

1-1-2010

Frontline Providers of Mental Healthcare: The Role of Police Officers in Involuntary Psychiatric Assessments Under the Mental Health Care and Treatment Act

Jude Hall

Follow this and additional works at: <https://digitalcommons.schulichlaw.dal.ca/djls>

Recommended Citation

Jude Hall, "Frontline Providers of Mental Healthcare: The Role of Police Officers in Involuntary Psychiatric Assessments Under the Mental Health Care and Treatment Act" (2010) 19 Dal J Leg Stud 107.

This Article is brought to you for free and open access by the Journals at Schulich Scholars. It has been accepted for inclusion in Dalhousie Journal of Legal Studies by an authorized editor of Schulich Scholars. For more information, please contact hannah.steeves@dal.ca.

FRONTLINE PROVIDERS OF MENTAL HEALTHCARE: THE ROLE OF POLICE OFFICERS IN INVOLUNTARY PSYCHIATRIC ASSESSMENTS UNDER THE *MENTAL HEALTH CARE AND TREATMENT ACT*

Jude Hall*

INTRODUCTION

This article advances the proposition that police officers in Newfoundland and Labrador are, and should be, viewed as frontline providers of mental healthcare services. A frontline provider of mental healthcare service could be defined as any person who in the performance of employment acts as a facilitator of initial delivery of mental healthcare for a consumer in need of such service. The central proposition requires qualification and context and is advanced through pursuit of the following research objectives: to assess the extent that variability in police officer mental health training programs may impact upon the performance of statutory duties of police officers under the Newfoundland *Mental Health Care and Treatment Act*;¹ to provide insightful commentary; and, where possible, to highlight counterproductive issues in the advancement of the quality of service that police officers provide to consumers of mental healthcare services, particularly within the context of initial psychiatric assessments as provided for under the Act.

The *MHCTA* is a broad and expansive piece of legislation governing the entire spectrum of involuntary mental healthcare, including initial assessment, involuntary admission, treatment, review and release of persons back into the community. The scope of this article is limited primarily to the role prescribed to police officers under the Act. As such, the article centres on the process and procedures surrounding apprehension and conveyance of a person to a medical facility for initial psychiatric assessment.

* Jude Hall is a graduate of the Schulich School of Law at Dalhousie University and presently works and lives in St. John's, Newfoundland.

1 *Mental Health Care and Treatment Act* SNL 2006 c M-9.1 [MHCTA].

I. METHODOLOGY

In order to advance the proposition outlined above and to fulfill the supporting research objectives, secondary and primary research was completed. Secondary research, including legislation, jurisprudence, articles, books, news sources and government documents, was gathered through a variety of means, notably through online database and search services such as LexisNexisQuicklaw, Novanet, and Prowler.

The *MHCTA* is a relatively new piece of legislation, having been introduced in late 2006. There is scant secondary literature concerning the Act, and no jurisprudence dealing with the Act was discovered during the writing of this article. Rather, as the intention of this report was to discover the extent to which the *MHCTA* actually works in practice, and to understand how police operate within the Act's jurisdiction, it was essential to speak directly to people involved on a daily basis with the provision of involuntary mental healthcare service in Newfoundland and Labrador. Individual consumers of mental healthcare services were not contacted in this initiative; however, consumer advocacy input was sought from the provincial branch of the Canadian Mental Health Association (CMHA-NL). To that end, primary research for this report was completed through in-person meetings, phone interviews and questionnaires with a number of key stakeholder representatives who work daily within the system, and who contributed greatly to the insights and observations reflected in this report.

II. HISTORICAL OVERVIEW OF MODERN MENTAL HEALTH LEGISLATION IN NEWFOUNDLAND AND LABRADOR

1. Post-Confederation (1949)

Newfoundland and Labrador became the tenth province in Canada after Confederation in 1949; given that section 92(7) of the *Constitution Act*² assigns jurisdiction to the provinces for the establishment, maintenance and management of hospitals and asylums, upon joining Canada the province retained its own legislation in place at that time. The *Health and Public Welfare Act* enacted in 1931 was a sweeping statute that included the provision of mental health services, many of which were delivered at the Hospital for Mental and Nervous Diseases in St. John's.³ This legislation was written during an era when persons with mental illness and mental disability were statutorily referred to as "lunatics," and psychiatric care would have included treatments that seem abhorrent and outmoded by today's standards, such as electroconvulsive and insulin shock therapy,⁴ and daily compulsory warm baths for asylum patients (which were thought

2 *Constitution Act, 1982, being Schedule B to the Canada Act 1982 (U.K.), 1982, c.11, s. 92 [Constitution Act].*

3 Patricia O'Brien, *Out of Mind, Out of Sight: A History of the Waterford Hospital* (St. John's: Breakwater Books, 1989) at 188.

4 *Ibid.* at 223.

to offer remedial – not just palliative – benefits).⁵ The social stigma surrounding persons with mental illness would have no doubt been significant during this time, and the psychiatric hospital served as a visible affectation of that stigma; in fact, a generation of Newfoundlanders and Labradorians would come to know, and perhaps carelessly, or derisively, refer to the province's primary psychiatric treatment facility as "the Mental."⁶

2. Mental Health Act (1971)

The statutory use of the terms "lunatic" and "insane" ended in 1966, when the *Health and Public Welfare Act* was amended with the language of "mentally disordered person."⁷ The Act itself remained in effect until 1975, at which time modern legislation dealing specifically with mental health came into force in the province. This new statute was the *Mental Health Act*,⁸ initially passed in 1971, with successive amendments during its thirty-five year statutory life. The *Mental Health Act* was considered modern mental health legislation at the time, in that it sought to focus on treatment of the mentally ill at "treatment facilities,"⁹ which were approved healthcare facilities with psychiatric services (i.e., not solely at the Hospital for Mental and Nervous Diseases), and to end the distinction between the mentally and physically ill.¹⁰ The *Mental Health Act* also provided for the physician-issued certificate committal process used extensively throughout Canada today. Under the Act, any physician (psychiatric qualifications were not required) could admit, treat, and detain a patient in hospital without patient consent if, in the opinion of the physician, the person was suffering from a mental disorder to a degree that they required hospitalization in the interests of their own or another's personal and property-based safety.¹¹ The Act also provided for defined periods of admission with mandated certificate renewals, and the establishment of a Mental Health Review Board to review applications for revocation of certificates.¹²

The *Mental Health Act* also specified statutory powers for police in dealing with persons with mental illness. Under the Act, police were able to apprehend a person and convey the person to a treatment facility for medical examination, or detain the person in a safe place for an unspecified period of time until medical examination was arranged. In order to detain in this manner, the officer needed to have personally observed the person acting in a disorderly or dangerous manner, and needed to have reasonable cause to believe the person was suffering from a mental disorder.¹³

In 1972, perhaps in acknowledgement of a growing awareness of the stigma surround-

5 *Ibid.* at 186.

6 *Ibid.* at 299.

7 *Ibid.* at 298.

8 *Mental Health Act*, R.S.N.L. 1990, c. M-9

9 *Ibid.*, s.3.

10 *Supra* note 3 at 298.

11 *Mental Health Act*, *supra* note 8, s. 5(1).

12 *Mental Health Act*, *supra* note 8, s. 8, 15, 16.

13 *Mental Health Act*, *supra* note 8, s. 12.

ing mental illness, the Hospital for Mental and Nervous Diseases in St. John's was renamed the Waterford Hospital, in keeping with its geographic location in the Waterford Valley (in the west end of the city).¹⁴ While in the years following the renaming of the province's primary psychiatric hospital, the use of the term "the Mental" may not be as prevalent, the author notes that, for many in Newfoundland and Labrador, "the Waterford" may have similarly evolved into a term of an often pejorative nature.

