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Exploring Police Officers' Perceptions of Mobile Crisis Rapid Response Teams Within a Nodal Policing Framework

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**EXPLORING POLICE OFFICERS' PERCEPTIONS OF MOBILE CRISIS RAPID
RESPONSE TEAMS WITHIN A NODAL POLICING FRAMEWORK**

By

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THESIS

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Abstract

An increasing portion of police service resources are being dedicated to interactions involving persons with mental illness (PMI). As a result, Mobile Crisis Rapid Response Teams (MCT) comprised of mental health professionals have been recently implemented to assist police officers in more efficiently handling police calls for service involving PMI. The current ethnographic study used data collected through researcher ride-alongs with police officers at a mid-sized police service in Ontario to assess how police officers interact with and perceive MCTs. Results from thematic analysis indicated that officers value the skill sets possessed by MCT workers, had relatively positive perceptions towards them, and viewed MCT members as ultimately more knowledgeable about mental health than themselves. While officers and the MCTs typically collaborated well, there was an identified need for further mental health resources in the form of additional MCT units and extended hours of MCT operation. Further, officers had different understandings regarding when they should call in an MCT and when they could safely leave a PMI with a mental health professional either on-scene or at the hospital. Finally, while officers often had tense relationships with and opinions towards hospital staff, the MCT mental health professionals have eased this tension. This improvement in police-hospital relations is largely due to MCTs ability to use medical language familiar to hospital staff when discussing mental health cases, thereby increasing legitimacy of police involved in Mental Health Act (MHA) apprehensions.

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Chapter 1: Introduction

Statistics show that 1 in 5 Canadians will at some point in their lives experience a mental illness, a condition that affects both males and females of all ages and all ethno-cultural and socio-economic groups (Canadian Mental Health Association, 2016). Canada's response to mental illness has been in flux over the past 100 years. Beginning in the 1950s, Canada moved towards deinstitutionalization, aiming to reduce psychiatric hospital beds and increase community integration of those with mental illness through various outpatient treatment options (Cordner, 2006; Green, 1997; Lamb & Weinberger, 2005). Regretfully, accessibility to mental health treatment in the community is limited, and mental illness tends to go untreated (Crocker et al., 2009). Unintended consequences of deinstitutionalization for people living with mental illness (PMI) include an increase in negative outcomes such as poverty, victimization, involvement in crime and other difficult social and physical situations (Crocker et al., 2009). These outcomes coupled with stigmatization of mental illness as dangerous increased likelihood of police contact (Crocker et al., 2009).

While there is limited quantitative data tracking the incidence of police interactions with PMI, there has undoubtedly been a significant increase in these interactions (Cotton & Coleman, 2014, Desmarais et al., 2014; Charette et al., 2011; Durbin et al., 2010; Hartford et al., 2005; Lurigio & Watson, 2010). Durbin et al. (2010), found that among municipal police services in Ontario, police contact involving PMI increased from 19,441 contacts in 2003 to 27,353 contacts in 2007. The increase in mental-health related calls for service has severely strained limited police resources. Moreover, increased police contact has led to unnecessary criminalization of PMI (Sapers, 2012), especially when individual officers do not have the skills or access to resources to address mental health concerns and choose to arrest instead (Desmarais et al., 2014).

Further, PMI tend to be arrested often for minor transgressions, such as nuisance calls (Coleman & Cotton, 2010). In sum, police services are overburdened by calls involving PMI, and consequently people too often do not receive adequate care (Cotton & Coleman, 2013) and are at risk for criminalization.

As a result of these issues related to police response to mental-health related calls for service, there is a growing need for policing to change and include other entities that can assist in improving such interactions. Consequently, police services have recently begun to share and defer duties to other specialized groups. One example of this diffusion of mental health duties is the relatively recent emergence of designated Mobile Crisis Rapid Response Teams (MCT). These teams involve mental health professionals who respond to calls involving PMI in tandem with uniformed police officers in order to provide immediate, and more accurate assessments of mental health crises (Cotton & Coleman, 2010). The benefit of this partnership is that police officers are able to ensure the safety of all parties and possess the legal authority to apprehend, while the mental health specialists use their expertise to assess the subject of the call and make recommendations on the best course of action concerning apprehension or safe diversion (Cotton & Coleman, 2010).

