Ottawa's Guiding Council on Mental Health and Addictions

Mental Health and Substance Use Crisis Response Systems – A Review of the Literature

Prepared by:

Manal Sayid
Sayid Consulting Inc.
Auriga Corporate Centre
38 Auriga Dr. Suite 202
Nepean, ON K2E 8A5
Tel: 647.607.0791
Email: manal@sayidconsulting.com

Table of Contents

Abstract 3
Methodology 3
Introduction 3
Factors Contributing to Police Intervention 4
Inequalities in Accessing Mental Health Services 5
Best Practices to Respond to Mental Health Crisis 7
Community Based Services 9
Conclusion 9
Gaps in Research 10
Works Cited 11

Abstract

This literature review aims to examine the cause of police brutality and force where mental health calls placed to the police force are resulting in injuries, harm, mass incarceration and sometimes even death. The literature recognizes that the issue is multilayered and stems from deeper societal issues related to limitations of the mental health system, lack of funding in community based mental health services as well as institutional discrimination. The literature review will explore the following:

1. Factors contributing to police intervention in mental health related calls and gaps in access to mental health services.
2. Experiences of black, indigenous and racialized people when it comes to crisis response services.
3. Best practices when responding to mental health related crisis calls.

Methodology

The criteria for research was focused on Canadian statistics and the Canadian racialized community experiences/inequities. As mental health systems and response protocols to mental health related calls can vary between nations, the literature review was aimed at highlighting police intervention in Canada and its associated societal issues.

Introduction

In light of public protests against police brutality and force in the media where mental health related calls placed to the police are resulting in either injuries, harm, mass incarceration and sometimes even death; this literature review aims to examine the causes of these incidents.

Persons living with a serious mental illness or emotional disorder often experience reoccurring and significant behavioral health crises. These crises frequently result in a concerned person placing a call to the police in order to seek assistance in dealing with the crisis. People often turn to the police service for help as they are the only continuous social emergency service. Consequently, this response to mental health crises inadvertently positions police officers as the default first responders to address the crises. As police officers are not subject matter experts when it comes to deescalating a behavioral health crisis that stems from a mental illness, this response system usually results in police officers using a level of force that consequently leads to many reported traumatic incidents; including, harm, injuries and sometimes even death; to either the police officers, the persons experiencing the mental health related behavioral crisis or others.

Moreover, studies and incidents reported in the media have shown that these traumatic incidents with the police disproportionately involve people of color; more specifically the Black and Indigenous communities. This inequality faced by these communities has raised concerns of systemic issues and institutional discrimination in police services and has urged the larger public to organize protests demanding the reduction of police involvement in mental health crises calls and encourage community based interventions instead in order to decrease aggressive and biased policing.

Factors Contributing to Police Intervention

In order to address the issue of police use of force when responding to mental health crisis calls, it is also important to consider the broader societal issues that contribute to these encounters. The Canadian Mental Health Association conducted a review of challenges and responses of police interventions with persons living with mental illness and discovered that police are becoming default first responders to mental health crisis calls because of deeper societal issues (Adelman, 2003).

All across North America, there has been a shift from institutionalized care to community based care which has resulted in more persons with mental illnesses living in the community (Canadian Mental Health Association, 2016). In addition, community support systems; such as crisis lines, mental health teams, and hospital emergency wards have not received sufficient funding to grow comparably to the increased need; with more than 6.7 million people in Canada reported to be living with a mental illness in 2011. These statistics translates into one in five persons in Canada who are living with a mental illness in any given year (Mental Health Commission of Canada, 2016).

In the 2006/07 fiscal year, the Ministry of Health and Long Term Care reported to have spent about $39 on community based services for every $61 it spent on institutional services. In addition, over half of community mental health service providers have received annual increases of only 1.5% over the last few years (2008 Annual Report of the Office of the Auditor General of Ontario). Service providers indicated that, as a result of wage inequalities between the community and institutional health care sectors, community based mental health services are significantly challenged in their ability to maintain mental health service levels and retain qualified staff resulting in a gap in services. Furthermore, community based care is limited in scope and has not been designed to integrate as a holistic response to mental health crisis calls with the police.