3. The Luther Inquiry (2003)

In the space of two months in late 2000, two men suffering from mental illnesses were shot and killed in altercations with police officers in the province. Norman Reid was a 43 year-old man living in the rural community of Little Catalina, roughly four hours driving time from St. John's. Mr. Reid had a long history of repeated hospitalizations for treatment of schizophrenia and numerous encounters with the Royal Canadian Mounted Police (RCMP), who were responsible for policing in that area of the province. Mr. Reid had charged at police outside his home on August 26, 2000, with a small axe, and was shot multiple times by the closest officer.¹⁵ Darryl Power was a 23 year old man living in Corner Brook, a small city on the western side of the island portion of the province. Mr. Power also had a history of mental illness, including numerous hospital admissions and treatment for depression, anxiety and threats of suicide. The Royal Newfoundland Constabulary (RNC) has responsibility for policing in the Corner Brook area. Mr. Power, like Norman Reid, charged at police outside his home with a knife and a hammer on October 16, 2000, and was shot multiple times by an officer in close proximity.¹⁶

The deaths of these two men led to a judicial inquiry, often referred to as the *Luther Inquiry*, conducted by Judge Donald Luther. He submitted his final report in December 2003.¹⁷ The report is extensive, and reviewed all relevant circumstances surrounding the fatalities, including the living conditions of the victims, their respective treatment histories for mental illness, the roles of healthcare providers and police in dealing with persons with mental illness, as well as the adequacy of the *Mental Health Act*. Justice Luther's broadest finding is that the health, social and justice systems all failed Mr. Reid and Mr. Power, and collectively contributed to their deaths.¹⁸ While Judge Luther found no specific procedural fault with the actions of either the RCMP or RNC in the incidents, he did note that both police forces had either non-existent or less than adequate mental health-specific training. The judge acknowledged that, given the violent behaviour of Mr. Reid and Mr. Power at the time of the incidents, extensive mental illness training for police officers may not have led to a different result.¹⁹

14 *Supra* note 3 at 299.

15 The Honourable Donald S. Luther *Report of Inquiries into the Deaths of Norman Reid and Darryl Power* (Provincial Court of Newfoundland and Labrador, 2003) at 32.

16 *Ibid.* at 130.

17 *Ibid.*

18 *Ibid.* at i.

19 *Ibid.* at 88-90, 151-153.

Perhaps the most targeted and forceful criticism in the report was aimed at the state of mental health legislation in the province at the time: the *Mental Health Act*. Judge Luther, in finding that successive governments had failed in providing adequate resources and initiative in modernizing the legislation to address issues such as competency, consent evaluation, patient rights and current service provision practices,²⁰ stated, “that we in our province have the oldest and most outdated *Mental Health Act* in the country goes beyond embarrassment – it is a grave concern.”²¹

A significant outcome of the judicial inquiry, addressed in the first seven of forty recommendations in the final inquiry report, was the call for mental health legislative reform by Judge Luther. In his recommendations he outlined a number of substantive reforms and a suggested timeline for the province in undertaking consultations in devising and enacting new mental healthcare legislation.²²

4. Mental Health Care and Treatment Act (2006)

The government of Newfoundland and Labrador enacted new mental health legislation in December 2006. The new statute, the *MHCTA*,²³ has been promoted by the government as “progressive” and “reflective of the needs experienced by individuals and families affected by the Act.”²⁴ The province, in enacting the new legislation, highlighted the following improvements of the *MHCTA*:

The new bill, which replaces legislation over 30 years old, contains several significant changes from the previous act including new eligibility criteria; provision of a range of individual rights and protections; expanded roles for nurses, nurse practitioners and peace officers; changes to the roles and operations of Mental Health Care Treatment Review Board; provision of Community Treatment Orders; and, a mandatory review of the act within five years.²⁵

Given that the *MHCTA* is a post-*Charter* statute, and considering the government’s previously stated concerns cited in the *Luther Inquiry* of enacting new mental health legislation vulnerable to *Charter* challenges,²⁶ it should come as no surprise that there is an explicit focus on enunciating patient rights under the legislation. Patient rights are listed in the “*Purpose*” section of the *MHCTA*, while procedural rights and the provision of a patient rights advisor are dealt with specifically in self-contained sections

20 *Ibid.* at 53.

21 *Ibid.* at 54.

22 *Ibid.* at 157-160.

23 *Mental Health Care and Treatment Act*, *supra* note 1.

24 “New mental health act overdue, N.L. minister says” *CBC News* (7 December 2006), online: CBC News: <<http://www.cbc.ca/canada/newfoundland-labrador/story/2006/12/07/mental-health.html>>.

25 Government of Newfoundland and Labrador, News Release, “Minister Introduces New Legislation for Mental Health” (7 December 2006), online: <<http://www.releases.gov.nl.ca/releases/2006/health/1207n01.htm>>.

26 *Supra* note 15 at 54.

of the Act.²⁷ The *MHCTA*, in legislating specific duties of various stakeholder groups, implicitly reinforces the importance of patient rights throughout the processes of initial psychiatric assessment through to certification, involuntary admission, review, and release of a person with mental illness.

Despite a focus on patient rights, however, the *MHCTA* (unlike other provincial mental healthcare legislation) provides the patient or his representative with little to no rights specific to actual treatment decisions.²⁸ The Act is written in such a way that once a person is under certification, the physician has full discretion, after consultation, to use any diagnostics or treatment deemed in the patient's best interest; the only statutory limit to a physician's treatment discretion is an outright prohibition on psychosurgery.²⁹ A patient's prior wishes, expressed while the patient had been deemed competent, must only be considered, and the Act does not provide an actual right to withhold consent for specific treatment if the involuntary patient's physician insists on a specific course of treatment.³⁰ At least on its face, the *MHCTA* appears to ignore the holding of *Fleming v. Reid*, in which the Ontario Court of Appeal stated that to override a patient's prior informed wishes or withheld consent to specific treatment, as expressed by their representative, was to violate s. 7 of the *Charter*, and such violation was not saved by a s. 1 analysis.³¹ The principles enunciated in *Fleming v. Reid* also appear to be endorsed by a majority of the Supreme Court of Canada (SCC), which stated in *Starson v. Swayze* that mentally ill patients are presumptively entitled to make their own treatment decisions, unless proven to be incompetent.³² Unfortunately, the SCC did not directly address the specific issue of prior informed consent and whether the patient representative should have the right to withhold consent to treatment based on a patient's wishes made during a prior period of competency.

The *MHCTA* has a number of sections that address peace officer duties related specifically to apprehension, detention and conveyance of a person with mental illness to a medical facility for an initial psychiatric assessment. The term "peace officer" under the Act refers to RNC and RCMP police officers, as well as various provincially-appointed sheriff and bailiff positions. Section 10 of the Act specifies procedural duties that look very similar to fundamental duties upon arrest in the criminal law context. These include providing reasons for the apprehension and informing the person of the destination for the psychiatric assessment and of the right to retain and instruct counsel without delay. Section 20 provides the authority for peace officers to make an apprehension based on their own reasonable belief that a person has a mental disorder

27 *Mental Health Care and Treatment Act*, *supra* note 1, ss. 3(1)(d), 12, 13, 14, 15.

28 The *Involuntary Psychiatric Treatment Act* S.N.S. 2005, c. 42 provides the patient's Substitute Decision Maker (SDM) with the right to provide or withhold consent to treatment and in s.39(a) states the patient's prior capable informed consent should be the basis for this SDM's decision. Admittedly, the Act does provide for a review board, with evidence, to conclude that the SDM is also not capable of providing informed consent.

29 *Mental Health Care and Treatment Act*, *supra* note 1, s. 36.

30 *Mental Health Care and Treatment Act*, *supra* note 1, s. 35.