While there is a growing body of literature related to police responses to people in mental health crisis (Coleman & Cotton, 2010; Morabito et al., 2012; Cotton & Coleman, 2013; Charette et al., 2014), there are still gaps in understanding how police services interact with and delegate duties to other entities. The existing literature focuses on aspects such as use of police resources, how police and PMI view each other, guidelines for police working with PMI, and existing models for involving other police and non-police actors. The current study addresses the identified gap by exploring how police officers interact with, perceive, and share duties with

MCTs. Involvement in policing duties by entities external to traditional police services is termed *pluralisation* (Crawford, 2006). As a theoretical backdrop, pluralisation will be applied and used to interpret the findings of the current study. The analysis will provide an understanding of whether or not police officers value and appreciate assistance in managing calls involving PMI. Currently, there is a paucity of research examining how officers perceive MCTs in the context of this pluralistic arena. It is imperative to understand how officers feel about deferring responsibilities associated with mental health crises response to third party mental health workers. It is possible that police are very willing to give these conventionally “non-police duties” to more capable parties such as mental health professionals, in order to return to their more traditional law enforcement duties. However, it is not currently known whether this circumstance is the case.

Further, despite the fact that police interact with PMI at higher rates than the general public, questions remain about how police engage resources in such interactions (Charette et al., 2014). Calls involving PMI typically use more time and resources on the part of police services (Charette et al., 2014); however, it is unclear how MCTs operate in practice to combat this demand on public resources. Reductions in wait times in emergency departments, diversion of PMI from hospitals, as well as more efficient use of police resources are some of the benefits that have been documented in analyses of MCT pilot programs (Bennett, 2015; De Caire, 2015; County O.P.P., 2016; Halton Regional Police Service, 2016). However, these reports are written by management who are viewing the program as a whole, often from a distance, and are not focusing on client-centered outcomes. Extant research does not attend to the collaboration between police officers and MCTs. It therefore remains unclear how the concept of pluralism applies to the day-to-day practical relationships between individual police officers and the

MCTs. Perhaps members of the two organizations work well together as part of a collaborative relationship, but it may also be the case that the relationship is less effective. An examination of how these two groups, both of whom play major roles in managing mental health calls, work together in the field is needed.

In addition, while current reports indicate significant decreases in hospital wait times, more research is needed on how these groups share resources and information with one another to accomplish this. Given that the personality and attitudinal attributes of individual officers may influence how they handle PMI (Cotton, 2004), it would be valuable to understand how officers in the community view the implementation of MCT programs. These mental health teams are available to police officers when requested by police for assistance, thus the perceptions of MCTs by the officers are important to understand. Officers with positive perceptions might utilize the teams more frequently and willingly compared to those who perceive the MCTs as less useful. Finally, understanding the nature of the collaboration between the police and MCTs has implications for the MCTs too, because knowing how officers perceive them could influence how they interact and work with one another in the field.

Purpose of Study

The purpose of the current study was to address the identified research gaps by examining the nature of police perceptions of the MCTs. The objective of the current research was to understand how frontline police officers engaged with the MCTs in order to manage mental health calls in the field. Further, this study sought to understand how persons in crisis were managed during these calls, with a focus on how police officers divided duties with the MCT workers. In examining these factors, it was imperative to focus on what duties officers viewed as being theirs, and what duties they deferred to the MCT workers. Uncovering and

understanding these elements is imperative to the future success and continued improvement of police services' relationships with MCTs and other entities with whom they work in resolving mental health related calls for service.

