BUSINESS CASE

Co-Responder Teams (CRTs)

9/28/2021

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The Strategic Context

Problem Statement

While alternative responses to mental health calls for service (CFS) inclusive of mental health/social service professionals currently exist at the VicPD, a gap exists in the continuum of mental health response to low-acuity mental health CFS. Additionally, while recent calls to divest or divert funds away from police and towards social and health services frequent public opinion, the lack of drop-in and immediate access services in addition to services that are not sobering assessment centres (SAC), jail, or the hospital remain unaddressed at the municipal and provincial level.

Business Need Summary

While mobile crisis teams (MCTs) made up of a team of mental health professionals, are certainly perceived to have an improved response to mental health crisis versus police presence, these models have not yet been fully evaluated empirically. Additionally, there are considerable limitations to the types of calls these teams can attend to. Alternatively, co-responder teams (CRTs) implemented in Canada and internationally have shown some promise through comprehensive evaluations. The research shows that that there is significant value in staffing a team inclusive of a police officer that has the ability to respond to all types of situations with a mental health component to mitigate risk. Therefore, a primary response CRT is recommended to address the full range of CFS, and further streamline service provision between health and social services and police. The implementation of three CRTs, in addition to the services already provided by IMCRT, will ensure service delivery along a continuum of care - from outreach and prevention to rapid response and follow-up. The CRT will be housed under the Central Access and Rapid Engagement Services (CARES) umbrella of the Vancouver Island Health Authority (VIHA). While IMCRT will continue to provide a regional response, the CRT will provide call response to Victoria and Esquimalt only.

Each CRT will include a plain clothes VicPD officer and a VIHA mental health worker. The CRT will respond to a broad range of mental health calls with a focus on early-intervention, crisis- intervention, rapid-response, and de-escalation.

Background

Over time, the majority of Canadian police service organizations shifted from a reliance on traditional law enforcement activities to more community or contemporary policing models which “rely on consultation, collaboration, and cooperation with communities to establish mutually beneficial relationships” (Morgan, 1986 as cited in Cotton & Coleman, 2010). In some areas, community policing models transformed into co-response teams (CRTs) and crisis- intervention teams (CITs). CRTs involve specialized police response to persons in crisis to improve police interactions and divert individuals away from the criminal justice system or emergency hospital services. While the structure and composition of CRTs vary according to jurisdictional needs and resources, CRTs are commonly comprised of: (1) an (uniformed or plain-clothes) officer and a mental health practitioner (e.g., registered psychiatric nurse, social worker) who work together on shift and jointly respond to calls for service at the request of 911 dispatch; or (2) an on-call team of mental health practitioners based out of a local hospital or community-based service that respond to crises at the request of dispatch and typically join officers already on scene (Parker et al., 2018 as cited on CANSEBP, 2020). CITs, commonly known as the

Memphis model are similar to CRTs in that their primary goals are to increase safety in police encounters with persons experiencing a mental health crisis and, where appropriate, to divert persons with a mental health challenge from the criminal justice system to treatment (Watson & Fulambarker, 2012). However, unlike CRTs, CITs do not include mental health practitioners as part of the response model. Instead, a select group of officers that volunteer to become CIT officers receive approximately forty hours of specialized training provided by mental health clinicians, consumer and family advocates, and police training (2012).

Despite the deployment of CRTs and CITs to more adequately address calls involving persons with perceived mental illness (PwPMI), police involvement in any model continues to be controversial. 2020 movements reignited the call to 'defund police' by reallocating a portion of a police department's budget to community supports. In Canada, the push to defund continues to gain momentum with some jurisdictions putting forward motions to cut city police budgets by up to 10% (Forani, 2020). As a result, the Victoria Police Board, in collaboration with the Island Health Board of Directors, put forward the following mandate:

THAT, the Island Health Board of Directors and Victoria Police Board endorse a partnership between Island Health and the Victoria Police to co-chair a 90-day task force that evaluates the need for, and potential models of, a civilian-involved mobile crisis intervention service integrated into the public safety system to address health (including mental health) and social needs. The service may possibly be dispatched through the South Vancouver Island 911/Police Dispatch Centre (E-Comm). As part of its work, the task force will work with associated stakeholders to conduct an environmental scan to assess all current mental health response programs, consider alternate models from other jurisdictions, assess the evidence base for such programs, and consider the role of police and other first responders in the program. The findings of the task force will be brought back to the respective boards by no later than September 2020.