31 *Fleming v. Reid* (1991), 4 O.R. (3d) (Ont. C.A.).

32 *Starson v. Swayze*, 2003 SCC 32 at paras. 75, 77.

and is likely to cause harm to themselves or another person, or is likely to suffer substantial physical or mental deterioration or serious physical impairment, and refuses to submit to a psychiatric assessment. The section also states that the peace officer must deem that it is not feasible given the circumstances to wait and obtain a judicial order for the assessment before apprehending a person. The *MHCTA* in section 21 provides that any person in the act of apprehending, which in most scenarios would be a peace officer, may take reasonable measures, such as entering premises and using appropriate physical restraint, to effect the apprehension and conveyance while balancing the principles of non-delay, least intrusive means possible and public safety.

The *MHCTA* provides a greater power of discretion to peace officers to apprehend and convey a person for initial psychiatric assessment than its predecessor, the *Mental Health Act*. Under the latter legislation, a peace officer with reasonable grounds was able to apprehend a person acting in a disorderly or dangerous manner contrary to the person's own safety, the public's safety, or contrary to the safety of property, provided the officer personally observed this behaviour. While the *MHCTA* specifies many more procedural rights for a person apprehended and detained for assessment, the new Act does not require an officer to personally witness any specific behaviour, instead allowing an officer to use any information at his disposal (such as assertions from family and friends) in forming reasonable grounds for the apprehension.³³ While the rationale for apprehension no longer includes likely risk of harm to property, it has expanded, in that the officer can also apprehend if she believes the person will suffer future physical or mental deterioration, whether or not the individual has ever presented a physical threat to themselves or others. In order for this latter grant of discretion to be invoked, it would require an officer to make an on-the-spot assessment of the present state of the person's physical and mental health in order to determine if the person is at risk for further deterioration.

II. POLICE OFFICERS AS FRONTLINE PROVIDERS OF MENTAL HEALTHCARE

1. Common Themes in Mental Health and Policing

Frequency of Contact

It is clear that police officers, in the course of their duties, and particularly in community policing, have frequent interactions with persons who have mental illness. Canadian estimates suggest that police interactions with persons who have a mental illness may account for anywhere between 6-33 percent of all police calls with the public.³⁴ Similarly, in the US, an average of 10 percent of police interactions involve

³³ *Mental Health Care and Treatment Act*, *supra* note 1, s. 20.

³⁴ Dorothy Cotton & Terry Coleman, "A Survey of Police Academy Training at the Basic Training Level Related to Working with People with Mental Illness" (Prepared on behalf of The Human Resources Committee of the Canadian Association of Chiefs of Police and The Mental Health and the Law Advisory Committee of the Mental Health Commission of Canada, December 2008) [unpublished]. In this study on page 3 the authors cite a low of 6% estimated by the Belleville (ON) Police Service, and a high of up to a third (33%) of calls dealing with persons with mental illness in parts of the jurisdiction of Vancouver (BC) Police.

persons with mental illness.³⁵ Encounters between police and persons with mental illness, due to a multiplicity of circumstantial factors, have an extremely wide range of possible outcomes for those involved. Police interactions with the person with mental illness can escalate into violence, and serious personal injury and death are possibilities for the person with mental illness, bystanders and the police. However, as tragic and public as these incidents might be, it seems likely that the vast majority of daily police calls involving persons with mental illness are routine matters of community complaints or minor crime, and do not deal with serious violent offenses. A study conducted in the US showed that despite previous indications that an elevated risk exists for violent encounters when police are dealing with persons with mental illness, persons with perceived impaired judgement are only mildly problematic for police. Furthermore, when police arrest tactics were employed, judgement-impaired persons were no more likely to injure police than persons with no judgement impairment.³⁶

The high frequency of contact between police and persons with mental illness naturally leads to a questioning of what factors have contributed to this phenomenon. The predominant theory well advanced in the literature, both in Canada and the US, is generally known as the “criminalization of the mentally ill” phenomenon.³⁷ The basic theory states that, with the deinstitutionalization of the mentally ill in the last fifty years, stricter civil commitment criterion in modern legislation, and a lack of community-based accessible mental health services, there are more persons with mental illness living in the community, many of whom find it difficult to integrate into society and for various reasons run afoul of the law.³⁸ This analysis may be an over-simplified theory, given the complexity of mental health issues and the provision of societal resources dedicated to serving persons with mental illness. Despite the extent to which the theory has been discussed in the past, there appears to be no authoritative study, theory, or series of factors that can reliably explain why the incidences of police encounters with persons with mental illness, and their subsequent interaction with the criminal justice system, are so prevalent in a modern context.³⁹

Canadian researcher Dorothy Cotton agrees that it remains unclear whether the arrest rate of persons with mental illness is higher relative to persons without mental illness because of actual increases in criminal or violent behaviour of the mentally ill, or a manifestation of the criminalization theory where, in the pursuit of social control, police use of arrest has increased for minor crime and for behaviours that may never

35 Amy Watson and Beth Angell, “Applying Procedural Justice Theory to Law Enforcement’s Response to Persons with Mental Illness” (2007) 58 *Psychiatric Services* 787 at 787.

36 Robert Kaminski, Clete DiGiovanni & Raymond Downs, “The Use of Force Between The Police and Persons with Impaired Judgment” (2007) 7 *Police Quarterly* 311 at 329.

37 Virginia Cooper, Alix McLearn & Patricia Zapf, “Dispositional Decisions with the Mentally Ill: police Perceptions and Characteristics” (2004) 7 *Police Quarterly* 295 at 296.

38 *Ibid.* at 296.

39 Melissa Morabito, “Horizons of Context: Understanding the Police Decision to Arrest People with Mental Illness” (2007) 58 *Psychiatric Services* 1582 at 1583.

be categorized as criminal in a person without mental disability.⁴⁰

While it is undisputed that the mentally ill have disproportionately higher rates of transaction with police and the criminal justice system, there is no way to gauge accurate numbers of police interactions with the mentally ill, beyond records of dispatch calls and arrests where mental illness is reported to be a factor in the incident. In fact, incidents or transactions between police and persons with mental illness are no doubt higher than recorded statistics indicate, due to pre-arrest diversion programs and unrecorded dispositions, including a phenomenon known as dumping, or Police-Initiated Transjurisdictional Transport (PITT).⁴¹ Under a PITT scenario, police officers, upon encountering problematic persons with mental illness, may elect to simply transport the individual out of their jurisdiction, rather than take the time during their shift to officially deal with the person. It is a covert practice that sounds more likely to occur in closely-situated urban jurisdictions in the US; however, forms of PITT have been practiced by police in Canada, most notably in Saskatoon with “troublesome” aboriginal peoples who have been picked up on city or neighbourhood streets and given a “starlight tour,” which abruptly ends beyond the outskirts of town.⁴²

To be fair, police officers are not the only group to engage in forms of dumping. A strong case may be made that persons with mental illness are dumped with regularity between jurisdictions within the criminal justice system, and likely the mental health-care system as a whole. Examples of jurisdictional dumping of the mentally ill are evident within the justice system of Newfoundland and Labrador. In *R v. Hynes*, the Court of Appeal overturned a trial judge’s sentencing decision in which he applied the maximum 2 year penalty for a minor crime by an offender with schizophrenia, on the basis it was better to keep him incarcerated and on his medication than to allow him back on the streets earlier with the likelihood of not taking medication.⁴³ The Court of Appeal quoted from an earlier English case, *R v. Clarke*, in which the judges stated:

Her Majesty’s Courts are not dustbins into which the social services can sweep difficult members of the public. Still less should Her Majesty’s judges use their sentencing powers to dispose of those who are socially inconvenient. If the Courts became disposers of those who are socially inconvenient the road ahead would lead to the destruction of liberty. It should be clearly understood that Her Majesty’s judges stand on that road barring the way.⁴⁴

R v. Hynes is not an isolated case of transjurisdictional transfer. In *R v. Patey*, a sentence

40 Dorothy Cotton, “The attitudes of Canadian police officers towards the mentally ill” (2004) 27 *International Journal of Law and Psychiatry* 135 at 136.