With respect to the structure of this thesis, the paper begins with a literature review discussing trends in policing the mentally ill, with a focus on developments within the Canadian landscape. A chapter follows outlining the development and early findings concerning MCTs as an innovative program. Finally, a chapter is dedicated to a review of pluralism in the policing arena, as the current study draws upon this theory to explain the distribution of power and responsibility within the field of policing (Johnston & Shearing, 2003; Loader, 2000; Crawford, 2013). To answer the research questions of the current study, an ethnographic field study was conducted to analyze police officers' interactions with and perceptions of MCTs. This field work and data collection was followed by a qualitative analysis where emergent themes were identified in the data. Implications of the themes are discussed empirically as well as through the interpretive lens of pluralism.

Chapter 2: Literature Review

There is a burgeoning literature pertaining to police interactions with PMI. In order to understand this literature, it is imperative to begin with a brief history of the rise of police interactions with PMI in the community. Further, understanding the nature of such interactions will provide necessary context for the current study, and bring to light the need for a different approach to responding to mental health calls for service. Finally, outlining past implementations and initiatives that have improved police-PMI interactions is required to understand the steps that preceded the development of the current MCTs.

The Rise of Police – PMI Interactions

Police-PMI interactions have been on the rise in recent years. For example, between 2012 and 2015, the Halton Regional Police Service in Southern Ontario observed a 37% increase in the number of reportable mental health occurrences attended by police (Halton Regional Police Service, 2016). While this increase could be, in part, explained by a change in reporting practices, it is nonetheless noteworthy. The general estimate is that incidents involving a PMI make up about 1 in 5 calls depending on the police service, a rate that vastly over represents those affected by a mental illness (Cotton, 2004; Hartford et al., 2005; Wilson-Bates & Chu, 2008). Indeed, a recent study in Canada found that of the 5 million Canadians aged 15 or older who reported having come into contact with the police over the last year, 18.8% of these people had a mental illness or a substance use disorder, which are often concurrent (Boyce, Rotenburg & Karam, 2012). Further, a study looking specifically at police-citizen encounters involving PMI in Ontario found that contact with PMI rose from 287 to 397 per 100,000 from 2003 to 2007 (Durbin et al., 2010). It has been recently estimated that 40% of individuals with a mental illness have been arrested at least once within their lifetime (Brink et al., 2011), compared to only a

15% arrest rate of the general public. Finally, a study in London, Ontario found that PMI have 3.1 times more interactions with the police than the general public, and following such interactions are twice as likely to become reinvolved with the police, and sooner (Coleman & Cotton, 2010). Taken together, the research evidence clearly demonstrates an increase in police contact among PMI, as well as a disproportionate rate of criminal justice system contact among those with mental illness compared to the general population.

In addition to this overrepresentation, PMI tend to have repetitive police interactions (Charette, Crocker & Billette, 2014). Of concern is that when PMI encounter police, they are at greater risk for injury or a fatal outcome compared to the general public. (Watson et al., 2010). High profile cases such as the deaths of two 18-year-olds in Ontario, Sammy Yatim and Evan Jones, both of whom had mental illness, have brought increasing attention to such altercations that end in tragedy (Ireland, 2016; Gillis, 2016). Both males wielded knives and were eventually shot to death by Toronto and Brantford police officers respectively (Ireland, 2016; Gillis, 2016). These cases have shown that common policing strategies utilized to control situations such as shouting commands at people or drawing weapons in a show of force are often ineffective with someone experiencing a mental health issue, and in fact tend to backfire and lead to escalation (Ireland, 2016; Iacobucci, 2014). In the U.S., increasing rates of police officers arresting those with a mental illness (Watson et al., 2010) between 1997 and 2010, led to rates of such persons' entry into the federal correctional system increasing by 61% for males and 71% for females (Sorenson, 2010). Despite these findings and popular media depictions of PMI as violent, research suggests that most people with a mental illness do not commit violent or criminal acts (Douglas et al., 2009; Livingston et al., 2014). In fact, it's been estimated that 40% of offences that see a PMI charged are minor, nuisance offences (Coleman & Cotton, 2010). In terms of

police interactions with the mentally ill, the most important issue is balancing the needs of society with the needs of PMI (Green, 1997). Society requires protection of the public, while PMI require the right to treatment along with their own safety (Green, 1997).

