervention, improved service coordination, and reduced reliance on police as primary responders. While co-response models remain valuable, additional frameworks such as Situation Tables and interagency information-sharing initiatives have emerged to complement traditional crisis response approaches. Situation Tables connect representatives from health, social services,

housing, and justice sectors to collaboratively identify and assist individuals or families experiencing elevated risk before a crisis necessitates police intervention. Through structured information-sharing protocols and rapid coordination, participating agencies can mobilize tailored supports to address underlying social and health-related needs. These proactive, community-based interventions aim to prevent harm, reduce repeat emergency calls, and strengthen overall community well-being. In parallel, expanding 24/7 phone and telehealth access to mental health professionals provides frontline officers with immediate clinical consultation, enhancing decision-making and reducing unnecessary apprehensions.

Emergency departments remain a bottleneck in the crisis response system, with long wait times often exacerbating distress for persons with mental health issues (Cohen et al., 2025). One alternative is to train psychiatric nurses or other specialized mental health professionals to conduct initial assessments, allowing for faster triage and more efficient use of resources. As noted earlier, the British Columbia *Mental Health Act* does permit for Nurse Practitioners to make the initial assessment for emergency commitment to a mental health unit. Some hospitals have also piloted on-site crisis teams, stationed within emergency departments, to provide rapid evaluation, stabilization, and linkage to outpatient services (Cohen et al., 2025). These models have the potential to improve patient experiences while reducing strain on both hospitals and police.

Diversionary initiatives that minimize police involvement altogether represent another innovative pathway. Community-based crisis stabilization programs, peer-led crisis centers, and housing-first models offer safe environments for individuals to receive immediate support without criminal justice consequences (James, 2010). These approaches may be effective in reducing repeat emergency calls, improving client outcomes, and lowering system costs.

Geographic isolation presents unique challenges for rural and remote communities where on-site crisis teams are not feasible. Modern innovations such as *tele-psychiatry* in which individuals can access psychological support via phone or video (Chan et al., 2015; Costanza et al., 2020) and *mobile mental health apps* in which users can access psychological support through mobile phone apps (Aryana et al., 2019) offer promising solutions, enabling individuals in crisis to access specialist care regardless of time or location. Equally important are partnerships with community organizations, including Indigenous-led services, that can provide culturally appropriate, locally grounded support that reduces the need for law enforcement involvement. In these contexts, models like Situation Tables or intervention circles may be especially valuable, as they enable communities to mobilize existing resources effectively and tailor interventions to local needs. Together, these strategies illustrate a shift toward multi-sector collaboration, technology-enabled care, and community-driven responses. They offer scalable alternatives that can be tailored to both urban and rural contexts, ultimately reducing the reliance on law enforcement as default responders to mental health crises.

Police officers hold a fundamental responsibility to protect the public while safeguarding vulnerable individuals from harm. Their ability to fulfill this role depends heavily on the strategies, tools, and training provided to them. Without systematic, evidence-based training on how to respond to mental health crises, police officers are placed at a disadvantage. Expecting them to manage highly complex psychiatric emergencies without sufficient preparation raises important questions of accountability, while also increasing the risk of harmful outcomes. Addressing this gap

through comprehensive, standardized training is essential to ensure both officer effectiveness and community safety. At the same time, training alone cannot resolve the issue. Mental health crises occur at any hour of the day or night, yet specialized services are not consistently available 24/7. Although police worldwide have adopted several approaches to respond effectively to calls involving persons with mental health issues, there remains a striking lack of support following this initial contact. Persons with mental health issues are at significantly greater risk of recidivism, rearrest, reincarceration, and rehospitalization after release into the community, reflecting a revolving-door pattern that highlights systemic shortcomings in both mental health and justice systems (Charette et al., 2015; Goulet et al., 2021; Watson et al., 2019).

Too often, police officers are the only responders dispatched to psychiatric emergencies, despite lacking the clinical expertise required to de-escalate and provide ongoing support. This mismatch contributes to frustration among police officers, distress among persons with mental health issues, and public criticism of police responses. The literature largely suggests that embedding mental health professionals directly into emergency response systems or providing joint crisis teams that can be dispatched alongside police officers would ensure individuals receive timely, specialized care and reduce the reliance on law enforcement as the only responder to mental health calls.

Compounding these gaps is the broader lack of accessible mental health resources across the community. Individuals unable to access appropriate treatment and support are far more likely to experience deteriorating symptoms, engage in high-risk behaviours, and come into contact with the criminal justice system (Costigan et al., 2021; Osher & Thompson, 2019). In effect, the criminal justice system has become a stand-in for an underfunded mental health system, drawing police deeper into roles they were never designed to fulfill. British Columbia has made important strides through initiatives, such as ACT-PI, co-response teams, and Situation Tables, yet challenges remain. Reliance on emergency departments for assessments, limited authority among non-physicians, and uneven access in rural and remote regions present ongoing barriers. Innovations, such as tele-psychiatry and Indigenous-led Intervention Circles, are already being explored and offer promising solutions, but they require sustained investment and coordination to reach their full potential.

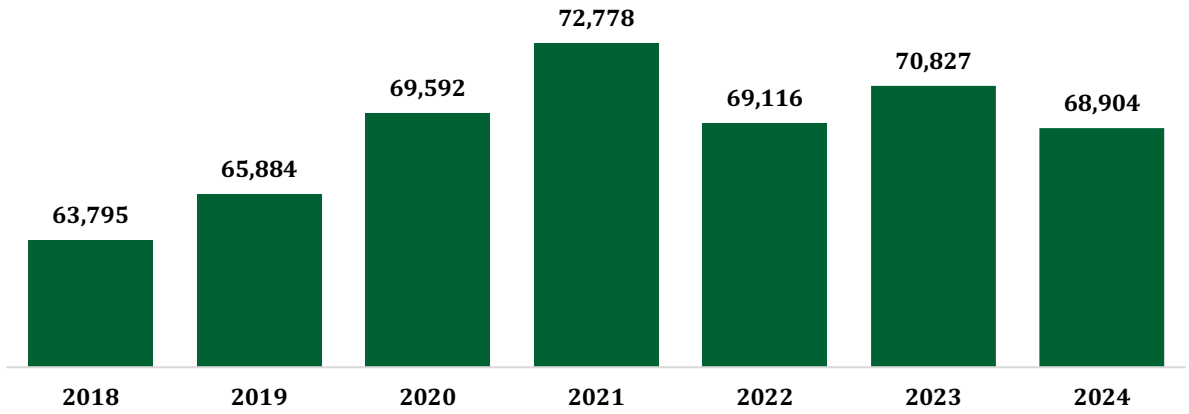
Taken together, these findings point to several areas for policy reform in BC. Expanding assessment authority beyond emergency room physicians would reduce delays in accessing care and is supported by the BC *Mental Health Act* that enables nurse practitioners to make the initial assessment and authorize short-term certification of a patient. Strengthening hospital-police partnerships would improve transitions from crisis to care, reduce recidivism, and build trust across sectors. Finally, supporting culturally grounded, community-driven approaches, particularly in Indigenous and rural communities, would help ensure responses are both effective and equitable. By addressing these gaps through evidence-based, collaborative reforms, BC can move toward a system that truly prioritizes safety, dignity, and recovery for persons with mental health issues while alleviating pressure on police services.

Quantitative Analysis of RCMP Data

"E" Division RCMP provided the authors of this report with a database of mental health-related occurrences[7] between 2018 and 2024 for all RCMP detachments in British Columbia. This dataset included all police records documented as involving a mental health component between 2018 and 2024, including criminal offence files that were founded or unfounded, as well as assistance files, information files, and prevention files. The following section provides a descriptive overview of the patterns of these calls for service and some of the preliminary file outcomes. Mental health files were identified in two ways. All police general occurrence records must have a mental health field study flag completed by the member. This mandatory study flag requires police officers to select either 'mental health related' or 'mental health not related' for all files. This was one source for identifying the mental health files to extract. The second source was through a mental health-related UCR code on the file. For example, this could include a provincial statute, such as the *Mental Health Act*.

Over this seven-year period, analysts identified that the "E" Division RCMP were involved in 480,896 mental health related calls for service. Of these, 25.6% resulted in an apprehension under the provincial *Mental Health Act*. As demonstrated in Figure 1, the number of mental health-related calls for service per year fluctuated over this seven-year period. While 2021 had the largest number of mental health-related calls for service over this period of time, there was an increase of 8% in the number of calls for service for mental health-related incidents between 2018 and 2024.

FIGURE 1: MENTAL HEALTH-RELATED CALLS FOR SERVICE PER YEAR FOR "E" DIVISION RCMP, 2018-2024 (N = 480,896)



[7] The police data provided to the research team reflects general occurrence data rather than call for service data. A call for service is the call generated by the public's request for service and reflects the information provided to dispatch at the time the request for service was made. General occurrence data is the investigative file that contains updated and additional information on the file, including offence and clearance codes. However, for consistency across the different methods used to gather data for this study, the authors will use the phrase "call for service data" when referring to the analyses of police data.

Overall, “E” Division RCMP were involved in an average of 68,699 mental health calls for service each year. This translates to 188 mental health related occurrences per day for RCMP detachments operating in British Columbia. However, the number of mental health occurrences increased by nearly 4,000 files per year at the onset of COVID-19 pandemic and remained consistently higher than pre-COVID years. When examining the average number of mental health occurrences during and following the COVID-19 pandemic, the average number of mental health occurrences between 2020 and 2024 increased to approximately 70,243 occurrences per year, or 192 files per day across British Columbia RCMP detachments.

Given that most British Columbians reside in the Lower Mainland, it was not surprising that nearly one-half (43.5 per cent) of all the mental health-related calls for service between 2018 and 2024 occurred in the Lower Mainland District (see Figure 2).

FIGURE 2: DISTRIBUTION OF MENTAL HEALTH OCCURRENCES BY POLICING DISTRICT, 2018-2024 (N = 480,896)

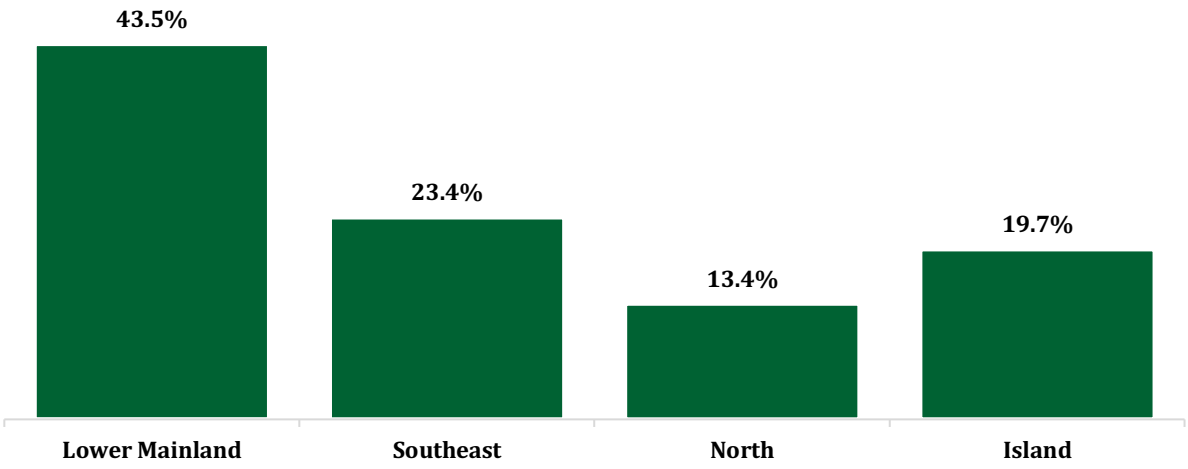


Table 1 provides the annual number of mental health occurrences received by each of the four police districts. While there was only a moderate increase overall for the Lower Mainland District from 2018 to 2024 (+1.2 per cent), the data indicates that there was a steady increase in volume from 2018 to 2023 (+8.7 per cent) until there was a decrease in 2024 from 2023 (-6.8 per cent). For the Island District, there was a very large increase in mental health-related calls for service from 2018 through 2021 (+28.5 per cent) followed by a small but consistent decrease the following year until 2024 (-8.2 per cent). Moreover, over the entire period, there was a 15.5% increase in the number of mental health-related calls for service in the Island District. In the North District, there was a steady increase in mental health-related calls for service from 2018 through 2021 (+16.6 per cent). While there was a slight decrease in 2022 from the previous year (-7.9 per cent), the North District has experienced a slight increase in 2023 (+9.9 per cent) and a very small decrease in 2024 (-2.1 per cent). Overall, between 2018 and 2024, there was a 13.8% increase in mental health-related calls for service in the North District. Finally, for the Southeast District, mental health-related calls for service increased consistently from 2018 through to 2021 (+16.7 per cent) (see

Table 1). And while there was a decrease in 2022 from the previous year (-9.9 per cent), the number of mental health-related calls for service increased in 2023 (+1.0 per cent) and again in 2024 (+5.2 per cent). Overall, between 2018 and 2024, in the Southeast District, the volume of mental health-related calls for service increased by 11.7%.

TABLE 1: MENTAL HEALTH-RELATED CALLS FOR SERVICE PER YEAR BY "E" DIVISION DISTRICT, 2018 – 2024 (N = 480,896)

	Lower Mainland District	Island District	North District	Southeast District
2018	28,569	7,906	12,299	15,021
2019	29,372	8,475	12,955	15,082
2020	30,272	9,926	13,029	16,365
2021	30,743	10,162	14,343	17,530
2022	30,320	9,796	13,212	15,791
2023	31,042	9,318	14,513	15,954
2024	28,918	8,994	14,209	16,783

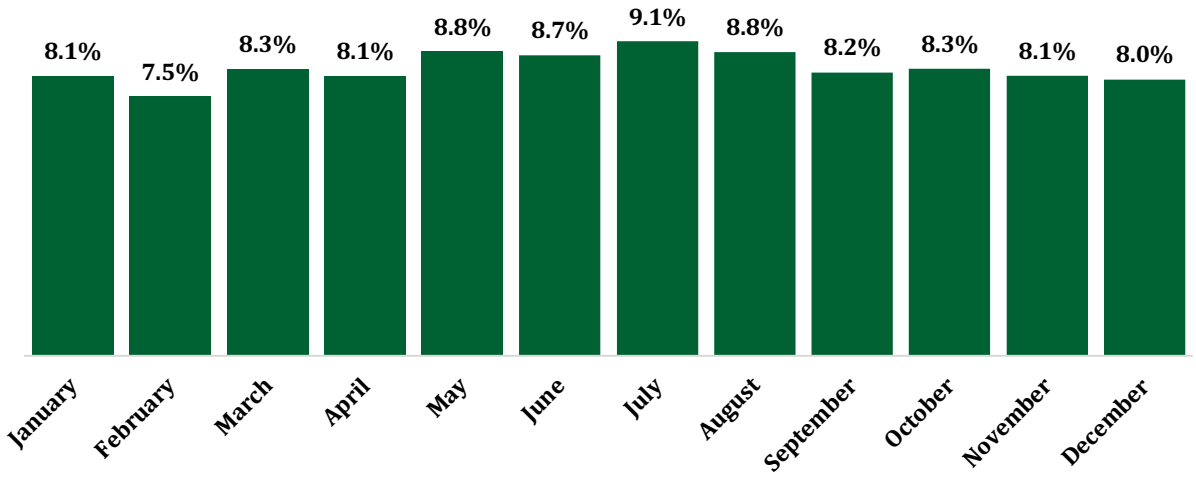
Although three of the four police districts experienced increases in the number of mental health-related calls for service between 2018 and 2024, the percent of mental health calls for service relative to the overall number of calls for service remained relatively stable. On average, mental health-related calls for service accounted for 5.7% of all "E" Division RCMP general occurrence calls for service between 2018 and 2024, which is at the lower range of the estimate provided in the literature reviewed above. This trend was fairly consistent across the four police districts, with the Lower Mainland District reporting a slightly lower percentage of mental health-related calls for service relative to the overall number of general occurrence calls for service (5.3 per cent with a range of 5.0 per cent to 5.6 per cent), and the Island District reporting the highest percentage (6.4 per cent with a range of 5.9 per cent to 6.8 per cent). In the North District, the average between 2018 and 2024 was 5.6% with a range of 4.6% to 6.0%, and the average in the Southeast District was 5.8% with a range of 5.4% to 6.2%.

When compared to the full sample of 'E' Division calls for service between 2018 and 2024, the 25 jurisdictions that were invited to participate in the research study were responsible for 56.7% of all files. However, they were responsible for nearly two-thirds (64.2 per cent) of all mental health-related files examined in this study. In other words, the jurisdictions that were invited to participate in the current study were slightly overrepresented in the proportion of mental health-related calls for service recorded throughout 'E' Division RCMP detachments.

When examining "E" Division as a whole, the number of mental health-related calls for service were fairly evenly divided over the year (see Figure 3). Given that there are fewer days of the month, it was not unexpected that there were fewer mental health occurrences in February. Of note, there was a higher proportion of mental health-related calls for service in July. When comparing these

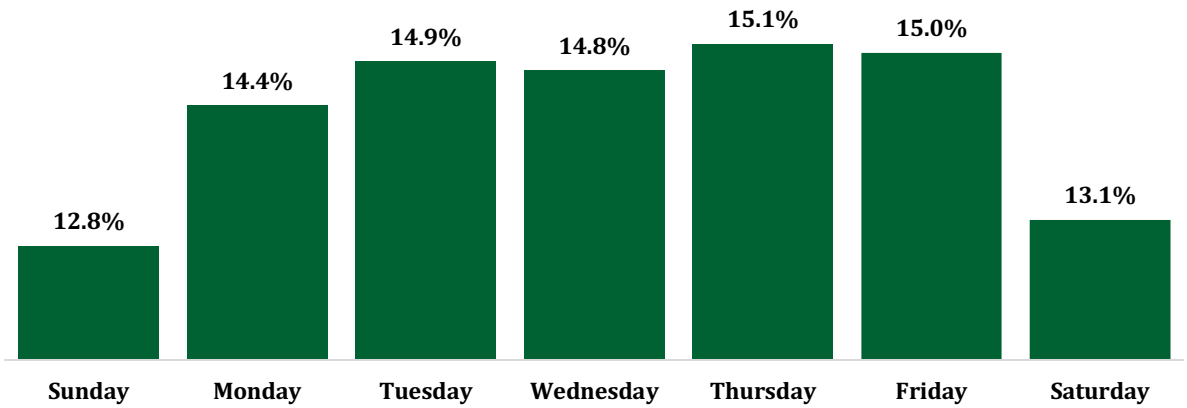
two months, there were 21.4% more mental health-related calls for service in July than in February. Overall, the months with the largest number of mental health-related calls for service were the summer months of May through August. Of note, this pattern was very consistent when examining each of the four police districts.

FIGURE 3: DISTRIBUTION OF MENTAL HEALTH-RELATED CALLS FOR SERVICE BY MONTH, 2018-2024 (N = 480,896)



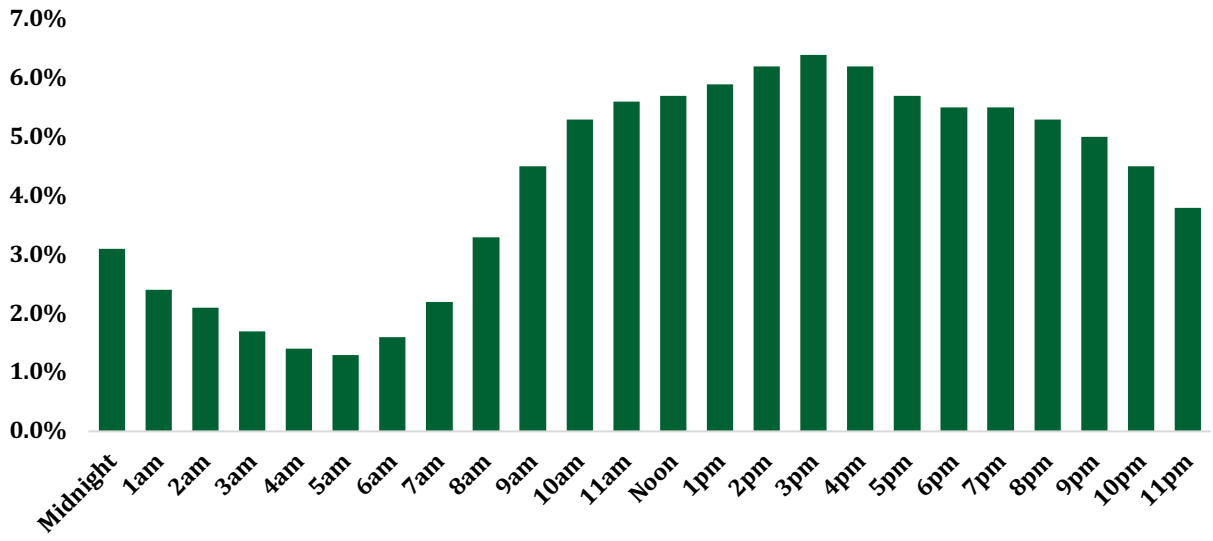
Call volumes where mental health was a factor were lowest on Sundays (12.8 per cent) and highest on Thursdays (15.1 per cent) and Fridays (15.0 per cent). Overall, as shown in Figure 4, calls for service involving mental health were more common during weekdays than on weekends.

FIGURE 4: DISTRIBUTION OF MENTAL HEALTH-RELATED CALLS FOR SERVICE BY DAY OF WEEK, 2018-2024 (N = 480,896)



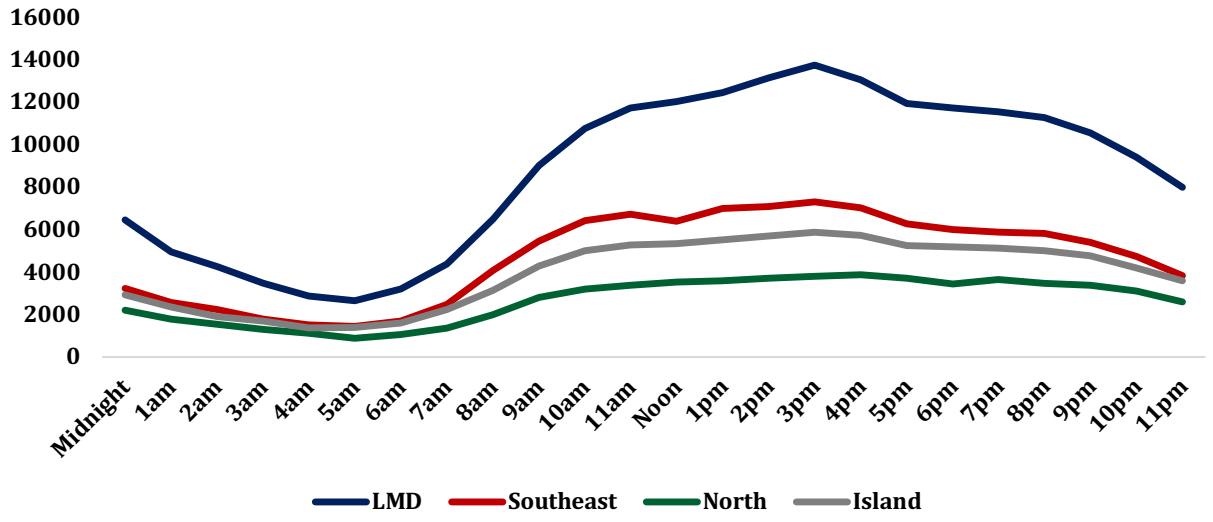
In terms of the distribution of mental health-related calls for service by time of day, while there were fewer calls for service between midnight and 08:00, calls for service began to increase around 09:00 and peaked between 14:00 and 17:00 before declining in the evening (see Figure 5). This is consistent with prior research in Canada. In their study of mental health-related calls to police in one police agency in Ontario, Shore and Lavoie (2018) found that 58% of calls occurred between 6am and 6pm.

FIGURE 5: TIME OF DAY FOR MENTAL HEALTH-RELATED CALLS FOR SERVICE, 2018-2024 (N = 480,896)



As shown in Figure 6, the same pattern was observed in all four police districts, though the overall pattern was more pronounced for the Lower Mainland district, which is most likely because this police district contributed the largest volume of mental health-related calls for service to the sample. Of note, the same general pattern was found in each police district for each year between 2018 and 2024.

FIGURE 6: TIME OF DAY OF MENTAL HEALTH-RELATED CALLS FOR SERVICE BY POLICE DISTRICT, 2018-2024 (N = 480,896)



Most commonly, mental health-related calls for service files occurred in some form of housing (54.3 per cent). Of the 480,879 files, over one-third (37.3 per cent) occurred in a single home, townhouse, or duplex while another 17.0% occurred in a residential dwelling unit, such as an apartment, condo, rooming house, or dorm. Again, this is consistent with the research by Shore and Lavoie (2018) where the majority (60 per cent) of mental health-related calls to police came from a residence. Another 13.4% of mental health-related calls for service occurred outside on the street, road, or highway and another 6.3% occurred in hospitals. All other location types composed less than 4% of the data each; however, together, they constituted the remaining 26% of all mental health-related calls for service. As displayed in Table 2, there were some statistically significant differences in the location of mental health-related calls for service by policing district.[8] Compared to the other three police districts, the Lower Mainland District was significantly more likely to receive mental health-related calls for service in residential dwelling units, and significantly less likely to receive mental health-related calls for service in single homes, townhouses, or duplexes. The Lower Mainland district was also significantly more likely than the North or Island Districts to receive mental health-related calls for service that involved an 'other' type of location. The Southeast District was significantly more likely than the Lower Mainland or North Districts to receive mental health-related calls for service that occurred on a road and were significantly more likely than all other districts to receive mental health-related calls for service that occurred in an 'other' location. The North District was significantly more likely than all other police districts to receive mental health-related calls for service that occurred in single homes, townhouses, or duplexes, or that occurred in hospitals, and were significantly less likely than all other police districts to receive mental health-related calls for service in residential dwelling units, such as condos or apartments, or that occurred

[8] x^2 (12) = 5,146.38, p < .001

on the road. The Island District was significantly less likely than all other districts to receive mental health-related calls for service that occurred in hospitals.

TABLE 2: INITIAL VERSUS FINAL DISPATCH FILE TYPES (N = 480,896)

	LMD	Southeast	North	Island
Single home, townhouse, duplex	34.8%	36.8%	41.7%	40.4%
Residential dwelling unit (e.g., apartment, condo)	20.2%	14.8%	12.2%	15.9%
Road (street, road, highway)	13.0%	14.2%	12.5%	14.1%
Hospital	5.8%	6.8%	9.2%	4.8%
Other	26.3%	27.4%	24.4%	24.8%

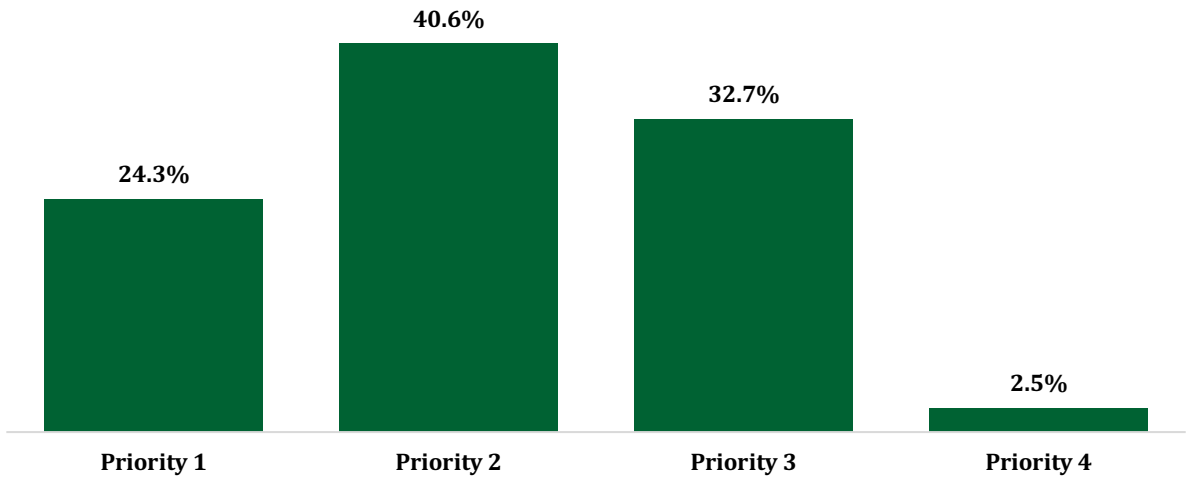
When calls for service are received by dispatch, an initial file type is assigned. For mental health-related calls for service between 2018 and 2024, the most common file type initially assigned by dispatch was a suicidal person (23.8 per cent) followed by a check wellbeing file (18.7 per cent). Generally, these file type assignments remained the same, although there were some changes (see Table 3). For example, 6.5% of the final file types assigned by dispatch were for the *Mental Health Act* (n = 31,304), which was only the initial file type assigned to 63 files. In other words, some mental health-related calls for service were substantially more likely to be scored as *Mental Health Act* after a police officer arrived on scene. Prior to this, *Mental Health Act* files were primarily scored initially as suicidal persons (31.9 per cent) or check wellbeing (15.3 per cent) files.

TABLE 3: INITIAL VERSUS FINAL DISPATCH FILE TYPES (N = 480,896)

	Dispatch Initial File Type	Dispatch Final File Type
Suicidal Person	23.8%	20.7%
Check Wellbeing	18.7%	18.2%
Disturbance	7.9%	7.3%
Assist Police, Fire, or Ambulance	7.3%	6.8%
Assist Mental Health	5.1%	4.6%
Assist General Public	4.5%	5.1%
Missing Person	4.0%	3.9%
Assist Other Agency	3.0%	2.8%
Suspicious Circumstances	2.9%	2.8%
Domestic in Progress	2.4%	1.9%
Unwanted Person	2.4%	2.3%
Abandoned 911	2.3%	2.1%
Threats	2.0%	1.8%
Other	13.7%	19.7%

When police officers are dispatched to a call for service, a priority code is assigned to indicate the urgency of the response. Priority 1 files are the most urgent where there is an imminent threat to life. Up to 9 different priority levels were recorded on the mental health-related calls for service; however, as less than 1% of these involved Priority 5 to Priority 9, these calls for service were not included in the analyses presented below. As shown in Figure 7, 40.6% of mental health-related calls for service were dispatched as Priority 2, which are considered emergency calls where there may be a serious injury or major property damage, and approximately another one-third (32.7 per cent) were dispatched as Priority 3, where there may be a crime in progress but it is not considered to be a major threat. Just under one-quarter (24.3 per cent) of mental health-related calls for service were considered Priority 1. Finally, very few (2.5 per cent) mental health-related calls for service were dispatched as Priority 4, which include non-urgent/possible apprehension files. Overall, nearly two-thirds (64.9 per cent) of the mental health-related calls for service that "E" Division RCMP responded to between 2018 and 2024 were considered Priority 1 or Priority 2 calls for service, which involve an immediate lights and siren emergency response.

FIGURE 7: PRIORITY DISPATCH FOR MENTAL HEALTH-RELATED CALLS FOR SERVICE, 2018 – 2024 (N = 480,440)



Between 2018 and 2024 there was a slight, but significant, shift in priority assignments for mental health-related calls for service (see Table 4).[9] There was a small reduction in the proportion of mental health-related calls for service assigned either Priority 1 (-4.8 per cent) or Priority 2 (-6.9 per cent), while the proportion of files assigned Priority 3 (+11.3 per cent) or Priority 4 (20.0 per cent) increased. As discussed below, this shift may have to do with changing call types as there was a reduction in violent offences and provincial statute files between 2018 and 2024 and an increase in other occurrences.