41 William King & Thomas Dunn, “Dumping: Police-Initiated Transjurisdictional Transport of Troubled Persons” (2004) 7 *Police Quarterly* 339.

42 *Ibid.* at 342.

43 *R v. Hynes*, [1991] N.J. No. 89 (C.A.).

44 *Supra* note 43 at 5.

decision for an offender was premised solely on the jurisdiction in which a mentally ill offender would have the greatest opportunity for psychiatric treatment. Lamenting the lack of correctional institutional psychiatric services available in the province, the judge assigned a 30-month sentence to be served in a federal institution, and stated:

I note also that the continuing costs to society from having individuals such as Charles Patey detained in correctional institutions or from leaving them on the street to cause property damage and physical injury, is probably a lot greater than the costs that would be involved in, for example, having some form of secure treatment facility available through a hospital to provide the sort of structured environment described by Dr. Ladha.⁴⁵

Police Officer Attitudes Towards Persons with Mental Illness

Mental illness and disability in society, throughout the centuries and into the present, is laden with negative stereotypes, misperception, and the often-noted stigma defined as a “characteristic mark or sign of defect, degeneration or disease.”⁴⁶ The continued negative stereotyping and stigma attached to mental illness is fuelled by pervasive attitudes held by society at large and often individually by those who interact with persons with mental illness, including police officers and healthcare professionals. The attitudes that police officers display towards persons with mental illness have been the subject of study in both Canada and the US in recent years. A Canadian study indicated there were common, albeit complex, attitudes measurable against a selected sample of police officers across several forces.⁴⁷ Subjects surveyed had a benevolent attitude with feelings of obligation towards persons with mental illness, yet also felt that society needed to be protected from them. Most subjects, many of whom may be frustrated with the system (and the time it takes to manage calls with a mental health component) agreed that dealing with persons with mental illness was part of their job, and felt they required additional mental health training to handle this responsibility.⁴⁸ A study conducted in the US found a number of similar police attitudes toward persons with mental illness, including a feeling of responsibility for working with the mentally ill, a desire for increased training, and strained relations with mental health providers,⁴⁹ which seem analogous to frustration with the system in general.

Basic Mental Health Training

Basic or minimal levels of training on mental health are prevalent within Canada and the US, particularly for new police recruits. A recent Canadian study surveyed the extent of training for new police recruits across the various police forces in Canada and found that the total number of hours of mental health training a new recruit may

45 R v. Patey, [1999] N.J. No. 191 at para. 24 (N.L. Supt. Ct.).

46 Webster’s New Universal Unabridged Dictionary, 1st ed., s.v. “stigma”.

47 *Supra* note 40.

48 *Ibid.* at 143-144.

49 *Supra* note 37 at 304-305.

receive ranged from 5- 30 hours.⁵⁰ The study did not address training for in-service police officers; however it is reasonable to assume that many in-service officers have received at least minimal amounts of mental health training to supplement their practical field experience in dealing with persons with mental illness. A noteworthy aspect of the study was that it highlighted a wide variability in the degree of, and approaches to, training on mental illness for new police recruits at the various police academies and forces across the country⁵¹. It was not evident from the study if there is any impetus for national standardization or best practice adoption in Canada at this time.⁵²

In the US, a survey of major police departments indicated that 88 percent of respondent forces offered some form of mental health training to their officers.⁵³ In 2002, a national report was released from a study undertaken in the US known as the Criminal Justice / Mental Health Consensus Project. The purpose of the study was to develop and issue recommendations for local, state and federal policy makers on improvements that should be made to enhance the manner in which the criminal justice system deals with persons with mental illness. One of several areas in which recommendations were made was a suggested framework for or outline of varying levels of police training and training topics regarding mental illness, depending on the types of officers.⁵⁴

Specialized Models

Beyond basic training on mental illness for new recruits and in-service police officers lies the realm of specialist training and police pre-arrest diversion programs, or models designed specifically to increase the quality, appropriateness and efficacy of police responses to persons with mental illness. There are a number of models that appear to incorporate a variation of police officer(s) with specialized mental illness training who may be designated as first responding officers in situations where it is determined a person with a mental illness is in some form of crisis.⁵⁵ Often this officer may attend the scene in the presence of a mental healthcare specialist such as a psychiatrist, nurse practitioner, or psychologist, where the focus of the interaction is crisis management, problem resolution, and apprehension of the person in question if necessary. These specialized models have been referred to as Crisis Intervention Teams (CIT), Mobile Crisis Teams (MCT) and Psychiatric Response Teams (PERT), and as stated, all appear to be variations on the same type of multi-disciplinary crisis response model.⁵⁶

It is obvious that, in order to support specialized resources such as CITs, commitment, coordination and funding must be advanced and maintained between police

50 *Supra* note 34 at 9.

51 *Supra* note 34.

52 *Ibid.*

53 Kathleen Hartford, Robert Carey & James Mendonca, "Pre-arrest Diversion of People with Mental Illness: Literature Review and International Survey" (2006) 24 *Behav. Sci. & L.* 845 at 849.

54 Council of State Governments, *Criminal Justice / Mental Health Consensus Project* (Policy Recommendations) (New York: Council of State Governments, 2002) at 213.

55 *Supra* note 53 at 847.

56 *Supra* note 53 at 850.

forces and local mental health healthcare providers. This level of specialization, while likely common in larger US urban areas, may not be available in rural areas in either the US or Canada. There has been some sporadic use of specialized pre-arrest diversion programs in Canada at least since 1995, including mobile mental health teams in Vancouver, mental health community liaison police officers in Winnipeg, and a pre-charge diversion project between Ottawa Police and the Salvation Army;⁵⁷ programs such as these have likely been increasing in usage in urban areas since that time.

2. Police Officers and The System of Involuntary Mental Healthcare

Involuntary mental healthcare can be a controversial concept and is often portrayed and perceived to fall on the spectrum of government services as an essential and benevolent one, or as an unjustified intrusion on the civil rights of individuals who are simply different from “normal” people in society. Despite the multitude of divergent views, it is indisputable that involuntary mental healthcare is a system, albeit a system within the broader fora of public healthcare and, specifically, the mental healthcare system. As a system, it has a legitimizing set of rules under which it must operate, and a defined group of stakeholders with assigned roles, all of which must be fulfilled in order for the system to function according to its design. Police officers play an integral role in the involuntary mental healthcare system, a role that is defined in the system rules typically enunciated in mental healthcare legislation existing in each province of Canada.⁵⁸

The provincial governments, in delivering or imposing involuntary mental healthcare upon a person, (by definition) suspend or hold in abeyance the autonomy of the person, overriding the will of the person in order to ensure that the person receives the service. There are two predominant legal rationales or justifications for the delivery of involuntary mental healthcare: *parens patriae* power and the public safety rationale.⁵⁹ The *parens patriae* power is a legal right and obligation invoked by the state in acting for those persons under its jurisdiction whom the state determines are unable to act or protect themselves; the state becomes a “parent” to such a person, and acts on his or her behalf as if the person were a child. The public safety rationale holds that a person’s liberty or autonomy right can be curtailed if the person is a risk to others and the public’s safety. The public safety rationale is embodied in both criminal law and civil commitment legislation. Police officers in Canada, when interacting with a person with mental illness whom they believe must be removed from the scene, must decide upon the most appropriate course of action: arrest under the criminal law, or, if there appears to be no serious crime involved but a risk of harm to the person or others, apprehension under mental healthcare legislation. Unlike in the US, where courts have expressed that *parens patriae* justification for involuntary mental healthcare can-

57 Health Canada, *The Mentally Ill and the Criminal Justice System: Innovative Community-Based Programs 1995* (Program Guide) (Ottawa: Mental Health Division, 1995) at 19-24.