Explanations for the increase in police interactions with PMI are numerous. Deinstitutionalization policies have had major implications for the police who have been described as de facto frontline mental health workers (Cotton, 2004; Desmarais et al., 2014, Short et al., 2014). Along with deinstitutionalization and the subsequent increase of PMI living in the community, reductions in psychiatric beds and stricter hospital commitment criteria have limited access to mental health care and consequently led to rises in the frequency of police contact with PMI (McLean & Marshall, 2010). Often fueling this increased contact is a misconception that PMI are dangerous and unpredictable (Alexander & Link, 2004). This misconception and subsequent stigma of those who are mentally ill contributes to increased contact with the police due to public fear and hinders PMI in accessing care (Cotton, 2004). Unfortunately, community services that are tasked with alleviating mental health issues in the community do not have sufficient resources, as they are often overburdened and do not provide adequate care for mental health consumers (Cotton & Coleman, 2013). Currently, mental health care is one aspect of Canada's health care system that is lagging behind the rest of the health care system in terms of availability (Cotton & Coleman, 2013).

One notable issue that compounds the effects of the overburdening on community mental health services is the rise in homelessness in Canada. Since the mid 1900s there has been a drastic rise in the number of homeless people in Canada, 66% of whom have a history of mental illness and substance abuse (Cotton & Coleman, 2013). This increase in transience has further strained resources by leaving more vulnerable people out in the community, often with a mental

illness, who do not have access to the care they need (Cotton & Coleman, 2013). Effective deinstitutionalization requires the coordination of multiple services, such as housing, rehabilitation, financial and medical services, all of which are too often unavailable or significantly lacking in the community (Hartford et al., 2005). Together, unfulfilled needs in these areas contribute to PMI coming into more frequent contact with police officers (Cotton & Coleman, Desmarais et al., 2014; Charette et al., 2011; Hartford et al., 2005; Lurigio & Watson et al., 2010). As research has shown, however, this increase in police-PMI contact can have negative impacts for both the police and PMI by placing a strain on limited police resources and unnecessarily criminalizing PMI (Sapers, 2012).

Police officers are often the first to arrive on scene to situations involving mental health concerns, obliging them to play the role of social worker and police officer simultaneously (Desmarais et al., 2014). Mental health calls for service are known to take the police significantly more time and effort when compared to responding to the general public, which can influence the decision police make to arrest to avoid the frustration of taking a PMI to the hospital (Short et al., 2014). Police interactions with PMI have been described as long and complicated processes that may discourage police officers from initiating medical care for a person. Police officers have reported frustration that they often spend hours in the hospital waiting to have a person evaluated by a physician under the Mental Health Act (MHA), only to have a doctor discharge the person, frequently without the proper resources to eliminate future police contact (Charette et al., 2011; Short et al., 2014). Too often, it is these same people who have recently been taken to the hospital by police under a MHA apprehension that are the subject of future police contact. This revolving door phenomenon can cause police officers to be apprehensive to try and connect PMI with these mental health resources in the future (Godfredson et al., 2011).

Unfortunately, while contact between police officers and PMI is increasing, there is evidence that the police are not always equipped to deal with such situations. Most police services do not have well established policies for handling mentally ill individuals, and there is no standardized training for police officer response to mental health related calls across Canada (Coleman & Cotton, 2010). Officers themselves have revealed that they do not feel they are adequately trained to respond to mental health calls for service (Cotton & Coleman, 2013). Until recently most services did not have specialized officers or teams to respond to these types of calls (Cotton & Coleman, 2013; Cotton & Coleman, 2010; Durbin et al., 2010). Combined, this lack of a specialized response and resources has left both the police and the mentally ill in a vulnerable position (Cotton & Coleman, 2013). Guidelines for police officers working with the mental health system have been implemented with the help of the Canadian Association of Chiefs of Police (CACCP), that call for police services to implement measures that increase communication and information sharing with mental health resources in the community (Cotton & Coleman, 2013). These guidelines, along with increased research on police interactions with PMI, have led to some promising improvements to police responses to people in mental health crisis (Coleman, 2014).