Emergency services based in hospitals are difficult to access due to bed reductions; The Ministry of Health and Long Term Care developed an deinstitutionalization target of reducing the number of psychiatric beds to 35 per 100,000 people (2008 Annual Report of the Office of the Auditor General of Ontario). Additionally, hospitals also have a tendency to only offer treatment to patients who are experiencing illness that warrants involuntary treatment under the Mental Health Act. A BC Early Intervention Study found, individuals who seek help voluntarily from emergency wards are often considered unqualified for limited acute care resources. A practice that the study discovered resulted in over 30% of persons with serious mental illness having contact with police prior to accessing the mental health system.

The shift in community based care to the mental health system and decreased funding in the area has inadvertently placed police officers as first responders to mental health crisis. According to recent data issued by the Royal Canadian Mounted Police (RCMP), police officers respond to 2.8 million mental health crisis calls on average each year (Carlos Rios Espinosa, 2021). As police officers are mandated to provide protection and safety to the public, they often perceive erratic behavior as a possible threat and use force as a response. The forceful response to mental health crisis calls results in either injury or incarceration; it is estimated that the number of untreated mental illness in the criminal justice system ranges from 15–40% of the incarcerated population in Canada (Mental Health Commission of Canada, 2016). These increased numbers are not only a result of the police lacking the comprehensive training and knowledge to appropriately respond to illness induced behaviors, but also the societal issue of a severe lack of support from the mental health system and funding of community based services.

Inequalities in Accessing Mental Health Services

Social, economic, and political factors all shape the conditions in which individuals grow, live, work, and age which are vitally important for health and wellbeing (Solar O and Irwin A., 2010). Considering this, obtaining reasonable and equitable access to universal health services determines earlier detection of illnesses, lowers mortality and comorbidity rates, and ensures improved physical, mental, emotional, and social outcomes (Cauchie, 2019). However, Black Indigenous and people of color have been disadvantaged in these areas for generations in Canada. Colonialism, oppression, and racism continue to have a persistent impact on the following communities:

Black communities

The Public Health Agency of Canada reported the following effects of discrimination faced by Black communities:

1) Lower levels of education: Among those with a postsecondary education in 2016, the unemployment rate for the Black population was 9.2%, compared to 5.3% for those in the rest of the population (Statistics Canada, 2020).
2) High unemployment rates: In 2016, 20.7% of the Black population aged 25 to 59 lived in a low-income situation (based on market basket measure), compared with 12.0% of their counterparts in the rest of the population (Statistics Canada, 2020).
3) Housing: In 2016, 20.6% of Black Canadians reported living in housing below standards, which means their housing costs more than they can afford, and/or is crowded, and/or requires major repairs. In contrast, 7.7% of White Canadians reported living in housing below standards (Statistics Canada, 2020).

Over time, these issues have resulted in a mental health service access gap. According to a survey by the Mental Health Commission, 38.3% of Black Canadians living with mental health issues used mental health services between 2001-2014 compared to 50.8% of White Canadians. Black persons in Canada have higher unemployment rates, as well as lower average incomes (Public Health Agency of Canada, 2020) which may prohibit them from a wider selection of mental health services available to those who are able to pay for private health care services or go through insurance plans covered by their employers. Overall, Black persons in Canada are more likely to experience challenges in finding family physicians, who often serve as an important gateway to mental health care (Fante-Coleman, & Jackson-Best, 2020).

In recent years, Canada has recognized racism and discrimination directed at racialized Canadians as an important factor of inequitable health outcomes (Paradies et al., 2015). Discrimination and racism against Black people is deeply rooted and normalized in Canadian institutions, policies, and practices and is often overlooked and unrecognized unless one is directly affected by the consequences. Systemic discrimination and racism has a long history, dating as far back as the European colonization in Africa and the legacy of the transatlantic slave trade. Almost two centuries later, racist beliefs established during those periods in history continue to guide processes of stigma and discrimination (Henry and Cooper, 2022). Examples at institutional and societal levels that exist today include:

1) Racial profiling and over policing; which include, surveillance, harassment, excessive use of force etc. (Hayle S, Wortley S & Tanner J., 2016).
2) Overrepresentation of Black people in criminal justice systems (Office of the Correctional Investigator, 2014).