58 See, for example, *Mental Health Act*, R.S.O. 1990, c. M.7.

59 Archibald Kaiser, *Canadian Health Law and Policy*, 2nd ed. by Jocelyn Downie, Timothy Caufield & Colleen Flood (Toronto: Butterworths, 2002) at 273-274.

not replace due process protections, Canadian courts readily accept and rely upon a paternalistic justification, arising from *parens patriae*, for the imposition of involuntary mental healthcare.⁶⁰

Police officers play a unique and vital frontline role as mental healthcare providers in the involuntary mental healthcare system, because in most instances where hospitalization is required and the patient is an unwilling participant, she has likely not arrived at the hospital upon her own will. Police officers, in either executing judicial or medical certificate orders, or in using discretionary powers to apprehend and convey a person to a medical facility for assessment and potentially admission, have a significant impact on the initial experience of a person who may be in serious psychiatric crisis. Police officers in Canada and the US, in fulfilling this role, have been described as “defacto mental health providers,”⁶¹ and “firstline, around the clock, emergency responders, mediators, referral agents, counsellors, youth mentors, crime prevention actors and much more.”⁶²

While it is clear that police officers play a frontline role in the system, that role must be delimited and coordinated efficiently with other system service providers, such as mental healthcare professionals. It is only when all service providers are fulfilling their roles and duties in a coordinated and integrated manner that a person who is receiving the service may be assured of the best possible experience. When there is confusion or apathy in the system, as was noted in the *Luther Inquiry*, the provision of involuntary mental healthcare service can have tragic consequences for its recipients: “the provision of fragmented services proved nugatory. Generally, service providers did what was required of them to an acceptable level most of the time but lack of a coordinated effort was sadly demonstrated.”⁶³

3. Police Officer Duties in Facilitating Involuntary Psychiatric Assessment

Police officers can have a much broader role and impact upon the quality of interaction with a person with mental illness than is narrowly defined under provincial mental health legislation. The disposition of a call involving a person with a mental illness may occur under criminal law powers; the officer may determine no action is warranted; or, the officer may simply refer the person to other social services. The scope of this article, however, is focused on the execution of police duties and obligations under the *MHCTA* in Newfoundland and Labrador, and particularly on the role of police officers in facilitating the involuntary psychiatric assessment.

Under the *MHCTA*, involuntary psychiatric assessment may be triggered in a number of ways, including an initial physician certification, revoked community treatment or-

60 Isabel Grant, “Mental Health Law And The Courts” (1991) 29 Osgoode Hall L.J. 748 at 749.

61 *Supra* note 40 at 135.

62 *Supra* note 54 at 34.

63 *Supra* note 15 at *i*.

der, judicial order, and by discretion of a peace officer.⁶⁴ The first three triggers would typically require the police officer to diligently carry out the order to apprehend and convey the person who is the subject of the order to a facility for assessment, while the latter trigger would require the officer to be the sole decision-maker in determining if apprehension and conveyance is appropriate. It is with this use of discretion that the police officer is afforded a significant statutory power, and corresponding duties and obligations are placed upon the officer in the exercise of that power.

Under section 20 of the Act, where an officer upon reasonable grounds believes a person has a mental disorder and as a result is likely to harm himself or another, or to suffer physical or mental deterioration, and refuses to voluntarily submit to a psychiatric assessment, the officer may apprehend the person and convey them to a facility for involuntary psychiatric assessment. The Act provides no specific guidance as to what may constitute reasonable grounds, but the officer would be expected to use whatever information is gleaned from the scene in making the decision.

Section 10 of the Act specifies procedural duties for apprehension or detention of a person by police, which are written in a way that look strikingly similar to informational criminal procedural duties provided for under sections 10(a) and (b) of the *Charter*,⁶⁵ including the right to be promptly informed of the reason for the apprehension/detention, the fact that the person is being conveyed to a facility for involuntary psychiatric assessment, and of the right to retain and instruct counsel without delay. The Act is silent on the implementational aspect of these duties, and it is not clear, owing to a lack of jurisprudence on the *MHCTA*, if police owe any implementational duties to the person, such as actually assisting the person in contacting their lawyer or duty counsel, as would be expected in the criminal law context. This issue was raised in Ontario as it relates to that province's mental health legislation: in *C.B. v. Sawadsky*, a trial judge, in ruling against the plaintiff in a civil action in which the plaintiff was alleging to have been unlawfully detained, stated:

Because of the different public purpose, it is difficult to analyze procedural protections in a hospital setting by reference to criminal standards. For the reasons that follow I find that the procedural protections set out in the MHA meet the Charter obligations for a detention under the MHA. The more extensive Charter obligations that require police to inform a detainee for criminal purposes orally of the right to counsel and the opportunity to access free legal advice do not apply.⁶⁶

The Ontario Court of Appeal dismissed the appeal but stated that the judge should not have waded into this issue as it was not specifically raised by either party at trial,

64 *Supra* note 1 at ss. 18, 19, 20 and 51.

65 *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c.11.

66 *C.B. v. Sawadsky* (2005), O.J. No. 3682 at para. 54 (Sup. Ct.).

acknowledging that it may need to be judicially assessed at some point in the future.⁶⁷ That assessment is unlikely to happen any time soon, as the SCC provided no reasons in declining to grant leave to hear the appeal.⁶⁸

Section 21 of the *MHCTA* provides other process-oriented powers and duties for any person apprehending and conveying a person to a facility for involuntary psychiatric assessment. These duties provide further specification for how the process of involuntary psychiatric assessment should work, and in most cases they will likely be executed by police officers. The section provides for the entering of premises and use of physical restraint, on a least-intrusive means basis, in apprehending and conveying a person to a facility. The police officer, upon arriving at the facility with the detainee, must provide the order to the facility staff or a written statement setting out factual details that led to the officer taking custody of the individual. The officer is also required to stay with the individual at the facility until the assessment is complete, unless relieved of her obligation to maintain custody by the person conducting the assessment; the Act allows for a person to be detained for up to 72 hours from arrival at the facility before the involuntary assessment must be completed.

It is evident from the powers and duties described in the *MHCTA* that police officers in exercising their powers under the Act will need to be familiar with the Act itself and trained on how best to perform these duties. As demonstrated in the following section of this report, all police officers in the province receive specific seminar instruction on the *MHCTA*. Additionally, it is clear that officers must also be able to effectively interface with mental healthcare professionals at assessment facilities in order to ensure the best possible experience for persons in custody. Tensions or system inefficiencies at this crucial handoff juncture between police and mental healthcare professionals have been experienced in other jurisdictions,⁶⁹ and will be assessed in this report as an area for potential mental health training for police officers in Newfoundland and Labrador.

4. Standard and Opportunity-Based Police Officer Mental Health Training in Newfoundland and Labrador

The RNC is primarily an urban police force serving the cities of St. John's and Corner Brook, with rural coverage around the Northeast Avalon Peninsula and in the towns of Labrador City and Churchill Falls.⁷⁰ The RCMP is predominantly a rural police force throughout the island portion of the province and Labrador with policing jurisdiction (notwithstanding federal or joint policing initiatives) in all areas where the RNC is not

67 *C.B. v. Sawadsky* (2006), 82 O.R. (3d) 661 at para. 32 (C.A.).

68 *C.B. v. Sawadsky* [2006] S.C.C.A. No. 479 (S.C.C.).