Improvements in Police Interactions with PMI

Crisis intervention training (CIT) is quickly gaining popularity in Canada, as several services have prioritized the training of as many officers as possible (Mills & Wingrove, 2012). CIT is a training method that focuses on strategies such as minimizing use of force by officers dealing with PMI and more effectively recognizing symptoms of mental illness. Further CIT assists in reducing risk to officers and developing a stronger partnership between the mental health community and police officers (Cotton & Coleman, 2010). CIT is considered the industry

standard and involves approximately 40 hours of training on how to deal with mental health related calls (Morabito et al., 2012). The Vancouver Police Department in British Columbia was one of the first in Canada to use CIT, and their goal is to eventually have 100% of their patrol officers trained in crisis intervention through a three-day, 36-hour course (Cotton & Coleman, 2010). This specialized training is particularly important so that officers learn to identify behaviours indicative of mental illness and use safer ways to interact with PMI (Durbin et al., 2010). In addition to these developments, the Ontario Police College (OPC) has developed a written guide to working with PMI (Cotton & Coleman, 2010).

Within Ontario, several police services (e.g., Peel Regional Police, Ontario Provincial Police, and Halton Regional Police Services) have all implemented their own in-service training for encounters involving PMI (Cotton & Coleman, 2010). In addition, the Brantford Police Service has made clear their commitment to making CIT a priority, and have boosted the provincial mandate of 12 hours of less lethal use of force options to 16 hours of training (Ball, 2014). With this increase, the four extra hours of training are dedicated specifically to mental health de-escalation and after care (Ball, 2014). Finally, one tool that can supplement police training in order to successfully divert PMI from hospitals is good access to follow-up mental health care (Durbin et al., 2010). When follow-up options are lacking, police officers tend to be more hesitant to utilize diversion and instead resort to arrest (Wilson-Bates & Chu, 2008).

While changes in police training are certainly a promising step, as a result of the overall lack of police training or effective specialized mental health teams, discretion is often used among police officers (Schulenberg, 2014). The use of such discretion is typically based on officers' personality and attitudes towards PMI (Schulenberg, 2014), and is more likely to be used in cases where a person does not clearly meet criteria for a MHA apprehension. In acting as

mental health workers in these interactions, police exercise a significant amount of discretion, assuming the role of a gatekeeper in deciding whether the mental health or criminal justice system (or informally resolving the situation) is a more appropriate course of action (Durbin et al., 2010; Schulenberg, 2014; Livingston et al., 2014). The use of discretion is expected in police work given the situational factors, and this discretion is often based on theories officers develop for certain neighborhoods or groups of people (Schulenberg, 2014). Police must use their discretion quickly in order to determine what type of action to take, from a verbal warning to an arrest and charge (Schulenberg, 2014).

The use of discretion has implications for PMI, and is based on complex processes that extend to factors beyond whether or not a crime was committed. Such factors include individual officer characteristics and past experiences with PMI, the amount of time the encounter is expected to take, and the accessibility of mental health resources in the community (Godfredson et al., 2011; Charette et al., 2011). The discretionary powers of the police can be problematic, especially when dealing with socially marginalized and stigmatized individuals such as PMI (Godfredson et al., 2011). Decision making and the use of discretion can have negative outcomes for PMI, especially if an officer has unfavourable views towards interactions with PMI (Godfredson et al., 2011) or does not know what mental health resources are available (Durbin et al., 2010).