This business case is an output of the above mandate.

Current State

The VicPD currently contributes resources to five response and follow up models related to mental health:

1. Patrol - Call for Service response
2. Early Warning System (EWS)
3. Integrated Mobile Crisis Response Team (IMCRT)
4. Greater Victoria Emergency Response Team (GVERT)
5. Assertive Community Treatment (ACT) Program
6. Housing Action and Response Team (HART)

Jurisdictional Scan Findings

A jurisdictional scan of over 30 police agencies in North America, the United Kingdom (UK), Sweden, Australia, and New Zealand was conducted to determine:

1. Types of response models;
2. Variations in operationalization;
3. Services offered and service limitations; and
4. Challenges and successes of the various models.

There was considerable variation in how mental health response models across identified jurisdictions are operationalized. There is variety in how teams are dispatched; whether the teams provide a primary or secondary response; whether teams provide crisis-intervention, early-intervention, after-event support, or a combination of all three; operating days and time; how teams are triaged; and what services are offered.

Responses that leverage existing emergency medical response systems with or without law enforcement participation (also known as mobile crisis teams (MCT)) continue to develop; however, descriptive overviews from pilots in North America and early data from initiatives in Australia and Sweden suggest that while these models have been well received, formal research is lacking and evaluation must continue alongside program development. In particular, there is a need for additional research on stakeholder acceptability as well as experimental research testing the impact of this type of service model on police/emergency service contacts and mental health and criminal justice outcomes (Watson, Compton, & Pope, 2019).

Overall, researchers agree that while Canadian officers receive mental health training as part of CITs, the literature suggests that co-responder team (CRT) contacts with persons potentially experiencing mental illness not only result in more positive interactions, but also better outcomes in contrast to frontline (CIT) interactions (Koziarski, O'Connor, & Frederick, 2020). Canadian evaluations of CRT models suggest they may decrease injuries, increase hospital admissions, decrease involuntary commitment, and decrease the time officers spend at the hospital when compared with officers responding alone (Lamanna, 2018).

Unfortunately, significant variation in implementation of the models results in difficulty generalizing findings from the existing research. Therefore, while a growing body of descriptive research exists on CRTs in comparison to any other type of mental health response model, a lack of controlled research about the model's effectiveness results in an inability to conclude that CRTs are evidence-based (Watson, Compton, & Pope, 2019).

Drivers for Business Need

- Increase in mental health related calls and apprehensions
- Need for enhanced assessment
- Coroner inquests
- Disproportionate use of police resources
- Need for diversion to community-based services
- Inclusive service provision