[9] x^2 (18) = 471.45, p < .001

TABLE 4: PRIORITY ASSIGNMENTS FOR MENTAL HEALTH-RELATED CALLS FOR SERVICE, 2018-2024 (N = 480,440)

	Priority 1	Priority 2	Priority 3	Priority 4
2018	25.2%	42.0%	30.9%	2.0%
2019	25.0%	40.8%	32.0%	2.2%
2020	23.9%	40.1%	33.3%	2.6%
2021	24.6%	40.7%	32.1%	2.7%
2022	24.2%	40.6%	32.5%	2.8%
2023	23.0%	41.1%	33.3%	2.7%
2024	24.0%	39.1%	34.4%	2.4%
Change between 2018-2024	-4.8%	-6.9%	+11.3%	+20.0%

There were also significant associations between the priority assignment to mental health-related calls for service and police district.[10] A significantly larger percentage of mental health-related calls for service in the North District were assigned Priority 1 status (33.5 per cent) compared to any other policing district, while a significantly smaller percentage of mental health-related calls for service files in the Lower Mainland District were assigned Priority 1 status (18.7 per cent) compared to the other districts (see Table 5). In contrast, a significantly larger percentage of mental health-related calls for service files in the Lower Mainland district (50.7 per cent) were assigned Priority 2 status compared to the other police districts, while the North District had significantly less Priority 2 mental health-related calls for service (25.6 per cent) than any of the other three police districts. A significantly larger percentage of mental health occurrence files in the Island district received a Priority 4 designation (5.0 per cent) as compared to all other policing districts.

TABLE 5: PRIORITY ASSIGNMENTS FOR MENTAL HEALTH-RELATED CALLS FOR SERVICE BY POLICING DISTRICT, 2018 - 2024 (N = 480,440)

	Lower Mainland District	Southeast District	North District	Island District
Priority 1	18.7%	27.3%	33.5%	26.7%
Priority 2	50.7%	36.0%	25.6%	34.1%
Priority 3	28.6%	35.0%	39.3%	34.3%
Priority 4	2.1%	1.7%	1.6%	5.0%

When considering only the Priority 1 through Priority 4 files, between 0 and 90 members were recorded as having been dispatched to the file. To address outliers or data entry errors, mental

[10] x^2 (9) = 21,057, p < .001

health-related calls for service with 0 assigned members or 16 or more assigned members were removed from the analysis. Based on the remaining 457,258 files, on average, 2.4 members (SD = 1.6) were dispatched to the scene. Most commonly, mental health-related calls for service had two members dispatched to the call (36.3 per cent), while one member was dispatched more than one-quarter of the time (30.1 per cent). Three members were dispatched 17.6% of the time, and less than 1% of the mental health-related calls for service had nine or more members dispatched to the file. Significantly more members were dispatched, on average, to mental health-related files involving traffic (*M* = 2.9), violent (*M* = 2.5), drugs (*M* = 2.6), federal statute (*M* = 2.5), or provincial statute (*M* = 2.5) calls for service than were to property-related calls for service (*M* = 2.1) or other occurrences (*M* = 2.1).[11] Overall, significantly more members were dispatched to traffic offences than to any other file type. There was a statistically significant negative correlation between the priority assignment and the number of members dispatched, meaning that significantly more members were dispatched when the file was considered of a higher priority.[12]

A series of analyses were conducted on the response time to calls for service. Response time is the difference between when the call for service was received by dispatch and when the primary police officer arrived on scene. Of note, data was missing for 53,968 of the calls for service, and another eight cases had a negative response time and were eliminated from the analysis. For the remaining 426,920 cases (88.8 per cent of the data), the response time ranged from 0 seconds to 539.2 days. Presuming that some of the longer response times were errors and given that 99% of all files were responded to in less than four hours, any file with a response time longer than four hours was removed from the analysis (n = 4,636 or 1.1% of the 426,920 files).

When considering the 422,284 files that were responded to within four hours the average response time was 23.6 minutes (SD = 21.2). As expected, there was a statistically significant difference in the response time based on the priority level assigned to the call for service. Priority 1 calls for service had the fastest average response time of 14.5 minutes (SD = 17.5) compared to 20.5 minutes for Priority 2 calls for service (SD = 25.1). Interestingly, Priority 4 files had a slightly faster response time (*X* = 35.1, SD = 48.3) than Priority 3 calls for service (*X* = 36.1, SD = 42.4); however, this difference was not statistically significant, whereas all other response times did significantly differ from each other.[13]

When considering response times in minutes to mental health-related calls for service by police district, response times were significantly faster in the North district (*M* = 21.7, SD = 28.4) than both the Lower Mainland (*M* = 24.2, SD = 33.5) and the Southeast District (*M* = 24.9, SD = 31.0). The

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[11] F_{Welch} (7, 5,352.2) = 1,089.6, p < .001. While statistically significant, this was considered a weak effect, eta-squared = .015.

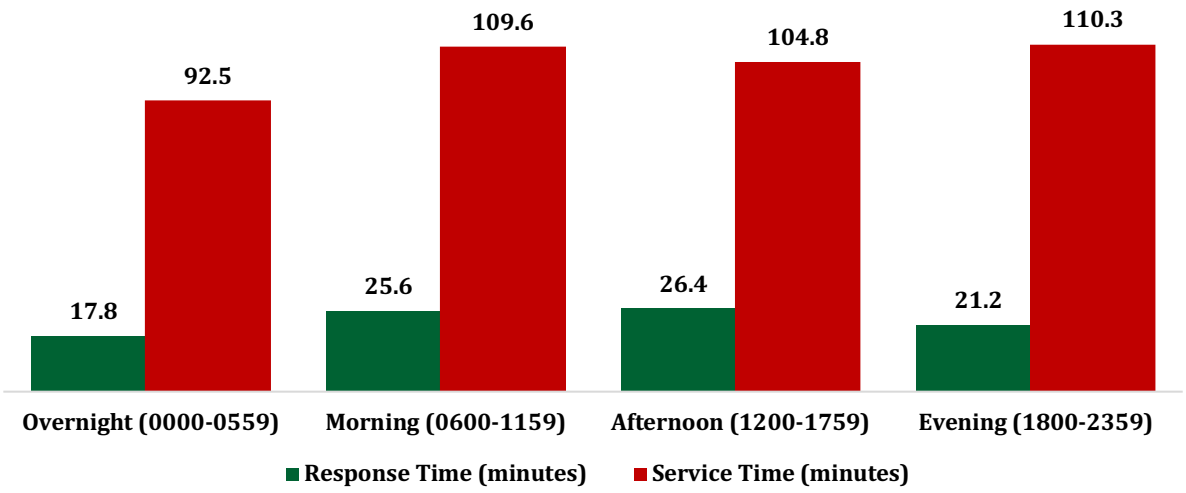
[12] *r* (457,256) = -.283, p < .001. This is considered a negative relationship due to the scoring of Priorities, where a lower number indicates a higher priority file. This relationship was of moderate strength with an *r* of .283.

[13] Due to small sample sizes for priority levels 5 through 9 (n = 36), this analysis focused on the 422,248 Priority 1 through Priority 4 files. F_{Welch} (3, 25,176.29) = 9,449.09, p < .001

response times for the Island District (M = 21.9, SD = 27.3) to mental health-related calls for service were also significantly faster than the Lower Mainland District and the Southeast District.[14]

There was also a statistically significant difference in response time in minutes when considering the time of day for mental health-related calls for service.[15] Response times were significantly faster for mental health-related calls for service reported overnight compared to any other time of day (see Figure 8). Service time, which refers to the number of minutes between the time when the primary police officer was dispatched to the mental health-related call for service and when that call for service was recorded as being cleared, also differed significantly according to the time of day, with police officers spending significantly less time at the scene for files originating overnight compared to files at any other time of day (see Figure 8).[16] Police officers spent the longest period of time on files that occurred in the evening or morning.

FIGURE 8: RESPONSE (N = 422,284) AND SERVICE TIME IN MINUTES (N = 416,881) FOR MENTAL HEALTH-RELATED CALLS FOR SERVICE BY TIME OF DAY, 2018 – 2024



In considering the data presented in Figure 8, 53,969 calls for service (11.2 per cent) had a "null" value and were considered missing, and five calls for service had data that indicated a negative amount of time spent as service and were also excluded from the analysis. Any file with service time less than 30 seconds (0.8 per cent) was also excluded from the analysis. Finally, 6,655 mental health-related calls for service (1.4 per cent of the data) had a service time lasting more than a typical 12-hour shift and so were also removed from the analysis. With these caveats in mind, when considering the remaining 416,881 calls for service (86.7 per cent of the full dataset), the average

[14] F_{Welch} (3, 174,345.91) = 251.33, p < .001

[15] F_{Welch} (3, 187,123.41) = 1636.48, p < .001

[16] F_{Welch} (3, 179,658.0) = 541.6, p < .001

number of minutes that police officers spent on the call between dispatch and clearing the scene was 106.0 (SD = 96.4), or a little under two hours (1.8 hours).

There were statistically significant variations in the service time based on the priority level assigned to the call for service.[17] As with the response time data, the service time differed as expected, with significantly more time spent on Priority 1 (*M* = 2.0 hours, SD = 1.6 hours) files, followed by Priority 2 (*M* = 1.8 hours, SD = 1.6 hours). On average, officers spent approximately 1.5 hours on Priority 3 (SD = 1.5) and Priority 4 (SD = 1.7) files.

There was a statistically significant difference when comparing police districts' service time. Police officers in the Lower Mainland District spent significantly and substantially more service time, on average, on mental health-related files as measured in hours (*M* = 2.1, SD = 1.7). This amount of time was followed by police officers in the North District (*M* = 1.6, SD = 1.6), then by police officers in the Southeast District (*M* = 1.5, SD = 1.4), and those in the Island District (*M* = 1.4, SD = 1.4).[18] Other than a decline in service time during the initial stages of the COVID-19 pandemic when police officers spent an average of 102.9 minutes (SD = 92.1) or 1.71 hours per file, service time has generally increased year over year. In 2018, police officers spent, on average, 104.2 minutes (SD = 96.0) or 1.73 hours per mental health-related call for service. As of 2024, they spent, on average, 108.4 minutes (SD = 99.6) or 1.81 hours per file. In other words, police officers, on average, spent approximately four minutes longer per mental health-related call for service in 2024 compared to 2018.

MENTAL HEALTH-RELATED CALL FOR SERVICE TYPES AND OUTCOMES

Mental health-related calls for service types were examined based on the assigned Uniform Crime Report (UCR) code originally assigned to the file. Up to four UCR codes were assigned to a file. The first UCR code is the primary code that indicates the most serious violation reported. For example, if both a mischief offence and an assault occurred during the same incident, the violent offence would take precedence. The UCR codes were organized into UCR types based on the most serious violation recorded as part of the file. As shown in Table 6, over one-half (55.7 per cent) of the nearly 500,000 mental health-related calls for service were related to provincial statutes. Of the 268,009 provincial statute, 96.5% were provincial legislation incidents under the provincial *Mental Health Act*. As will be discussed below, it is important to note that slightly more than two-thirds (68.0 per cent) of the provincial statute files were information files where there was no investigative action taken; rather, information was simply documented. Another 17.6% of the provincial statute-related files were assistance files in which the police officer assisted another agency, and 11.3% were recorded as 'unsubstantiated', which is a clearance code used only prior to 2019. In other words, most police calls for service related to mental health were not for criminal offences.

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[17] As above, the small number of Priority 5 through Priority 9 files were excluded from this analysis. Based on the remaining 416,838 files, there was a statistically significant relationship, F_{Welch} (3, 25,377.6) = 2,474.8, p < .001

[18] F_{Welch} (3, 170,267.2) = 6,177.6, p < .001

TABLE 6: UCR FILE TYPES FOR MENTAL HEALTH OCCURRENCES, 2018-2024 (N = 480,896)

	n	
Provincial Statutes	268,009	55.7%
Other Occurrences	124,940	26.0%
Violent Crimes Against Persons	36,349	7.6%
Other *Criminal Code* Offences	28,259	5.9%
Property Crime Offences	20,403	4.2%
CDSA/CA Offences	1,365	0.3%
Traffic Offences	953	0.2%
Federal Statute Offences	618	0.1%

This was further evidenced by the remaining distribution of the most serious UCR code attached to the file, where the next most common category assigned was "other" occurrences (26.0 per cent). Most commonly, this classification was used to refer to a range of non-criminal events, such as a check wellbeing (37.0 per cent), providing unspecified assistance (19.1 per cent), a missing person (11.4 per cent), a suspicious person, vehicle, or occurrence (10.6 per cent), or a breach of the peace (7.8 per cent). For violent offences, 28.3% of these 36,349 files were classified as common assaults, while 21.5% were for uttering threats. Another 15% were scored as an assault file but flagged with a ZZZ code, which indicates that the police officer was either recording information, providing assistance, or taking action to prevent an offence. With respect to other *Criminal Code* offences, two-thirds (66 per cent) were for causing a disturbance. An additional 5.4% of the calls for service were for breaching conditions or bail violations. When it came to the 20,403 property offences, over one-half (51.9 per cent) involved mischief-related offences. The next most common property offences were theft under $5,000 (11.7 per cent) followed by a break and enter into a residence (11.0 per cent). There were 1,365 drug-related offences (0.3 per cent), and slightly more than one-quarter (26.7 per cent) of these calls for service were for possession of methamphetamine, followed by possession of cocaine (12.4 per cent), and possession of fentanyl or fentanyl analogs (10.1 per cent). Of the 953 traffic offences, nearly one-half (45.6 per cent) were for driving while impaired by alcohol, followed by driving while impaired by drugs (10.6 per cent). Of the 618 federal statute offences, slightly more than one-quarter (26.9 per cent) were non-*Criminal Code*/provincial legislation incidents under the *Firearms Act* and 17.5% were criminal offences under the *Firearms Act*.

There were statistically significant differences when comparing the UCR file types between the four police districts.[19] While most mental health-related calls for service in all four police districts were coded as provincial statute files, all four districts experienced a significantly different proportion of their files that were coded this way (see Table 7). Compared to the others, the Lower Mainland District (54.1 per cent) experienced a slightly lower proportion of provincial statute-based mental

[19] x^2 (21) = 4,028.30, p < .001

health-related calls for service, while the North District (58.6 per cent) experienced a slightly larger proportion than the other districts. Similarly, the Lower Mainland District (2.8 per cent) experienced a statistically significantly lower proportion of property-related mental health-related calls for service compared to the other three police districts (5.8 per cent in the Southeast District and 5.1 per cent the North District and Island District). Compared to the other three districts, the Southeast District experienced a significantly though only slightly larger proportion of violence against persons and property crime-related mental health calls for service compared to the Lower Mainland District, the North District, and the Island District (see Table 7).

TABLE 7: MENTAL HEALTH OCCURRENCES BY POLICE DISTRICT, 2018 – 2024 (N = 480.896)

	Lower Mainland District	Southeast District	North District	Island District
Provincial Statutes	54.1%	56.2%	58.6%	56.8%
Other Occurrences	28.8%	22.9%	23.1%	25.3%
Violent Crimes versus Persons	7.5%	8.5%	7.8%	6.6%
Other *Criminal Code* Offences	6.2%	6.1%	4.9%	5.5%
Property Crime Offences	2.8%	5.8%	5.1%	5.1%
CDSA/CA Offences	0.3%	0.3%	0.2%	0.3%
Traffic Offences	0.2%	0.2%	0.2%	0.3%
Federal Statute Offences	0.1%	0.1%	0.1%	0.2%

There were also statistically significant differences based on year. Over time, a significantly smaller proportion of mental health-related calls for service involved provincial statutes, while the proportion of files involving "other" occurrences more than doubled (see Table 8).[20] Between 2018 and 2024, the percent of mental health-related calls for service that involved provincial statutes, which were mainly *Mental Health Act* incidents, dropped by 25%, whereas the percent that involved "other" occurrences, which were mainly incidents like check wellbeing or unspecified assistance, increased by 133.1%. The percent of mental health occurrences involving violent offences also decreased significantly (-16.3 per cent) between 2018 and 2024.

[20] x^2 (42) = 10,953, p < .001

TABLE 8: MENTAL HEALTH-RELATED CALLS FOR SERVICE TYPES BY YEAR, 2018 – 2024 (N = 480,896)

	2018	2019	2020	2021	2022	2023	2024
Provincial Statutes	64.4%	62.4%	57.6%	55.7%	52.6%	50.3%	48.3%
Other Occurrences	14.8%	19.1%	24.1%	26.9%	29.6%	31.6%	34.5%
Violent Crimes versus Persons	8.6%	7.8%	7.5%	7.1%	7.3%	7.5%	7.2%
Other *Criminal Code* Offences	6.5%	5.9%	6.0%	5.6%	5.8%	5.9%	5.5%
Property Crime Offences	4.7%	4.2%	4.1%	4.1%	4.2%	4.3%	4.2%
CDSA/CA Offences	0.7%	0.3%	0.4%	0.2%	0.2%	0.1%	0.1%
Traffic Offences	0.3%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
Federal Statute Offences	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%

Focusing only on Priority 1 through Priority 4 calls, there were some interesting patterns when it came to priority dispatching of mental health-related calls for service and the type of file that the mental health call for service was scored as (see Table 9).[21] Over two-thirds (72.1 per cent) of provincial statute files were dispatched as Priority 1 or 2, whereas nearly one-half of all files (45.9 per cent) involving a reported violent crime were dispatched as a Priority 3 call for service. Of note, nearly one-half of property crime offences (45.7 per cent) and federal statute offences (44.0 per cent) were also coded as Priority 3 calls for service.

TABLE 9: MENTAL HEALTH-RELATED CALLS FOR SERVICE PRIORITY DISPATCH BY UCR TYPE, 2018 – 2024, (N = 480,440)

	Priority 1	Priority 2	Priority 3	Priority 4
Provincial Statutes	34.1%	38.2%	25.7%	2.1%
Violent Crimes versus Persons	17.7%	34.6%	45.9%	1.8%
Federal Statute Offences	14.8%	29.1%	44.0%	12.2%
CDSA/CA Offences	13.0%	41.2%	32.9%	12.8%
Traffic Offences	12.8%	57.2%	22.1%	7.9%
Other Occurrences	11.1%	47.0%	39.9%	2.0%
Other *Criminal Code* Offences	10.7%	45.8%	40.5%	3.0%
Property Crime Offences	7.7%	36.4%	45.7%	10.2%

There was a statistically significant relationship between the file type and service time spent on the file. On average, police officers spent the most time on mental health-related calls for service that were coded as a traffic offence (M = 2.5 hours, SD = 1.9), followed by provincial statute (M = 2.0, SD = 1.6) and federal statute files (M = 2.0, SD = 1.8), violent crime files (X = 1.9 hours, SD = 1.7), and

[21] x^2 (21) = 43,059.97, p < .001

drug-related files (*M* = 1.9 hours, SD = 1.6).[22] Comparatively speaking, police officers spent less time with property crimes (*M* = 1.4 hours, SD = 1.5), other *Criminal Code* offences (*M* = 1.4 hours, SD = 1.4), and other occurrences (*M* = 1.3 hours, SD = 1.5).

When considering all the mental health-related calls for service in the database, over one-third (38.1 per cent) were cleared as 'information only' files, while more than one-fifth (22.8 per cent) were cleared as 'CCJS non-reportable', which is an internal RCMP code or municipal bylaw code used to indicate that the file is not reportable to Statistics Canada as part of the standard reporting of UCR data (see Table 10). This might include bylaw violations, a breach of the peace, or reports of a suspicious person, vehicle or occurrence.[23] Another one-in-ten files were coded as 'assistance', which is commonly used when the police are called to assist another agency, such as another policy agency or Emergency Health Services. It is important to note that a coding change occurred after 2018 that affected these patterns. Starting January 2019, the RCMP were no longer able to use the clearance status of 'unsubstantiated' or 'founded not cleared'. Mental health-related calls for service that were documented as unsubstantiated made up more than one-half (53.1 per cent) of all mental health-related calls for service in 2018. However, there were 0 unsubstantiated mental health-related calls for service between 2019 and 2024. Instead, there was an increase of 1,907.7% in the use of CCJS non-reportable, and an increase of 764% in the use of information as clearance codes for mental health-related calls for service. Importantly, 'information' can only be used as a clearance code for provincial statute files while 'CCJS non-reportable' can only be used with the 8000 (internal codes or bylaws) series.

TABLE 10: CLEARANCE STATUS OF MENTAL HEALTH-RELATED CALLS FOR SERVICE, 2018 - 2024 (N = 480,896)

	Overall % (n = 480,896)	% in 2018 (n = 63,795)	% in 2019-2024 (n = 417,101)
Information Only	38.1%	5.0%	43.2%
CCJS Non-Reportable	22.8%	1.3%	26.1%
Assistance	11.3%	10.7%	11.3%
Unsubstantiated	7.0%	53.1%	0
Insufficient Evidence	6.1%	0.8%	6.9%
Departmental Discretion	4.2%	4.5%	4.1%
Other	14.7%	24.6%	8.4%

Again, the most common UCR type and code in the sample was for non-criminal *Mental Health Act* files. When considering the clearance status, more than two-thirds (69.6 per cent) of the non-criminal *Mental Health Act* files were 'information only' files, while another 17.7% were 'assistance'

[22] F_{Welch} (7, 4,817.8) = 2,506.4, p < .001

[23] https://gsg.uottawa.ca/data/rtra/rdc_users_nanual_final_2013_feb_7rvd.pdf

files. An additional 11.6% of these files were unsubstantiated files or where there was insufficient evidence that a crime had occurred. The remaining clearance outcomes each made up less than 1% of the files.

The CCJS status variable displayed in Table 10 above was recoded into seven groups for further analysis. These groups were information only, CCJS non-reportable, assistance, the previously unsubstantiated clearance type, insufficient evidence to proceed, departmental discretion, and other file clearance outcomes and then compared by police district, year of file occurrence, and UCR type. When comparing the CCJS status by police district, there were some statistically significant patterns.[24] For example, while the proportional differences were somewhat small, there was a significantly lower percentage of information files (35.1 per cent) and non-reportable CCJS file (20.7 per cent) outcomes in the Southeast District compared to the other districts, whereas the Southeast District reported a statistically significantly larger percentage of assistance file (13.7 per cent) outcomes. Compared to the other police districts, the Lower Mainland District reported a significantly larger percentage of CCJS non-reportable file (24.4 per cent) outcomes. The Island District reported a significantly larger percentage of mental health-related calls for service that were cleared by Departmental Discretion (6.0 per cent) compared to the other police districts (see Table 11).

TABLE 11: MENTAL HEALTH-RELATED CALLS FOR SERVICE FILE CLEARANCE OUTCOMES BY POLICE DISTRICT, 2018 – 2024 (N = 480,896)

	Lower Mainland District	Southeast District	North District	Island District
Information Only	38.2%	35.1%	40.4%	39.9%
CCJS Non-Reportable	24.4%	20.7%	21.4%	22.6%
Assistance	10.6%	13.7%	10.7%	10.3%
Unsubstantiated	6.9%	7.2%	6.5%	7.6%
Insufficient Evidence	6.5%	6.4%	5.8%	5.0%
Departmental Discretion	2.6%	5.7%	4.0%	6.0%
Other	10.8%	11.3%	11.3%	8.6%

Different file outcomes may be due to the different file types. There was a statistically significant pattern when comparing the CCJS outcomes based on the UCR type (see Table 12).[25] Compared to all other UCR types, provincial statute occurrences (68.0 per cent) were the most likely to be concluded as an information file, followed by federal statute (25.4 per cent) occurrences. Other occurrences (87.2 per cent) were most likely to be recorded as CCJS non-reportable occurrences.

[24] x^2 (18) = 5,155.55, p < .001

[25] x^2 (42) = 810,705.37, p <. 001

Violent crimes (57.2 per cent) were most likely to result in an "other" outcome. Similarly, property crime (40.7 per cent) and traffic crime offences (43.7 per cent) were more likely than many other file types to result in being concluded in an "other way". Other *Criminal Code* offences (41.4 per cent) were more likely than any other UCR type to be concluded as having insufficient evidence to proceed.

TABLE 12: MENTAL HEALTH-RELATED CALLS FOR SERVICE FILE OUTCOMES BY FILE TYPE, 2018 – 2024 (N = 480,896)

	Provincial Statutes	Other Occurrences	Violent Crimes	Other CC Offences	Property Crimes	CDSA / CA	Traffic	Federal Statute
Information Only	68.0%	0.3%	0.8%	0.4%	0.6%	1.3%	0.2%	25.4%
CCJS Non-Reportable	0.2%	87.2%	0.0%	0.1%	0.0%	0.0%	0.3%	0.2%
Assistance	17.6%	3.8%	3.4%	1.9%	1.2%	2.0%	4.6%	25.1%
Unsubstantiated	11.3%	0.1%	4.6%	2.5%	4.0%	7.6%	4.2%	2.3%
Insufficient Evidence	0.5%	0.3%	24.1%	41.4%	31.6%	23.4%	13.6%	12.3%
Departmental Discretion	0.8%	0.3%	9.9%	29.7%	21.9%	46.1%	33.4%	7.6%
Other	1.5%	8.1%	57.2%	24.0%	40.7%	19.6%	43.7%	27.2%

As described above, after 2018, RCMP members were no longer permitted to use the clearance code pertaining to 'unsubstantiated' or 'unfounded'; therefore, the year-by-year table below does not include the data for 2018 (this data is available above in Table 12). There were some patterns of interest in the use of different file outcomes between 2019 and 2024, which were also statistically significant.[26] In particular, although the use of 'information' as a clearance code increased substantially in 2019 compared to 2018, between 2019 and 2024, the use of this file clearance code dropped by 26% (see Table 13). In contrast the use of 'CCJS non-reportable' as a file outcome increased by 83% between 2019 and 2024. These patterns are consistent with the changes noted above in the types of mental health occurrences that RCMP in British Columbia were dealing with between 2019 and 2024, where there was a decrease in the percent of provincial statute files, which generally end in an information clearance, and an increase in the 'other' occurrences, which were primarily the files that are 'non-reportable' to Statistics Canada.

[26] x^2 (30) = 6,168.61, p < .001

TABLE 13: FILE CLEARANCE CODES 2019-2024, (N = 417,101)

	2019	2020	2021	2022	2023	2024
Information Only	50.7%	46.8%	44.8%	40.5%	39.3%	37.2%
CCJS Non-Reportable	17.7%	22.6%	25.4%	27.9%	30.0%	32.4%
Assistance	11.3%	10.9%	10.9%	12.4%	11.4%	11.3%
Unsubstantiated	0	0	0	0	0	0
Insufficient Evidence	6.3%	6.8%	6.5%	7.1%	7.6%	7.1%
Departmental Discretion	4.7%	4.3%	4.2%	4.0%	3.9%	3.6%
Other	9.3%	8.7%	8.1%	8.2%	7.9%	8.5%

MENTAL HEALTH ACT APPREHENSIONS

One-quarter (25.6 per cent) of all mental health-related calls for service resulted in an apprehension under the provincial *Mental Health Act* (see Table 14). This was much lower than the prior research by Shore and Lavoie (2018) where 55% of all mental health-related calls for service to one police agency in Ontario resulted in an apprehension, although only one-half of those files resulted in an admission to hospital. In the current study, nearly all (99.7 per cent) of these files were recorded as a non-criminal offence under the *Mental Health Act*, and they were primarily cleared as 'information' files (68.8 per cent), with nearly one-fifth (18.9 per cent) recorded as an 'assistance' file. The proportion of mental health occurrences resulting in an apprehension under the *Mental Health Act* changed significantly between 2018 and 2024. For example, a significantly larger percentage of mental health occurrences resulted in a *Mental Health Act* apprehension between 2019 through 2023 compared to 2018 and to 2024. There were also statistically significantly fewer *Mental Health Act* apprehensions in 2018 compared to 2024.[27]

TABLE 14: PROPORTION OF MENTAL HEALTH-RELATED CALLS FOR SERVICE RESULTING IN A *MENTAL HEALTH ACT* APPREHENSION, 2018-2024 (N = 480,896)

2018	23.8%
2019	26.0%
2020	26.0%
2021	26.3%
2022	26.3%
2023	25.9%
2024	25.1%
Average	*25.6%*

[27] x^2 (6) = 165.68, p < .001

When comparing the four police districts, police detachments in the Lower Mainland District were statistically significantly more likely than those in the other police districts to use a mental health apprehension in mental health-related calls for service occurrences.[28] Overall, one-third (33.3 per cent) of the mental health-related calls for service between 2018 and 2024 in the Lower Mainland District resulted in a mental health apprehension under the *Mental Health Act* compared to slightly more than one-fifth (21.3 per cent and 21.7 per cent) of files in the Island and North Districts, and 17% of files in the Southeast District (see Table 15. Based on the police data alone, it is unclear why this pattern occurred. However, when comparing the proportion of mental health-related calls for service resulting in a *Mental Health Act* apprehension between 2018 and 2024, the Lower Mainland District saw a reduction of 1.9% over this seven-year period, whereas the other three districts saw increases. The largest increase in the proportion of files resulting in a *Mental Health Act* apprehension was in the Southeast District (+29.1 per cent) followed by the Island District (+14.0 per cent) and the North District (+4.4 per cent). Of note, as discussed above, these three districts also experienced the largest increase in the mental health files between 2018 and 2024 (Island +15.5 per cent; North +13.8 per cent; Southeast +11.7 per cent) whereas the Lower Mainland District only experienced a 1.2% increase. It is possible that not only did the Southeast, Island, and North Districts experience increases in the amount of mental health-related calls for service but also an increase in the severity of the underlying mental health condition. However, the police data did not contain any additional information regarding the mental health characteristics of the individual involved in the file.