Over the past ten years, there has been greater interest on the part of police services in finding more efficient and effective ways to allocate resources and training efforts for interactions involving PMI (Charette et al., 2014). Police often respond negatively to expressions of certain symptoms of mental illness which may be perceived as hostile or disrespectful (Charette et al., 2014). Increased training and specialized mental health intervention teams can

help officers recognize these symptoms as expressions of a mental illness so that more appropriate resolutions can be made (Charette et al., 2014). The Iacobucci Report (2014), prepared by former Supreme Court Justice Frank Iacobucci for the Toronto Police Service (TPS) has been a seminal report in influencing specifically Ontario police services, but also Canadian police services as a whole. The report provides a review of topics such as training, supervision and oversight, the role of MCTs, and policies and practices of the TPS. This review led to several recommendations and implementation plans, including the creation of a police and mental health oversight body, more active education of officers on available mental health resources, notifying MCT units for calls involving a PMI, and the consideration of ways to bridge the gap between officers and PMI.

Available Dispositions and the Mental Health Act

There are a number of available dispositions to a police officer in resolving an encounter with PMI. Apprehensions under the provincial Mental Health Act involve a police officer taking a person into custody and transporting them to a hospital to be evaluated by a physician. (Centre for Mental Health and Addiction, 2012). All provincial Mental Health Acts in Canada authorize a police officer to apprehend a person acting in a disorderly manner who is apparently suffering from a mental disorder in situations where the person has displayed indications of actual or potential harm to themselves or others, or a lack of competence to care for him or herself.

Within Ontario, the MHA has been implemented to legislatively govern police responses to mental health calls for service. This act was first implemented in 1990, with the latest revisions being made in 2015. Under this act, police are able to bring people to the hospital or another psychiatric facility if they pose an immediate threat to themselves or others, or if they are unable

to care for themselves. Section 17 of the MHA, for example, outlines action that can be taken by a police officer when responding to a call involving a PMI:

Where a police officer has reasonable and probable grounds to believe that a person is acting or has acted in a disorderly manner and has reasonable cause to believe that the person,

(a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;

(b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or

(c) has shown or is showing a lack of competence to care for himself or herself,

and in addition the police officer is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

(d) serious bodily harm to the person;

(e) serious bodily harm to another person; or

(f) serious physical impairment of the person,

and that it would be dangerous to proceed under section 16, the police officer may take the person in custody to an appropriate place for examination by a physician. 2000, c. 9, s. 5. (Mental Health Act, RSO 1990, c. M.7).

Once officers have made an apprehension under the MHA they must transport the PMI to the nearest psychiatric facility for an assessment by a physician. Based on the results of the assessment, the person may be involuntarily committed to a psychiatric unit for a period of time. Research suggests that as many as one third of mental health referrals are made by police officers (McLean & Marshall, 2010). This high number highlights the important role police have in handling mental health concerns. Within Ontario, PMI apprehensions by police under the MHA have increased from 520 in 1997 to 8,441 in 2013 (Kane, 2014). Police officers often feel burdened with responsibility for PMI leading them to over-apprehend PMI to be evaluated at the hospital (McLean & Marshall, 2010). This over-referral has led mental health service

professionals to unfairly criticize officers who are often left with few other options. Many times, individuals who officers have referred to the hospital are discharged quickly, or not admitted at all, which increases officer frustration (McLean & Marshall, 2010). Further, this rise in PMI apprehensions has raised questions about whether there are sufficient community services and supports for PMI (Kane, 2014).

Other dispositions open to police officers include making arrests for criminal offences where the person appears to have a mental illness. Officers may choose informal resolutions, such as voluntarily transporting the person to a family residence, outpatient crisis counselling services, or other social services such as a shelter. Police officers may also come into contact with PMI for minor offences (e.g., petty theft), non-criminal disturbances, where a PMI has been criminally victimized, or situations where family supports of a PMI call the police for assistance (Coleman & Cotton, 2013). All of these situations require decision-making and frequently, discretion on the part of the responding officer. Apprehension is the most commonly used disposition in police encounters with PMI when an offence has not been committed (Coleman & Cotton, 2013; Shore, 2015). Unfortunately, when the criminal justice system is engaged through mechanisms like arrest, or when a PMI is released from hospital without admission following a MHA apprehension, PMI are often not appropriately connected to treatment and resources, and instead have repeated future police contact. Currently, PMI do not receive follow-up from police agencies or emergency departments, which is problematic. Follow-up could assist in reducing the overuse of police resources by preventing future and repeat mental health crises. Recognition of this missed opportunity has been the impetus for the development of novel techniques to be used to help police services respond more effectively to mental health-related calls for service.