69 Jacklin Fisher, "Mental Health Nurses: De facto Police" (2007) 16 *International Journal of Mental Health Nursing* 230 at 230.

70 Royal Newfoundland Constabulary, online: <<http://www.rnc.gov.nl.ca/about/locations.html>>.

the primary designated police force.⁷¹ It became apparent during the compilation of this report that there are two distinct forms of mental health training for police officers serving the public in Newfoundland and Labrador: standard, and opportunity-based training. Both forms of mental health training are used by both of the province's police forces with new recruits, and, to a lesser extent, with in-service officers.

Standard Mental Health Training

Standard training for police officers in mental health-related issues occurs within the context of new recruit training and for in-service officers. All new RNC recruits undergo a 12-month training program that is jointly delivered by Memorial University (Police Studies Program) and the RNC.⁷² During the first eight months of training, recruits are full-time university students in the Memorial program, which has compulsory psychology courses in areas such as forensic psychology, adverse drug behaviour and abnormal behaviours.⁷³ The recruits also receive two nights of training per week at RNC headquarters during this period, and then switch to full-time training at the RNC for the remaining four months. During this last phase of training, the recruits receive classroom and scenario training on interacting with persons with mental illness; this training would also include use of force training for which annual evaluations occur. The RNC has also incorporated a number of seminars and workshops into the recruit training program that deal with a range of mental health issues, both nationally produced (Canadian Police Network) and locally developed by advocacy groups such as the Canadian Mental Health Association (NL Chapter).⁷⁴ All new recruits participate in field trips to various mental healthcare centers and service organizations during the recruit training period⁷⁵. Finally, new recruits, before beginning their initial six months of service when they are partnered with experienced "coaching" officers, receive a one-day seminar delivered by Crown counsel on the specific statutory duties and procedures specified in the Mental Health Care and Treatment Act.⁷⁶

All new RCMP recruits throughout Canada undertake an initial 6-month Cadet Training Program in Regina, Saskatchewan. The Cadet Training Program is uniquely designed with an emphasis on role-playing and scenario-based training, as opposed to relying heavily on classroom or lecture-oriented curriculum.⁷⁷ Throughout the program, there is a specific focus on mental health issues, incorporated into lecture and

71 Royal Canadian Mounted Police, online: <http://www.rcmp-grc.gc.ca/nl/detach/images/bdiv_map_e.pdf>.

72 In-person interview of Sgt. Junior Small, Royal Newfoundland Constabulary (6 November 2009).

73 Program description for Police Studies Program, online: Memorial University website <<http://www.mun.ca/regoff/calendar/sectionNo=ARTS-0307>>.

74 Questionnaire of George Skinner, Executive Director, Canadian Mental Health Association (NL) (23 November 2009). *Changing Minds* is a CMHA-NL educational program that teaches communication skills for better understanding and talking to persons with mental illness.

75 *Supra* note 72.

76 *Ibid.*

77 Program description of the Cadet Training Program, online: Royal Canadian Mounted Police <<http://www.rcmp-grc.gc.ca/depot/ctp-pfc/index-eng.htm>>.

scenario training exercises, dealing with mental health awareness and social bias, intervention, and risk assessment/management techniques when dealing with people who may be suffering from mental illness. RCMP recruits also participate in lectures given by advocacy groups such as the Schizophrenia Society of Saskatchewan. Before new recruits are placed in service, a field placement training seminar is held, at which time RCMP officers placed in Newfoundland and Labrador are instructed on statutory duties and procedures specified under the *MHCTA*.⁷⁸

The extent of standard mental health training for in-service officers, with either the RNC⁷⁹ or the RCMP,⁸⁰ is not as obvious but is nonetheless in place primarily through the process of annual “use of force” testing and certification. Both forces report that scenario-based testing in the annual certification process includes situations wherein officers must interact with persons in some form of mental or emotional crisis. This is not to suggest that annual use of force testing is the only training in-service members receive on mental health issues; rather, as discussed in the following section, in-service police officers from both forces do receive ongoing training in mental health subject matter from opportunity-based sources. With respect to training for statutory duties and procedures under the *MHCTA*, both the RNC⁸¹ and RCMP⁸² held one day workshops for all in-service members on the Act when it was introduced in 2006.

Opportunity-Based Mental Health Training

In evaluating police officer mental health training in the province, it became evident that a separate form of training exists which can be categorized as opportunity-based mental health training. Police officers from both the RNC and RCMP are receiving training opportunities on a semi-regular basis on a range of mental health issues that is not standard or compulsory training, but should be recognized nonetheless as a valuable and effective form of continuous learning. Examples of opportunity-based training at the RNC include the use of an allotted training day during each 8-week cycle when topics related to mental health, such as Fetal Alcohol Syndrome, Autism Awareness and the proposal for a provincial mental health court may be added onto the agenda.⁸³ The RCMP in the province also take advantage of opportunity-based training through use of consumer advocacy materials (e.g., Alzheimer’s Awareness)⁸⁴ and unique community-based collaboration projects. An example of the latter is as a recent initiative on the Northern Peninsula during which the RCMP and local mental healthcare workers co-authored a police officer’s guide to mental illness, which will be

78 Questionnaire/Phone interview of Staff Sgt. Chris Fitzgerald, Royal Canadian Mounted Police (18, November 2009).

79 *Supra* note 72.

80 *Supra* note 78.

81 *Supra* note 72.

82 *Supra* note 78.

83 *Supra* note 72.

84 *Supra* note 78.

distributed to RCMP members in that part of the province.⁸⁵

The willingness of both police forces to take advantage of opportunity-based mental health training is a significant indication of the implicit understanding of mental health as a complex and evolving subject, and in particular provides a means to ensure that in-service officers who may or may not have received standard recruit mental health training are also well-versed in the subject – supplementing obvious practical policing experience. The extent and frequency of opportunity-based training in mental health issues on a continuous basis and the actual participation rate amongst officers were not explored in the completion of this report.

5. Theory to Practice: Performance of Statutory Duties under the Mental Health Care and Treatment Act

Irrespective of the number of classroom or scenario-based training hours that new recruits and in-service police officers may have under their belts, ultimately the actual experience of a consumer in an involuntary mental health service (i.e., initial psychiatric assessment) will be influenced by a plethora of factors including, but not limited to formal mental health training, officer experience, familiarity with and adherence to statutory procedures, and the dynamics of interaction between police and frontline mental health professionals. In this regard, the ability of police officers to competently perform statutory duties and procedures under the *MHCTA* is also dependent upon the efficacy of the system itself for involuntary mental healthcare services in the province. Provision of involuntary mental healthcare services is the responsibility of the provincial Department of Health as delivered through the four regional health boards: Eastern Health, Central Health, Western Health and Labrador/Grenfell Health.⁸⁶

Pre-Apprehension Decision

When a police officer is called to a scene or requested to provide assistance in a matter where a member of the public may be dealing with a mental illness or emotional crisis, the officer must make a decision as to how to best to proceed given the situation at hand. Typically, there are two primary routes that can be taken if it becomes apparent that custody of the individual is required: arrest under criminal law powers, or an apprehension under the *MHCTA*.

Neither the RNC nor the RCMP has issued any formal policy to police officers with respect to disposition decision-making in encounters with persons who may be mentally ill. Understandably, an officer will be required to use his or her best discretion depending upon the unique circumstances at hand. If a serious crime has been committed, officers will arrest the subject and make a determination based on the level of potential

85 Tara Kennedy, "Health-care professionals partner with RCMP on mental illness" (2009) 105 Canadian Nurse 38.

86 Government of Newfoundland and Labrador Department of Health, online: <<http://www.health.gov.nl.ca/health/divisions/boardservices/newboard.swf>>.

harm to either the subject or others whether to convey an individual to the station for processing or directly to a facility for an initial psychiatric assessment. Alternatively, if no crime or minor infraction has occurred, an officer may forgo the criminal law process and undertake an apprehension under the *MHCTA*, or determine that the individual is not in need of service under the *MHCTA* and leave the scene.