TABLE 15: PER CENT OF MENTAL HEALTH-RELATED CALLS FOR SERVICE RESULTING IN A *MENTAL HEALTH ACT* APPREHENSION BY YEAR (N = 480,896)

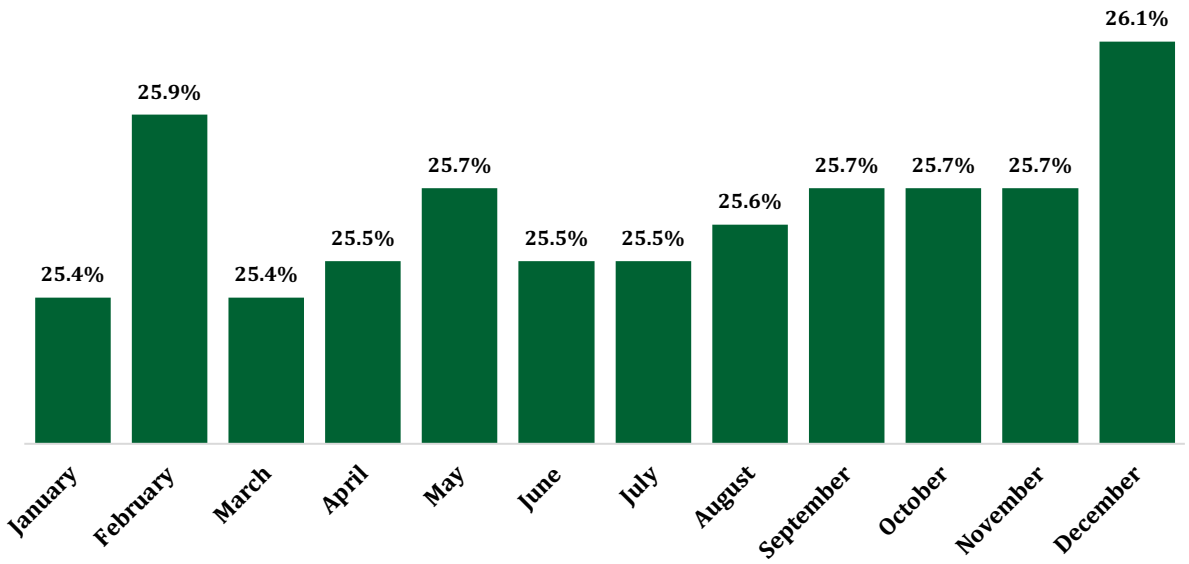
	Lower Mainland District	Island District	North District	Southeast District
2018	32.1%	18.7%	20.8%	14.2%
2019	34.3%	20.8%	22.2%	16.5%
2020	35.1%	20.8%	20.3%	16.8%
2021	35.2%	22.7%	20.2%	17.1%
2022	32.6%	25.3%	22.6%	17.3%
2023	31.8%	22.9%	24.5%	17.9%
2024	31.5%	21.3%	21.7%	18.4%
Average	***33.3%***	***21.8%***	***21.6%***	***16.9%***

There were no statistically significant differences when comparing the number of mental health-related calls for service resulting in a *Mental Health Act* apprehension by month of occurrence. Apprehensions ranged from 25.4% of all mental health-related calls for service in January and

[28] x^2 (3) = 12188.30, p < .001

March to 26.1% of mental health-related calls for service in December, which only represented a 0.7% difference from the lowest month to the highest one.[29]

FIGURE 9: PER CENT OF MENTAL HEALTH-RELATED CALLS FOR SERVICE RESULTING IN A MENTAL HEALTH ACT APPREHENSION BY MONTH (N = 480,896)

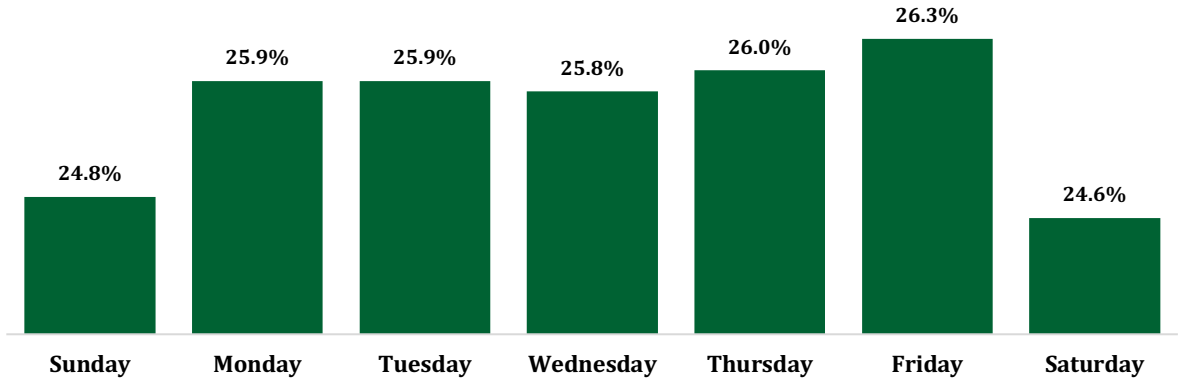


However, there were some statistically significant differences when considering the day of the week. While the differences were small, a significantly smaller proportion of mental health-related calls for service resulted in apprehension on the weekends, specifically Saturday and Sunday, compared to the rest of the days of the week (Figure 10).[30] While it is unclear whether co-response mental health teams where police and nurses partner together to respond to mental health-related calls for service reduce or increase the per cent of mental health-related files that result in a mental health apprehension, Cohen et al.'s (2025) report on co-response models operating in eight RCMP detachments in British Columbia found that co-response teams responded to more calls during weekdays than weekends, which may present some evidence indicating that mental health co-response teams are associated with more apprehensions under the *Mental Health Act*. However, an important caveat is that only approximately 16% of mental health-related calls for service involved a mental health co-response team. Thus, more research should be conducted on the effect of co-response teams on mental health apprehensions.

[29] x^2 (11) = 9.85, p > .05

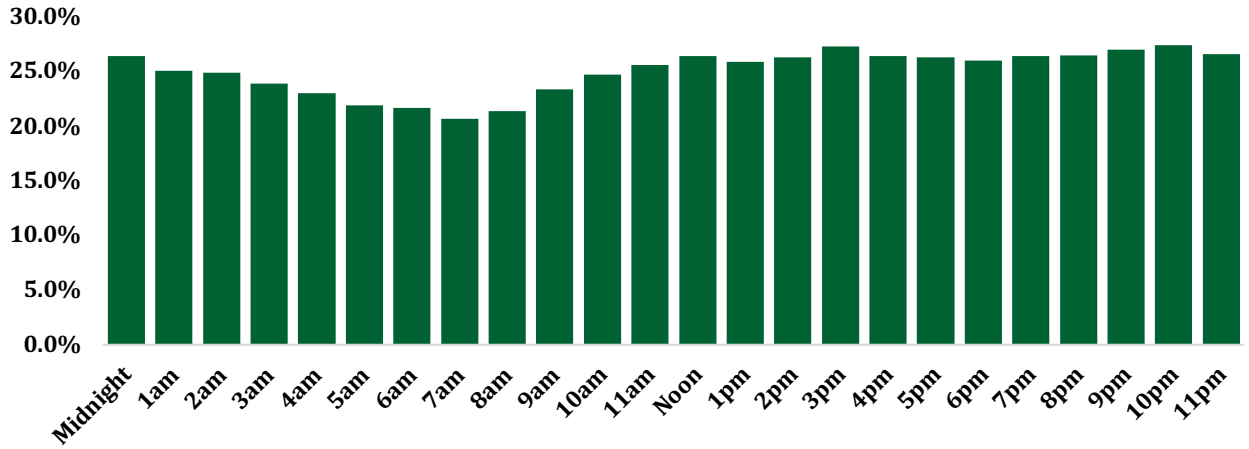
[30] x^2 (6) = 86.5, p < .001

FIGURE 10: PER CENT OF MENTAL HEALTH-RELATED CALLS FOR SERVICE RESULTING IN A MENTAL HEALTH APPREHENSION BY DAY OF THE WEEK (N = 480,896)



There were also statistically significant differences in mental health apprehensions according to the time of day when mental health-related calls for service were reported. Time of day was grouped into four blocks: overnight (occurrences reported between midnight and 05:59), morning (between 06:00 and 11:59), afternoon (between 12:00 and 17:59), and evening (between 18:00 and 23:59). Significantly more mental health-related calls for service resulted in *Mental Health Act* apprehensions during the afternoon (26.4 per cent) and evening (26.6 per cent) categories compared to the overnight (24.6 per cent) and morning (23.6 per cent) categories. However, as Figure 11 demonstrates, the pattern of apprehension does not reflect call volume. Instead, there was very little variation in the proportion of mental health-related calls for service that resulted in an apprehension based on the time that the call for service occurred. Instead, the proportion of apprehensions ranged from a low of 20.7% between 07:00 and 07:59 to a high of 27.4% between 22:00 and 22:59. Still, when viewed as a proportion of the overall mental health-related calls for service volume by time of day, apprehensions were least likely to occur overnight or in the early morning hours, and were more likely to occur during the daytime and evening.

FIGURE 3: PROPORTION OF MENTAL HEALTH-RELATED CALLS FOR SERVICE RESULTING IN A *MENTAL HEALTH ACT* APPREHENSION BY HOUR OF THE DAY, 2018 – 2024 (N = 480,896)



There was a statistically significant relationship between *Mental Health Act* apprehensions and UCR type.[31] A slight minority (41.2 per cent) of all Provincial Statute files resulted in a *Mental Health Act* apprehension, as did more than one-quarter (28.0 per cent) of drug-related offences, and nearly one-fifth (18.0 per cent) of traffic offences (see Table 16). By comparison, only approximately one-in-ten (10.8 per cent) violent offences against a person resulted in a *Mental Health Act* apprehension, while less than one-in-ten other *Criminal Code* (6.4 per cent), property offences (6.3 per cent), or other occurrences (4.1 per cent) did. Overall, when examining the Provincial Statute files involving the *Mental Health Act*, 42.6% of the non-criminal *Mental Health Act* occurrences resulted in the individual being apprehended. Interestingly, only 5.3% of criminal *Mental Health Act* occurrences (n = 1,589) resulted in an apprehension under the *Mental Health Act*.

TABLE 16: UCR TYPE FOR FILES RESULTING IN A *MENTAL HEALTH ACT* APPREHENSION, 2018 – 2024 (N = 480,896)

	% Mental Health Act Apprehension
Provincial Statutes	41.2%
CDSA/CA Offences	28.0%
Traffic Offences	18.0%
Violent Crimes against a Person	10.8%
Federal Statute Offences	9.2%
Other Criminal Code Offences	6.4%
Property Crime	6.3%
Other Occurrences	4.1%

There were two significant patterns with respect to mental health files that resulted in a *Mental Health Act* apprehension and the response time and time on scene. On average, mental health-related calls for service resulting in a *Mental Health Act* apprehension were responded to significantly faster, with an average of 21.7 minutes (SD = 30.0) compared to 24.3 minutes (SD = 31.6) for mental health-related calls for service that did not result in an apprehension.[32] As a lengthy wait at the hospital for a mental health assessment may be expected, police officers spent twice as much service time on mental health-related calls for service that resulted in a *Mental Health Act* apprehension (*M* = 2.8 hours, SD = 1.7) than they did on mental health-related calls for service that did not result in an apprehension (*M* = 1.4 hours, SD = 1.4), which was a statistically significant difference.[33]

[31] x^2 (7) = 78,193.68, p < .001

[32] *t* (221,927.69) = 25.3, p < .001

[33] *t* (178,540.6) = -266.7, p < .001

SUMMARY OF THE ANALYSIS OF THE POLICE DATA

Between 2018 and 2024, RCMP police officers in British Columbia responded to 480,896 mental health-related files, most of which involved non-criminal events, such as check wellbeing or suicidal threats. Overall, less than one-fifth of all mental health-related calls for service involved a non-traffic *Criminal Code* offence, many of which involved causing a disturbance. Most of the mental health-related calls for service that RCMP in British Columbia responded to were information or assistance files, thus not involving any investigative action.

All four police districts experienced an increase in mental health-related files. This increase was most pronounced outside of the Lower Mainland District. Of note, overall call volume also increased over this period for all four districts. Moreover, mental health-related calls for service consistently represented between around 5% to 6% of call volume. However, between 2018 and 2024, the proportion of mental health-related calls for service that resulted in a mental health apprehension increased for all police districts outside of the Lower Mainland. Given the nature of the data, it is unclear whether this was the result of increasing severity of mental health issues or perhaps was more reflective of the presence of co-responder police/nurse mental health cars or other jurisdictional initiatives that are better positioned to assess whether the subject of complaint required apprehension under the *Mental Health Act*. Overall, between one-fifth to just over one-quarter of mental health-related calls for service resulted in an apprehension under the provincial *Mental Health Act*.

Analysis of Persons with a Mental Illness Police Survey Data

In total, 25 detachments from the four police districts in British Columbia were invited to participate in the surveys and interviews for this study. This included seven detachments from the Lower Mainland District, six from the North District, six from the Southeast District, and six from the Island District. Primary contacts at each of these 25 RCMP detachments were identified by the 'E' Division Mental Health Coordinator in Community Policing Services. Contact information for the primary contacts was provided to the research team who reached out via a series of emails with information about the study. One email explained the survey collection that was being conducted with frontline police officers. The email explained that the police officer survey was estimated to take approximately 15 minutes and was both voluntary and anonymous. The email included a QR code to the survey and the survey link. Primary contacts were requested to forward the email to all frontline members who could then opt to participate. At least one follow-up email was sent to all primary contacts with a reminder to share the survey link with their members.

In total, 143 participants fully or partially completed the online survey. In terms of gender, most respondents were male (73.6 per cent) with much smaller proportions of participants who identified as female (20 per cent), transgender (0.9 per cent) or preferring not to identify their gender (5.5 per cent). With respect to years of service, the average number of years was 13.5 (SD = 8.35). However, there was a large range of years of service from one to 44 years. There were 17 police agencies represented in the survey, with nearly half of all participants (42.7 per cent) from the Lower Mainland District. Approximately one-fifth of participants were from the North District

(21.8 per cent) and the Island District (20.9 per cent). The remainder of participants (14.5 per cent) were from the Southeast District.

Most participants did not specialize in working with persons with mental illness, as more than three-quarters (80.3 per cent) indicated that they had not worked in a policing position specific to mental health files. Of the 21 participants who did work in a specialized unit or team dedicated to persons with a mental illness, close to three-quarters (71.4 per cent) had been in the role for three years or less, with the remainder having been in the position for four to five years (14.3 per cent), six to seven years (4.8 per cent), or eight years or more years (9.5 per cent) (see Table 17). Similarly, most participants did not work in a field relevant to mental health or addictions before becoming a police officer as only 23 participants (16.8 per cent) indicated that they worked in a relevant field prior to their work as a police officer.

TABLE 17: POLICING YEARS OF SERVICE IN A SPECIALIZED PERSONS WITH A MENTAL ILLNESS UNIT OR TEAM (N = 21)

	% of Participants
Less than 1 Year	28.6%
1 Year	14.3%
2 Years	23.8%
3 Years	4.8%
4 Years	9.5%
5 Years	4.8%
6 Years	0.0%
7 Years	4.8%
8 or More Years	9.5%

TRAINING

Most participants (86.7 per cent) indicated that they received training on managing calls for service involving persons with mental illness. When asked about specific training courses, all participants completed the AGORA crisis intervention de-escalation course, and most completed the AGORA incident management intervention model training (98.4 per cent). Nearly three-quarters (74 per cent) of participants completed training through the Pacific Regional Training Centre and more than one-half (57.7 per cent) had completed the Canadian Police Knowledge Network mental health and de-escalation training. Of note, less than one-half (47.2 per cent) of participants completed the Canadian Police Knowledge Network recognition of emotionally disturbed persons course, only slightly more than one-third (35.0 per cent) of participants completed the Canadian Police Knowledge Network scenario based mental health and de-escalation training, and approximately one-fifth (21.1 per cent) completed any online workshops through 'E' Division's Community Policing Section. A small proportion of participants (8.4 per cent) indicated that they completed other courses or training, such as attending the Crisis Car conference in Calgary, Alberta, crisis negotiator courses, or connected with local practitioners or agencies to learn about persons with a mental illness.

When training was examined across the four policing districts, the findings were generally consistent. Within the Lower Mainland District, all participants completed the AGORA crisis intervention de-escalation course, and most (97.5 per cent) completed the AGORA incident management intervention model training, training through the Pacific Regional Training Centre (70.0 per cent), and the Canadian Police Knowledge Network mental health and de-escalation training (60.0 per cent) (see Table 18). Less than one-half (45.0 per cent) of participants completed the Canadian Police Knowledge Network recognition of emotionally disturbed persons course, the Canadian Police Knowledge Network scenario based mental health and de-escalation training (37.5 per cent), and online workshops through 'E' Division's Community Policing Section (27.5 per cent). Within the Island District, all participants completed the AGORA crisis intervention de-escalation course and the AGORA incident management intervention model training, and more than four-fifths (86.4 per cent) completed training through the Pacific Regional Training Centre. The Canadian Police Knowledge Network recognition of emotionally disturbed persons course was completed by slightly more than three-quarters (72.7 per cent) of Island District participants, and the Canadian Police Knowledge Network mental health and de-escalation training (72.7 per cent). One-half completed the Canadian Police Knowledge Network scenario based mental health and de-escalation training (50.0 per cent) while only approximately one-quarter (27.3 per cent) completed online workshops through 'E' Division's Community Policing Section.

Within the North District, all participants completed the AGORA crisis intervention de-escalation course and the AGORA incident management intervention model training, and two-thirds (66.7 per cent) completed training through the Pacific Regional Training Centre (see Table 18). Less than half (46.7 per cent) completed the Canadian Police Knowledge Network mental health and de-escalation training and slightly more than one-third (38.1 per cent) completed the Canadian Police Knowledge Network recognition of emotionally disturbed persons course. Slightly less than one-quarter (23.8 per cent) completed the Canadian Police Knowledge Network scenario based mental health and de-escalation training. A very small proportion (4.8 per cent) completed online workshops through 'E' Division's Community Policing Section. Within the Southeast District, all participants completed the AGORA crisis intervention de-escalation course and the AGORA incident management intervention model training, and most completed training through the Pacific Regional Training Centre (80.0 per cent). Less than one- half completed the Canadian Police Knowledge Network mental health and de-escalation (40.0 per cent), Canadian Police Knowledge Network recognition of emotionally disturbed persons (26.7 per cent), Canadian Police Knowledge Network scenario based mental health and de-escalation training (20.0 per cent), and online workshops through 'E' Division's Community Policing Section (13.3 per cent).

In effect, while there was near universal completion of the two AGORA trainings, there was a lot of variation for other types of training. For example, there was a range from 26.7% to 72.7% by district for whether participants had completed the Canadian Police Knowledge Network recognition of emotionally disturbed persons training, and a fair degree of variation for the Canadian Police Knowledge Network mental health and de-escalation training (40.0 per cent to 72.7 per cent) and the Canadian Police Knowledge Network scenario-based mental health and de-escalation training (20.0 per cent to 50.0 per cent).

TABLE 18: PROPORTION OF PARTICIPANTS THAT COMPLETED TRAINING BY DISTRICT

	Lower Mainland District (N = 40)	Island District (N = 22)	North District (N = 21)	Southeast District (N = 15)
AGORA Crisis Intervention De-Escalation Course	100%	100%	100%	100%
AGORA Incident Management Intervention Module Training	97.5%	100%	100%	100%
Pacific Regional Training Centre Training	70.0%	86.4%	67.7%	80.0%
Canadian Police Knowledge Network Mental Health and De-Escalation Training	60.0%	72.7%	46.7%	40.0%
Canadian Police Knowledge Network Recognition of Emotionally Disturbed Persons Training	45.0%	72.7%	38.1%	26.7%
Canadian Police Knowledge Network Scenario-Based Mental Health and De-Escalation Training	37.5%	50.0%	23.8%	20.0%
Online Workshops through 'E' Division Community Policing Section	27.5%	27.5%	4.8%	13.3%

The most common content included in training and courses was crisis intervention (100 per cent), de-escalation (100 per cent), assessing for signs of mental illness (72.4 per cent), scenarios (70.7 per cent), and addictions or substance use (55.3 per cent). Less common content covered in training and courses included role playing (36.6 per cent), mental health first aid (26.8 per cent), and cross-training with other first responders (13 per cent). With respect to the recency of training, for the specific training courses highlighted above, the most common response was that participants completed the course or training within the past 12 months; this ranged from 25.7% to 81.5% of the sample.

Despite the recency of training and the breadth of content, less than one-third of participants felt that their training adequately prepared them to manage these kinds of files. More specifically, only 14.6% indicated that they felt that the training they received prepared them 'a great deal' to respond to persons with a mental illness, and only 17.9% indicated that their training prepared them 'a lot'. In addition, 38.2% indicated that the training they received prepared them 'a moderate amount', 26.8% indicated that their training prepared them 'a little', and 2.4% indicated that the training did 'not prepare them at all'.

When asked what recommendations participants had for changing or adding to the mental health training provided, the most common responses centred on mental health content, such as suicide intervention, recognition of symptoms, and the distinction between mental health and addictions, more scenario-based training, the need for cross training with other agencies, first responders, and mental health professionals, having in-person training, updated training that provided more realistic examples, revising training videos, and a greater focus on current best practices. Other recommendations highlighted the need for how to assess risk, a greater and more nuanced overview of mental health-related legislation and policies, and interpersonal skill development on topics like compassion, communication, and rapport building. It is also worthwhile noting that, while these comments were raised relatively less frequently, participants also expressed that training should be conducted by mental health experts and there should always be ongoing and more training in general.

PERCEPTIONS OF POLICING PERSONS WITH A MENTAL ILLNESS

Participants were asked to rate how easy or difficult it was to assess various items when managing persons with mental illness. As demonstrated in Table 19, most participants found it somewhat or very easy to articulate why they apprehended someone under the BC *Mental Health Act* (89.9 per cent), to understand when they could apprehend someone under the BC *Mental Health Act* (89.1 per cent), to know when they could arrest a person with a mental illness (81.2 per cent), and to recognize when someone was in a mental health crisis (75.4 per cent). In contrast, participants found it somewhat or very difficult to access community-based resources (58.7 per cent), to distinguish between a mental health issue and substance-induced behaviour (44.9 per cent), and to manage calls for service involving persons with mental illness (42.0 per cent).

TABLE 19: ABILITY TO RESPOND TO PERSONS WITH A MENTAL ILLNESS (N = 143)

	Somewhat or Very Easy	Neither Easy nor Difficult	Somewhat or Very Difficult
Articulating why I have apprehended someone under s.28 of the BC *Mental Health Act*	89.9%	6.5%	3.6%
Understanding when I can apprehend someone under s.28 of the BC *Mental Health Act*	89.1%	6.6%	4.4%
Knowing when I can arrest a person with a mental illness	81.2%	14.5%	4.3%
Recognizing when someone is in a mental health crisis	75.4%	17.4%	7.2%
Accessing a hospital for a person with a mental illness	52.2%	11.6%	36.2%
Using de-escalation techniques with persons with a mental illness	39.9%	32.6%	27.5%
Distinguishing between a mental health issue and substance-induced behaviour	37.0%	18.1%	44.9%
Managing calls for service involving persons with a mental illness	31.2%	26.8%	42.0%
Accessing community-based resources for a person with a mental illness	21.0%	20.3%	58.7%

When examined across the four districts, the findings were largely similar in terms of what participants found easy versus difficult. The only statistically significant difference across the regions concerned managing calls for service involving persons with a mental illness.[34] There was a greater percentage of participants who found it somewhat or very difficult to manage calls for service involving persons with a mental illness (see Table 20). More specifically, a greater proportion of police from the Southeast (68.8 per cent) and Island (52.2 per cent) Districts found it somewhat or very difficult compared to police from the Lower Mainland (38.3 per cent) and North (29.2 per cent) Districts. While not statistically significant, there was some other interesting findings. For example, more than one-half (52.2 per cent) of Island participants found it somewhat or very difficult to access a hospital for a person with a mental illness compared to one-quarter to slightly more than one-third of participants from the other districts. And, while a minority of participants from the Lower Mainland (46.8 per cent), Island (39.1 per cent), and North (45.8 per

[34] $\chi^2 = 14.30$, $p < .05$

cent) Districts found distinguishing between a mental health issue and a substance-induced behaviour somewhat or very difficult, slightly more than two-thirds (68.8 per cent) of participants from the Southeast District reported finding this somewhat or very difficult.

TABLE 20: PROPORTION OF SAMPLE THAT FOUND IT SOMEWHAT OR VERY DIFFICULT TO RESPOND TO PERSONS WITH A MENTAL ILLNESS

	Somewhat or Very Difficult			
	Lower Mainland District (N = 47)	Island District (N = 23)	North District (N = 24)	Southeast District (N = 16)
Articulating why I have apprehended someone under s.28 of the BC *Mental Health Act*	0.0%	8.7%	4.2%	6.3%
Understanding when I can apprehend someone under s.28 of the BC *Mental Health Act*	2.1%	8.7%	4.2%	6.3%
Knowing when I can arrest a person with a mental illness	0.0%	4.3%	4.2%	6.3%
Recognizing when someone is in a mental health crisis	4.3%	4.3%	16.7%	6.3%
Accessing a hospital for a person with a mental illness	31.9%	52.2%	37.5%	25.0%
Using de-escalation techniques with persons with a mental illness	27.7%	21.7%	37.5%	31.3%
Distinguishing between a mental health issue and substance-induced behaviour	46.8%	39.1%	45.8%	68.8%
Managing calls for service involving persons with a mental illness	38.3%	52.2%	29.2%	68.8%
Accessing community-based resources for a person with a mental illness	63.8%	56.5%	62.5%	50.0%

PERCEPTIONS OF CALLS FOR SERVICE

Participants indicated that approximately one-half (48.2 per cent) of their calls for service involved a person with a mental illness as the subject of complaint (SD = 24.6), which is a considerable departure from the calls for service data noted in the previous section that found that 5.7% of all calls for service were mental health-related. While the detachments that were invited to participate in the current study were responsible for a slightly disproportionate number of mental health-related calls for service occurring in RCMP detachments across the province, the proportion of calls for service that involved mental health ranged from a low of 4.5% in 2018 to a high of 13.7% in 2021. Overall, 6.6% of the overall call volume between 2018 and 2024 for the invited detachments involved mental health-related calls. There are several possible explanations for this discrepancy. First, members may not be using the mental health flag as often or as accurately as they should, thus underestimating the proportion of calls for service that involve mental health. Alternatively, participating police officers may be overestimating the proportion of their files that involved mental health-related calls for service. A third possible explanation is that police officers may be conflating mental health issues with other challenges, such as living unhoused. Of note, there was considerable variability in the perceived percentages, ranging from 5% to 100% of calls for service.

When examined by the type of criminal behaviour or nature of the call for service, more than one-half (59.6 per cent) of the calls for service were perceived to involve drug or alcohol intoxication (SD = 24.3) (see Table 21). Most calls for service (53.4 per cent) were also perceived to relate to an

individual who was homeless or unhoused (SD = 26.5), or was for nuisance behaviour, such as trespassing (48.8 per cent, SD = 29.1) (see Table 21). In contrast, less than one-quarter of calls for service (22.4 per cent, SD = 18.0) involved a person with a mental illness as the victim, with reported percentages ranging from 0% to 80%. When the person with a mental illness was the victim associated to a call for service, the nature of the call for service was similar to when the person with a mental illness was the subject of complaint. Here, the most common types of perceived issues were a victim who was homeless or unhoused (44.6 per cent, SD = 30.2), drug or alcohol intoxication (42 per cent, SD = 30.8), and nuisance behaviour (32.6 per cent, SD = 28.2).

TABLE 21: PERCEIVED REASON FOR CALLS FOR SERVICE INVOLVING PERSON WITH A MENTAL ILLNESS (N = 116-118)

	Subject of Complaint	Victim of Complaint
Drug or alcohol intoxication	59.6%	42.0%
Homeless or unhoused	53.4%	44.6%
Nuisance behaviour	48.8%	32.6%
Non-violent criminal behaviour	41.8%	23.5%
Threatening behaviour towards others	34.5%	25.1%
Self-harming behaviour	34.1%	22.0%
Violence toward others	28.2%	23.9%

When examined across the four districts, there was general consistency in the most common reasons for calls for service when the person with a mental illness was the subject or victim of the complaint (see Tables 22 and 23). There were no statistically significant differences across the districts when the individual was the subject of the complaint.

TABLE 22: PERCEIVED REASON FOR CALLS FOR SERVICE BY DISTRICT WHERE THE PERSON WITH A MENTAL ILLNESS WAS THE SUBJECT OF COMPLAINT

	Subject of Complaint			
	Lower Mainland District (N=46-47)	Island District (N=22-23)	North District (N=22-23)	Southeast District (N=15)
Drug or alcohol intoxication	53.6%	65.7%	68.3%	58.7%
Homeless or unhoused	51.8%	57.3%	47.5%	64.7%
Nuisance behaviour	49.8%	45.3%	45.2%	66.0%
Non-violent criminal behaviour	41.3%	42.0%	37.2%	51.3%
Threatening behaviour towards others	33.0%	37.3%	33.2%	38.3%
Self-harming behaviour	34.7%	31.8%	38.7%	30.0%
Violence toward others	27.9%	33.0%	22.8%	29.0%

In contrast, there was one significant difference when the individual was the victim of the complaint. In calls for service involving the victim and nuisance behaviour, the Southeast District (52.7 per cent) reported a higher proportion compared to the Lower Mainland (31.1 per cent), Island (27.0 per cent), and North (27.0 per cent) Districts.[35]

TABLE 23: PERCEIVED REASON FOR CALLS FOR SERVICE BY DISTRICT WHERE THE PERSON WITH A MENTAL ILLNESS WAS THE VICTIM OF THE COMPLAINT

	Victim of Complaint			
	Lower Mainland District (N=44)	Island District (N=20-21)	North District (N=22-23)	Southeast District (N=15)
Drug or alcohol intoxication	38.6%	45.3%	41.8%	51.3%
Homeless or unhoused	43.6%	41.1%	41.5%	58.7%
Nuisance behaviour	31.1%	27.0%	27.0%	52.7%
Non-violent criminal behaviour	23.2%	22.4%	27.6%	25.0%
Threatening behaviour towards others	25.5%	27.9%	19.3%	27.1%
Self-harming behaviour	25.6%	22.9%	17.0%	20.1%
Violence toward others	23.9%	26.6%	16.3%	29.1%

When asked to estimate how much time a typical call for service involving persons with a mental illness took, the reported average was 10.1 hours (SD = 19.8) with a range from one to 100 hours. As some participants may have responded to this question to include hospital wait times, the data was reanalyzed removing responses of more than 12 hours (i.e., greater than the length of a shift). Doing so resulted in a reported average of 3.1 hours (SD = 1.8) with a range from one to 12 hours, which was more consistent with the average service time data reported in the previous section of 1.8 hours for all mental health-related files, or 2.8 hours more specifically for mental health-related files involving an apprehension. Approximately three-quarters (79.8 per cent) of participants reported that the average mental health-related calls for service took between one and five hours to conclude with the remainder of participants indicating that mental health-related calls for service took between six and 12 hours to conclude (7 per cent) and 30 hours or more to conclude (13.2 per cent) (see Table 24).

[35] $F = 3.30$, $p < .05$

TABLE 24: CALL FOR SERVICE LENGTH OF TIME IN HOURS (N = 114)

	% of Cases
1 Hour	9.6%
2 Hours	29.8%
3 Hours	20.2%
4 Hours	13.2%
5 Hours	7.0%
6 to 12 Hours	7.0%
30 Hours or More	13.2%

When examined across the four districts, the reported average was highest in the North District at 15 hours (SD = 28.0), followed by the Lower Mainland District at 7.7 hours (SD = 14.5), Southeast District at 6.4 hours (SD = 14.9), and Island District at 5.6 hours (SD = 10.1). These average differences were not statistically significant. Similarly, although there were some differences across the districts in terms of the distribution of hours, these were also not statistically significant (see Table 25).