3) Overrepresentation of Black youth and children in child welfare systems (Clarke, 2011)

The Centre for Addiction and Mental Health (CAMH); hospital that treats people facing addiction and mental health challenges, recently reported that the facility detains Black patients 44% more often than they do white patients, and 22% more often than all other races (2021). A CBC investigation found that between the years 2000 to 2017, there were 461 deadly police interactions, and 70% of the victims suffered from mental-health issues with Black people accounting for 37% of the victims. Furthermore, between January 1 and November 30 of 2020, there were 55 police shootings in Canada, 34 of which were fatal. Many of the victims were Black, Indigenous or people of color experiencing a mental health crisis. The victims whose race could be identified, 48% were Indigenous and 19% were Black.

Indigenous communities

Indigenous people in Canada face substantial socioeconomic inequality due to the lingering effects of colonization, such as forced removal from their communities (Durand-Moreau, Q., Lafontaine, J., & Ward, J., 2022). The Truth and Reconciliation Commission of Canada conducted a narrative review on the topic of work and health issues faced by Indigenous communities in Canada and reported the following:

1) Location of residence:
    - According to Statistics Canada (2017), approximately 80% of Métis live in urban centers; close to half (44.2%) of registered First Nations people live on reserve, with the remainder living off reserve; while the majority (72.8%) of Inuit continue to live in Nunangat. All of these regions are either rural and remote locations with a small population size of communities and its challenging to recruit and retain health professionals which leaves many communities with shortages of medical personnel. For First Nations living on reserves, long wait lists and lack of available doctors or nurses pose significant barriers to receiving health care.
2) Racism and discrimination:
    - According to the 2019 General Social Survey (GSS) on Canadians' Safety;
        - Discrimination was more common among the Indigenous population than among populations who are both non-Indigenous and non-visible minority (33% versus 16%). More specifically, 44% of First Nations people had experienced discrimination in the 5 years preceding the survey, as had 24% of Métis and 29% of Inuit.
        - Among those who were discriminated against, 21% of Indigenous people and 16% of Black people said it was when dealing with police, compared with 4% of non-Indigenous, non-visible minority people who experienced discrimination.
        - Experiences of discrimination were more common among Indigenous people in 2019 (33%) than they were in 2014 (23%).
    - A review into racism, stereotyping and discrimination against Indigenous peoples in the B.C. health care system was conducted by a former judge and resulted in the publication of a report entitled *In Plain Sight*, which is based on consultations with nearly 9,000 people, including 2,780 Indigenous people and 5,440 health care workers. The report highlighted that 84% of Indigenous peoples described personal experiences of racism and discrimination which discouraged them from seeking necessary health care which subsequently affects their health negatively.