Despite a lack of formal policy on disposition decision-making, both the RNC⁸⁷ and RCMP⁸⁸ report having Memoranda of Understanding (MOU) with the various provincial health boards that may have an effect on the disposition process. One such example exists between the RCMP and Central Health: the police, when called to deal with an individual in the community known to have mental health issues, will call mental health personnel at the local hospital to arrange for a planned ambulance intervention with police nearby on standby in order to encourage the person to attend for psychiatric assessment without the police invoking an apprehension. If the situation requires police apprehension, a call is made en route to the facility (e.g., typically regional hospital ER) by police so that mental health staff can prepare and ensure a safe room is ready to receive the individual.⁸⁹ It is unclear the extent to which this level of cooperation, or pre-apprehension planning, occurs or is practical with the RNC in urban centers, due to the realities of dealing with a much larger and more anonymous general public.

Apprehension and Conveyance

A primary difference between the *MHCTA* and its predecessor statute, the *Mental Health Act*, is the extent to which the consumer or patient's procedural rights are specified in the new Act. This enunciation of specific procedural rights of the consumer or patient from initial psychiatric assessment through to involuntary hospitalization, treatment and review was a central motivating factor for the government in drafting and implementing the *MHCTA*.⁹⁰

Most of a police officer's statutory duties under the *MHCTA* are performed in series of actions that take place once an officer decides it is necessary to apprehend a person (with reasonable grounds) under s. 20 of the Act, or in carrying out a medical or judicial conveyance order in ss. 18 and 19 of the Act. Once this decision is made, s. 10 of the Act outlines specific procedural duties that the officer must follow. Officers from both forces are trained to view the s. 10 apprehension and conveyance process as akin to a criminal law arrest, and will actually read from portions of their *Charter* card in informing the person of the reason for the apprehension, the facility to which the person is being transported for assessment, and the right to retain and instruct counsel without

87 *Supra* note 72.

88 *Supra* note 78.

89 Phone interview of Desmond Coombs, Director of Mental Health Services, Central Health (18 November 2009).

90 Phone interview of Karen Stone, Department of Health Legislative Consultant, Government of Newfoundland and Labrador (17 November 2009).

delay. RNC officers are given explicit instructions not to read the caution portion of the card as to clearly distinguish the process from an arrest under the criminal law.⁹¹ RCMP instructions are not as explicit, although the direction is that the s. 10 *MHCTA* information rights corresponding to the *Charter* card information rights are to be read, without mentioning the caution portion of the *Charter* card.⁹² It is encouraging to discover that both the RNC and RCMP officers are trained, in relation to the *MHCTA*, to provide the toll-free NL Legal Aid Commission duty counsel telephone number, and to provide at the earliest practical time (i.e., typically upon arrival at the medical facility) access to a telephone for the person who wishes to contact counsel. The provincial government ensured in drafting the Act that the NL Legal Aid Commission was aware of this expanded duty counsel service,⁹³ and the NL Legal Aid Commission confirms this service coverage is in place.⁹⁴ The degree to which mental healthcare consumers avail themselves of legal aid services in the context of involuntary psychiatric assessment and hospitalization was not determined in the research for this report.

With respect to conveyance itself, both police forces instruct officers to search and handcuff an individual if the person is formally being brought to the facility under the Act and is actively displaying aggressive tendencies. There is, however, some variation in informal policy between the forces in respect of conveyance procedures. The RNC, operating in primarily urban areas closer to regional hospitals, will transport a person who is voluntarily agreeing to go to a facility for assessment; in such cases, the powers of the Act are not technically invoked (i.e., the officer would be offering a ride) unless the person decides en route they no longer wish to voluntarily attend.⁹⁵ The RCMP, however, will not provide transport to a facility unless a safety concern exists, and prefers, even when an order exists, for the person's family or an ambulance service to convey the person in question. The rationale for this RCMP position is that longer duration rides to a medical facility are too great a strain on RCMP resources and should only be used when public safety is at risk in conveying a person to an involuntary psychiatric assessment.⁹⁶ All relevant stakeholders participating in the report, including the RNC,⁹⁷ RCMP,⁹⁸ Department of Health,⁹⁹ Eastern Health,¹⁰⁰ Central Health,¹⁰¹ and Western Health,¹⁰² agree that there is an explicit presumption that a person will always be immediately conveyed to a medical facility upon apprehension under the Act, and

91 *Supra* note 72.

92 *Supra* note 78.

93 *Supra* note 90.

94 Phone interview of Kenneth Hollett, Staff Lawyer, Newfoundland and Labrador Legal Aid Commission, (17 November 2009).

95 *Supra* note 72.

96 *Supra* note 78.

97 *Supra* note 72.

98 *Supra* note 78.

99 *Supra* note 90.

100 Questionnaire of Colleen Simms, Director of Mental Health Services, Eastern Health, (11 November 2009).

101 *Supra* note 89.

102 Questionnaire of Carol Anne Wight, Director of Mental Health Services, Western Health, (16 November 2009).

that only under the most rare of circumstances (e.g., emergency snowstorm, excessive violent behaviour) should a person be detained in police cells before conveyance to a facility for initial psychiatric assessment.

Interaction with Mental Healthcare Providers

Upon a patient's arrival at a facility for initial psychiatric assessment, the *MHCTA* also specifies a number of procedural requirements for police officers. Interestingly, this is also the juncture at which police officers will often have the most interaction with mental healthcare providers. There is a degree of variability in the ease, efficiency and concerns felt with this interaction with frontline mental health staff when comparing both the RNC and RCMP, although it may largely be due to urban versus rural realities in the system. Generally, the rural health boards (Central Health,¹⁰³ Western Health¹⁰⁴) report few, if any, concerns with respect to tension in the interaction between RCMP and frontline mental health staff, either with respect to officers having to wait with the individual at the facility until they are released from custodial responsibility (s. 21(3) and (4) of the Act), or with respect to any documentation (s. 21(2)(c)) or liability concerns by the RCMP. It should be noted that both Central Health and Western Health report that the establishment and operation of "safe rooms" in their regional hospitals has seemed to increase the overall efficiency (and positive experiences) of the initial psychiatric assessment process. The "safe room" has been described as a separate room near the Emergency Room in a hospital which is cleared of any "sharps" (i.e., syringes, scalpels, scissors etc) and is a designated room in which a person in crisis can be held to await medical staff. The issue of the appropriateness or justification of employing a separate or secluded room for persons in mental distress upon arriving at the hospital was not explored.

There are some noted concerns from both the RNC and the health boards (Eastern Health, Western Health) in jurisdictions in which the RNC operate. Given the larger, more anonymous nature of the general public in the centres of St. John's and Corner Brook, RNC officers often are unable to call ahead to a facility. Accordingly, wait times for an officer with an individual to begin the initial assessment may be extended, resulting in some cases in a reluctance by officers to use the Act to effect an apprehension/conveyance.¹⁰⁵ It should be noted, however, that both healthcare boards report that the wait time issue is being actively addressed.¹⁰⁶ Unlike Central and Western Health, Eastern Health has not fully prepared all of its safe rooms to date,¹⁰⁷ and may not be experiencing the benefit that having these facilities may provide in the process. There also appears to be some concern expressed with respect to potential liability for unlawfully detaining a person (i.e., police requesting documentation from the hospital

103 *Supra* note 89.

104 *Supra* note 102.

105 *Supra* note 100.

106 *Supra* note 100 and *supra* note 102.