TABLE 25: CALL FOR SERVICE LENGTH OF TIME IN HOURS BY DISTRICT

	Lower Mainland District (N = 43)	Island District (N = 22)	North District (N = 23)	Southeast District (N = 15)
1 Hour	9.3%	18.2%	4.3%	6.7%
2 Hours	23.3%	31.8%	39.1%	46.7%
3 Hours	23.3%	27.3%	4.3%	26.7%
4 Hours	18.6%	4.5%	8.7%	6.7%
5 Hours	7.0%	9.1%	8.7%	6.7%
6 to 12 Hours	9.3%	0.0%	17.4%	0.0%
30 Hours or More	9.3%	9.1%	17.4%	6.7%

RESPONSES TO PERSONS WITH A MENTAL ILLNESS

Participants were asked to estimate what percentage of calls for service involving a person with a mental illness as the subject of complaint resulted in an arrest. The average was 26.9% (SD = 20.51) and ranged from 0% to 100%. Information on arrests was not available in the call for service data. When asked what percentage of mental health-related calls for service resulted in an apprehension under the BC *Mental Health Act*, the average was 44.6% (SD = 27.18), which is a considerable departure from what was found in the calls for service data analysed above (25.6 per cent). In contrast, the average percentage of cases whereby a person with a mental illness was the victim and the incident resulted in an apprehension was 19.7% (SD = 19.51). Of note, the call for service data did not provide the role code for the individual, therefore, it was unclear how the 25.6% reported above breaks down between subjects of complaint versus victims. In general, respondents

reported that they were very confident (43.5 per cent) or extremely confident (22.6 per cent) in the ways that they responded to calls for service involving persons with a mental illness, with a very small proportion noting that they were not at all confident (1.7 per cent).

When examined by district, the average percentage of mental health-related calls for service that were estimated to result in an arrest was highest in the Lower Mainland District at 30.9% (SD = 22.36), followed by the North District at 26.7% (SD = 17.98), the Southeast District at 24.6% (SD = 14.82), and the Island District at 23.7% (SD = 22.67) (see Table 26). With respect to the percentage of calls for service that were estimated to result in an apprehension under the BC *Mental Health Act*, this was highest in the Southeast District at 53.9% (SD = 29.9), followed by the Lower Mainland District at 44.6% (SD = 25.8), the North District at 44.4% (SD = 24.9), and the Island District at 33.2% (SD = 28.8). This reported pattern was different from what was found in the data reported above where the Lower Mainland District had the most apprehensions (33.3 per cent) compared to the Island District (21.3 per cent), North District (21.7 percent), and Southeast District (17.0 per cent). In terms of the perceived percentage of calls for service whereby a person with a mental illness was the victim and the incident resulted in an apprehension, this was highest in the Lower Mainland District at 24.2% (SD = 23.2), followed by the Southeast District at 16.7% (SD = 15.7), Island District at 16.6% (SD = 14.7), and North District at 14.3% (SD = 14.4). None of these differences were statistically significant.

TABLE 26: OUTCOME OF MENTAL HEALTH-RELATED CALLS FOR SERVICE BY DISTRICT

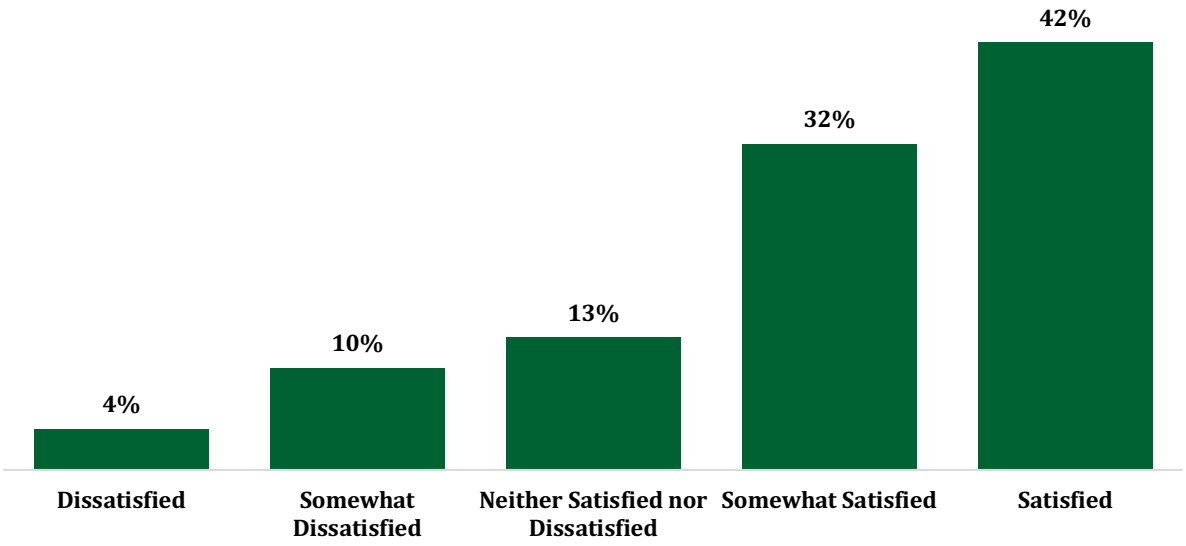
	Lower Mainland District (N = 46)	Island District (N = 23)	North District (N = 22-23)	Southeast District (N = 15-16)
Resulted in an Arrest	30.9%	23.7%	26.7%	24.6%
Resulted in an Apprehension	44.6%	33.2%	44.4%	53.9%

When examining confidence in responding to calls for service by district, while there were some differences in terms of the proportions that indicated high levels of confidence, these were not statistically significant. For example, the percentage of participants who noted they were extremely confident were: 39.1% Island, 21.7% North, 21.3% Lower Mainland, and 12.5% Southeast. In contrast, the order was different for the percentage of participants who noted they were very confident: 50% Southeast, 46.8% Lower Mainland, 43.5% Island, and 21.7% North. The only district that reported they were not at all confident was a small percentage from the Lower Mainland at 4.3%.

As noted in Figure 12, most participants were satisfied with their detachment's approach to calls for service involving persons with a mental illness as the subject of complaint. In support of this, participants commented that they recognized that their detachment was doing their best under the circumstances, such as lengthy hospital wait times and lack of community mental health supports, and with the training that police officers received, but they expressed their frustration. For example, one participant stated: "[The] detachment does what it does. We have very little power to influence what the Health System and other organizations do. Our detachment has done well at

pushing back at the hospital for forcing members to wait for hours on end to see a doctor with [an] apprehended person." Another participant commented: "I think overall people respond to these calls based on how they're trained. If they haven't received appropriate training, they are more likely to respond by apprehending or escalating the conflict. If they've received additional training, they can make a full assessment ensuring the safety of the client involved." Lastly, one participant highlighted the struggle with mental health-related calls for service: "Our detachment is overwhelmed with these calls for service. The majority of which should not be police matters; however, there is woefully inadequate resources for these people and in my experience, the entire health care system downloads the responsibility to police." Of note, no police officers selected "very satisfied" as a response option for this question.

FIGURE 12: SATISFACTION WITH POLICING AGENCY'S RESPONSE TO PERSONS WITH A MENTAL ILLNESS (N = 114)



RESOURCES TO RESPOND TO PERSONS WITH A MENTAL ILLNESS CALLS FOR SERVICE

When asked what resources or programs were needed to more effectively manage calls for service involving persons with a mental illness as the subject of complaint, the two most frequent recommendations were the need for a mobile crisis response team or a police-nurse partnership, and an improvement to health care services. With respect to the health care system, participants frequently noted that wait times at the hospital were lengthy, which took up police resources, and that it would be helpful for emergency rooms to prioritize police officers when they brought an apprehended person to the hospital. Other common suggestions included the need for more mental health resources in the community and the need for a mental health liaison officer or team to manage mental health-related calls for service. Similarly, when asked about the need of their policing agency to undertake actions that were not currently being implemented, commonly provided responses were the need for a mobile crisis response team or a police-nurse partnership, as well as deploying mental health liaison officers or teams. Participants were also asked if there was anything that their police agencies were doing that they should not be doing. Here, there were

no common themes as responses varied considerably. A few comments noted issues related to the hospital setting, such as the aforementioned long wait times and having the client in police custody when they should be in the hospital's custody. Participants also highlighted the changing nature of police work, in that they were responding to a large proportion of calls for service that were health or social in nature, rather than criminal, and having to provide security at hospitals while awaiting a client assessment by a physician.

Participants were asked whether specific resources were available in their jurisdictions for persons with mental illness. The most common resources were assertive outreach teams (70.1 per cent), crisis intervention trained officers (64.1 per cent), and assertive community treatment teams (58.1 per cent) (see Table 27). According to participants, it was rare for their jurisdiction to have specialized dispatchers or dispatch systems for persons with a mental illness (5.2 per cent) and on-call designated mental health specialists (14.7 per cent).

TABLE 27: AVAILABLE RESOURCES (N = 116-117)

	Resource is Available
Assertive Outreach Teams	70.1%
Crisis Intervention Trained Officers	64.1%
Assertive Community Treatment Teams	58.1%
Integrated Mobile Crisis Response Services	53.0%
Mental Health and/or Substance Use Liaison Officers	50.0%
Situation Tables or Complex Needs Tables	44.8%
Intensive Case Management Teams	42.7%
On-Call Designated Mental Health Specialists	14.7%
Specialized Dispatchers or Dispatch Systems for Persons with a Mental Illness	5.2%

When compared across the four districts, there were statistically significant difference in two resources (see Table 28). For mental health and/or substance use liaison officers, the North District (16.7 per cent) reported a lower proportion of this resource, and the Lower Mainland District (69.6 per cent) reported a higher proportion of this resource compared to the Island (43.5 per cent) and Southeast (43.8 per cent) Districts.[36] For situation tables or complex needs tables, the Island (73.9 per cent) and North (62.5 per cent) Districts reported a greater proportion of this resource compared to the Southeast (37.5 per cent) and Lower Mainland Districts (23.9 per cent).[37]

[36] $\chi^2 = 21.16$, $p < .01$

[37] $\chi^2 = 20.21$, $p < .01$

TABLE 28: AVAILABLE RESOURCES BY DISTRICT

	Lower Mainland District (N=46-47)	Island District (N=23)	North District (N=23-24)	Southeast District (N=16)
Assertive Outreach Teams	63.8%	91.3%	70.8%	62.5%
Crisis Intervention Trained Officers	70.2%	82.6%	45.8%	50.0%
Assertive Community Treatment Teams	68.1%	69.6%	33.3%	43.8%
Integrated Mobile Crisis Response Services	59.6%	60.9%	33.3%	50.0%
Mental Health and/or Substance Use Liaison Officers	69.6%	43.5%	16.7%	43.8%
Situation Tables or Complex Needs Tables	23.9%	73.9%	62.5%	37.5%
Intensive Case Management Teams	42.6%	60.9%	29.2%	43.8%
On-Call Designated Mental Health Specialists	14.9%	13.0%	20.8%	12.5%
Specialized Dispatchers or Dispatch Systems for Persons with a Mental Illness	6.4%	8.7%	4.3%	0.0%

When asked how often these resources were used for mental health-related calls for service, the most common resources that participants reported using 'often' or 'always' were integrated mobile crisis response services (63.8 per cent) and crisis intervention trained officers (58.7 per cent).

As there may be several barriers interfering with the ability of clients to access community-based resources, programs, or services, participants were asked about how often they experienced specific barriers. As demonstrated in Table 29, the most common barriers that were classified as 'always' being present were lengthy waitlists (72.8 per cent), the lack of mental health professionals (64.3 per cent), and the hours of operation (43 per cent). Some barriers that only a very small proportion of participants believed were 'never' present included hours of operation (1.8 per cent), days of operation (4.4 per cent), and lack of mental health professions (5.2 per cent). When given the opportunity to provide additional comments about barriers to resources, programs, and services, issues of no or under-funding were raised as was a lack of sufficient resources. Challenges with service providers and clients were also noted. For example, as one participant expressed, "mental health workers don't appear to want to work evenings or nights when most call outs occur." Another participant stated that, "often times, it is a combination of clients not wishing to receive help, and the resources being provided being minimal." These examples highlighted the complexity of the issue, which could result with clients and service providers believing the police or the hospital were the only options, both of which tended to be short term solutions.

TABLE 29: PRESENCE OF SERVICE ACCESS BARRIERS (N = 111-115)

	Never	Sometimes	Always
Lengthy waitlists	9.6%	17.5%	72.8%
Lack of mental health professionals	5.2%	30.4%	64.3%
Hours of operation	1.8%	55.3%	43.0%
Availability of services	3.5%	56.5%	40.0%
Days of operation	4.4%	58.8%	36.8%
Lack of transportation to services	15.7%	48.7%	35.7%
Don't respond quickly enough when needed	7.0%	63.5%	29.6%
Location of services	25.7%	50.4%	23.9%
Restrictions on clients (e.g., no drugs/alcohol)	23.7%	52.6%	23.7%
Curfew policies	36.8%	43.9%	19.3%
Don't accept referrals from police	44.1%	41.4%	14.4%
Services are not relevant to what is needed	31.5%	55.9%	12.6%

When the presence of service access barriers was examined across the four districts, although there were some differences in the specific barriers that were never, sometimes, and always present, none of the differences were statistically significant (see Table 30). For example, although one of the most common barriers that was 'always' reported across all four districts was the lack of mental health professionals, the percentages reported varied from 80.0% in the Southeast District to 47.8% in the Island District. Again, while not statistically significant, there were some other interesting findings. For example, while 40.4% of participants from the Lower Mainland District and 43.5% of participants from the North District reported that a lack of transportation to services was always a barrier, this proportion dropped to 26.7% in the Southeast District and just 17.4% in the Island District. The same general pattern was found for curfew policies and services not being relate to what was needed. In effect, across nearly all types of barriers, participants in the Island District had lower proportion of participants reporting that these barriers were 'always' present. The exceptions were for hours of operation, availability of services, days of operation, and services not responding quickly enough when needed.

TABLE 30: PRESENCE OF SERVICE ACCESS BARRIERS WAS REPORTED AS 'ALWAYS' BY DISTRICT

	Barrier was Always Present			
	Lower Mainland District (N=46-47)	Island District (N=22-23)	North District (N=22-23)	Southeast District (N=14-15)
Lengthy waitlists	76.6%	68.2%	65.2%	73.3%
Lack of mental health professionals	74.5%	47.8%	56.5%	80.0%
Hours of operation	46.8%	43.5%	36.4%	40.0%
Availability of services	46.8%	39.1%	34.8%	33.3%
Days of operation	36.2%	39.1%	31.8%	40.0%
Lack of transportation to services	40.4%	17.4%	43.5%	26.7%
Don't respond quickly enough when needed	29.8%	30.4%	34.8%	26.7%
Location of services	26.1%	17.4%	26.1%	20.0%
Restrictions on clients (e.g., no drugs/alcohol)	21.3%	18.2%	34.8%	26.7%
Curfew policies	23.4%	9.1%	21.7%	26.7%
Don't accept referrals from police	17.4%	9.1%	13.0%	21.4%
Services are not relevant to what is needed	10.9%	4.5%	26.1%	14.3%

It is worth highlighting that participants wanted to emphasize the complex nature of this issue and that solutions needed to be diverse and involve time and commitment from the police, the health authorities, mental health support organizations, and the public. Participants stated that there was also a need for the public to better understand what police did when responding to a mental health-related call for service and why they took the actions they did. The following quote highlights the awareness that the police have about their roles and limitations, and their desire to be part of the solution.

> "I don't believe any more training will make police officers more equipped to respond. As with any other skill, you need to be doing it in order to get better at it. Within the police organizations there are many police officers who don't work in the first responder capacity, even less in the RCMP. The uniformed, frontline police officers primarily deal with most of the PWMIs. They receive quiet an enormous amount of information/training about all sorts of topics and are then required to, sometimes, make split decisions based on training, experiences they've gathered. It is then easier for the next group of people removed to judge the actions of the ones that face that challenge. Police are equipped well enough to deal with the basic tools to address the situation they are facing, the more they do, the better they become at handling them. A call with a PWMI should not be a police primary response, but a different group/agency with police assistance. The amount of mandatory training and online courses that police have to do is too much as it is and, in some cases, leads to police inaction due to fear of potential consequences."

Analysis of Qualitative Interviews

As explained above, primary contacts for this research study were identified and their contact information shared with the research team. The researchers reached out to all provided contacts with an explanation about the study and an invitation to participate directly via a virtual interview conducted with the researchers. In some cases, the primary contact was the individual who elected to participate, and in other cases the person identified one or more contacts from their detachment to invite for the interview. Interviews were conducted with 18 participants. At least four interviews were conducted per policing district.

When asked to consider their current role within their agency, a central theme was the increasing formalization of police roles dedicated to mental health response. Participants described a range of specialized positions, including mental health liaison officers, corporals and constables within Integrated Crisis Response Teams, supervisors of mental health co-response teams, and detachment commanders with explicit responsibility for addressing homelessness, poverty, addictions, and mental illness in their communities. These roles represent a shift in organizational priorities, with policing resources being strategically allocated to address the volume and complexity of mental health-related calls for service. The creation of distinct positions suggests an acknowledgment by police agencies of the operational demands generated by this client population and the inadequacy of traditional enforcement-based responses in addressing underlying mental health issues.

In discussing their current positions, many participants highlighted inter-agency collaboration as a defining feature of emerging mental health policing practice. Participants consistently reported working alongside registered nurses, psychiatric nurses, social workers, and community mental health teams, including Assertive Community Treatment (ACT) and Intensive Case Management teams. These integrated models, which many participants referred to as “Car” programs or crisis response teams, were designed to combine the authority and first-response capacity of police with the clinical expertise of mental health professionals. In these roles, many participants viewed their position as a facilitator who initiated referrals, presented cases to community teams, and advocated for clients to receive follow-up care. In effect, many participants saw their role as part of a collaborative approach designed to reduce repeated police contact by linking individuals directly to mental health and social supports and creating a continuum of care that extended beyond the immediate crisis that formed the basis of the call for service.

Another theme that emerged from participants in describing their current position was the extent to which policing has expanded into domains that intersected with, but extend beyond, criminal law. In describing their role, participants reported frequent involvement in issues tied to homelessness, addictions, poverty, and elder abuse. Rather than approaching these matters through enforcement alone, participants described that their position required a deep understanding of their jurisdiction’s social services in addition to strong crisis intervention skills. The comments by participants underscored the blurring of boundaries between policing and social/health services.

A small portion of participants held supervisory or command positions, such as corporals, sergeants, non-commissioned officers, and detachment commanders. These participants spoke about their roles as requiring the ability to balance administrative responsibilities with the

operational demands of crisis response work. Some of these participants described their roles in terms of fostering resilience within their mental health teams. Supervisors also reported adopting a dual perspective—drawing on their experiences as police officers while incorporating knowledge from other professionals, such as social workers, to encourage a more holistic and collaborative approach to mental health calls for service.

Perhaps the most profound theme related to the cultural and philosophical transformation of policing practice. Several participants explicitly contrasted earlier orientations that were focused on "catching bad guys" or traditional enforcement with their current roles, where most interactions involved individuals experiencing mental illness, addictions, and socio-economic vulnerabilities. Here, participants highlighted the ability to de-escalate crises, connect people to resources, and reduce harm as key aspects of their roles, rather than arrests or enforcement outcomes. In effect, many participants viewed their current position as operating at the nexus of law enforcement, health care, and social support.

In sum, the themes raised by participants highlighted a transformation in the role of policing within the context of mental health and social vulnerability. Specialized units and liaison positions have become a more common response to address the volume of calls for service involving individuals in crisis, underscoring the reality that mental health, addictions, homelessness, and poverty are core features of frontline police work. In effect, there appeared to be a greater emphasis on the role of policing in crime prevention and the need to take a holistic, systems approach to addressing criminal behaviour.

Participants had considerable variation in both overall policing experience and the length of time they had served in mental health–related positions. Participants ranged from very new members, with only weeks or months of service in their current position, to highly experienced officers with over two decades of policing, some of whom spent a significant portion of their careers in mental health–specific roles. This diversity highlights the breadth of professional backgrounds represented within mental health policing and suggests that units are staffed by both long-tenured officers who carry institutional knowledge and relatively new members who bring fresh perspectives or prior experience from other jurisdictions. Of note, several participants noted that their mental health appointments were temporary or transitional, such as short-term secondments or interim roles, while others indicated that they had been tasked with building or restructuring their mental health units over multiple years. This variability underscores both the emerging nature of police–mental health partnerships and the lack of uniformity in how such roles are institutionalized across police agencies.

The interviews also detailed the degree of movement across units and roles. As expected, many participants began in general duty before transitioning into specialized functions, such as a mental health team. Moreover, several participants were explicitly requested by their agency to assume leadership over mental health units when existing models were perceived as ineffective. In addition, promotions into supervisory roles, such as corporal, sergeant, and staff sergeant, also reflected the integration of mental health responsibilities into the experience needed for professional advancement. In other words, some participants indicated that their knowledge and experience in mental health was an asset in being promoted into their current role.

In describing how long they have been in their current position, some participants took the opportunity to describe policing models that shifted from case management approaches to crisis response teams, or from liaison roles to integrated response partnerships. To some degree, participants felt that this highlighted the experimental and adaptive nature of police–mental health integration, where team structures and mandates continued to be refined in response to perceived gaps and operational challenges. In effect, the coexistence of veteran expertise and new, sometimes temporary, appointments in mental health teams reflects both the importance and the unsettled nature of mental health work within the broader policing mandate.

In discussing their specific roles in relation to persons with mental illness, it was clear that, among this sample, mental health policing exists along a spectrum defined by the orientation of work (reactive vs. proactive), the nature of their role (frontline vs. oversight), and the degree of organizational formalization (formal vs. ad hoc). More specifically, in terms of the nature of their role, some participants worked within crisis response teams and were engaged in *Mental Health Act* apprehensions, which is a more reactive orientation, and there were those who were also engaged in case coordination, agency referrals, and prevention through relationship-building, which is a more proactive orientation. In terms of the nature of their role, frontline members were often embedded in crisis teams with clinicians responding directly to mental health-related calls for service and there was also the oversight role of more senior members responsible for coordinating interagency teams, integrating clinicians, and managing the mental health team or unit. Finally, there was variation in the degree of organizational formalization with some participants working in units embedded in operations, community policing, or support services with defined mandates while other participants worked in standalone positions that had been developed informally or experimentally without clear institutional recognition.

Still, within this sample of participants, a prominent theme was the centrality of frontline crisis response conducted in partnership with mental health professionals, most commonly through models in which police officers worked alongside nurses or clinicians. When this was the case, the role of the police participants was largely framed as ensuring safety and exercising statutory authority under the *Mental Health Act*, while clinicians provided clinical assessment, diversion from hospital, and referrals to community supports. To connect to the previous paragraph, this approach reflected a reactive orientation, where the primary mandate was immediate crisis intervention.

A second theme highlighted the blending of policing and social work functions. Several participants described their work as bridging gaps between police, health, and community supports, such as referrals to shelters, addictions programs, ACT teams, or Situation Tables. Some participants explicitly framed their work in social work terms, such as educating other agencies, advocacy, case coordination, and promoting trauma-informed or de-escalation approaches across community agencies. From some of the comments raised by participants, it appears that this type of role often emerged informally or evolved out of necessity, underscoring the absence of a standardized organizational framework for mental health policing. Participants engaged in this type of work frequently described their role in social service terms, reflecting a shift away from purely enforcement-based approaches toward holistic, community-centered engagement.

Of note, the information provided by participants demonstrated a degree of variation in organizational placement of mental health teams. In some police agencies, addressing mental health

calls for service were embedded in general duty or operations. In others, this role was situated within support services, vulnerable persons units, or community policing, creating opportunities for proactive and relationship-based interventions. In several cases, as mentioned above, participants reported functioning in a standalone or liminal space within the organizational hierarchy. As expected, this variation leads to different levels of authority, access to resources, and recognition with the policing agency and the community.

Unexpectedly, participants in supervisory positions played a distinct role that emphasized managing teams of constables and nurses, chairing meetings, supporting interagency collaboration, and ensuring training. They also emphasized their role in the integration of civilian professionals into the policing environment. Among this sample of participants, the theme of the importance of leadership functions in sustaining collaborative mental health responses was highlighted. While discussed in greater detail below, these participants outlined resource gaps and staffing challenges as consistent obstacles. These participants reported unfilled liaison roles, limited clinical availability often restricted to business hours, and insufficient personnel to balance crisis response with proactive follow-up. These constraints were most pronounced in smaller or rural police agencies, where capacity and resources made experimental models difficult to sustain.

Finally, in discussing their role in relation to persons with a mental illness, participants spoke of the tension between the scope of policing and mental health work. Some participants expressed concern with being tasked with responsibilities outside of their policing expertise, such as long-term case management of clients, and other responsibilities traditionally associated with health or social services. Others defended proactive, relationship-based approaches as critical to reducing repeat crises, even if such work lay outside conventional policing mandates. This tension illustrated a broader structural debate about whether mental health policing should remain primarily reactive and enforcement-focused, or whether it should evolve toward a hybrid model that incorporates elements of prevention, case coordination, and community engagement. In other words, participants were not consistently aligned on how far police should be involved in mental health cases versus deferring to other community agencies. In effect, when discussing their roles, participants demonstrated that their roles were highly varied and shaped by local resources, policing agency size, and organizational philosophy. Participants' roles could be placed on a spectrum from frontline crisis responders to coordinators and supervisors, sometimes in hybrid roles that blurred organizational boundaries.

TRAINING

Participants were asked several questions about the training they received before and during their role working with persons with mental illness. A recurring theme was the limited formal training provided by the policing agency. Many participants reported receiving minimal or very basic mental health training. Mandatory courses tended to focus on general crisis intervention, de-escalation, operational skills, or cultural/unconscious bias and rarely addressed the complexity of mental health conditions or provided guidance on differentiating between mental health and substance-related behaviours. Participants consistently noted that formal training alone was insufficient to prepare them for the nuanced situations encountered in the field with persons with a mental illness. In effect, while mandatory, these training components were often considered

generic, limited in scope, and repetitive, providing foundational skills but lacking depth in understanding specific mental health conditions, neurodivergence, or culturally informed approaches.

To compensate for gaps in formal education, many participants sought additional training outside their policing agency. This included attending conferences, seminars, and workshops that focused on topics like psychiatry, neurodevelopmental conditions, autism, schizophrenia, and addiction. Participants also drew on prior academic and professional experience, including backgrounds in psychology, criminology, social work, corrections, or health care, to enhance their understanding of mental health issues. Furthermore, exposure to mental health professionals through collaborative units, such as the Integrated Mobile Crisis Response team, provided participants with practical insight and guidance that they felt could not be obtained through formal police training alone. While some participants reported taking online courses offered by their police agencies, this was frequently critiqued as repetitive, superficial, or "click-through" in nature, and lacking in depth and realism.

Experiential learning was highlighted as a central component of skill development. Participants emphasized that hands-on experience through attending mental health-related calls for service, scenario-based exercises, and rotations in specialized units was critical for developing effective communication and crisis management skills. It was also felt that scenario-based training, including critical incident negotiation programs, offered participants the opportunity to apply theoretical knowledge to realistic situations. For many participants, scenario-based training supported the development of practical skills by exposing police officers to the kinds of challenges they were likely to encounter in the field, making the training both recognizable and directly transferable to operational contexts. A further strength of scenario-based training highlighted by participants was the involvement of subject-matter experts in its design. Scenarios developed in collaboration with psychologists and crisis nurses were reported to be particularly valuable, as these professionals provided insights into how individuals in crisis may respond to police presence and provided guidance on effective communication strategies. This collaboration helped ensure that scenarios reflected the realities of crisis encounters and reinforced the importance of avoiding certain language or behaviors that may escalate situations. Participants expressed that developing these skills required direct engagement with persons with a mental illness in real-world contexts, mentorship from senior officers, and collaboration with health professionals such as nurses, social workers, or community mental health specialists. Of note, this form of learning was highly context-dependent, but also considered the most impactful by participants, particularly for nuanced communication, risk assessment, and crisis management.

However, the delivery of scenario-based training varied considerably. In some instances, training was conducted through live, immersive exercises, such as hostage or armed and barricaded simulations. These sessions were viewed as highly engaging and effective. In other cases, training was delivered through online video scenarios or case studies, which, while still informative, were seen as less interactive and impactful. Notably, several participants indicated that there was limited scenario training focused specifically on mental health crises, with some relying only on case studies or policy updates provided through email rather than in-person or scenario-based instruction. Participants also emphasized that scenario-based training was broadly applicable

across jurisdictions. Skills in negotiation, de-escalation, and crisis response were described as relevant regardless of regional context, suggesting that well-designed scenarios can prepare police officers for a wide range of situations. Overall, participants viewed scenario-based training as accurate, relevant, and directly connected to operational realities, while also identifying opportunities to expand its scope and improve its alignment with mental health-specific challenges.

Role-playing emerged as another important but inconsistently applied method of training. Participants expressed that while most formal training involves very little role-playing, some police agencies and specialized programs incorporated it in more targeted ways, such as through crisis intervention and de-escalation courses. Participants emphasized that the value of role-playing depended heavily on its realism, particularly in portraying the behaviour of individuals experiencing mental health crises. Exercises involving health professionals, trained actors, or cross-disciplinary partners, such as nurses, fire, ambulance, and hospital staff, were considered more effective in fostering realistic responses and clarifying inter-agency roles. However, many participants noted that the lack of authenticity in some training scenarios undermined their usefulness. In addition, resource and logistical constraints were reported as presenting ongoing challenges to implementing role-playing consistently. For example, participants from smaller police agencies in particular reported finding it difficult to organize in-person sessions because such activities took police officers off the road, and limited availability of personnel often prevented the development of joint exercises. To address these constraints, some training is delivered through lower-resource methods, such as tabletop discussions or online modules, while larger police agencies occasionally facilitate more comprehensive physical exercises. Importantly, where they do occur, role-playing sessions typically included opportunities for feedback and reflection, allowing police officers to adjust their approaches and deepen their learning. Overall, while role-playing was not uniformly embedded in police training, it was regarded as a valuable tool with significant potential if applied consistently and realistically.

Of note, virtual reality and virtual simulation training were largely absent from current police mental health training programs. Across participants, there was a consistent report that virtual reality exercises were not provided or mandated, and police officers typically did not have access to this form of training within their police agencies. Despite its absence, several participants recognized the potential value of virtual simulations, emphasizing that such training could provide a safe, controlled, and realistic environment in which they could practice decision-making and crisis response without risk to themselves or the public. The main barriers to implementation reported by participants included high costs and logistical challenges, such as the need for specialized equipment or travel to dedicated facilities. In the absence of virtual simulations, participants reported relying on alternative methods, such as watching scenario-based videos and responding to questions. However, this method provided minimal interactivity and realism. Overall, participants indicated that the integration of virtual reality could significantly enhance training by improving reaction skills, scenario authenticity, and decision-making capabilities, highlighting a clear opportunity for future development if resources permit.

Interactions and presentations by people with lived experience of mental illness were also largely absent from standard police training programs. Most officers reported that they have not participated in sessions where individuals with mental health challenges shared their experiences.

Despite this, participants recognized the potential value of such interactions. For those who had this experience, presentations by individuals with lived experience provided officers with a deeper understanding of mental health issues, contextualized behavioral responses, and humanized the experiences of clients. In some communities, these sessions were considered particularly important for ensuring that diverse perspectives were represented and understood. In the absence of formal training, participants reported often relying on their experiences to develop empathy and practical understanding. This highlighted a gap that structured interactions could fill. Additionally, exposure through external conferences featuring speakers with lived experience was described as highly impactful. Overall, there was a degree of recognition that integrating individuals with lived experience into training would enhance empathy, improve decision-making, and increase effectiveness in responding to mental health-related incidents.