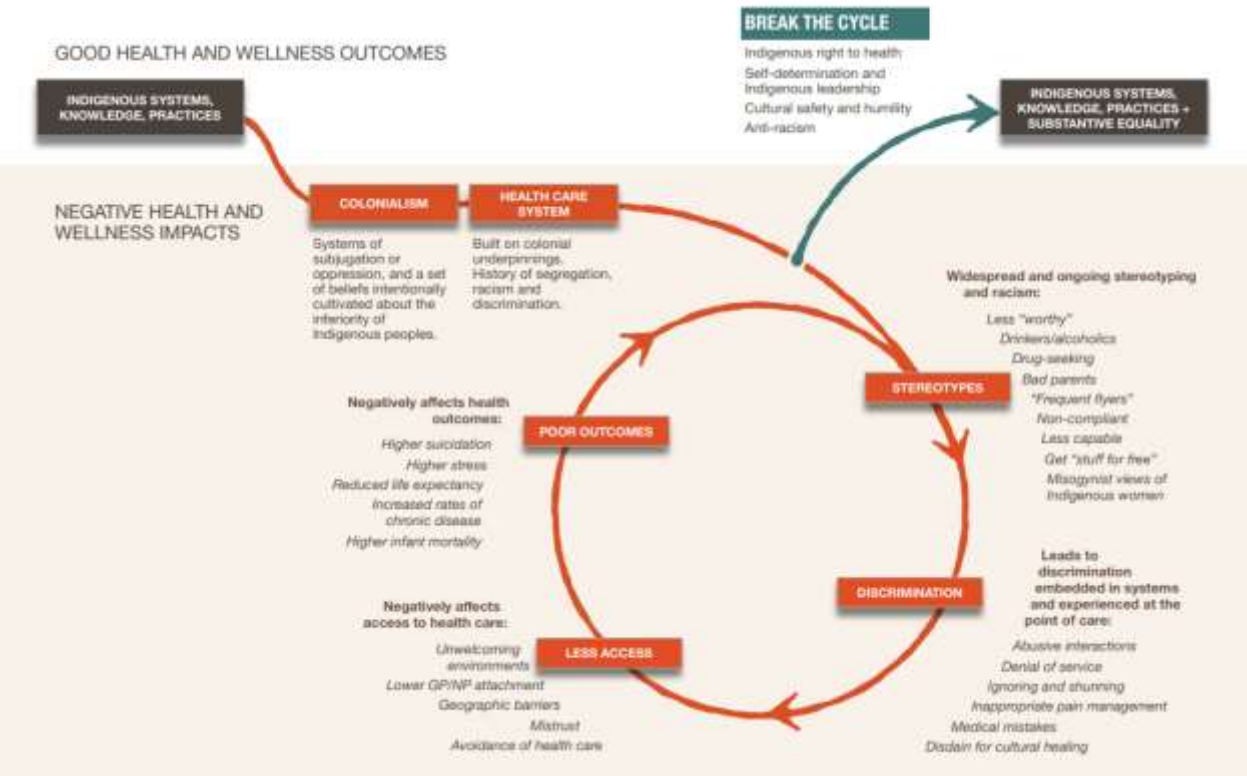

Figure 1: Findings associated to *'In Plain Sight Report; Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care'* (Turpel-Lafond, 2018).

The above figure outlines the negative cyclical effects of colonialism in the health care system. The report outlines the need for culturally safe health care practices, knowledge, and equality in order to break the cycle.

3) Culturally incompetent/sensitive healthcare practices:
    - According to the American Healthcare Association's definition, cultural competency in health care is described as; "*the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including the tailoring of health care delivery to meet patients' social, cultural and linguistic needs.*" In the context of the Indigenous community, this practice requires involving Indigenous ideologies which includes spiritual or traditional practices in mental healthcare instead of a biomedical approach to treating mental health challenges.

An analysis in the Canadian Medical Association Journal by researchers in the Rady Faculty of Health Sciences and Indigenous elders reveals that there is evidence that suggests Indigenous led health care partnerships are improving health outcomes in Indigenous peoples as well as access to care, prevention uptake and compliance to care plans (Allen L, 2020). Although more health professionals are now becoming aware of the challenges associated with providing health care to a more culturally and racially diverse population, the form of care and the organizational performance frameworks to assess impacts are still under developed (Bhui et all, 2007).

Furthermore, culturally incompetent practices also affects Black communities. There is a severe lack of representation and lack of culturally competent Black professionals in the

Canadian healthcare system (Kalambay, 2023). According to 2015 census by Statistics Canada, Black physicians are approximately only a mere 2.3% of the physician population. It is important to have professionals who understand the complexities of Black communities in order to administer proper care otherwise it is extremely difficult for someone to seek help. This is particularly true if the person feels that the professional is unable to relate to their experience or understand their particular challenges. Moreover, a 2018 survey found that 60% of Black Canadians would be more willing to use mental health services if the mental health professional was Black.