107 *Supra* note 100.

prior to an assessment¹⁰⁸) or for what may occur during the custodial conveyance.¹⁰⁹ These concerns may indicate a heightened liability concern for unlawful police action by the RNC relative to the RCMP, or may simply be a function of the fact that the Act is relatively new, and officers may be uncertain of their statutory authority under the *MHCTA*.

CONCLUSIONS

The proposition that police officers are, and should be viewed as, frontline providers of mental healthcare in Newfoundland and Labrador is sound, but it requires context and qualification. It is unreasonable to expect a police officer to diagnose a person with a mental illness in the field. In fact, diagnosis, and obviously treatment, is substantively not part of the police officer's role in the overall system of involuntary mental healthcare as envisioned in the *Mental Health Care and Treatment Act*. Nonetheless, police officers play an integral role in the system of involuntary mental healthcare in the province in serving as primary conduits and facilitators between members of the public who may be experiencing mental and emotional crisis, and mental health professionals who are able and entrusted to diagnose and provide treatment. In working within the system of involuntary mental healthcare, and community support systems in general, police officers are vital frontline providers of service.

In performing this role and particular statutory duties and obligations under the Act, the importance of mental health training for police cannot be overstated. Training in the complex subject matter of mental health, and specifically within policing and mental health, can and should take many forms. What is essential is that a police force recognize the importance of improving the quality of experience a person suffering from a mental illness has when interacting with police and the involuntary system, and that the force must be open and committed to utilizing as many tools as possible in seeking this improvement. Both the RNC and RCMP police forces in Newfoundland and Labrador have arguably demonstrated this commitment. This conclusion arises through the review of literature for this report, and admittedly has been shaped by discussions with primary research sources; it is not based on any objective standard of measurement.

Despite differences in the approach or amount of mental health training, particularly in recruit training programs, between the RNC and RCMP, it remains unclear whether greater uniformity in this respect would increase the overall efficiency or ability of officers from both forces to perform their statutory duties under the *MHCTA*. Both the RNC and RCMP currently provide a significant amount of focus on mental health awareness and interactions with persons with mental illness in their respective recruit

108 *Ibid.*

109 *Supra* note 72.

programs, and demonstrate a willingness to take advantage of opportunity-based mental health training for in-service members. Counting the number of hours dedicated to mental health training, at the recruit level or for in-service members, will not necessarily provide a reliable measure of readiness and competency in interacting effectively with persons suffering from mental illness.

There are two distinct factors, independent of either RNC or RCMP jurisdiction, which became evident during the study that likely have an effect upon the quality of experience of an individual who finds himself apprehended and conveyed for involuntary assessment. The first and most obvious factor is the level of experience of the officer involved in the interaction, irrespective of whether the officer is from the RCMP or RNC; mental health training by itself is rarely going to prepare an officer to handle a real life scenario with a person in mental or emotional crisis as well as previous field experience dealing with similar situations would prepare the same officer. Consequently, scenario training used by both the RNC and the RCMP seems particularly relevant in preparing officers for the exigencies of these situations. Because police officers spend a significant amount of their time dealing with persons with mental illness on a daily basis, mental health training through trial and, unfortunately, error will be a by-product of community policing experiences regardless of the extent of formal mental health training previously undertaken. It is an intuitive proposition that an experienced officer is likely to have a more relaxed, confident and “steadier hand” when dealing with given scenarios, and research does indicate that an inverse relationship exists between an officer’s years of experience and arrest dispositions of persons with mental illness.¹¹⁰ However, experience without contextual training could also result in a continuation of negative social biases and ineffective techniques in dealing with persons with mental illness. Given the practice of partnering younger officers with more experienced officers and the use of in-service mental health training seminars by both the RNC and RCMP, it is likely that this risk is at least acknowledged and hopefully reduced.

Perhaps the most significant factor that may affect the quality of experience that a person may have when interacting with police in Newfoundland and Labrador in the context of involuntary mental healthcare is whether the incident is occurring in a rural or urban setting. It is situational coincidence, based on the geographic vastness of the province and the assignment of policing jurisdiction, that most rural incidents will involve the RCMP while most urban incidents (St. John’s, Corner Brook) will involve the RNC. Any observations therein are not meant to praise nor to criticize either force, as the rural versus urban context essentially changes the nature and challenges surrounding delivery of community services in general.

It is trite to state that equality under the law will translate into all consumers in the province having a similar experience or equal quality of service under the *Mental Health Care and Treatment Act*. While this objective is presumably a legislative aspiration, the practical realities of providing public community services in rural relative to

110 *Supra* note 37 at 298.

urban areas, coupled with the limitless situational circumstances surrounding each encounter with police in respect of the Act, make this proposition unlikely. Despite sincere efforts from all stakeholder groups in the province, there do appear to be some noteworthy differences that a person may experience if apprehended and conveyed for initial psychiatric assessment, depending on the rural versus urban distinction. These differences are likely to present themselves in the pre-apprehension decision process; in rural areas the RCMP and health boards appear to have developed MOUs that encourage, where practical, collaborative interventions wherein police and frontline mental health staff discuss the best approach for dealing with a member of the community who is often known to police and mental health staff to be having difficulties. By coordinating ambulance conveyances and working with family members in resolving crises, direct police involvement can be minimized.¹¹¹ Accordingly, when police do find it necessary to apprehend and convey someone to a facility, social relationships that are common in rural areas provide a level of personal familiarity between police and healthcare staff, so that en route calls and cooperative approaches to facilitating an efficient initial psychiatric assessment are common.

From a qualitative perspective, this rural community-intervention approach appears to function as a natural and organic form of the more specialized mobile mental health crisis teams often employed in larger urban areas. This assertion is based solely on the author's view that the common denominator in enhancing the experience for the consumer, whether in a rural or urban setting, is increased communication and collaboration between police and mental healthcare staff in addressing the consumer's needs as a priority during resolution of the crisis or incident.

In practice it is likely more difficult to implement pre-apprehension techniques in population dense urban parts of the province due to the following factors: increased numbers of socially marginalized individuals, healthcare resource constraints, and the large number of people involved in policing and healthcare. Officers may often not know the individuals they are encountering, nor may the person be known to healthcare professionals; as such, the first collaboration between police officers and frontline healthcare staff (who may also be strangers to each other) may occur upon arrival at a busy hospital emergency room. There are no formal or specialized police and mental healthcare crisis intervention models currently in place in the province, although there is on-going collaboration between the RNC¹¹² and Eastern Health¹¹³ to develop a mobile mental health/crisis response service.

Despite the practical challenges and differences that exist in community policing and provision of mental health care services in urban areas relative to rural ones, both the RNC and RCMP, in consultation with each of the four health boards in the province, appear to be committed to improving the quality of experience and care that individuals can anticipate under the *Mental Health Care and Treatment Act*, particularly with re-

111 *Supra* note 89.

112 *Supra* note 72.

113 *Supra* note 100.

spect to initial psychiatric assessment. In this context, mental health training for police is only one aspect of that sought-after improvement. Other aspects include enhanced communication between groups, and the development of joint solutions in resolving operational problems and issues in the system at large. All of the aforementioned stakeholder groups, along with the Department of Health and various consumer advocacy groups, participate in this collaboration through informal regional working groups and a formal regularly-meeting provincial-wide stakeholder's committee.

The *Mental Health Care and Treatment Act* provides the legislative structure for the provision of involuntary mental healthcare services in Newfoundland and Labrador. Police officers in the province play a pivotal and frontline role in the provision of involuntary mental healthcare in the province, and on balance are well-trained and capable of performing this role as specified under the Act. More importantly, both the RNC and RCMP appear committed to continued collaboration with their fellow stakeholder groups in ensuring that, when the Act is invoked in providing involuntary mental healthcare service, the person involved is treated with respect, and the utmost care is given for their personal dignity in a manner that recognizes the fundamental rights of every member of society.