Nearly all participants noted that crisis intervention, de-escalation, and communication skills were core competencies essential for their roles. Participants expressed that annual or periodic training reinforced these skills but were not an adequate substitute for real-world experiences. Participants stressed that effective responses often required discretion and judgment; all of which could not be effectively taught exclusively in a classroom or online setting but could be reinforced through the training methods discussed above. It was felt that their roles resulted in many participants being in situations where understanding the behavioural nuances of individuals was essential to managing risk safely. Given this, in general terms, it was felt by many participants that there were gaps in their mental health knowledge. More specifically, participants reported that they did not have sufficient understanding of personality disorders, suicidal behaviours, and the assessment of mental health conditions. There was a recognized need for structured and mandatory mental health education that extended beyond online courses, ideally combining theoretical instruction with practical, in-person training.

It was also felt by some participants that the lack of integration between police and health systems, including limitations in information sharing, further complicated their ability to respond effectively to individuals in crisis. Given this, overwhelmingly, participants expressed that specialized units and collaboration with mental health professionals provided substantial benefits. These teams allowed police officers to work closely with nurses, social workers, and clinicians, which participants felt reduced unnecessary apprehensions and improved outcomes for individuals experiencing mental health crises. Some participants also highlighted the value of regional knowledge sharing through conferences and meetings that promoted promising practices and collective learning.

While those in specialized units or with extensive experience possessed strong mental health skills, participants expressed that frontline police officers in their police agencies had not received sufficient training to effectively respond to calls for service involving persons with a mental illness, which was consistent with the findings of the police officer survey presented in the previous section. Participants felt that most frontline police officers struggled with understanding complex mental health legislation, forms, and procedural nuances. This gap led to inconsistent decision-making, uncertainty around legal authority, and moral distress when police officers were required to respond to mental health calls without adequate training. Participants noted that brief online courses often failed to provide meaningful engagement, with police officers merely completing

modules to fulfill requirements rather than internalizing the content. It should be noted that some participants expressed that some frontline police officers benefited from close mentorship; however, many had very limited formal training and relied primarily on on-the-job experience. Experiences that increased frontline officers' exposure to the ways mental health assessments were conducted and collaboration with mental health teams were seen as valuable in providing knowledge that would otherwise be inaccessible.

Still, as outlined above, participants expressed a need for more comprehensive understanding of mental health diagnoses, medications, and strategies to safely manage individuals in the community without necessarily resorting to hospital transport for frontline officers. It was felt that, while existing training equipped police officers with the basic skills necessary to respond to crises, understanding subtle behavioural indicators, psychosis, and the nuances of the *Mental Health Act* required deeper, ongoing education. Small, targeted sessions with mental health professionals, like briefings on personality disorders or crisis interventions, were cited as useful in supplementing formal training. The importance of feedback, both during field training and following real-world incidents, was repeatedly emphasized as a mechanism for reinforcing learning and improving responses. Nonetheless, participants stated that training was often constrained by scheduling, with frontline police officers needing to balance education with demanding shift work, court obligations, and other duties. This can limit opportunities for more extensive, in-depth training.

When asked about what additional training participants would like to receive, it was interesting to note that a common theme was for a tiered approach to mental health training. In effect, they advocated for foundational awareness programs to benefit all police officers, while more advanced, assessment-focused training targeted toward specialized units and investigators. Given this, there was demand for mandatory, standardized, and recurring specialized mental health training, especially for those in dedicated mental health roles. Participants also placed an emphasis on practical skills, such as risk assessment, mental health interviewing, distinguishing between mental health and substance use behaviours, and understanding relevant legislation, including the *Mental Health Act*. It was expressed that "learning by doing" was more impactful than online modules or annual refresher courses. Additionally, participants noted the potential of technology, such as virtual reality simulations, to enhance training effectiveness and provide opportunities for reflective learning.

In summary, while formal, focused mental health training within the police agencies participating in this project was rather limited or non-existent, it appeared that many participants leveraged prior frontline experience, external education, mentorship, and collaboration with other health professionals, such as nurses, to develop competencies related to responding and addressing mental health issues. Experiential learning plays a central role in preparing officers to navigate complex situations, but gaps remain in structured training, particularly regarding mental health assessment, personality disorders, identifying safety risks, understanding psychosis, and systemic integration with health services. The need for more comprehensive, mandatory, and practical training was a consistent theme throughout participants' experiences. Gaps in training or insufficient experiential exposure was felt to limit a police officer's responsiveness, while combining formal, experiential, and self-directed learning enhanced an officer's knowledge and skills. Overall, participants expressed that effective mental health policing relies on a combination

of practical experience, interdisciplinary collaboration, structured training, and ongoing education tailored to the realities of frontline work.

MODELS OF MENTAL HEALTH RESPONSES

Given that participants came from different types and sizes of police agencies representing all four policing districts in British Columbia, there was not one model that everyone used. Instead, jurisdictions had a range of approaches to responding to and addressing mental health calls for service and persons with a mental illness. For the most part, the model and structure used by participating police agencies were a mobile crisis response team/co-response model in which a police officer is paired with a civilian clinician or nurse to respond to mental health calls for service allowing for proactive engagement, follow-ups with clients, and transporting individuals to hospital when necessary. In general, the team responds to calls based on priority, with the police officer and the nurse meeting clients and making informed decisions regarding risks and supports. Participants indicated that they contacted additional resources if needed, such as a homeless shelter or a drug rehabilitation centre. Some participants reported that they worked closely with community service providers to manage lower acuity cases. Regardless of whether the policing agency had a mobile crisis response team, it was common for two-person cars to be dispatched to manage mental health crises to enhance safety and accountability during incidents as the nurses support interventions but do not engage in de-escalation in the field due to safety considerations. Participants highlighted that mental health liaison officers provided additional support, combining police history with health information to make informed decisions regarding apprehension and care. They also expressed that the objective was to keep individuals in the community and prevent hospitalizations while coordinating follow-ups with care teams, including medication administration, whenever possible. Of note, in those jurisdictions with mobile crisis response teams, most calls for service originate through the 9-1-1 system, and frontline police officers respond first, with the crisis car dispatched as needed once the site has been secured. Still, in high-risk situations, policy requires that the nurse remain in the vehicle while the police officer assesses and manages the scene.

Some participants spoke about their connections to ACT teams, which are multidisciplinary teams designed to manage individuals with complex mental health or substance use issues, providing medication administration and ongoing monitoring. Participants indicated that they offered contextual support and facilitated navigation through the criminal justice system to address the needs of clients who have not responded to traditional mental health services. Participants also highlighted Intensive Case Management programs that operated voluntarily and did not force participation with psychiatric nurses who provided hospital-based assessments and coordination with community resources. Moreover, some participants indicated that because they did not have access to any of these models or approaches, they relied on internal meetings within their police agencies to facilitate timely intervention by connecting clients to appropriate services without delaying assistance.

Regardless of the jurisdiction, all participants expressed that collaboration with their local health authority was central to responding effectively to persons with a mental illness. In jurisdictions with a Situation Table, participants reported that this allowed them to coordinate with health and social services for non-criminal cases, particularly for high-frequency mental health interactions.

Participants also emphasized that their approaches focused on relationship building with clients, understanding their history, and minimizing unnecessary hospitalizations or criminalization. Given their roles, participants expressed that there was a degree of flexibility in their approaches to persons with a mental illness. Participants indicated that different clients may engage better with civilians, police officers, or both. Given this, many participants, especially those in larger police agencies or in urban settings, reported that their police agency's approach or model adapted to individual needs. Related to this, these participants indicated that the regular review of clients' well-being, medication management, and follow-ups prevented crises before they escalated.

It is important to note that participants recognized that in many police agencies senior leadership actively supports these types of programs, recognizing community demand and operational benefits. Still, participants reported that staff shortages, part-time nurses, and funding constraints limited the full implementation of mental health-focused policing models or resulted in these types of programs not existing at all in some policing jurisdictions. In sum, participants reported that frontline police officers handled most mental health calls and referred non-emergency cases to a crisis team, if one existed in their jurisdiction, or to community resources. Programs, such as ACT Team, Intensive Case Management teams, and mobile crisis response teams, enhanced service delivery by coordinating with health authorities and providing targeted interventions. Resource limitations and high caseloads remained challenges, but collaborative efforts with hospitals, community partners, and specialized teams aimed to improve outcomes for individuals experiencing mental health crises.

THE STAFFING AND RECRUITMENT OF MENTAL HEALTH POLICE OFFICERS

Again, there was a great deal of variability when participants were asked to discuss how many police officers were assigned to these programs, models, or teams, and their typical hours of operations. Still, most programs operated with small, specialized teams, often consisting of one to two police officers paired with one or more nurses or civilian clinicians. Several programs were transitioning to expand their coverage, such as adding additional police officers or nurses to extend operational hours from weekdays to seven days per week. Shifts were typically structured to balance police officer and nurse availability, with common patterns for participants being four days on followed by four days off, 10-to-12-hour shifts, and staggered start times to ensure overlap for team cohesion and handovers. Some programs, like mental health liaison roles, operated with only a single police officer or a civilian resource, typically Monday to Friday, with extended responsibilities for follow-up and coordination with community services. Larger programs with larger teams might include corporals, constables, nurses, and civilians, with team members selected based on skills in de-escalation and crisis management.

Nursing support was typically full-time with scheduled shifts of 8 to 12 hours, sometimes supplemented with casual or vacation-relief staff to maintain continuous coverage. For many participants, the nurses were co-located with police officers and collaborated closely in the field to address and respond to persons with a mental illness. Participants indicated that casual or backup police officers and nurses were occasionally assigned to backfill positions if regular team members were unavailable. Operational hours were generally designed around call for service volume, with peak activity during the afternoon and early evenings. Of note, some participants reported that

despite limited staffing, the coverage met local needs; however, others indicated that additional resources, such as a second car or more nurses, would improve responsiveness and reduce reliance on frontline police officers. Overall, participants expressed that staffing reflected a mix of resource availability, community needs, and operational pragmatism, emphasizing both immediate crisis response and follow-up to reduce recurring contacts with police.

The main themes that emerged from participants about recruitment for mental health policing teams focused on selection processes, personal attributes and skills, diversity and representation, the importance of interest and passion, and tenure or rotation in the role. To begin, a central theme was the variety of recruitment approaches used across different police agencies. For example, some processes were formal and involved individuals submitting applications, resumes, panel interviews, and structured evaluations, while other police agencies relied more on internal transfers, self-identification, or an interest-based selection process. In effect, the lack of standardization suggested that recruitment practices, particularly in smaller police agencies or those in more rural areas, were shaped by local needs and leadership preferences.

Another major theme identified by participants was the emphasis on personal attributes and the demonstration of soft skills. Communication skills, patience, empathy, emotional regulation, and the ability to de-escalate crises were commonly highlighted by participants as critical qualities for police officers in these roles. Participants stressed that these traits were often more important than formal education or technical training, as the ability to build rapport with clients and work collaboratively with people in the community, including nurses, was essential. Moreover, diversity and representation also emerged as a concern among participants. For example, one participant noted that the current composition of their team lacked gender diversity, which created challenges in engaging with female clients who had trauma related to male authority figures. This point underscores the need to consider both visible identity and interpersonal demeanour in the recruitment process to enhance client rapport and minimize the retraumatization of clients.

Importantly, participants also identified interest in and a passion for mental health work as critical for any recruitment strategy. Several participants emphasized that not every police officer was suited for this type of role, and that those who applied must demonstrate a genuine desire to support people with mental health challenges. In effect, it was felt that experience and technical skills could be built over time, but without the proper motivation and empathy, effectiveness of the officer and the team would be limited. Finally, participants spoke of the challenges posed by tenure and duty rotation. For example, for some participants, there were positions that were permanent, while others may be rotational, with varying expectations for length of service. While this is very common in policing, there was recognition among many participants of the value of building long-term rapport with clients and community partners that needed to be balanced against the benefits of reintroducing experienced officers back into general duty to share expertise and opening spots for new police officers to gain the experience of working with persons with a mental illness. Overall, participants expressed that recruitment for mental health policing roles was shaped by a combination of formal processes, soft skill evaluation, and individual motivation, which needed to be balanced with attention to diversity, role suitability, and stability with rotational opportunities.

High call volumes and workload intensity were consistently emphasized by participants. Some participants reported that their unit or team managed 120 to 150 files monthly, with daily

fluctuations ranging from a single case to as many as 25 files. Participants also noted frequent shortages in staffing with units or teams often operating below the number of officers allocated to the shift or relying on team or unit members to take on additional responsibilities. Supervisors described the challenges of securing additional personnel, negotiating with leadership for expanded resources, and managing the operational strain created by demand that outpaced available capacity. These pressures were not only logistical but also carried a substantial emotional toll, as participants encountered a steady stream of individuals in crisis without always having the necessary systemic supports in place to effect sustainable change.

As discussed above, participants emphasized the value of integrated models that paired a police officer with a mental health professional, which not only broadened the scope of expertise available in crisis situations but also helped to bridge systemic gaps between emergency response and longer-term care. At the same time, these models placed additional demands on police organizations, as police officers were increasingly required to act as navigators of complex health and social systems, a role that extended beyond their traditional mandate.

CALLS FOR SERVICE WHERE A PERSON WITH A MENTAL ILLNESS IS THE SUBJECT OF COMPLAINT

While participants represented a wide range of police agencies in British Columbia, when asked to outline some of the more common outcomes of calls for service where the subject of complaint was a person with a mental illness, a major theme was the prevalence of apprehension under mental health legislation, especially when the individual was considered a risk to themselves or others. Many participants described apprehension as their default or most frequent response, though they pointed out that an apprehension was distinct from an arrest in that it was not a criminal but a health-related intervention. Of note, while some participants emphasized exercising discretion and only using apprehension when absolutely necessary for the safety of the client or others, there were some participants who acknowledged that apprehension was the most common resolution used by their policing agency.

Given this, it was interesting to note that many participants stated that diversion from hospitals or custody to community-based resources was a more effective approach. Specialized units, such as crisis response teams paired with nurses, were seen to reduce unnecessary hospital admissions by supporting individuals in their homes and connecting them directly to services. These approaches were believed to be more effective and less disruptive than defaulting to hospital transport. Collaborative programs, such as crisis cars or partnerships with nurses, were credited with lowering hospitalizations and easing pressures on frontline police officers.

As indicated above, the role of discretion and professional expertise also emerged as a consistent theme among participants. Specifically, the presence of mental health professionals was thought to significantly and positively influence outcomes. For example, participants expressed that frontline police officers often leaned toward caution and apprehension, whereas specialized teams with nurses or clinicians applied a more nuanced assessment of the client and did a much better job of differentiating between behavioural issues and mental health concerns, which led to fewer hospital transports and unnecessary hospitalizations. In effect, the presence of mental health professionals was described as improving overall on-scene decision-making and client outcomes.

Another important theme related to call for service outcomes was the intersection of mental health, addictions, and criminal behaviour. Participants described cases where individuals in crisis could potentially be diverted to health supports, but aspects of their behaviour crossed into criminality allowing for an arrest. This co-occurrence of issues highlighted the complex nature of calls involving people with mental illness, the need for well-trained police officers who possessed both empathy and nuanced judgment, as well as the need to balance health and safety considerations of the client and the public. Somewhat related, participants also spoke of the strain placed on police resources by repeat or chronic callers. Some participants described dealing with the same individuals hundreds of times, creating frustration, burnout, and recognition that systemic gaps in healthcare and social supports were pushing unresolved mental health issues onto police agencies. This created situations where repeated apprehensions occurred without meaningful long-term solutions. In sum, participants emphasized the tension between health-based and enforcement-based responses. While apprehension remained a common outcome, participants recognized the value of specialized partnerships with mental health professionals in diverting individuals from hospitals and custody. At the same time, systemic challenges, including repeat callers and the overlap between mental health and criminal behaviour, placed considerable demands on police resources.

One of the most consistent themes from participants was the significant variability in the time required to respond to mental health-related calls. The amount of time spent on calls for service where a person with a mental illness was the subject of complaint was reported by participants as ranging from as little as 20 to 30 minutes to several hours, depending on the circumstances of the individual in crisis and the resources available. In more complex cases, follow-up work may extend the process over several days or weeks. Importantly, hospital wait-times emerged as a central factor affecting the overall duration of these calls for service. Participants frequently reported wait-times ranging from 45 minutes to two hours, but, in some cases, they reported having to spend up to six, eight, or even ten hours waiting in the hospital with the client.

Another common theme related to the differences between specialized mental health teams and frontline police officers. Participants who worked in dedicated units, often paired with nurses or other mental health professionals, reported that they could devote more time to building rapport with clients, conducting thorough mental health assessments, and ensuring that clients felt supported. In contrast, participants described frontline police officers as having fewer resources and less available time, often resulting in quicker decisions that defaulted to apprehension and hospital transport. Specialized teams were also viewed as more effective at streamlining hospital processes, both through clinical expertise and established relationships with medical staff.

Many participants commented about the cumulative strain that lengthy calls and hospital wait-times place on police resources. Several participants noted that when multiple police officers were tied up with mental health apprehensions, it affected the capacity of their police agency to respond to other calls for service. This was particularly evident in smaller police agencies and those that experienced high volumes of mental health calls, where police officers might regularly spend multiple hours on a single file. As such, the importance of discretion and flexibility in managing time was another common theme. In other words, some participants highlighted the need to balance thorough relationship-building with clients against overall efficiency, while others emphasized

strategies, such as “unarresting” when grounds for apprehension no longer existed. These practices demonstrated that police officers, regardless of where they served, had to negotiate between the demands of public safety, the needs of individuals in crisis, and the realities of limited time and resources.

Police responses to calls for service involving persons with a mental illness differed based on whether the nature of the call for service was a *Criminal Code* or a social disorder/nuisance type of incident. It was interesting to note that participants reported that they generally prioritized addressing mental health concerns before pursuing criminal charges. When an individual experienced a mental health crisis, participants expressed the goal of ensuring the client’s immediate safety and access to appropriate care. Participants reported that, in many instances, criminal charges were delayed until the individual’s mental health needs were addressed. Even when a criminal act occurred, participants indicated that assessment and intervention for mental health issues often preceded legal proceedings. Police officer discretion was again highlighted as a key factor in responding to incidents. Participants reported that decisions were informed by the severity of the situation, the nature of the offence, the risk to others, and any substance involvement. High-risk scenarios, including the presence of weapons or immediate threats to safety, might necessitate actions to address criminal activity and to mitigate imminent danger, with mental health intervention occurring concurrently or immediately afterward.

Moreover, participants highlighted several interrelated themes regarding the use of police discretion in mental health-related calls. As suggested above, a central theme was that discretion was both necessary and constrained. Participants consistently acknowledged that they exercised judgment when determining whether to apprehend under the *Mental Health Act*. This involved assessing whether an individual presented a risk to themselves or others, weighing available information, considering alternative responses, and, where deployed, considering the advice of a nurse or other clinician serving in a mobile crisis response team. At the same time, discretion was limited by legislative requirements. Many participants emphasized that once an individual clearly met the legal threshold for apprehension, police officers were obligated to act, with little room for alternative decision-making. This created tension between the officer’s duty to ensure safety and their recognition that apprehension can feel like a form of criminalization of health issues.

Another important theme was the variability in how discretion was applied in practice. Some participants described a black-and-white approach where the presence of risk triggered an automatic apprehension, while others reported a more nuanced use of discretion. For example, discretion might be used to leave a teenager in the care of parents rather than undertaking an apprehension, or to connect an individual with shelter or community supports when their behaviour was disruptive but not dangerous. This variability appeared to be linked to police officer experience, personality, and comfort with risk. Some participants expressed a willingness to take calculated risks when supported by input from a nurse or other clinician, whereas others felt pressure to act conservatively out of fear of liability if a negative outcome occurred after they interacted with the subject of complaint.

One of the important considerations in the use of police officer discretion was the input of mental health professionals. Several participants highlighted that working alongside nurses or clinicians supported more balanced decision-making, as their expertise provided additional context and could

help validate or challenge initial impressions. For those who had access to them, these participants reported that having a clinical partner both improved outcomes for clients and reduced the sense of personal liability that could be carried by the police officer(s) at the scene, as decisions were more easily justified when informed by a professional assessment. Nonetheless, liability and accountability emerged as another consistent theme. Participants expressed awareness that their decisions, whether to apprehend or not, carried significant professional and personal responsibility. Some participants described an informal rule of being held accountable for up to 48 hours after contact[38], which shaped decision-making and could push police officers toward more cautious or defensive choices. This fear of repercussions, even in the absence of formal policy, could lead to over-apprehension and what some participants described as negative outcomes for clients.

Finally, the interviews revealed that there were structural differences in how discretion was applied depending on the police agency. Frontline police officers were often the first to respond to a call for service and often had to make decisions with limited information. Mental health-specific or co-response teams, by contrast, may monitor call lists, select which cases to attend, and use more discretion in how they intervene. In these contexts, discretion was often exercised in deciding whether their presence was even necessary, or whether another service could address the issue more appropriately. Taken together, discretion in mental health calls was characterized by a constant balancing act as police officers weighed legal obligations, professional accountability, what they experience at the scene, and the input from their nurse or clinician partners. While discretion allowed police officers to adapt to the unique circumstances of each client, it was also shaped by systemic pressures, liability concerns, and the availability of collaborative supports. This complexity highlighted the need for clearer policies, stronger interagency partnerships, and ongoing training to help police officers exercise discretion in ways that maximized safety, fairness, and client well-being.

Where they were in operation, participants expressed that collaboration with mental health teams, hospitals, and crisis units was also central to an effective response, with police officers often transporting individuals to hospitals for assessment or medication administration while maintaining custody as required. Participants believed that this ensured timely and controlled mental health interventions.

As mentioned above, participants again mentioned challenges in balancing criminal justice obligations with mental health considerations. For participants, this included their interactions with courts, considerations of not criminally responsible by reason of mental disorder (NCRMD) determinations and responding to family concerns. Systemic gaps, such as the limited presence of specialized mental health courts, were identified as constraints on effectively addressing both

[38] This concept refers to the belief held by some participants that the lead police officer present at the scene of a call for service bears responsibility for any incidents that transpire to or involving the subject of complaint for 48 hours if the police officer decides to not apprehend or arrest the individual. For instance, if a police officer chooses to release the subject of complaint into the custody of a family member following their initial contact, and that individual subsequently engages in assaulting another person later that evening, the police officer has to justify their decision to allow the individual to remain with a family member rather than apprehending or arresting them.

criminal and health needs. Many participants also felt that training, culture, and policy played an important role in shaping responses. For example, participants spoke about trauma-informed and brain-based training guiding their responses, and that some police agencies were experiencing a cultural shift that prioritized mental health needs while maintaining legal responsibilities. Moreover, formal policies, such as directives related to mentally ill prisoners, provided a framework for responding to both detained and non-detained individuals with mental health needs. Finally, some participants indicated that the input from the client's family, community engagement, and case management were also integral to police responses. For example, maintaining individualized records and seeking guidance from other professions for how best to respond to known individuals, and, when possible, engaging in follow-ups with clients and their family was thought to support long-term stability and reduce repeat crises.

Finally, while participants indicated that police officers typically maintained call logs and all relevant documentation, review processes were often limited due to operational demands. Participants expressed that there was a need in some police agencies for additional administrative support to ensure consistent review and tracking of incidents involving mental health considerations. In summary, participants argued that police responses to individuals experiencing mental health crises were guided by a nuanced approach that prioritized mental health while maintaining legal accountability. Decision-making was typically informed by risk assessment, policy directives, training, and collaboration with health services, emphasizing both the safety of the individual and the broader community.

The interviews revealed several key themes about police involvement in follow-ups with persons experiencing mental health issues. One theme was that conducting follow-ups was very inconsistent across jurisdictions and largely dependent on available resources, local mandates, and interagency collaboration. Many participants described follow-ups as secondary to primary response, with most of their time consumed by immediate calls for service. Participants frequently stated that while they conducted some follow-ups, this comprised a small proportion of their work compared to initial crisis response, often estimated at less than 20% of their duties. Another theme was the reliance on partnerships with health and social service agencies. Participants consistently referred to the role of mental health nurses, ACT teams, community mental health centres, and victim services as the lead providers of ongoing support. In this way, the police often served as connectors focused on making referrals and facilitating communication between clients and community services, programs, or resources, rather than directly carrying out long-term case management. However, participants also highlighted challenges, particularly around information sharing. Strict privacy restrictions, lack of formal agreements between the police and community organizations, and differing levels of system integration created barriers for police when attempting to coordinate follow-ups or assess whether referrals to programs, services, or resources were successful. Several participants emphasized that better information-sharing agreements, such as memoranda of understanding, would allow for more effective collaborative follow-up.

Participants also suggested that follow-ups were often informal or unrecorded. Police officers might check in with individuals during routine patrols or encounter them repeatedly due to recurring crises; however, in these cases, the follow-up work was more relational than procedural, helping to maintain rapport or encourage engagement with services, even though it may not be formally

tracked. This ad hoc model reflected both resource limitations and the reality that many individuals cycle repeatedly through crisis contacts. Some participants, particularly those with co-response experience or liaison roles, advocated for more structured follow-up, arguing that investing more time in proactive monitoring and support could prevent future crises and reduce overall calls for service.

Finally, participants highlighted systemic gaps that hindered effective follow-up. These included insufficient low-barrier services in their jurisdictions, a lack of transportation or phones for clients, and gaps in community outreach that made it difficult for vulnerable individuals to remain engaged with care. Several participants noted that engaging in follow-ups was more effective when services were brought directly to clients, rather than expecting clients to access them independently. The absence of dedicated follow-up capacity within many police agencies led to a degree of frustration, as some participants recognized that without continuity, individuals often returned to crisis situations, generating repeat calls for service. While not the experience of all participants, the interviews suggested that while follow-up was recognized as an important component of supporting persons with mental illness, it was inconsistently implemented and often overshadowed by immediate response demands. Effective follow-up depended heavily on collaboration with health and community partners, and its success could be constrained by systemic barriers in both service access and information sharing. Participants suggested that more resources, structured partnerships, and a shift toward proactive follow-up would improve outcomes for clients and contribute to reducing the burden on frontline police services.

COMMUNITY RESOURCES

Given the diversity of police agencies that participated in interviews, it was not unexpected that there would be a great degree of variation in the types of community resources available to the police when it came to responding to and addressing the needs of persons with a mental illness. As such, participants described a wide range of health and social service agencies, including ACT teams, intensive case management programs, mental health intervention services, crisis lines, and specialized youth and women's supports. These resources offered avenues for counselling, addiction treatment, housing, medical care, and case management, providing most police officers with multiple referral options when statutory apprehension was not warranted. Still, a recurring theme was the uneven availability and accessibility of housing supports. Participants frequently identified housing scarcity as a critical gap in community resources, noting that without stable housing, safety planning and longer-term recovery were substantially undermined. Even when shelters existed, capacity limitations often restricted their effectiveness, forcing police officers to rely on temporary solutions or cycle individuals back into unsafe conditions.

Another prominent theme was the collaborative potential of community partnerships. Many participants highlight positive experiences working with outreach programs, friendship centres, probation services, and specialized teams, such as overdose outreach and Situation Tables, where these types of services or programs were available. Participants expressed that these partnerships allowed for more holistic interventions, particularly in cases involving addiction, chronic social issues, or repeated police contact. However, challenges in collaboration were also reported, particularly with health authority outreach services that were described by some participants as

risk-averse, appointment-driven, and reluctant to work directly alongside police in the field. Some participants felt that this created tension between the need for trauma-informed, health-led interventions and the reality of police assuming primary responsibility in high-risk situations.

Participants also underscored the importance of youth-specific and culturally tailored resources. Here, it was noted that, for the most part, more child and youth mental health services, Indigenous health authorities, and family counselling supports were needed as participants recognized that early intervention and culturally appropriate services were critical in reducing long-term reliance on the police. Similarly, some participants drew attention to specialized services for marginalized groups, such as safe consumption sites, sexual health programs for sex workers, and women's shelters, which addressed both health and safety concerns. Finally, participants expressed an acute awareness of service gaps and limitations. For some participants based on jurisdiction, many community resources existed, gaps were consistently identified in low-barrier health services, specialized supports for conditions, such as brain injuries or hoarding, and the need for broader or 24-hour coverage by ACT and other related teams. These gaps often placed frontline police officers in the position of filling service voids and exacerbating the reliance on law enforcement as the default responder.

Participants also noted several interrelated barriers that hindered access to community resources, particularly for individuals experiencing mental health and substance use challenges. While these barriers were not experienced in all jurisdictions, a recurring theme was the restriction of service availability outside standard business hours. Participants indicated that many necessary services or programs operated Monday to Friday, 08:00 to 16:00, which left significant gaps during evenings, nights, and weekends. As a result, participants felt that the police often became the default responders after hours, even when the issues being experienced by the subject of complaint were primarily medical or social in nature. This reliance on policing placed additional burdens on law enforcement agencies and put police officers in the position of responding to individuals or addressing issues outside of their expertise or mandate.

Another major theme was the role of waitlists and delays in clients being able to access necessary services, programs, or resources. Participants described counselling, psychiatric services, housing, and other specialized supports as frequently operating with long wait times that contributed to the deterioration in individual wellbeing, increased calls for police service, and additional strains to emergency systems. For individuals without primary care physicians or stable housing, these waitlists posed particularly acute barriers.

Substance use also emerged as a critical point of tension in accessing mental health services. Hospitals and some community programs often excluded individuals from care when drug use was detected, treating the issue as distinct from mental health despite the high rates of overlap between the two. For many participants, the lack of integrated care for co-occurring substance use and mental illness was viewed as a systemic gap that perpetuated cycles of crisis. In addition, socioeconomic and cultural barriers further compounded these issues. Poverty, lack of transportation, the absence of owning a cell phone, and bureaucratic challenges created obstacles to accessing or maintaining services. Certain populations, such as Indigenous peoples, elders, individuals with brain injuries, and men seeking culturally safe supports, were identified as facing particularly pronounced barriers in many jurisdictions. Participants noted that even individuals

who were motivated to address their challenges struggled to navigate complex systems without dedicated guidance. Marginalized individuals, particularly those living in encampments, often required outreach-based approaches, as expecting them to consistently attend appointments or meet program requirements was viewed by participants as unrealistic.

Environmental and structural barriers were also mentioned by several participants. Institutional settings that were not trauma-informed, such as facilities with harsh lighting or crowded waiting areas, may deter vulnerable individuals from seeking help. Intake processes that required punctuality and organization, such as arriving at a shelter at a set time, were often unworkable for those struggling with substance use or cognitive impairments. These seemingly small barriers created significant exclusion from services. Finally, many participants argued for low-barrier and collaborative approaches. Here, participants emphasized the need for services that could engage individuals where they were, both physically and in terms of readiness for change. Outreach, flexibility, and co-response models were seen as essential for bridging gaps that police alone cannot fill. Moreover, the lack of available beds in detox facilities, insufficient weekend coverage, and inadequate resources for specialized populations were highlighted as ongoing challenges. In many cases, participants described themselves as filling roles that extended beyond policing, underscoring the extent of systemic shortfalls. In effect, many participants described a fragmented system in which access to community resources was constrained by time, availability, systemic exclusion of people with concurrent disorders, socioeconomic realities, and a lack of trauma-informed and low-barrier services. For police agencies, these gaps translated into repeated involvement in social and medical crises underscoring the need for structural reforms and the establishment of more formal partnerships in service accessibility and delivery.