Best Practices to Respond to Mental Health Crisis

Although there is increased evidence of the ineffectiveness of police service using force to respond to mental health crisis, the City of Ottawa has consistently invested more and more in the police service. The police budget rose almost $50 million from 2015 to 2019 (Ottawa Police 2019 Annual Report). Moreover, in addition to the rapid increases in police budget, the police service went over their budget by at least $4 million every single year over that 4 year period. Consequently, the larger public has expressed significant concern in investing in a service that provides poor health outcomes to those involved in a mental health crisis responses. In Canada, there has been a call for a national defunding of police services and instead allocating funding and more investments in communities to promote public safety (Alliance for Healthier Communities, 2022).

In an attempt to improve the outcomes of responding to mental health crisis calls, the Toronto Mobile Crisis Intervention Teams program was formed which has produced cost effective and positive outcomes in resolving issues stemming from police intervention on mental health crisis calls. The program started in 2000 and is a small and limited project that aims to provide a community co-response to mental health crisis calls by partnering a mental health registered nurse and a specially trained police officer. The program aims to achieve the following:

1) Provide prompt assessment and support to persons experiencing a mental health crisis.
2) De-escalating behavioral crisis' and preventing injury.
3) Linking people in mental health crises to appropriate community services if follow-up treatment is recommended.
4) Reducing pressure on the justice system.
5) Reducing visits to emergency department.

The program has resulted in reduced pressure on the justice system through lower rates of arrest (Steadman, 2000), as well as reductions in officers' time spent on location (Kisely, 2010) and accompanying clients to Emergency Departments (Bailey, 2018). There is mixed evidence on the programs' capacity to decrease health system pressures; some work has found significant reductions in client hospitalizations when compared to police intervention services (Scott, 2000). However, some research has found these programs frequently connected clients to community based services (Kisely, 2000) which may lead to reduced use of acute care services over time. There is also some evidence that co-responding police mental health programs have been cost effective due to the savings to justice and health systems.

Community Based Services

As one of the responses to a co-response program is access to community-based services, it is also important to examine the effects of community based services in improving access to mental health services and reducing discrimination. Community intervention programs aim to decrease structural and social inequities in addressing mental health issues (Castillo, 2019). As mental health related issues are multilayered, community-based services applies multi-sector partnership and emphasizes the importance of community members as essential to the intervention. This approach to health care examines cases at a social-ecological level to promote mental health and social well-being. The social-ecological levels that were examined in recent studies include the following:

1) Individual level – increase access to mental health services and treatments.
2) Interpersonal/Family level – provision of education to families in order to increase mental health literacy and how to seek help.
3) Organizational/Institutional – embedding mental health services within community locations for easy access.
4) Community – incorporate multi-sector coalitions in the planning and implementation of mental health services.
5) Policy – provide financial support to encourage multi-sector partnerships to address mental health issues.

Studies show that there is evidence for the efficiency of community interventions for improving mental health and some social outcomes through addressing social-ecological levels of care. However, studies indicate the importance of ongoing resources and training in order to maintain long term outcomes as well as policy reform to support sustainable healthcare and community collaborations (Castillo, 2019). Working in partnerships with communities and policy leaders, future community interventions in mental health can improve health and achieve positive social outcomes through addressing institutional and social inequities.

Conclusion

Police use of force in addressing mental health related calls has grown to be a national concern in Canada. The police service is not a health service; it is simply a force and should be treated as such by policy makers and governments instead of positioning them as default first responders to address mental health crises; a duty in which they are not well equipped to respond appropriately because of lack of knowledge and training in deescalating illness induced behaviors.

A decrease in funding allocated to police services and a greater investment in community based interventions to address mental health crisis calls is recommended and should be advocated as they have been proven to be successful in addressing the issues stemming from relying on police intervention. Investment in community based practices in mental health crisis responses will also eliminate the inequalities faced by racialized communities in receiving health care as all mental health related cases will be addressed similarly and community resources will be made easily accessible to all who require services regardless of background and social status.