Recommendation and Resource Requirements

Resource Request

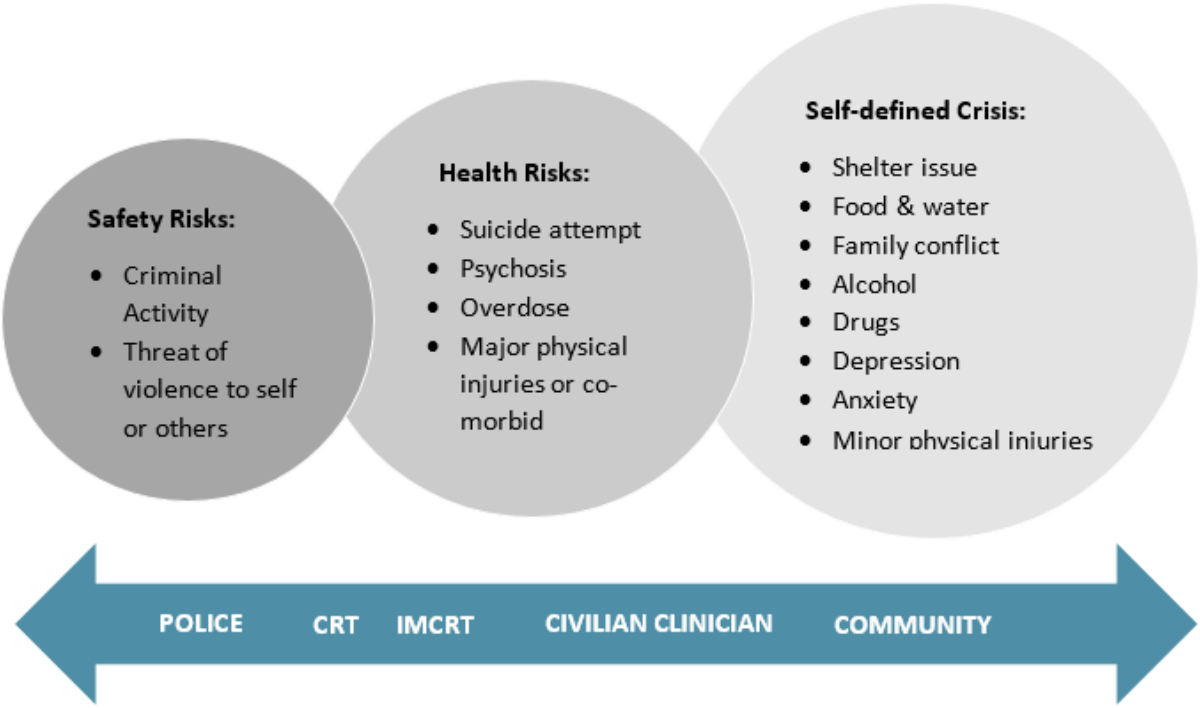
A primary response CRT is recommended to address the full range of CFS, and further streamline service provision between health and social services and police. The implementation of three CRTs, in addition to the services already provided by IMCRT, will ensure service delivery along a continuum of care - from outreach and prevention to rapid response and follow-up. The CRT will be housed under the Central Access and Rapid Engagement Services (CARES) umbrella of the Vancouver Island Health Authority (VIHA). While IMCRT will continue to provide a regional response, the CRT will provide call response to Victoria and Esquimalt only. The CRT will respond to a broad range of mental health calls with a focus on early-intervention, crisis- intervention, rapid-response, and de-escalation.

The police role on the CRT will include:

- Accompanying the mental health worker to all calls;
- Assessing and establishment scene safety;
- Providing security and risk assessment;
- Facilitating access to services in a less enforcement-oriented manner;
- Providing de-escalation and crisis response;
- Participating in meetings with leadership, steering, and working committees;
- Providing direct liaison to other VicPD members in the field regarding team activity when appropriate;
- Collaborating with Community Partners to identify where other mental health supports are needed; and
- Facilitating education sessions to help educate team members and other community partners (Street Drug education; 911 Communications).

A visual representation of the recommended general response systems approach to mental health has been added below. The CRT model falls within the police/health part of the spectrum.

VicPD Jurisdiction Crisis Response



***Adapted from**

Canadian Mental Health Association British Columbia *Mental health for all*

Definition of Crisis

Resource Requirements

Personnel: Three teams, which each team including a plain clothes VicPD officer and a VIHA mental health worker.

Operating Hours: 7-days-a-week, 16-hours per day

	2022 Impact				Full Year Impact (2023 On)	
Estimated Date	One-Time[1]	Ongoing (prorated)	Total	% Impact on Budget	Ongoing	% Impact on Budget
May-22	150,000	296,233	446,233	0.75%	444,350	0.75%

Note: *The police budget request represents only the police portion of the CRT teams. All costs for health resources will be borne by Island Health.*