To that end, participants were asked to identify whether they had any partnerships with a diverse range of community resources. Given the geographical distribution of participants, there was a certain degree of variability in the types of services that law enforcement agencies partnered with and the nature of those partnerships. Consequently, the following provides a general description of the nature of police partnerships with service providers, rather than providing specific details about which police agencies established partnerships with which types of services. To begin, police partnerships with addiction services were generally informal and built largely on personal relationships and ad hoc collaboration rather than structured agreements. Participants consistently reported that while communication with addiction service providers was functional and often positive, it was not governed by formal memoranda of understanding. In most cases, the only established MOUs were with hospitals or regional health authorities, leaving direct relationships with addiction services dependent on local meetings, Situation Tables where they existed, or personal connections. This reliance on individual police officers to maintain relationships raised concerns about continuity, as partnerships may weaken if key personnel leave their positions.

While formal agreements might not always be seen as strictly necessary, participants felt that they could strengthen consistency and ensure accountability. Several participants suggested that memoranda of understanding or more structured arrangements would be beneficial for information sharing, continuity of service, and maintaining connections beyond personal relationships. Still, other participants expressed skepticism about the added value of formalization, noting that effective collaboration already occurred through informal communication and

integrated meetings. Participants also reported that referrals were often required through health practitioners, limiting the police's ability to connect individuals directly to detox or treatment services. Structural barriers, such as resource shortages also limited the effectiveness of existing partnerships between the police and addiction services. Many participants expressed that, in practice, addiction services were frequently engaged on a case-by-case basis, often only when a client already had an existing relationship with a provider. Given this, while many participants emphasized the benefits of open communication and collaboration, others expressed caution, suggesting that overt partnerships between police and addiction services might discourage engagement among individuals who already distrusted law enforcement.

Importantly, positive examples were identified in some jurisdictions, such as strong working relationships with opioid treatment clinics, integrated mental health and addiction teams, and collaborative roundtable meetings, such as Situation Tables, that brought together multiple agencies. For many participants, these examples demonstrated the value of partnerships in improving access to treatment for individuals in custody or in the community. However, these successes were often resource-dependent and localized rather than system-wide. Overall, partnerships between police and addiction services were predominantly informal, heavily reliant on individual initiative, and constrained by systemic barriers in accessibility. While informal networks often functioned well, their sustainability was uncertain, and more consistent structures could improve accountability, information sharing, and long-term collaboration. At the same time, care must be taken to ensure that formalization did not inadvertently undermine client trust or their engagement with addiction services.

When it came to diversion programs, participants indicated that partnerships were generally limited, inconsistent, and often informal. Participants commonly reported that they had no formal agreements or consistent referral pathways with community diversion services. Instead, any connection to diversion was typically situational, based on individual police officer discretion or personal relationships. Of note, restorative justice programs were the most commonly referenced form of diversion. Several participants noted that restorative justice programs existed in their jurisdictions, but eligibility criteria were narrow, often restricted to youth, minor offences, or first-time offenders. This limited scope significantly reduced the number of individuals who benefited from this type of program. Participants highlighted positive examples of restorative justice coordinators who actively built relationships with community agencies, advocated for expanded programming, and reduced the administrative burden on frontline police officers by managing referrals. It was also interesting to note that there was an absence of adult-focused diversion opportunities. Participants frequently observed that while youth diversion programs existed, there were few equivalent pathways for adults. This created critical gaps in services, particularly for individuals with complex needs related to addiction and mental health who cycled through the criminal justice and health systems without access to meaningful alternatives.

In addition to restorative justice, cultural and community-based diversion partnerships was another area identified as being successful. For example, some participants described close collaboration with Indigenous outreach teams that played a key role in diverting individuals away from police custody by facilitating culturally appropriate care. These partnerships not only reduced the likelihood of criminalization but also ensured more effective and respectful responses for

Indigenous individuals experiencing mental health or substance use crises. Such collaborations highlighted the potential of culturally grounded diversion models to reduce police involvement and improve community trust. A recurring challenge identified by participants was that diversion efforts remained largely voluntary. If potential clients refused to participate, the police were often left with limited alternatives, particularly when behaviours were linked to untreated mental illness.

Partnerships between police agencies and shelter or dry bed programs were common in practice but typically informal, inconsistent, and dependent on the local context. Most participants described frequent interactions with shelter staff, often daily, yet noted that these relationships were not governed by memoranda of understanding or formal service agreements. Instead, connections relied heavily on individual relationships, familiarity, and shared problem-solving in response to immediate issues. While this flexibility allowed for practical communication, it also raised concerns about continuity, accountability, and equitable access. What was clear was the variability in both the availability and quality of shelter resources across the different jurisdictions that participated in this project. In some jurisdictions, participants reported strong, cooperative relationships with shelters that integrated counselling, outreach, and access to mental health services. In other jurisdictions, the absence of shelters or the reliance on seasonal, volunteer-driven emergency shelters left participants with few diversion options other than hospitals or custody. Participants noted that these gaps increased the workload of police officers and reduced their ability to connect vulnerable individuals to safe and stable environments.

Another recurring theme was the issue of access and priority. Many participants explained that their clients did not receive priority placement in shelters, even when presenting in crisis. In some cases, informal relationships allowed participants to secure access more quickly, but in others, rules about bans, timeouts, or eligibility criteria prevented the police from placing individuals in need in a shelter. Some participants expressed frustration that this left vulnerable people without options, creating repeated cycles of calls for service. Participants also highlighted challenges around shelter policies and barriers. Some participants described cases where restrictive rules, such as sobriety requirements or limitations on re-entry, forced individuals into unsafe behaviours. At the same time, shelters also face legitimate concerns about safety, overcrowding, and disruptive behaviours, which complicates their ability to accept all police referrals. These structural and operational barriers create tensions between service access and risk management, leaving police to manage the consequences when individuals cannot be placed.

Finally, there was some debate among participants about the need for formal agreements. While some participants saw no benefit beyond existing informal communication, others argued that structured partnerships could streamline information sharing, improve efficiency, and reduce repeat calls for service. Examples included the potential for shelters to confirm whether a missing person was safely housed, or for shelters to prioritize individuals referred by the police. Nonetheless, participants generally agreed that while informal relationships worked reasonably well, formalization could strengthen consistency, especially in communities with high shelter demand and frequent turnover in shelter staff. Taken together, while many of the participating police agencies maintained ongoing relationships with shelter and dry bed programs, these partnerships were largely informal and unevenly effective. Access barriers, eligibility rules, and resource shortages limited the utility of shelters as diversion options, placing additional strain on

police agencies. At the same time, positive local examples demonstrated the potential of collaborative, culturally informed, and service-integrated shelter models to reduce police workload and improve outcomes for vulnerable individuals.

Like the services already discussed, police partnerships with emergency rooms were largely informal, variable across jurisdictions, and highly dependent on interpersonal relationships with medical staff. Participants consistently emphasized the absence of formal memoranda of understanding specific to emergency rooms, though in several jurisdictions ongoing communication and regular meetings with hospital administrators or psychiatric staff created functional working relationships. In smaller communities, the relationships were often described as personal and community-based, where police officers and medical staff knew one another and had relationships based on mutual trust. In larger communities, such as large urban centres, the relationships were described by participants as more strained, inconsistent, and dependent on which physician or nurse was on shift at the time the police officer and client arrived at the emergency room.

A common issue raised by participants was the lack of priority access for police when bringing in individuals under the *Mental Health Act* or related provisions. Participants reported that while the presence of a police officer might be flagged at triage, actual wait times varied widely and were often influenced by the discretion of emergency room physicians. Some participants expressed frustration at physicians' authority to delay or redirect cases, even when psychiatric nurses or police assessments supported urgent care. This created situations where individuals in crisis remained in police custody for extended periods, straining police resources and prolonging client distress. Another challenge was the role of communication channels and liaison roles. In several police agencies, monthly or ad hoc meetings with emergency room managers, psychiatric units, or hospital administration provided opportunities to resolve systemic issues, address wait times, and clarify police responsibilities while at the hospital. Crisis nurses, social workers, and patient care coordinators often served as effective bridges between police officers and emergency room staff, reducing miscommunication and occasionally expediting assessments. Participants noted that these intermediaries advocated on their behalf with physicians, leading to more timely care than police alone might achieve.

Several participants highlighted the strain placed on hospitals due to regional closures or limited resources that contributed to longer wait times at emergency rooms. Participants reported that their role was sometimes expanded to include being used as security in hospitals that lacked dedicated staff. This added a further burden to police workloads and underscored the absence of clearly defined protocols for managing mental health clients in emergency settings. These types of situations also eroded trust and accountability. Participants emphasized the importance of remaining with individuals apprehended under the *Mental Health Act* until they were assessed by a physician to ensure safety and to demonstrate accountability for the decision to apprehend. However, some participants described tension when their assessments conflicted with the physician's decision, particularly when doctors declined to admit individuals despite police and psychiatric nurse concerns. This tension speaks to the broader structural challenge of aligning police, medical, and legal frameworks in crisis response. Of note, participants felt that having a psychiatric nurse connected to the co-response model was beneficial because the nurses did a good

job of diverting those who did not require apprehension, while focusing apprehensions for those who clearly met the criteria.

Participants also stressed the need for more consistent, formalized structures. While some participants felt that existing informal relationships were sufficient, others argued that formal agreements could streamline information sharing, improve clarity of roles, and reduce the variability tied to physician discretion. Suggestions included designating emergency room managers or liaisons to ensure consistency, expanding police access to psychiatric emergency services directly, and co-delivering training with health partners to build shared understanding. Overall, when it came to emergency rooms, partnerships were functional but fragile and reliant on individual relationships rather than organizational agreements. Variability in physician discretion, hospital resources, and communication structures created inconsistent experiences for both police officers and clients. Strengthening formal protocols, ensuring clear points of contact, and improving coordination with psychiatric and nursing staff were identified as opportunities to reduce strain on both police and health systems while improving outcomes for persons with mental illness.

Again, participants revealed that partnerships between police and community-based mental health programs were generally informal, relationship-based, and varied considerably by police agency and jurisdiction. While some participants reported strong communication and working relationships with community mental health programs, these arrangements were rarely governed by formal agreements, such as memoranda of understanding. Instead, partnerships were typically sustained by personal relationships with mental health staff, a shared commitment to client care, and ad hoc problem-solving when specific issues arose. Here, it was felt that this informality created a helpful degree of flexibility but also resulted in inconsistency, a lack of continuity, and reduced accountability.

A recurring theme was that program availability differed significantly depending on community size and resources. Larger communities often benefited from dedicated psychiatric teams, case management, or specialized youth and elder supports, whereas smaller communities struggled with limited access to clinicians, long waitlists, and challenges recruiting medical professionals. Participants described frustration with referral systems that were challenging to navigate, overly dependent on specific clinicians, or inaccessible to clients with histories of violence. Delays of one to three months for intensive case management were reported, and gaps in continuity of care existed when individuals entered custody, where medication adherence was not consistently maintained.

Several participants noted that mental health partnerships could reduce the reliance on police-led approaches and contribute to reframing crises as medical rather than enforcement matters. Co-location of nurses or direct collaboration with psychiatric staff was seen as highly valuable in building trust, particularly with Indigenous communities where trauma and distrust of police was more pronounced. Informal arrangements or having trusted psychiatrists available by phone was also viewed as effective but these approaches were also recognized as being vulnerable to staff turnover or organizational change. In effect, while partnerships with mental health programs were viewed as beneficial, they are reported by participants to be inconsistent and fragile. The absence of formal structures meant that relationships depended heavily on individual police officers and clinicians, which limited sustainability. Participants frequently identified that more formalized

agreements, clearer referral pathways, and expanded resources would improve service delivery. At the same time, there was the recognition that funding limitations, staffing shortages, and community size may prevent the establishment of robust formal partnerships in some jurisdictions.

Partnerships with outreach services, like ACT teams, were uneven across police agencies, ranging from formalized memoranda of understanding to entirely informal relationships based on personal connections. In some areas, ACT teams and hospital-based assertive or quick response teams provided structured collaboration, often supported by regular meetings and information sharing. These teams were generally viewed as effective in reducing repeat contacts with police, stabilizing clients, and providing case management that continued after hospital discharge. Where such formal partnerships existed, participants reported positive outcomes, particularly in relation to shared accountability and improved client follow-up. However, in other jurisdictions, partnerships were informal or absent, with participants relying on individual outreach workers or case managers they knew personally. These participants reported that these relationships could be effective at the operational level but lacked the consistency and sustainability that formal structures provided. Participants also noted that coverage was inconsistent, with some police agencies lacking dedicated outreach services or depending on workers from neighbouring jurisdictions. In smaller communities, funding limitations and staffing shortages also made it difficult to establish or maintain local outreach teams, leaving frontline police officers to fill gaps.

In addition, several challenges were identified by participants that influenced the effectiveness of outreach partnerships. In some cases, outreach teams were identified as being too risk-averse or limited in their ability to manage high-risk clients, which results in police being drawn into these situations. Participants also raised concerns about some outreach models in larger urban areas where fragmented service delivery, lack of coordination, and even unprofessional conduct among quasi-professional outreach workers undermined trust and collaboration. The lack of formal agreements was repeatedly highlighted as a factor that left partnerships vulnerable to individual personalities, turnover, and anti-police sentiment among some staff.

Despite these challenges, outreach partnerships were consistently recognized as beneficial when they are well resourced and properly integrated. Participants described ACT teams and similar programs as reducing the burden on frontline police officers, decreasing the number of repeat calls for service, and ensuring continuity of care for people with complex needs. Formalizing partnerships, establishing clearer lines of accountability, and expanding outreach capacity were identified as strategies that would strengthen collaboration. Outreach programs that could directly support clients with follow-up, medication compliance, and case management were seen as critical to reducing repeat police involvement and improving long-term outcomes for clients.

The participation of police agencies with Situation Tables was generally widespread but varied in structure, consistency, and effectiveness. In many jurisdictions, Situation Tables operated with formal memoranda of understandings and non-disclosure agreements, creating a structured framework for interagency information sharing. These arrangements allowed police, health services, probation, outreach programs, and community organizations to coordinate responses for individuals at acutely elevated risk. Where formal agreements existed, participants described regular meetings with active involvement from a broad range of stakeholders. At the same time, some participants reported that their participation was informal, inconsistent, or dependent on the

individual's personal initiative to collaborate with the Situation Table, rather than an organizational commitment. In smaller or resource-limited police agencies, attendance was often irregular, and, in some cases, participants were unaware of what Situation Tables were or if they existed in their jurisdiction. Moreover, where Situation Tables did not operate regularly, participants expressed an interest in establishing them, citing the value of multi-agency discussions in providing a more complete picture of clients and enabling better decision-making.

A recurring challenge identified by participants with direct experience with Situation Tables was the uneven participation of health authorities and physicians leaving significant service gaps that limited the Situation Table's effectiveness. Participants also expressed concerns that Situation Tables sometimes lacked training, structure, or accountability that led to frustration when discussions failed to produce meaningful outcomes. The perception that some community partners adopted overly empathetic approaches without adequate training was also raised as a barrier to effective collaboration. Despite these challenges, participants consistently emphasized that Situation Tables provided valuable opportunities for interagency collaboration. They allowed the police to share frontline information about individuals whose instability may not be apparent in clinical settings, while also enabling the police to receive updates and referrals to community services. When functioning well, participants believed that Situation Tables reduced repeated police involvement, improved client outcomes, and promoted shared responsibility among agencies. Participants also noted the importance of Situation Tables being community-led rather than police-driven to enhances trust, improve optics, and foster greater buy-in from non-police partners.

In terms of how police agencies partnered with social workers, participants described social workers as essential for issues beyond the scope of policing, including guardianship, financial supports, housing insecurity, and discharge planning from custody or hospitals. However, the relationships between participants and social workers were often dependent on personal rapport rather than formal structures. Several participants described informal partnerships, where collaboration hinged on strong individual connections rather than consistent organizational agreements. Some formal arrangements, such as memoranda of understanding with the Ministry of Children and Family Development or Indigenous bands, did exist, but these appeared limited in scope. Participants also frequently noted challenges in building and maintaining productive relationships with social workers. There was a perception among some participants that social workers' scope of practice was more limited compared to nurses, particularly when it came to crisis response, leading some participants to prefer nurses in frontline roles. Other participants reported frustration with the lack of reciprocal information sharing, especially with the Ministry of Children and Family Development, describing situations where police officers provided information about a client but received little in return unless the matter was acute. It was felt by some participants that this eroded trust and reinforced the perception that police officers and social workers operated in distinct silos despite sharing objectives and clients.

Still, some participants recognized the unique value social workers brought to multidisciplinary teams and community collaborations. Participants highlighted the contributions of social workers in mental health services, Situation Tables, and ACT teams, for example, where they provided expertise that extended beyond enforcement. Social workers' ability to access income supports,

secure housing resources, and intervene in cases of elder abuse or domestic violence, as examples, was presented by some participants as a demonstration of how their involvement enhanced problem-solving and reduced the risk of issues escalating into criminal matters. Nonetheless, some participants stressed the clear benefits of social work involvement, particularly in connecting vulnerable individuals to services, while others remained skeptical of their practical utility within a policing context. This ambivalence reflected both organizational culture and structural barriers, such as staffing shortages, resource constraints, and differing mandates. In effect, while partnerships with social workers have the potential to significantly enhance police capacity to respond to complex social issues, from the perspective of participants, their effectiveness was constrained by the lack of formal agreements with police agencies, inconsistent reciprocity in information sharing, and cultural divides between the two professions. Strengthening these partnerships would likely require clearer agreements, formal information sharing protocols, and even joint training sessions to build mutual understanding and trust.

When asked about other social service agencies, a prominent theme was the reliance on established partnerships with social service agencies to extend support beyond the immediate scope of police crisis response. For example, agencies, such as the Ministry of Social Development, John Howard Society, and community builders were viewed as critical partners who assumed long-term responsibility for clients once police intervention ended. This distinction between immediate crisis response and ongoing case management emphasized the importance of sustained relationships between the police and agencies whose mandate is to provide housing, welfare, and mental health supports. Again, informal partnerships were common, and participants acknowledged gaps in the availability of resources. One area that was highlighted by several participants was the importance of Indigenous partnerships. Multiple participants stressed that many of the individuals they interacted with were Indigenous, and that partnerships with First Nations organizations and other Indigenous-focused services and programs were central to providing culturally safe and trauma-informed interventions. Not only were these partnerships considered vital, but several officers expressed the view that Indigenous collaborations were necessary for meaningful service delivery. These partnerships were still developing in some areas but were recognized as the foundation for culturally appropriate policing and social support.

The issue of information sharing and formal agreements also emerged as a theme when discussing partnerships with other social service agencies. According to participants, some partnerships operated under memoranda of understanding that enabled limited data sharing and coordination, such as with probation services or social workers embedded in ACT and Intensive Case Management teams. At the same time, confidentiality requirements and security clearance barriers could restrict or limit collaboration, creating tension between the need for timely information and the protection of client privacy. Participants generally described these barriers as manageable, but they nonetheless shaped the effectiveness of inter-agency cooperation to some degree.

Participants also described youth services as an area of partial engagement. School liaison officers and formal connections with the Ministry of Children and Family Development were identified, as well as emerging youth hubs. However, participants expressed less familiarity with the full range of youth-specific services compared to adult-focused supports, suggesting this was an area with potential for stronger partnerships in the future. In sum, the perspectives of participants suggested

that while strong and community-minded connections existed to some extent, especially in crisis response, housing, and Indigenous engagement, there remained challenges around access, formalization, and youth services. For participants, the effectiveness of partnerships was less about expanding formal structures and more about maintaining strong, trusted relationships with key community actors who could assume long-term responsibility for vulnerable individuals, including those suffering from mental illness.

When asked about partnerships with other types of specialized positions, participants expressed that there was a positive benefit of having relationships with other specialized teams and positions to support mental health cases. Participants highlighted partnerships with outreach-based positions, such as crisis nurses, ACT team members, and integrated court teams, which provided complementary expertise to bridge the gap between policing, healthcare, and the justice system. The presence of specialized roles, such as forensic psychologists or peer-assisted community teams, was also identified as contributing to more appropriate client-centered responses. Another key theme was the impact of community-based or peer-led initiatives. Participants noted that clients often responded more positively to peer-led or non-police interventions, such as being accompanied to hospital by a civilian support worker rather than a uniformed police officer. For many participants, these kinds of initiatives represented an important shift in how communities responded to mental health crises, offering culturally safe, less stigmatizing, and often more effective alternatives to traditional policing responses.

Participants also spoke of the significance of justice-linked partnerships, particularly probation and integrated court teams. Probation officers working alongside outreach services and the inclusion of community-based agencies in court processes were seen as extremely valuable for addressing the complex needs of individuals with concurrent justice, mental health, and substance use concerns. However, gaps in Crown participation were reported by some participants, which undermined the effectiveness of some collaborative meetings. The lack of consistency in these justice-focused partnerships suggested how tenuous inter-agency collaborations could be when not fully embedded across all stakeholders.

Again, geographical inequities emerged. Some participants expressed concern that rural and northern communities had limited access to specialized roles compared to larger urban centres. There was strong support for expanding regional models, such as mobile mental health cars, to ensure smaller communities had access to specialized expertise that may only exist in urban areas. Participants also emphasized that while some specialized partnerships were well established, others remained dependent on informal relationships and ad hoc arrangements. Resourcing challenges, organizational restructuring, and the absence of formal mechanisms for Crown engagement were seen as weakening the continuity of specialized support. Despite these challenges, participants consistently recognized the value of integrated, specialized approaches to policing persons with a mental illness, those suffering from addictions, and other vulnerable populations. Participants acknowledged that where these formal or informal partnerships exist, they enhance policing effectiveness by offering expertise, reducing stigma, and addressing root causes of vulnerability. However, their uneven distribution, reliance on individual professionals, and the fragility of inter-agency collaboration remained key challenges for ensuring consistent service delivery across various jurisdictions.

When asked about gaps in partnerships, one consistent theme was the need for stronger and more formalized relationships with health and emergency service partners. Several participants emphasized the importance of programs, such as Mobile Intervention Crisis Response or Car programs. As discussed above, these partnerships were viewed as critical in responding effectively to the high volume of mental health-related calls for service, yet resources, geography, and funding remained significant barriers to their broader implementation. In rural and smaller police agencies, the distance between communities further limited the feasibility of shared crisis response teams, again pointing to the notion that services were unevenly distributed across different policing districts and jurisdictions. Partnerships with Emergency Health Services were also identified as areas needing improvement. Participants expressed concern that limited communication between police agencies and these organizations, and inconsistent standards of care had undermined coordinated responses in crisis situations. A recurring sentiment was the need for better mutual understanding of each other's roles, responsibilities, and professional standards.

Another important theme related to information sharing and coordination, particularly in youth and mental health cases. Participants highlighted the difficulties in responding to youth crises without access to Ministry of Children and Family Development care plans, psychiatric records, or relevant case history. This lack of collateral information forced police officers to work with limited knowledge, increasing the risk of escalation and duplication of services. Participants emphasized that memoranda of understanding and designated liaison positions, such as Integrated Crisis Response Clinicians, could help bridge these gaps, but such structures were not consistently available across all communities. As previously mentioned, specialized expertise was also highlighted by participants who advocated for greater recognition of specific conditions, such as brain injury, which was often misclassified under broader mental health concerns. Participants noted that access to specific expertise, such as psychologists, could improve case outcomes by ensuring clients received appropriate supports. Similarly, some participants expressed interest in stronger partnerships with organizations like the BC Schizophrenia Society and Community Living BC.

In addition, participants underscored that while many partnerships existed, their quality varied. Some relationships with community agencies were well established and collaborative, while others remained tentative or inconsistent. Participants noted that building trust often depended on individual personalities and sustained efforts to demonstrate value in the relationship. Although few participants reported openly hostile relationships, several described past instances of hesitation or resistance from service providers, particularly around shelters or treatment facilities.

It is important to note that most participants expressed that effective partnerships were central to addressing the complex needs of people in crisis, particularly those with mental health challenges, substance use issues, and brain injuries. While participants reported that progress had been made in certain areas, there remained a need for more formalized crisis response models, improved information sharing between service providers and police agencies, and the integration of specialized expertise into the daily work of police officers. From the perspective of many participants, these partnerships were not ancillary but essential to ensuring safe, effective, and coordinated responses to persons with a mental illness.

GENERAL DEMOGRAPHICS OF CLIENTS

Participants were asked to provide general information about the population of persons with a mental illness that they interacted with. These questions were designed to elicit the impressions of participants about how their calls for service involving persons with a mental illness as the subject of complaint broke down.

With respect to gender, while estimates varied, participants consistently described men somewhat more likely to be the focus of police interactions in mental health crises, particularly when violence was involved. Several participants estimated that approximately 60% to 70% of their mental health contacts were male. These cases were often associated with conditions, such as schizophrenia or substance use, which participants identified as more commonly presenting in men. In contrast, participants described women as more frequently associated with suicidal ideation, borderline personality disorder, and wellness checks. Although gender-diverse individuals were much less frequently encountered, their presence underscored the importance of culturally safe and inclusive approaches. However, in some cases, participants noted that their local communities were highly conservative, which may limit the visibility of gender-diverse individuals in police contacts.

With respect to age, there was a clear consensus among participants that police involvement with youth under the age of 12 years old in mental health or crisis-related calls was rare, though not entirely absent. Most participants estimated the proportion to be between 1% to 10% of cases. One explanation provided by participants was that younger children tended to have more resources and supports in place, which reduced the likelihood of police intervention, and that, overall, less mental health concerns emerged during these younger ages. In cases where police became involved, it was often described as the result of extreme circumstances, such as violence or severe behavioural escalation that could not be managed by families or community services alone. Interestingly, a few participants noted a rise in cases involving children under 12 years old related to developmental disorders, autism, or cognitive challenges. These cases were described as particularly complex, often involving violent outbursts that strained the capacity of schools, families, and social service providers. Moreover, these few participants reported that these cases often involved Indigenous families and children suffering from intergenerational trauma. Participants also acknowledged that Integrated Crisis Response Teams often avoided direct involvement with children under 14 years old creating an even greater gap in coordinated crisis response for younger populations.

With respect to persons with a mental illness between the ages of 12 and 17 years old, participants estimated that this group comprised a small but noticeable portion of police calls for service related to mental health, though estimates of their prevalence varied widely across jurisdictions. Most participants placed youth in this range at between 10% to 25% of cases, though some reported higher proportions. A smaller number of participants described youth cases as relatively infrequent, making up less than 10% of their mental health-related calls for service. It was interesting to note that one participant reported that group homes frequently relied on the police as a default response to behavioural issues, sometimes in circumstances that did not warrant a law enforcement presence. This dynamic was described as an overuse of police resources and an underuse of specialized child and youth mental health services. Such calls for service were seen as both repetitive and preventable. Participants reported the disproportionate representation of Indigenous youth in police mental health calls. One participant estimated that approximately 35%

of their youth-related cases involved Indigenous young people, evenly split between girls and boys. This observation aligned with broader concerns about systemic inequities, intergenerational trauma, and the limited availability of culturally safe, trauma-informed services for Indigenous families.

Some participants also emphasized the nature of youth-related calls, which often involved suicidal ideation, behavioural crises linked to ADHD or other developmental conditions, and situations where caregivers felt unable to manage a child's actions. Participants noted that a small number of particularly complex youth generated a disproportionate number of calls for service, elevating overall statistics in certain jurisdictions. These cases were often described as emotionally demanding, requiring careful balance between de-escalation and ensuring safety for both the youth and their caregivers.

It was also interesting to note that while participants suggested that youth aged 12 to 17 years old were not the majority of mental health-related police contacts, they represented a significant operational concern. The unpredictability of youth behaviour, the reliance of some families on police as first responders, and the presence of underlying mental health and developmental conditions all combined to make these calls resource intensive. Some participants highlighted that without stronger access to youth-specific supports and information sharing with agencies, such as the Ministry of Children and Family Development, police will continue to be drawn into situations that might otherwise be better addressed by specialized services.

Participants consistently reported that most police calls for service related to mental health involved adults between the ages of 18 and 64 years old. Most participants estimated that between 60% and 80% of their mental health-related calls for service fell within this age group, with some reporting even higher proportions. Only one participant suggested that adults comprised closer to one-third of their mental health-related calls for service. Many participants described this age group as presenting the most complex and resource-intensive challenges, particularly in relation to substance use, chronic mental illness, and the cumulative effects of trauma. Several participants noted the cyclical nature of adult cases, where individuals transitioned from youth services into adulthood without adequate support, leading to escalating mental health and addiction concerns. In smaller communities, participants reported watching unmanaged mental health conditions and substance dependency lead to early death, incarceration, or long-term incapacitation.

Some participants also spoke of the intersection of addiction and mental illness for this age group. These participants highlighted that many individuals in this age group self-medicated with drugs or alcohol, which both masked and exacerbated underlying mental health issues. This dual presentation complicated crisis response and placed significant demands on police agencies. Participants reported that calls for service within this age group often involved repeat clients who cycled through emergency, criminal justice, and community systems without long-term resolution. The concentration of mental health-related calls for service in the 18 to 64 age group also underscored broader systemic gaps as participants emphasized that adults often fell between the cracks of service systems, with limited access to sustained mental health and addiction treatment. Unlike youth, who may have access to school or care-based supports, or seniors, who may be identified through health care pathways, adults frequently relied on the police as first responders during crises. As a result, some participants reported finding themselves managing issues of

housing instability, untreated psychiatric conditions, and substance-related behaviours that might be more appropriately handled by specialized health and social service providers.

Individuals aged 65 years old and older represented a smaller, though still notable, proportion of mental health-related calls for service. However, estimates varied significantly, with some participants reporting as little as 1% to 5%, while others suggested that the proportion could reach 20% to 30%. As expected, this variation was influenced by local demographics, repeat callers, and whether conditions, such as dementia, were classified as mental health-related concerns. Participants expressed that older adults commonly presented with issues linked to dementia, cognitive decline, or other age-related medical conditions rather than acute psychiatric crises. Participants frequently described calls for service related to the individual appearing confused or behaviour changes tied to physical health deterioration. While some calls for service involved immediate risks, many were seen as less acute due to the presence of home care or medical supports. However, gaps remained as families and caregivers often turned to the police when these supports were insufficient or unavailable. It was interesting to note that some participants also highlighted challenges related to defining and categorizing calls for service involving seniors. For example, some participants questioned whether dementia and related conditions should be captured within mental health statistics, noting that the frequency of calls for service involving older adults increased considerably if these types of calls for service were included. This uncertainty suggests that the actual volume of senior-related calls for service might be underestimated based on how mental health is conceptualized in data collection.

In terms of Indigenous representation in mental health-related police calls, there was a wide range of perceptions among participants shaped largely by local demographics and the availability of culturally specific supports. Estimates varied with some participants reporting that Indigenous people made up only 5% to 10% of their mental health-related calls for service, while others described rates as high as 80% to 85%, particularly in communities where Indigenous people made up most of the population. Participants emphasized that the proportion of Indigenous clients generally reflected the broader demographics of their community, rather than suggesting disproportionate representation. A recurring theme was the role of community-specific services and Indigenous-led organizations, such as friendship centres, First Nations health centres, and harm reduction teams that provided essential supports that reduced reliance on police. In some communities, strong formal partnerships had been established that outlined expectations for police involvement in crisis situations. These arrangements were described positively, as they promoted collaboration and ensured that police responses reflected community priorities and cultural realities. Another consistent observation was the visibility of Indigenous peoples among unhoused populations and within the youth in care system. Participants highlighted that many Indigenous youth with mental health issues were placed in care, often resulting in higher levels of police interaction. Similarly, participants noted that much of the unhoused population in some communities was Indigenous, which increased contact with the police during mental health or addiction-related incidents. It was interesting to note that several participants acknowledged that they did not systematically record whether an individual identified as Indigenous, and some expressed concern that directly asking this type of question could escalate interactions.