Gaps in Research

The key stakeholder groups in Canadian policing, which includes police service boards, municipal councils, and police associations do not have the capacity to conduct research on policing models in Canada. Therefore, it is difficult to access Canadian and international research studies and there is often little communication between academics and these key stakeholder groups. Considering this, collaborative partnerships could increase access to expertise in the field of policing in Canada. In order to bridge this gap, Canadian key stakeholder organizations have been relying on research findings from other international jurisdictions, particularly the UK and the US. This approach poses a challenge as other jurisdictions have different policing models and their findings cannot be used as comparable data (Griffiths, 2014). An RCMP official stated:

"If the RCMP is looking for law enforcement data research they will look to the US, UK, Australia and New Zealand. All of these countries are doing substantially more research than Canada and there appears to be an increase in research in the US and UK. Challenges occur because it can be comparing apples to oranges because of the policing model in Canada."

Another existing gap in research is that the practice of collecting race based data on police interactions is scarce in Canada in comparison to other areas in the world, particularly in America (CBC, 2021). Although the limited data available in Canada shows racial profiling and discrimination displayed by police disproportionately affects people of color, experts believe that more objective information is key to reducing the number of deadly interactions between police and people of color. The issue with lack of data/limited data is that the voices/experiences of racialized communities may not be validated through the data, therefore, change cannot be recognized and advocated for these communities. (Vermes, 2021).

Works Cited

1) 2008 Annual Report of the Office of the Auditor General of Ontario. (n.d.). Office of the Auditor General of Ontario. https://www.auditor.on.ca/en/content/annualreports/arreports/en08/306en08.pdf
2) Adelman, J. (n.d.). *Study in Blue and Grey, Police Interventions with People with Mental Illness: A Review of Challenges and Responses*. Retrieved January 26, 2023, from https://cmha.bc.ca/wp-content/uploads/2016/07/policereport.pdf
3) Bailey K; Paquet SR; Ray BR; Grommon E; Lowder EM; Sightes E; (2018, November 22). *Barriers and facilitators to implementing an urban co-responding police-mental health team*. Health & justice. Retrieved January 21, 2023, from https://pubmed.ncbi.nlm.nih.gov/30467739/
4) Castillo, E.G., Ijadi-Maghsoodi, R., Shadravan, S. et al. Community Interventions to Promote Mental Health and Social Equity. 29 March 2019 https://doi.org/10.1007/s11920-019-1017-0
5) Fante-Coleman, T., & Jackson-Best, F. (2020). Barriers and facilitators to accessing mental healthcare in Canada for Black youth: A scoping review. Adolescent Research Review https://link.springer.com/article/10.1007/s40894-020-00133-2
6) Hayle S, Wortley S & Tanner J. Race, street life, and policing: Implications for racial profiling. Canadian Journal of Criminology and Criminal Justice, 2016; 58(3), 322-353.
7) Henry, N., & Cooper, C. (2022). Black Enslavement in Canada. In *The Canadian Encyclopedia*.
8) JP;, S. H. J. D. M. W. B. R. M. (n.d.). *Comparing outcomes of major models of police responses to Mental Health Emergencies*. Psychiatric services (Washington, D.C.). Retrieved January 9, 2023, from https://pubmed.ncbi.nlm.nih.gov/10783184/
9) Kisely , S. (2010, October 1). *A controlled before-and-after evaluation of a mobile crisis partnership between Mental Health and Police Services in nova scotia*. Canadian journal of psychiatry. Retrieved January 10, 2023, from https://pubmed.ncbi.nlm.nih.gov/20964945/
10) Office of the Correctional Investigator. A Case Study of Diversity in Corrections: The Black Inmate Experience in Federal Penitentiaries. 2014. http://www.oci-bec.gc.ca/cnt/rpt/oth-aut/oth-aut20131126-eng.aspx
11) Ottawa Police Service, "Cost of Policing," Ottawa Police 2019 Annual Report, https://www.ottawapolice.ca/en/annual-report2019/cost-of-policing.aspx
12) Paradies Y, Ben J, Denson N, Elias A, Priest N, Pieterse A, et al. (2015) Racism as a Determinant of Health: A Systematic Review and Meta-Analysis. https://doi.org/10.1371/journal.pone.0138511
13) *Police and mental illness: Increased interactions - CMHA*. (n.d.). Retrieved January 20, 2023, from https://cmha.bc.ca/wp-content/uploads/2016/07/policesheets_all.pdf
14) *Policy statement on defunding the police*. Policy Statement on Defunding the Police | Alliance for Healthier Communities. (2022, May 5). Retrieved January 19, 2023, from https://www.allianceon.org/news/Policy-Statement-Defunding-Police
15) Rios Espinosa, Carlos. "Canada Program Leads the Way in Addressing Mental Health Crises." 2 December 2021.
16) RL;, S. (2000, September 1). *Evaluation of a mobile crisis program: Effectiveness, efficiency, and consumer satisfaction*. Psychiatric services (Washington, D.C.). Retrieved January 29, 2023, from https://pubmed.ncbi.nlm.nih.gov/10970919/
17) Statistics Canada. Canada's Black population: Education, labour and resilience. February 25, 2020. https://www150.statcan.gc.ca/n1/pub/89-657-x/89-657-x2020002-eng.htm