Participants suggested that individuals from racialized groups, excluding Indigenous peoples, made up a relatively small proportion of police interactions in mental health contexts. Most participants estimated involvement at less than 20%, with many placing it closer to 10% or lower. In several jurisdictions, participants emphasized that their populations were relatively homogenous, with residents being predominantly white or Indigenous. As a result, mental health calls for service involving racialized individuals were described as limited and largely proportional to their presence in the broader population.

At the same time, some participants identified emerging demographic shifts, particularly with an increasing South Asian population in certain communities. While the numbers remained low, participants noted that South Asian men were becoming more visible within mental health-related calls for service. Of note, South Asian women were rarely mentioned in this context. Other participants observed a growing immigrant population in some communities, including individuals with extensive histories of trauma. These participants noted that there existed significant barriers to engagement with the police because of a lack of trust in the police rooted in their experiences from their countries of origin. Participants expressed that while the proportion of calls for service involving immigrants may currently be low, service needs within these populations may increase as communities continue to diversify.

According to many participants, homelessness and insecure housing were major drivers of police interactions involving individuals with mental health issues, though the estimated proportion of calls for service varied widely between jurisdictions. Several participants reported that 60% to 90% of their mental health-related calls for service involved people who were homeless or living in unstable housing. In these communities, participants consistently emphasized the strong overlap between homelessness, substance use, and mental health crises, particularly drug-induced psychosis and addiction-related emergencies. At the same time, not all participants identified homelessness as the primary factor. A smaller number of participants reported that 20% to 40% of their mental health-related calls for service involved people who were homeless or insecurely housed.

Some participants commented homelessness complicated matters by making it difficult to determine whether a crisis was primarily rooted in mental health, substance use, or the instability of living without secure shelter. Another recurring theme was the perception that individuals who were homeless often fell through systemic cracks. Participants noted that despite their high visibility in public spaces and their disproportionate involvement in police calls for service, those who are homeless or insecurely housed were less likely to be consistently supported by mental health services. Some participants described becoming accustomed to a baseline level of crisis among homeless individuals, where symptoms and behaviours were normalized to the point that police might only intervene when conditions became acute. This reinforced the sense that homelessness both increased contact with the police and simultaneously reduced access to consistent health or social care. There was also an acknowledgement of the diversity within this population. While some participants highlighted unsheltered homelessness as central to their calls for service, others pointed out that insecure housing, such as camps, shelters, or unstable arrangements, also produced significant police contact. The relationship between housing status,

addiction, brain injury, and chronic mental illness was described as complex and mutually reinforcing.

Of note, a clear divide emerged between urban and rural settings in the way homelessness and insecure housing intersected with police responses to mental health crises. In larger or more urbanized communities, participants consistently reported that most mental health-related calls for service, often estimated at 70% to 90%, involved individuals who were unhoused or living in precarious conditions. These participants described a strong and visible overlap between homelessness, substance use, and mental health issues. In such settings, calls for service frequently involved individuals in public spaces, including encampments, shelters, or street-level situations. The combination of open drug use, public disorder, and untreated mental illness produced a significant volume of police workload that was directly linked to homelessness.

In contrast, participants in smaller or more rural communities often downplayed the scale of homelessness as a factor in mental health calls. In these contexts, some participants estimated that only 20% to 40% of mental health-related calls for service involved people without stable housing. Participants in these settings often emphasized that many people experiencing mental illness were in fact housed, and that their police involvement stemmed more from self-harm, family crises, or chronic psychiatric conditions rather than homelessness. This contrast suggests that while homelessness is still present in rural areas, it is perhaps less visible, less concentrated, and less frequently described as the primary driver of mental health calls for service.

At the same time, regardless of whether a participant served in an urban or rural context, structural service gaps for those who were homeless or unstably housed were identified. Urban participants emphasized that those who were homeless or insecurely housed were highly visible to police but under-supported by health services leading to repeated police contact. Rural participants, while identifying fewer homeless individuals overall, noted similar challenges around service access, particularly in relation to addiction, brain injury, and overlapping vulnerabilities. In both settings, the issue of people falling through the cracks in the system was a recurring theme highlighting the difficulty of sustaining consistent care for unhoused individuals regardless of geography.

Drug and alcohol addictions were described by participants as a dominant and pervasive factor in police encounters involving individuals with mental health needs. Most participants estimated that between 60% and 90% of the people they interacted with presented with addictions, often in combination with psychiatric issues. In many cases, participants emphasized that it was rare to encounter someone experiencing a mental health crisis without a concurrent substance use issue. The drugs most frequently referenced included alcohol, opioids, and marijuana, but participants framed the issue less around specific substances and more around the near-constant overlap of addictions with mental illness in police interactions.

Participants highlighted their difficulty in separating mental health concerns from addiction-related behaviours. Several participants noted that substance use often masked, complicated, or amplified underlying mental health issues making it difficult to disentangle whether the crisis was psychiatric in nature, drug-induced, or both. This overlap was especially pronounced in communities where Indigenous peoples were disproportionately affected, with participants observing that addictions were tightly woven into the broader picture of crisis response in these populations. In practical

terms, this blending of issues meant that participants were frequently called to situations where both psychiatric symptoms and substance use contributed to the volatility of a call for service.

Another recurring theme was the way in which addictions escalated police involvement. Some participants pointed out that many individuals suffering with mental illness were able to live relatively stable lives if they were not also struggling with substance use. By contrast, when addictions were present, individuals were more likely to come into contact with the police due to behaviours that were unsafe, disruptive, or criminalized. In effect, some participants felt that substance use was often the tipping point that transformed a manageable mental health concern into a police matter requiring intervention. Finally, there was acknowledgment of systemic gaps in services for people with concurrent disorders. Several participants remarked that many treatment facilities were not equipped to handle individuals with both mental health and addiction issues, despite these being the people police most frequently interreacted with. As a result, these individuals often cycled repeatedly through police, health care, and community systems without consistent or effective support. In terms of differences in urban and rural contexts, the lack of specialized treatment services in more rural jurisdictions was described as leaving the police as the default responders; however, those working in urban environments reported having access to a slightly wider range of services, such as specialized addictions programs, Indigenous health centres, and harm reduction initiatives that could sometimes divert calls away from the police. In effect, while both urban and rural participants viewed addictions as central to their mental health-related calls for service, rural contexts tended to emphasize an almost universal overlap between mental health and substance addiction, compounded by limited treatment resources, whereas urban participants described a more varied population but still noted addictions as a frequent and complicating feature.

A substantial proportion of police calls for service involving individuals experiencing a mental health crisis also featured some form of violence or threat of violence. However, participants consistently emphasized that most of this violence was directed inward, with self-harm and suicidal behaviour being far more common than aggression toward others. Across participants, estimates varied widely, ranging from as low as 1% to 2% of calls for service involving explicit violence, to as high as 90% when including self-harm threats or attempts. Still, most participants placed the proportion somewhere between 40% and 70%. Several participants noted that upwards of two-thirds of violent incidents involved risk to self, while only about one-third involved threats or violence directed toward others. This distinction was highlighted repeatedly, with participants pointing out that suicidal behaviour, self-injury, or threats of self-harm made up the bulk of police mental health-related calls for service. This is consistent with the prior research by Shore and Lavoie (2018) where half of all mental health-related calls to police involved violent threats or behaviour towards the self, while 11% involved violent threats or behaviour towards others.

It was interesting to note how violence was perceived and reported. Participants explained that calls for service were often made by a third-party interpreting behaviour as violent or threatening, even if the individual was not actively violent. For example, a person blocking traffic, yelling, or brandishing an object might be reported to the police as violent, though the situation may primarily reflect crisis-driven behaviour rather than intentional aggression. As a result, some participants expressed that violence was sometimes construed rather than objectively present complicating

how police classified and responded to these events. A smaller but still notable proportion of calls for service involved threats or acts of violence toward others. Participants acknowledged that when weapons were involved or there was imminent danger to bystanders, frontline officers were dispatched first, with specialized mental health teams providing support once the scene had been secured. Some participants also observed that even though actual violence was rare, the potential for escalation was always present, particularly when individuals were experiencing addictions, acute psychosis, or rapid emotional dysregulation.

For those working in rural and smaller communities, participants tended to describe violence as less frequent in absolute numbers but often more visible or dramatic when it did occur. Several participants from rural police agencies stated that suicidal threats were the most common form of self-directed violence but also emphasized the challenge of limited local resources resulting in the police often being the first and sometimes only responders. This heightened the perception that even lower-volume incidents carried more risk in rural or smaller communities. By contrast, in urban settings, participants more frequently reported higher proportions of violence in mental health-related calls for service, particularly when including self-harm. They stressed that the majority of this was inward directed, such as suicidal behaviors, cutting, and overdoses, rather than outward violence, but they also acknowledged that large city environments produced more incidents involving weapons, threats to others, or unpredictable escalations. The presence of group homes, shelters, and larger unsheltered populations in urban centres also contributed to more frequent encounters with threatening behaviour, especially when addictions or substance-induced psychosis were involved.

Most participants placed the proportion of mental health-related calls for service involving outward violence at between 10% and 30%. For some participants, this outward violence was described as typically low-level, such as trespassing, mischief, or outbursts within homes, rather than cases of extreme violence. Still, a minority of participants reported higher proportions, estimating that up to 40% or 50% of mental health-related calls for service involved aggression toward others. In these cases, violence was often linked to certain groups or contexts, such as individuals experiencing homelessness or addictions. Of note, in urban settings, participants tended to provide higher estimates of violence directed toward others, with some reporting that up to 50% of mental health-related calls for service involved threats or acts of violence towards someone else. Urban participants commonly linked this to factors such as homelessness, addictions, and crowded living conditions. In rural and smaller communities, estimates were generally lower, with most participants describing threats or violence against others as accounting for between 10% to 30% of their mental health-related calls for service. Some participants emphasized that the violence they encountered was often less severe, involving threats, yelling, or low-level mischief rather than physical harm. Rural participants also highlighted that community members sometimes perceived unusual behaviors as threatening, which led to calls for service that the police later determined were not true acts of violence. In summary, the urban–rural distinction showed that outward violence was more commonly reported as a feature of urban policing, where social and structural conditions like homelessness, addiction, and the density of services increased both the volume and visibility of incidents. Rural participants, by contrast, saw fewer cases of threats of violence or outward aggression, and they stressed the importance of distinguishing between genuine threats and behaviours that the public simply interpreted as violent.

Several participants reported that approximately half of their mental health-related calls for service could be linked to potential offences, most often in the form of disturbances, such as yelling, swearing, or disruptive behaviour in public. These incidents technically fell under the *Criminal Code* but were rarely pursued formally. Participants described these situations as "nuisance" or "cause disturbance" calls for service that prompted public complaints but seldom resulted in charges. These calls for service were often triggered by complaints from members of the public who were uncomfortable with disruptive conduct rather than by criminal intent. Other participants, particularly in smaller or rural communities, reported much lower rates suggesting that only around 10% to 30% of their mental health-related calls for service involved genuine or chargeable criminal behaviour. Rural participants highlighted that their calls for service more often reflected social and health-related concerns rather than legal ones, and that their responses leaned heavily toward de-escalation and connecting individuals with supports. They also noted that the same individuals were often well-known to local police officers, further reinforcing the practice of managing situations informally rather than through criminal charges. A few participants gave much higher estimates ranging from 70% to 80%, but these were largely framed around technical breaches, such as causing a disturbance or trespassing, rather than substantive criminal offences. Even in these accounts, participants noted that they generally avoided pursuing formal charges unless public safety or repeated disruptions required law enforcement intervention.

There was a great degree of consistency in participants' perception that most police interactions involving people with mental health issues were with individuals already known to them. Most estimates fell between 70% and 95%, with some participants suggesting that nearly all mental health-related calls for service involved repeat clients. Only a small minority of participants reported lower levels of repeat contact, though even those participants acknowledged that recurrent interactions remained a defining feature of their work. Many participants described a pattern in which the same individuals were apprehended, transported to hospital, released, and then encountered again in subsequent crises. This "revolving door" dynamic was described as frustrating for both the police and clients, with one participant stressing that once individuals become trapped in this cycle, it was extremely difficult to break. Participants also highlighted that repeat contacts were not necessarily criminal in nature. Many individuals were known for ongoing struggles with paranoia, addictions, brain injury, or suicidal ideation, rather than for criminal offences. In this way, the police became default responders to ongoing health and social problems.

Several participants linked the frequency of repeat encounters to local context. In smaller or more rural communities, participants reported that they knew nearly everyone involved in mental health-related calls for service, and could often predict who was involved as soon as the call came in. In these communities, the small population size and limited mobility of residents meant that participants routinely dealt with the same people over long periods of time. This familiarity was sometimes described as beneficial in that participants had prior knowledge of individuals' needs and histories, but it also underscored the lack of local treatment resources leaving police to cycle repeatedly through the same cases.

Urban participants similarly reported high repeat contact but also pointed to transience and mobility as contributing factors, noting that new individuals appeared more often in their caseloads, particularly those passing through shelters or living unstably. Seasonal fluctuations were

also noted, with some communities experiencing an influx of new individuals in the summer months. This created a more dynamic caseload compared to rural settings, where the same clients were consistently encountered. A few officers reflected on the small but significant portion of calls involving first-time or one-off encounters. These tended to be associated with suicidal threats or individuals experiencing acute distress who had not previously come to the police's attention. While less common, these cases were described as noteworthy because they disrupted the pattern of familiar faces and highlighted broader shifts in community need.

INTERNAL POLICE AGENCY COLLABORATION

Participants were asked what other units or sections they most collaborated with when handling calls for service involving persons with a mental illness. The most common collaborations reported were with frontline police officers, which were described as central to responding to calls for service involving mental health. In larger, urban settings, participants reported frequent collaborations with a wide range of specialized sections, such as with school liaison officers, particularly in cases involving youth, and with domestic violence coordinators where mental health and relationship dynamics overlapped. In several urban contexts, bike patrol units and downtown safety teams were highlighted as valuable partners as they were often the first to encounter individuals in crisis in public spaces. Specialized investigative units, such as serious crime, general investigation services, and crime reduction units were mentioned less frequently but were still viewed as important collaborators in certain circumstances. Participants described instances where mental health intersected with more serious criminal investigations, including homicides, assaults, or prolific offender management. While these units did not focus on mental health directly, they were engaged when cases overlapped with their mandates, such as locating individuals, managing drug-related crime, or investigating threats.

By contrast, in smaller or rural jurisdictions, the range of available units was far more limited due to fewer specialized sections. Participants often emphasized that frontline policing was the primary, and sometimes only, collaborative partner. In some rural areas, Indigenous Police Services and victim services played a more visible role, particularly in communities with significant Indigenous populations. Collaboration here was less about specialized enforcement and more about community engagement and crisis support. Community-oriented policing was also highlighted as a key partner in some jurisdictions. Participants emphasized the role of Indigenous policing units and victim services in supporting individuals in crisis and their families, particularly in rural or mixed communities. Community officers were noted as being especially engaged with youth, though some participants expressed that other vulnerable groups, such as seniors with dementia, received less targeted support.

Overall, the key theme is that cross-unit collaboration is both common and necessary, with front-line units serving as the central partner. However, in many cases, urban police agencies benefited from a broader network of specialized partners that allowed for more targeted responses to mental health-related calls for service. However, rural police agencies operated with fewer formal partnerships and relied more heavily on frontline police officers, Indigenous policing units, and community-based supports. This urban–rural divide highlights the importance of tailoring

collaboration strategies to local resource environments, with urban areas leveraging specialized units while rural areas depended more on community-oriented policing approaches.

SERVICE, PROGRAM, AND RESOURCE GAPS IN RELATION TO THE NEEDS OF PERSONS WITH A MENTAL ILLNESS

A recurring theme from participants was the absence of adequate treatment and support infrastructure, particularly in relation to the interconnected issues of mental health, addictions, and housing. Participants consistently highlighted the lack of detox beds, inpatient recovery facilities, and long-term treatment options. Many described a cycle in which individuals were discharged from hospital prematurely due to capacity pressures, only to re-enter police contact shortly thereafter. This gap was seen as unsafe for both individuals and the community, as the police were left managing people who were not stabilized but had nowhere appropriate to go. Addiction-specific services were identified as especially inadequate, with many participants calling for a structured continuum of care that included detox, rehabilitation, and life skills programs.

Several participants also underscored the need for specialized mental health services tailored to particular populations. These included ACT teams for individuals with serious psychiatric histories, geriatric psychiatry for older adults, youth-focused programs, and supports for people with brain injuries. Indigenous communities were noted as facing unique challenges, with participants emphasizing the lack of culturally based supports, such as land-based treatment and the broader absence of accessible education, transportation, and health infrastructure. Participants described how these structural deficiencies contributed to cycles of substance use, trauma, and crisis that frequently brought individuals into contact with the police.

Housing emerged as another critical gap. Participants explained that when shelters were full, many individuals had no safe alternatives leaving the police to manage the consequences of homelessness in the absence of systemic solutions. At the same time, examples were provided of how stable housing contributed to reducing repeated police contacts demonstrating the preventative value of investing in secure housing options. Participants also identified gaps in both staffing and professional knowledge. Shortages of psychiatric nurses, outreach workers, and physicians were frequently cited as barriers to effective and timely mental health interventions. In addition, participants pointed to the benefits of outreach models, in which services proactively met people where they were, rather than expecting individuals in crisis to seek out supports on their own.

There were some notable urban–rural differences. For example, urban-based participants were more likely to focus on shortages of specialized teams, such as ACT teams or mobile crisis cars, the need for additional psychiatric nurses, and the lack of integration between hospital discharge practices and community supports. In contrast, rural-based participants described much broader gaps in basic infrastructure. They highlighted the absence of accessible transportation, the lack of youth programs, and barriers facing Indigenous communities where leaving the community for treatment might mean disconnecting from culture, while staying often led to cycles of trauma, substance use, and victimization. Participants from smaller police agencies also reported operating without specialized units or health resources, which left frontline police officers to manage mental health-related calls for service with limited systemic support.

In effect, participants across different contexts described a fragmented and under-resourced system in which the police were often the default responders to crises that should be addressed by medical, housing, or social service systems. The missing pieces include treatment infrastructure across the continuum of care, specialized supports for distinct populations, adequate housing, culturally relevant services, and sufficient staffing of programs and services. These gaps contributed to perpetuating cycles of crisis that repeatedly involve the police, with urban participants emphasizing system capacity and coordination, and rural participants highlighting fundamental service shortages and geographic isolation.

SUCCESSES AND CHALLENGES IN RESPONDING TO CALLS FOR SERVICE INVOLVING PERSONS WITH A MENTAL ILLNESS

A consistent theme in participants' reflections on what was working well with how their police agencies were responding to persons with a mental illness as the subject of complaint was the strength of partnerships and collaboration. Many participants, particularly those working in urban contexts, highlighted the value of having access to embedded or partnered mental health professionals, such as psychiatric nurses or clinicians working alongside police. As outlined above, co-response models were described as highly effective in reducing apprehensions, decreasing wait times, and improving outcomes for people in crisis. Participants reported that these arrangements allowed for more appropriate triage, as some individuals responded poorly to the police but engaged more openly with nurses or social workers. This ability to combine law enforcement authority with clinical expertise was widely seen as extremely beneficial. In addition, good working relationships with hospitals and regional health authorities were repeatedly identified as crucial for ensuring continuity of care and avoiding repeat calls.

Several participants also emphasized the internal culture of their units as a positive factor. Respectful treatment of clients, strict expectations that individuals in crisis were not mocked or dismissed, and a high degree of compassion among newer police officers were described as hallmarks of contemporary policing in this domain. Participants valued management that actively supported mental health initiatives, whether by advocating for more resources, permitting innovation in team structures, or embedding social workers or nurses within the policing agency. This organizational backing was seen as critical in sustaining specialized responses and in encouraging police officers to engage with trauma-informed practices and ongoing training.

At the community level, participants described the benefits of rapport and trust. Smaller police agencies, often in rural settings, noted that repeated interactions with the same individuals and families allowed them to build strong relationships that facilitated better de-escalation and cooperation. In these contexts, participants valued the ability to liaise directly with community partners who would share information about clients in need of extra support. However, some participants acknowledged that these relationships were often highly dependent on individual police officers rather than formalized systems, which, as mentioned in a previous section of this report, raised concerns about sustainability should key personnel leave their organizations.

Interestingly, training and education were also cited as areas of progress. Both urban and rural based participants reported that new recruits were receiving more comprehensive instruction in mental health awareness, while some police agencies benefited from in-service sessions delivered

by social workers or community partners. This was seen as contributing to a cultural shift in which police officers were more open, receptive, and willing to learn about trauma-informed practices and mental health complexities. Still, differences between urban and rural experiences were apparent. Urban-based participants tended to highlight the benefits of structured resources, such as crisis cars, Situation Tables, and embedded clinicians. They described how these specialized responses helped streamline processes and reduced pressures on both the police and hospitals.

In contrast, rural-based participants emphasized the interpersonal aspects of their work and pointed to the strength of informal relationships, compassion within small police agencies, and the recognition that effective policing relied on treating people with dignity in close-knit communities. Rural participants also valued the flexibility to build partnerships with Indigenous outreach teams and community agencies, even if these were less formalized than what might be found in an urban context. Overall, participants described a policing environment in which meaningful partnerships, respect for clients, organizational support, and emerging training practices created a stronger foundation for responding to people with mental illness. While the mechanisms differed across urban and rural settings, both emphasized the importance of collaboration, compassion, and professionalism as central to what was currently working well.

Participants across both urban and rural jurisdictions provided insight into the limitations of current practices in responding to calls for service involving mental health. While some participants expressed general satisfaction with their policing agency's approach to responding to mental health-related calls for service, several systemic and operational challenges were identified. Participants consistently highlighted shortcomings within the healthcare system as a key barrier to effective and timely interventions. They described repeated instances in which individuals experiencing suicidal ideation were transported to hospital only to be discharged shortly afterward without treatment. In these instances, the police were often called to re-engage the same individuals, who remained in crisis. Participants attributed this cycle to systemic factors, such as limited psychiatric beds, assessments conducted by emergency physicians rather than mental health specialists, and the tendency for patients to minimize their symptoms once in hospital care. Participants expressed frustration that their assessments were not always given sufficient weight by emergency room physicians, and that responsibility fell back to police if an individual later harmed themselves. In rural areas, the additional gap of the lack of detox facilities was commonly identified. Individuals with addictions were often stabilized temporarily in hospital but released without access to structured treatment creating ongoing demand for a police response.

The need for more specialized resources and models of care was a recurring theme. Some participants suggested that embedding nurses in call centres or expanding the Car program could improve both triage and frontline response. These resources were seen as beneficial in reducing unnecessary apprehensions and ensuring that crises were met with appropriate medical expertise. In urban settings, participants stressed that such services should be available on a 24/7 basis, reflecting the reality that mental health crises occur outside of business hours. However, participants noted that institutional barriers, such as limited support from public health agencies, prevented the adoption of these models in some jurisdictions.

Other common themes were the need for more training and access to more reliable information about clients when on-scene. Participants reported that frontline officers often lacked sufficient

training in mental health leading to an over-reliance on apprehension or difficulty making independent decisions in the absence of a nurse or clinician. Rural participants raised concerns about the absence of accurate, up-to-date mental health information at the point of contact, which resulted in them often relying on third-hand accounts, unverifiable self-reports, or outdated records that heightened the risk of misclassifying calls and applying inappropriate responses. Finally, participants underscored the toll that these challenges took on their own wellbeing. Participants described the negative effects that repeated exposure to crises had on them, while supervisors acknowledged devoting significant time to supporting the mental health of their teams and highlighted the cumulative burden that repeated and unresolved calls for service placed on frontline officer resilience. In effect, the challenges identified by participants highlighted a complex interplay between limited police resources, gaps in healthcare and social services, training needs, and officer wellbeing. Urban participants confront high-intensity incidents with inadequate support from health systems, while rural participants face acute shortages in personnel, information, and treatment facilities. Across both contexts, participants stressed the importance of more specialized resources, enhanced interagency collaboration, and stronger supports for police officers themselves.

When asked what they should be doing that they are not already doing with respect to calls for service involving persons with a mental illness, several participants expressed a need for more proactive and immediate engagement during in-progress calls for service, particularly those involving suicide or acute mental health crises. In urban areas, this often took the form of requesting more frequent deployment of crisis teams to reduce unnecessary apprehensions and improve outcomes by having specialized staff present. Those working in smaller police agencies echoed these sentiments but were more constrained by limited resources and distance. Regardless of jurisdiction, resources were another consistent theme. Participants in urban contexts emphasized the potential benefit of expanding crisis teams to cover each watch, ideally consisting of both police and health professionals. While they acknowledged that a full 24/7 service may not be necessary given the volume and distribution of mental health-related call for service, many participants envisioned larger, more robust teams that could assume a greater share of calls for service from frontline police officers. In rural or smaller jurisdictions, resource scarcity was more evident, with participants highlighting the need for direct access to services, such as detox and counselling.

Several participants identified system-level improvements as a priority. The most consistent concern was the lack of coordination and integration with partner agencies. Participants noted the absence of a collaborative frontline presence from external partners, which left the police disproportionately responsible during crises. Again, the call for a dedicated nurse practitioner embedded within the police service also reflected a desire from most participants to formalize health–police partnerships and create smoother interactions with hospitals where this approach did not currently exist.

Preventive and follow-up measures were other areas where participants felt improvements could be made. Participants suggested the creation of a referral-based system, similar to victim services, where individuals with ongoing mental health issues could receive follow-up support from non-police personnel. Some participants felt that this would allow for a more proactive approach to

connecting vulnerable individuals with community services while reducing repeated police involvement. Linked to this was the request for additional staff capacity dedicated to referrals and follow-up, particularly in urban settings where demand was higher. And participants raised broader concerns around education, accountability, and systemic failures in mental health care. Some participants emphasized the need to better inform the public about the risks and harms faced by police in responding to mental health calls, including the personal toll on participants when forced into potentially lethal situations with individuals in crisis. Others pointed to the current state of the broader mental health system, where severely ill individuals remained in the community placing frontline police officers at risk and fueling public criticism. There was also a recognition of the importance of collecting demographic data, such as race and gender, to better understand trends and address issues of disproportionality.

Taken as a whole, while participants frequently described current practices as highly effective, they identified key areas for further development, including expanding mobile crisis response teams, implementing processes to allow for greater follow-up capacity, and stronger hospital and community service provider partnerships. In addition, participants highlighted the need for streamlined access to services and flexible resource allocation in those jurisdictions with limited infrastructure. In effect, there was a consistent call from participants for improved coordination, proactive engagement, and systemic reforms to ensure that crisis response efforts were both effective and sustainable.

When asked what participants were currently doing that could be done better by others when it came to responding to calls for service involving persons with a mental illness as the subject of complaint, a central theme was the misallocation of responsibility for non-policing matters. Participants frequently noted that they were called to situations that did not require a police response, such as wellness checks, overdoses, or individuals in distress who were not posing a safety risk. In these cases, the absence of accessible alternatives meant that the police became the default responders. Participants expressed frustration that these matters were more appropriately situated within health or social service systems yet were consistently directed to the police. This pattern was particularly evident in rural settings, where limited availability of health professionals or outreach staff left few alternatives, but all participants described being pulled into non-criminal, health-based incidents unnecessarily.

Given this, participants also emphasized the need for alternative response models that reduced reliance on the police. Many participants advocated for non-police teams to attend mental health-related calls for service where no danger was present, such as the Car 60 or Car 67 models, or to implement community-based crisis response initiatives run by civilian or Indigenous-led agencies. These models were seen as effective in diverting non-criminal calls for service away from the police while still providing timely support. Participants also called for a provincial framework or set of standardized practices to reduce inconsistencies across jurisdictions, noting that the lack of alignment creates inefficiencies and places uneven burdens on local police agencies.

A further theme concerned partnership gaps and role overlap. Some participants reported undertaking tasks normally associated with outreach or social work, such as supporting clients with income assistance, treatment applications, or medication compliance. They felt that this work fell outside their mandate and placed them in precarious positions, both in terms of personal safety

and organizational policy. These types of commented highlighted gaps in partnerships and resourcing from other agencies that forced the police to fill roles that should be the responsibility of health and social service providers. Finally, there was a strong recognition of the limits of policing in addressing systemic mental health issues. Participants argued that long-term care options, follow-up supports, and accessible treatment pathways were currently insufficient leaving the police to repeatedly engage with individuals in crisis. Participants expressed concern that without broader systemic investment, they remained on the front line of issues for which they were neither trained nor resourced that created risks for themselves, the client, and the public.

When asked about the main challenges in establishing and maintaining an effective response to persons with a mental illness, one of the most consistently mentioned issues raised by participants was the blurring of responsibility between policing and health care. Participants described being called to situations that were primarily health-related rather than criminal or safety matters, such as addiction, overdoses, and ongoing mental health crises. Urban participants emphasized the inefficiency created when police wait in emergency rooms for extended periods while clinical assessments were made, often with little ability to influence outcomes. Rural participants highlighted the scarcity of detox beds and health infrastructure, sometimes several hours away, which led to repeated police involvement in situations better addressed by medical professionals. Across settings, participants stressed that when health services were under-resourced or inaccessible, the burden defaulted to the police, as one of the only, if not only, 24/7 service.

Another prominent challenge concerned resource and staffing limitations. Participants noted that programs, like the mobile crisis response program, were jeopardized when police officers or nurses were absent due to training, leave, or illness. In urban police agencies, the issue was compounded by competing priorities across specialized units, with integrated crisis teams sometimes losing members to fill shortages elsewhere. Rural participants described similar strains, noting that limited personnel meant they were often required to cover multiple demands, leaving gaps in service. The lack of consistent staffing was described as undermining both program stability and the ability to deliver timely crisis response to persons with a mental illness. Participants from rural jurisdictions or smaller police agencies described feeling “forgotten” within broader resource distribution frameworks and highlighted the unique challenges of serving small, dispersed populations with rising rates of homelessness and substance use. Creative regional approaches were seen as essential in these contexts, such as rotating clinicians across communities or deploying integrated teams that could respond across jurisdictions. However, participants also noted the logistical barriers of distance and travel time, which limited timely response in small or remote areas.

Participants also identified inconsistencies in practice and coordination as a source of difficulty. Some participants mentioned that frontline police officers varied in how they handled mental health calls, with some defaulting to apprehension rather than involving specialized teams. Others described challenges with frontline police officers who lacked experience or interest in mental health work, occasionally escalating situations unnecessarily. In rural areas, this issue was compounded by limited training opportunities and a general reliance on less experienced police officers.

As alluded to above, the interaction with hospitals was described as particularly problematic. Many participants expressed frustration at long waits for medical certification, inconsistent responses from hospital staff, and the responsibility that police officers had for clients in emergency rooms until a physician assumed formal care. Participants reported situations where patients absconded from hospital while still under police responsibility resulting in additional administrative and investigative burdens. In rural contexts, where hospitals were often smaller and understaffed, participants described health services as overwhelmed leading to patients being discharged prematurely and returning to police attention shortly thereafter.

Participants further pointed to systemic challenges in addressing addiction and mental health issues. Participants described struggling to engage individuals who did not recognize that they were unwell, particularly those living with addictions. Some participants expressed concern that current approaches, such as safe supply programs, were ineffective or even harmful, suggesting that they perpetuated rather than reduced underlying issues. Others emphasized that without secure long-term care options, individuals cycled repeatedly between crisis, hospital, and community, with police continually drawn back into their care.

It is also important to recognize that several participants noted the unpredictability and personal toll of crisis response work. Participants described the difficulty of anticipating the nature of calls for service they attended, the strain of repeated interactions with high-need individuals, and the frustration of seeing limited progress despite intensive effort. In both urban and rural settings, participants spoke to the emotional and organizational challenges of being tasked with responsibilities outside of traditional policing mandates, often in the absence of adequate support from health or social service partners.

Recommendations

TRAINING

There is a need to expand the scope and depth of formal training offered by police agencies. As discussed in the literature review, in-depth training on responding to mental health-related calls for service is unusual, yet the research demonstrates that the 40-hour programming provided through CIT tends to reduce stigmatic attitudes towards persons with mental illness, leaves police officers feeling prepared to effectively manage these calls for service, and is associated with reduced use of force and increased diversion to relevant community programs. While co-response models appear to achieve the most benefits empirically, CIT training can be used in conjunction with these teams or on its own when it is not feasible to implement a co-response team. However, the main limitation with CIT is that it is difficult for police agencies to afford 40-hours of training time when already challenged with understaffing of frontline personnel.

It is recommended that mandatory training include in-depth modules on specific mental health conditions, personality disorders, and the distinction between mental health and substance-induced behaviours. This training should be standardized across British Columbia while allowing for contextual adjustments to reflect jurisdictional mental health needs. Training should also adopt a more experiential and scenario-based format. Participants in both surveys and interviews consistently emphasized the value of real-world practice in developing effective crisis management

skills. Incorporating scenario simulations, role-play, and virtual reality-based training would provide police officers with opportunities to apply theoretical knowledge to realistic situations. In addition, the regular use of reflective tools, such as body camera reviews, could be used to support ongoing learning and accountability.

The integration of collaborative learning with health professionals should be prioritized. Opportunities for police officers to work alongside nurses, social workers, and clinicians within specialized units should be expanded. Joint training exercises with health authorities would foster mutual understanding, reduce unnecessary apprehensions, and improve outcomes for individuals in crisis. Establishing formalized partnerships for cross-training could also help bridge the knowledge gap between policing and health care. Moreover, this training should include information on trauma and historical context ensuring culturally sensitive and proportionate responses to vulnerable populations (Shore & Lavoie, 2018).

To address needs across the police agency, training should be structured in a tiered system. Foundational training on mental health awareness, requirements under the *Mental Health Act*, crisis de-escalation, and non-violent communication should continue to be mandatory for all police officers. More advanced training focusing on mental health interviewing, risk assessment, and legislative frameworks should be provided to those in specialized units or investigative roles. This approach would ensure that all police officers possess essential competencies while allowing for the development of advanced expertise where it is most needed. Police agencies should also encourage and support external professional development opportunities as police officers commonly benefit from attending and participating in conferences, workshops, and academic training. Providing institutional support for attendance at such events and integrating external learning into professional development plans would enhance officers' knowledge and practice.

Scenario-based and virtual reality training should be expanded and standardized as a core component of police officer preparation, particularly for encounters involving individuals in mental health crisis. The realism and practical value of these exercises make them an effective means of bridging theory and practice, and participants consistently reported that such training mirrors operational realities. To enhance its effectiveness, there is a need to increase the frequency and accessibility of immersive, live scenario-based exercises. While online scenarios and case studies provide some educational value, they lack the interactive, dynamic qualities of live training. Greater emphasis should be placed on simulations that allow police officers to practice negotiation, de-escalation, and crisis response in controlled but realistic settings. Moreover, scenario design should more explicitly incorporate mental health-related content. Commonly, police officers receive updates on legislation and policy primarily through email or written communication, which limits opportunities for practical application. Embedding these updates into scenarios would enable officers to practice applying legislative frameworks, such as Section 28 provisions, within realistic operational contexts.

In addition, collaboration with subject-matter experts should be strengthened and formalized. Input from psychologists, crisis nurses, and other professionals has been shown to increase the authenticity and relevance of training scenarios. Expanding these partnerships can ensure that police officer training is informed by clinical expertise, particularly in relation to how individuals experiencing mental health crises may react to police presence and communication strategies.

Moreover, evaluation mechanisms should be built into scenario-based training. This could include structured feedback from both instructors and health professionals, as well as opportunities for police officers to reflect on their performance. Incorporating evaluative practices would support continuous learning, reinforce effective de-escalation strategies, and ensure that training remains aligned with evolving operational realities.

Role-playing should be expanded and systematically integrated into police training programs to enhance practical preparedness, particularly for interactions with individuals experiencing mental health crises. To improve the effectiveness of role-playing, exercises should prioritize realism and authenticity. Involving trained actors, health professionals, or crisis specialists can help simulate the behaviors and responses of individuals in mental health crises, providing police officers with more accurate and transferable learning experiences. Addressing resource and logistical challenges is critical for expanding role-playing opportunities. Smaller police agencies face barriers related to personnel availability and operational demands. To mitigate these constraints, police agencies could adopt a blended approach, combining low-resource methods, such as tabletop exercises and virtual simulations, with periodic in-person immersive sessions. This strategy would allow more frequent engagement without significantly disrupting frontline duties. By doing so, role-playing can serve as a practical complement to theoretical learning, equipping officers with the knowledge and confidence needed to respond effectively to complex, real-world situations.

Finally, mechanisms for information sharing and consistency across regions should be strengthened. The lack of coordinated practices can create challenges for police officers and limit the effectiveness of their responses to mental health crises. Establishing regular inter-agency meetings, regional knowledge exchange forums, and guidelines for police–health collaboration would address these challenges and promote best practices across jurisdictions. Taken together, these recommendations highlight the need for a more comprehensive, practical, and collaborative approach to mental health training in policing. Such an approach would not only enhance officers' confidence and competence but also improve the safety and well-being of persons with mental illness during police interactions. More specifically, in larger police agencies, where the frequency and variety of mental health calls is high, training should include collaborative decision-making with health professionals. In smaller police agencies and in rural areas, training should prioritize equipping frontline police officers with the skills to manage mental health calls in contexts where health partners may be unavailable through advanced courses or cross-training.

RECRUITMENT

The recruitment of police officers for mental health policing units requires careful consideration to ensure that candidates possess the appropriate skills, attributes, and commitment. Effective recruitment for mental health policing requires more than traditional competency-based approaches. A structured, skills-based, and inclusive recruitment process that emphasizes soft skills, diversity, and commitment will strengthen the effectiveness of police–based mental health teams. The ability to demonstrate patience, empathy, effective communication, and de-escalation skills was consistently identified by participants as more important than technical knowledge or prior training. Recruitment processes should consider prioritizing the assessment of these qualities through scenario-based evaluations and input from mental health professionals. Candidates who

can remain calm under pressure, read body language effectively, and collaborate respectfully with other service providers, such as nurses, might be particularly well suited for these roles. Moreover, the importance of diversity within mental health policing teams was highlighted by participants as essential to establishing and maintaining client rapport and trauma-informed practice. For example, the presence of female officers was considered critical when responding to clients with histories of gender-based trauma. Recruitment strategies should, therefore, consider demographic balance and representation, ensuring that mental health teams reflect the diverse communities they serve.

Candidates who demonstrate a genuine interest in mental health policing and a passion for working with persons experiencing mental illness might be best positioned to succeed. While self-identification is valuable, additional screening for motivation and long-term commitment is recommended. This will ensure that those who join mental health units are prepared for the demands of the role and are likely to remain effective over time. To that end, stability in staffing is important for building rapport with clients and maintaining strong community partnerships. At the same time, structured opportunities for rotation may support knowledge transfer throughout the policing agency. Therefore, where they do not exist, clear policies regarding tenure should, be developed to balance continuity with broader organizational needs.

EXPANSION OF CO-RESPONSE TEAMS AND PARTNERSHIPS

Given the challenges and opportunities described by participants, expanding access to specialized co-response teams that pair police officers with mental health professionals should be prioritized. These teams are typically more effective in assessing risk, reducing unnecessary apprehensions, and providing community-based support. Increasing their availability across police agencies would not only improve outcomes for individuals in crisis but also alleviate pressure on frontline police officers. At the very least, all police agencies should develop proactive outreach approaches to addressing persons with a mental illness. Where they do not currently exist, police agencies should partner with local health and social service agencies to pilot multidisciplinary teams embedded within police agencies. These teams should be focused on addressing high-need individuals before crises escalate, support treatment and discharge planning, and reduce repeat calls for service. Larger police agencies may be able to sustain permanent teams, while smaller police agencies or those in more remote areas can explore mobile or rotating outreach units that can serve multiple smaller communities and be shared across communities. Police leaders can also champion preventive programming as part of community policing strategies, emphasizing early intervention over reactive response. Moreover, strategies to address repeat and chronic callers should be developed in collaboration with health and social service providers. A coordinated case management approach could ensure that high-frequency users receive sustained support, reducing the cycle of repeated police involvement without meaningful resolution.

To make a mobile crisis response approach most effective, greater collaboration and communication with hospitals is needed to improve the efficiency of emergency department processes. Standardized procedures for police handovers, clearer expectations around police officer involvement at the hospital, and improved information-sharing could reduce wait times and allow police officers to return to frontline duties more quickly. Another way to address this issue is

through the training and guidance of police officers that continues to emphasize the use of discretion, particularly in balancing enforcement with health-based responses. By equipping police officers with tools to differentiate between behavioral issues, substance use, and mental illness, decisions can better reflect the complexity of these situations, and unnecessary apprehensions could be avoided. In addition, it is recommended that police agencies continue to integrate addiction and mental health education into both general and specialized training. Given the intersection of these issues with criminal behavior, police officers must be prepared to navigate overlapping health and public safety concerns effectively.

One of the key challenges identified by participants was inconsistency among frontline police officers in determining when to apprehend and when to involve crisis response teams, if they exist. This variation not only created inefficiencies but could also erode relationships with health partners. Given this, it is recommended that police agencies implement standardized training so that all frontline police officers follow consistent practices and understand when to reach out to a crisis response team. Doing so should contribute to reducing unnecessary apprehensions and enhancing confidence among both police and community partners.

Moreover, clear policies and procedures should be established to prioritize mental health intervention while ensuring that criminal accountability is not neglected, promoting consistent practice across all police agencies. As outlined above, regular, mandatory training should be provided for police officers in trauma-informed care, de-escalation techniques, brain-based response strategies, and engagement with neurodiverse populations. Interagency collaboration with hospitals, mental health teams, and crisis units should be strengthened, potentially including dedicated liaison officers to coordinate assessment, treatment, and follow-up care. Whenever possible, family members and caregivers should be engaged through structured plans that guide individualized responses, ensuring both safety and recovery.

Systematic incident review procedures should be implemented to monitor outcomes, identify trends, and inform future practices. Resource allocation should be guided by risk, ensuring that high-priority mental health calls receive sufficient support without compromising public safety. Clear procedures should be developed for incidents involving both mental health and criminal elements, defining when to prioritize safety, legal action, or mental health intervention. Finally, structured follow-up protocols should be established for individuals with repeated interactions with police, promoting long-term stability and reducing the likelihood of recurring crises.

ENHANCING DEPLOYMENT AND COVERAGE

Resourcing was a central issue for most participants, particularly with respect to staffing shortages and the vulnerability of programs when staff were absent due to leave, illness, or training. Police leadership should prioritize maintaining adequate staffing levels in integrated units and consider flexible models of deployment that allow teams to adapt to changing demands without jeopardizing core operations. A second step might include assessing the feasibility of assigning dedicated police officers to hospital liaison duties. While full 24-hour coverage may not always be necessary, ensuring that resources are concentrated during peak demand periods could mitigate pressure on frontline police officers and better align capacity with community needs. In effect, mental health units or teams should be resourced to manage high call volumes, including hospital wait times, to

prevent frontline police officers from being overwhelmed. In smaller or rural police agencies where staffing shortages may be more acute, the addition of even one or two police officers dedicated to mental health and hospital liaison duties would likely contribute to significantly improving service delivery.

As outlined in several places in this report, it is recommended that police agencies analyse their unique calls for service patterns and trends to reach an evidence-based assessment of whether there would be a benefit in expanding crisis response capacity by creating dedicated teams for each watch. Two benefits of this allow for a more consistent presence of team members at in-progress calls, particularly those involving self-harm and acute crises, and this would reduce the reliance on frontline police officers to address mental health issues. Again, in many jurisdictions, full 24/7 coverage is not required, but staffing levels should align with peak demand periods. For smaller police agencies or those in rural areas, it is recommended that the focus should be on the development and implementation of flexible and scalable deployment models that account for resource limitations and geographic distance. Options could include regional teams or rotational coverage to ensure smaller communities are not left unsupported.

REDUCING HOSPITAL WAIT TIMES FOR PERSONS WITH MENTAL ILLNESS

As the amount of time that police officers spent waiting with clients at hospital was a consist theme among participants, there might be some value in establishing a Memoranda of Understanding between the police agency of jurisdiction and the appropriate health authority to ensure timely admission of individuals apprehended under the *Mental Health Act*. In addition, hospitals should be encouraged to explore the expansion of mental health triage zones or dedicated crisis response pathways in hospitals to reduce emergency department bottlenecks, especially in those jurisdictions that experience a lot of mental health-related calls for service. As outlined throughout this report, it is also recommended to increase the investment in co-response and specialized mental health units to allow for more time-intensive, relationship-based approaches. When doing so, it might be valuable to explore some permanent staffing models to build consistency, expertise, and stronger working relationships with health partners and other community-based service providers.

It is also recommended to develop joint training and cross-sector protocols that standardize expectations for both police and hospital staff, which could contribute to minimizing delays and improving overall efficiency. An additional way to address wait-times could be to assign dedicated liaison roles (either police or health professionals) to expedite communication between the police and the hospital during hospital transfers. On the police side, it is recommended to continue to encourage police officer discretion in determining whether hospital apprehension is necessary. To that end, again, it is important to provide all police officers with training in de-escalation, trauma-informed practice, and rapport-building to help resolve crises in the community when appropriate, thereby reducing extended on-scene times and apprehensions. Finally, it is recommended that police agencies track the amount of time police officers spend on mental health calls for service to identify resource impacts and justify additional supports or staffing where call volumes are high. Related to this, it might be helpful for police agencies to explore options for rotating backup police officers engaged in a lengthy hospital guard duty to minimize strain on frontline service delivery.

FOLLOW-UPS WITH PERSONS WITH A MENTAL ILLNESS

Based on the interviews conducted for this study, there appears to be the need for clearer mandates and resource allocation to support structured follow-up. From the information collected through interviews, with very few exceptions, follow-up with persons with a mental illness after a call for service was treated as secondary to primary response, which results in inconsistent practices across jurisdictions. Establishing formal expectations for follow-up within specialized teams, along with sufficient staffing and time allocation, would allow police officers to engage in proactive monitoring and reduce the recurrence of crisis calls. One possible approach might be to have dedicated staff or seconded frontline police officers handle proactive follow-ups, ensuring continuity of care and reducing repeat crises. In addition, many participants described their reliance on mental health nurses, ACT teams, and community agencies to provide continuity of care, but highlighted barriers caused by information-sharing restrictions. Developing memoranda of understanding between police and health agencies that permitted limited, health-focused information exchanges would allow for a more coordinated follow-up strategy while respecting privacy legislation. This would also reduce duplication of effort and help ensure that clients are successfully linked to services.

Moreover, what happens during a follow-up should be better recorded and tracked. Several participants reported engaging in informal or unrecorded check-ins, which, while beneficial, make it difficult to measure effectiveness or demonstrate outcomes. Introducing simple documentation practices for informal follow-ups would provide valuable data for evaluating the benefits of these activities and identify patterns of repeated contact. Related to this point, proactive outreach models should be expanded. Participants noted that many individuals faced critical barriers to accessing services, program, or resources, such as a lack of transportation, no phone access, or anxiety about attending appointments. Police working in partnership with outreach teams could bring services directly to individuals, ensuring that vulnerable persons remained engaged with care. Embedding social workers or mental health professionals directly within police teams would further strengthen this capacity.

Finally, training and cultural alignment are necessary. Participants consistently recognized the importance of a client-centred response yet acknowledged gaps in knowledge and available police and community resources. Cross-training between police and health partners, along with joint case reviews, would enhance shared understanding and improve the quality of police-based follow-up. In effect, dedicating resources to structured follow-up, improving interagency information sharing, formalizing documentation, expanding outreach capacity, and enhancing training should create a more consistent and effective follow-up system. This would not only improve outcomes for individuals in crisis but also reduce repeated calls for service and support broader goals of community safety and wellness.

USE OF POLICE DISCRETION

Given the variations in the use of police discretion, police agencies should clarify the scope of police officer discretion and provide specialized training in discretionary decision-making. These actions could be implemented relatively quickly through policy updates, scenario-based training, and enhanced communication from leadership, helping police officers distinguish between statutory obligations and discretionary opportunities while reducing reliance on overly cautious practices.

Addressing liability concerns is also an immediate priority, as police officers' fear of organizational or public blame certainly influences decision-making and can contribute to unnecessary apprehensions. Given this, clear messaging and supportive supervisory practices can contribute to reducing this pressure.

Wherever possible, greater emphasis should be placed on integrating mental health professionals into frontline decision-making and strengthening collaboration with community resources. Expanding co-response models, establishing formal referral pathways, and ensuring timely access to clinical expertise can reduce unnecessary criminalization of health issues and improve outcomes for individuals in crisis. These initiatives require partnership-building and resource allocation but are vital for sustainable improvements and address some of the concerns regarding the misuse of police discretion. Over the longer term, police agencies should institutionalize supervisory oversight mechanisms and implement systematic monitoring and evaluation of apprehension practices. By formalizing consultative protocols and reviewing decision-making patterns, police agencies can create consistency across units, ensure accountability, and provide constructive feedback to police officers. This long-term focus on evaluation and oversight will contribute to embedding or strengthening a culture of balanced discretion, evidence-based decision-making, and collaboration within police agencies.

COMMUNITY RESOURCES

There are several recommendations that can improve the integration and effectiveness of community resources in supporting persons with mental illness. There is a clear need in many jurisdictions for enhanced coordination and formalized partnerships between police agencies and community-based mental health, substance use, and housing agencies. The absence of either standardized protocols or formal liaison arrangements can contribute to inconsistencies in community responses and missed opportunities for early intervention. Establishing interagency memoranda of understanding, shared communication protocols, and joint operational planning would enable police officers to navigate available resources more effectively while ensuring continuity of care for clients.

There is a need for policies that expand access to 24-hour and mobile clinical services. While programs such as ACT teams and mobile crisis outreach teams exist in many regions in British Columbia, their limited hours and jurisdictional constraints can impede timely intervention, particularly during overnight crises when other community-based resources are unavailable. Policies that encourage funding for extended coverage, mobile clinical units, and on-call mental health professionals would enhance police capacity to respond safely and effectively to calls for service involving persons with a mental illness, reduce unnecessary apprehensions, and mitigate risk for clients, police officers, and the community.

While this has continued to expand across the province, policies should ensure to integrate trauma-informed and culturally responsive practices, particularly when engaging with First Nations communities, youth, and individuals with complex needs, such as brain injuries or behavioural disorders. Participants indicated that coordination with culturally specific services, youth programs, and specialized counselling centers was somewhat ad hoc. Given this, institutionalizing referral mechanisms, ensuring cultural competency training, and embedding trauma-informed

response frameworks into all aspects of police policy would improve outcomes and foster community trust. Finally, policy must address knowledge management and accessibility of community resources. Participants referenced the use of pamphlets, resource cards, and informal knowledge, but highlighted challenges in keeping up to date on all programs, services, and resources in their jurisdiction. It is recommended that every police agency, if they have not already done so, create a centralized, regularly updated resource database. This database would serve to enhance operational efficiency, support informed decision-making, and promote consistent application of community supports across the policing agency. Policies that support collaborative responses between police, health, and social services need to be developed and implemented. Police officers are already filling gaps by assisting individuals in navigating complex systems, but this is neither sustainable nor within the core policing mandate. In effect, these recommendations collectively aim to strengthen the interface between policing and community-based resources, reduce reliance on criminal justice interventions for mental health-related issues, and support the development of evidence-based, policy-driven approaches to mental health crisis response.

POLICE-COMMUNITY SERVICES PARTNERSHIPS

It is recommended that where beneficial, police agencies should develop memoranda of understanding with addiction services to ensure continuity, clarity of roles, and accountability. These agreements should focus on information sharing, referral pathways, and collaborative responses, while leaving flexibility for local adaptation. Still, it is important that police agencies continue to support informal collaboration with community services, resources, and programs. These informal relationships are often more agile and responsive than formal agreements, and they allow officers to maintain direct lines of communication with service providers. It is also recommended that police agencies establish streamlined processes that allow police officers to connect individuals directly to detox and treatment services, reducing reliance on health practitioners as gatekeepers. One consideration might be to create dedicated intake protocols between the police and addiction services that could improve timely access to care.

It is also recommended that police agencies introduce or maintain initiatives where addiction service providers engage directly with individuals in custody, such as opioid treatment that provides assessments and prescriptions in police cells. These approaches reduce harm and build continuity of care for high-risk individuals. To that end, it is critical that police agencies recognize that overt partnerships between police and addiction services may discourage some clients from seeking help due to distrust of law enforcement. Formal collaboration should be carefully designed to maintain client confidence, for example by ensuring addiction services retain independence in frontline delivery while coordinating with the police behind the scenes.

The challenges associated with hospital processes also highlighted the importance of sustained interagency collaboration. Current hospital processes presented a significant challenge, with participants describing lengthy delays and unclear responsibilities once individuals were brought into care. These delays not only strained police resources but also increased risk for clients. It is recommended that police agencies and hospitals explore alternatives, such as streamlined intake processes, designated mental health intake pathways, embedded clinicians, or agreements allowing earlier transfer of responsibility to health professionals, which would contribute to addressing

these concerns. Such measures would allow police to return to core duties more quickly while ensuring individuals in crisis received timely care.

Another recommendation is to explore the ability to provide frontline police officers with direct consultation lines to health professionals, ensuring timely advice when in-person support is unavailable, particularly in rural areas. This could also include create a structured referral pathway, similar to victim services, that would allow police officers to refer individuals for follow-up by non-police case managers. In addition, enabling police officers to directly connect clients to supports, such as detox and counselling, without requiring additional medical referrals would also streamline processes. Related to this last point, in rural communities, where geographic isolation and limited treatment facilities can create additional barriers, it is particularly important to develop stronger referral systems and to advocate for increased access to detox beds and mental health supports closer to home. This would lessen the reliance on the police as the default responders and reduce the strain associated with transporting clients long distances for care. Moreover, in larger urban centres, police agencies should attempt to increase coordination with the wide range of community partners already available to ensure that police involvement is appropriately limited to situations where public safety is at risk.

While it is important to maintain informal relationships and partnerships, it is recommended that police agencies attempt to reduce the reliance on personal relationships by ensuring that partnerships exist at both the organizational and individual levels. Establishing consistent points of contact, joint training, and shared protocols can contribute to ensuring that relationships continue even when personnel change. Finally, it is recommended that police agencies encourage health authorities and local governments to invest in integrated mental health and addiction teams that include police representation. These models have demonstrated their ability to facilitate shared responsibility for complex cases and provide more coordinated responses for individuals with overlapping needs.

INFORMATION SHARING

Improving information sharing, particularly health information, between police and health systems is critical. Participants repeatedly emphasized the operational challenges posed by limited access to relevant health information, especially when determining whether an individual should be transferred to hospital or held in custody. Police leaders can work with health authorities to negotiate formal protocols for information-sharing designed to ensure that police officers have timely access to essential data while respecting client privacy obligations. Formalized protocols would support informed decision-making.

SUPPORTING OFFICER WELLBEING

Given the emotional toll participants described when responding to high-risk mental health calls and their repeated exposure to complex mental health and substance-related crises, it is recommended that all police agencies ensure that they place an emphasis on police officer wellness and psychological support. Participants often felt unprepared to manage the long-term implications of persons with a mental illness, particularly when clients cycled repeatedly through multiple police contacts without sustained support. Several participants stressed that the cumulative effects of

constant exposure to crisis situations led to stress, fatigue, and mental health challenges for police officers. Participants described the paradox of "sick people treating sick people," acknowledging that without adequate organizational supports, police officers responding to these calls for service were at risk of burnout or secondary trauma. Given this, where they do not currently exist, it is recommended that police agencies establish a protocol of regular debriefings, access to counselling, peer-support programs, supervisory training on police officer mental health, and a recognition among police leaders of the unique stresses associated with these types of calls for service should contribute to sustaining morale, strengthen the long-term resilience among those working in these demanding environments, and reduce the risk of burnout.

Study Limitations

The current report analyzed police mental health-related calls for service occurring between 2018 and 2024 for RCMP detachments in British Columbia. While the analyses identified some key trends, including that mental health files consistently represented between 5% and 6% of call volume for the 'E' Division RCMP, that most of the mental health-related files concerned non-criminal events, and that approximately one-quarter of mental health-related files result in an apprehension under the *Mental Health Act*, there were some limitations to the data that precluded further analysis of these trends.

One limitation was that the researchers did not have a database of calls for service that did not include mental health, and so while the analyses provided estimates of the response and service times for calls for service involving mental health, the researchers were unable to compare this statistically to response and service times for non-mental health related calls for service. In addition, it was unclear whether service time included hospital wait times for those files that involved an apprehension. Moreover, in some cases, a different police officer than the primary officer dispatched to the file may have taken the client to the hospital for an assessment, or a mental health co-response team may have taken over the file. In these cases, while there was still ongoing police involvement in the file, the primary officer would have 'cleared the scene' resulting in an apparent end to police involvement in the file. It is very difficult to extract information from the police databases that more accurately reflects the entire length of a mental health file. Given this, a study that follows a sample of mental health files from initial report through to the conclusion of the file, including as it is passed between police officers or specialized teams, would be important to yield more valid information on the true extent of police officer involvement in mental health files. This would also provide useful information on where mental health files were referred to, as this information was also not available in the police data provided to the researchers. Another variable of interest would be the proportion of mental health apprehensions that resulted in the individual being certified under the *Mental Health Act*. With the data that was available, the researchers were only able to determine that a person was apprehended, but not what the outcome was once the individual was taken for a hospital assessment.

As discussed by Cohen et al. (2025), a growing number of police agencies use mental health co-responder models. As there is currently no co-response flag in the police database, it is very difficult to reliably identify the files that involved a co-response or other type of crisis response integrated

team response. Creating clear documentation as to when a mental health co-response team was requested, when they were able to assist or take over a file, the length of time they were involved in the file, whether the file resulted in an apprehension, and whether the individual was certified under the *Mental Health Act* would provide extremely useful data to better understand the impact of co-response teams on mental health-related calls for service.

Variations in the proportion of mental health files were reported by police district, as were changes over time. One factor that may affect these trends is the use of the mental health flag. While police officers must complete the mental health study field on every file, what they determine as mental health-related may vary (see Koziarski et al., 2022 for a discussion about the dark figure of mental health calls). Without additional mental health-related data in the file, the researchers were unable to explore the types or severity of mental health issues that may have been present or even verify that the file involved a substantiated mental health issue. As noted in this report, mental health-related files were identified either through the study flag or by a mental health-related UCR code on the file. Given this, it may be of interest to examine the overlap in files with a mental health study flag to those with a mental health-related UCR code as this may potentially identify files where the mental health study flag was not used accurately. A second recommendation relates to enhancing the clarity of the mental health study flag drop down options, which currently are 'mental health related' and 'mental health not related'. It is possible that police officers do not clearly distinguish between these as the 'not' is hidden in the middle of the text. It may be useful to adjust the language in the mental health study flag drop down to 'mental health-related' and 'not mental health-related'.

While the interviews yielded some information on perceived demographic trends for mental health-related files, the researchers were unable to explore these trends in the police data as it was not provided. Not all the mental health-related calls for service involved a subject of complaint (e.g., someone suspected of having committed an offence); some may have involved a complainant or victim with a mental health issue. The mental health study flag was used to identify many of the mental health files, and this flag only identifies whether there was a mental health element to the file and not who the involved party with the mental health issue was, or even how many persons involved in the file had a suspected mental health issue. Similarly, the researchers were unable to determine what percentage of mental health-related calls for service involved repeat calls for service with the same individual, as no individual-level data was included in the database. It is possible that, in some police detachments, a large proportion of the mental health-related calls for service may be driven by a few individuals, which may affect the trends in calls for service based on factors, such as apprehension and certification or geographic relocation. Still, given the large amount of data included in the current study, it is unlikely that these files exerted a strong effect on the overall trends across the province.

Conclusion

Based on the data used in this project, the RCMP in British Columbia respond to an average of 68,699 mental health-related calls for service per year or nearly 190 every day. Between 2018 and 2024, the number of mental health-related calls for service increased by 8%; however, so did the total number of calls for service to police. Presumably mental health-related files could be dealt

with more effectively and efficiently through a non-policing response that prioritizes the involvement of health care professionals where police officers may attend to assist rather than to take on the primary responsibility of the files. While there is an increase in the availability of co-response models involving a police/mental health nurse response to mental health-related calls for service received by police, Cohen et al. (2025) suggested that less than one-in-five mental health-related calls for service currently receive support from a co-response team. The interviews conducted for the current report identified that co-response models were among the more common programs used by police to strategically manage mental health-related calls for service. The empirical literature also suggests that the co-response model can be most effective at reducing apprehensions, reducing police officer time spent on mental health-related calls for service, and increasing connections with community services. However, many communities, particularly those in rural areas, do not currently have access to these teams. Consistent with the recommendations by Cohen et al. (2025) there is a clear need to expand the availability and resourcing of such programs, reducing the demands on police officers to be mental health experts while increasingly involving trained mental health professionals.

When police officers are repeatedly tasked with responsibilities better suited to health or social service providers, they are placed in situations for which they are not fully trained or resourced, increasing risk of harm to themselves and the client. Inconsistent practices and strained staffing further undermine confidence that can leave members feeling unsupported and overextended. Prolonged wait times in hospitals or repeated involvement with high-need individuals contribute to frustration and burnout, while systemic gaps in mental health and addiction services create a cycle that police cannot resolve alone. Unless these challenges are addressed through clearer role delineation, adequate resourcing, and stronger interagency partnerships, the effectiveness of crisis response programs will be threatened, with direct consequences for officer well-being, public trust in policing, and most importantly, for the individual experiencing a mental health crisis.

From the analysis of the data collected for this report, it seems that demand is rising, and current police and health approaches are often reactive rather than strategic. Call volumes related to mental health are unlikely to decrease, yet there has been limited planning for how police are to effectively address this increase in service demand. The result, as one participant described, is a sense of "flying by the seat of our pants," with police officers improvising rather than relying on clear structures or sufficient resources.

Broader systemic investments are required to address the gaps that leave the police as the default responder to persons with a mental illness. There is a need for more supportive housing, expanded access to long-term psychiatric care for individuals unable to live safely in the community, and specialized court or diversion mechanisms for low-level offences linked to mental illness across British Columbia. These approaches would provide alternatives to the criminal justice system, reduce the cycle of repeated police contact, and enable individuals with mental illness to be connected to appropriate medical and social supports.

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