18) Solar O and Irwin A. Social Determinants of Health Discussion Paper 2 (Policy and Practice). 2010.
19) Griffiths, C. T. (2014). Baseline for Policing Research in Canada - publicsafety.gc.ca. Retrieved January 20, 2023, from https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/bsln-plcng-rsrch/bsln-plcng-rsrch-en.pdf
20) Vermes, J. (2021, April 16). Even limited data shows traffic stops in Canada disproportionately affect people of colour, says expert | CBC Radio. CBCnews. Retrieved January 30, 2023, from https://www.cbc.ca/radio/day6/trouble-with-traffic-stops-pandemic-ramadan-take-2-st-vincent-s-layered-emergencies-brittlestar-more-1.5989233/even-limited-data-shows-traffic-stops-in-canada-disproportionately-affect-people-of-colour-says-expert-1.5989472
21) Durand-Moreau, Q., Lafontaine, J., & Ward, J. (2022, August). *Www.thelancet.com*. The Lancet Global Health. Retrieved February 5, 2023, from https://www.thelancet.com/action/showPdf?pii=S2214-109X%2822%2900203-0
22) NCCIH Communications Officer, L. C. (2019, October). *Access to health services as a social determinant of First Nations, Inuit and Métis Health*. NCCIH. Retrieved January 29, 2023, from https://www.nccih.ca/495/Access_to_health_services_as_a_social_determinant_of_First_Nations,_Inuit_and_M%C3%A9tis_health.nccih?id=279
23) Kitching GT;Firestone M;Schei B;Wolfe S;Bourgeois C;O'Campo P;Rotondi M;Nisenbaum R;Maddox R;Smylie J; (2019, August). Unmet health needs and discrimination by healthcare providers among an indigenous population in Toronto, Canada. Canadian journal of public health from https://pubmed.ncbi.nlm.nih.gov/31435849/
24) Turpel-Lafond , D. M. E. (2018). (rep.). In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care. Retrieved from https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Summary-Report.pdf.
25) Allen L;Hatala A;Ijaz S;Courchene ED;Bushie EB; (2020, March 2). Indigenous-led Health Care Partnerships in Canada. CMAJ : Canadian Medical Association journal . Retrieved from https://pubmed.ncbi.nlm.nih.gov/32122977/
26) Bhui K;Warfa N;Edonya P;McKenzie K;Bhugra D; (2007, January 31). Cultural competence in Mental Health Care: A review of Model Evaluations. BMC health services research. Retrieved from https://pubmed.ncbi.nlm.nih.gov/17266765/
27) Kalambay, M. (2023, February 7). Breaking down barriers to mental health in Black Communities. Virtual Healthcare & Well-Being Programs for Organizations. Retrieved from https://www.dialogue.co/en/blog/addressing-mental-health-challenges-in-black-communities