Mental Health Policing Initiatives

Most Canadian police services consider themselves to be community or contemporary police organizations, where police are seen as members of the community that work together with the population to address citizens' varying needs (Coleman & Cotton, 2010). This collaborative ideal has led to three major developments for police interactions with PMI. First, guidelines have been created for police services about how to develop relationships with the mental health system and for working with PMI. These principles include recommendations such as designating specific police personnel to be responsible for mental health related issues and establishing formal liaisons with the mental health system to facilitate effective collaboration and communication (Coleman & Cotton, 2013). Along with these recommendations, the establishment of formal agreements between police services and local hospitals is encouraged to assist in improving communication.

The second major development is an increase in education and training for police personnel about mental health, mental illness, and mental health resources. A recent review of police training and education programs by the Mental Health Commission of Canada (MHCC) led to the development of a model called "Training and Education about Mental Illness for Police Organizations" (TEMPO), (Coleman & Cotton, 2014). TEMPO was developed by the MHCC to reflect the unique Canadian context with an emphasis on human rights and the need to address stigma (Coleman & Cotton, 2013).

Finally, there have been increases in a variety of formal joint response initiatives between police services and mental health agencies (Coleman & Cotton, 2013). Modern Canadian policing has moved towards a more militarized persona, where police agencies employ specialized teams such as an Emergency Response Team or Tactical Teams (Coleman & Cotton,

2010). There are a variety of different models in use that aim to address the need for a more effective way of managing PMI. In many larger services where there are more than 50 officers, at least one is the Designated Mental Health Officer (Coleman & Cotton, 2013). The Designated Mental Health Officer is tasked with being the contact point between mental health and police agencies in order to facilitate communication about a PMI (Coleman & Cotton, 2013). Smaller police services, on the other hand, have adopted a Comprehensive Advanced Police Response model. In this model, all police first responders receive advanced training and education on mental illness. This training is desirable but presents challenges for larger services who do not have the resources to make this possible (Coleman & Cotton, 2013). Thus, MCTs have emerged as a potential solution to combat the lack of organizational and financial resources.

Overall, the large and growing number of PMI apprehended by police under the MHA is problematic for both parties. Numerous apprehensions often leave PMI without access to the resources they require and place a large burden on limited police resources. Together, the aforementioned issues cement the growing need for different approaches such as the MCTs to be implemented and utilized when handling PMI and mental health calls for service.

Chapter 3: The Development of Mobile Crisis Rapid Response Teams (MCT)

Prior to discussing the theoretical framework used to understand officers' perceptions toward and use of Mobile Crisis Rapid Response Teams (MCT), it is first necessary to describe what MCTs are and how they operate. One of the first Canadian initiatives to pair police officers with mental health workers was the Crisis Outreach and Support Team (COAST), launched in 1998 in Hamilton, Ontario. Within the COAST model, plain-clothes officers work with St. Joseph's Healthcare, a community mental health agency. Officers are paired with either child and youth workers or a mental health worker to form teams of two. Together, they respond to calls made by civilians to a 24-hour mental health crisis line (Hamilton Police Service, 2016). Mental health workers have the option to respond to concerns with a mobile visit or utilize telephone support. In addition to this constantly available support system, follow-up plans including linkage to community agencies and crisis support help individuals and families that are dealing with crisis (Hamilton Police Services, 2016). Since its implementation in Hamilton, the COAST program has been adopted by Halton Regional Police Service, Peel Regional Police, and the Niagara Regional Police Service.

Although these types of teams have been operating in different formats in Ontario since 1998, recently, dedicated MCTs have been developed in Canada. Unlike COAST, MCTs have specially trained, uniformed police officers and mental health professionals respond in tandem to calls involving persons in crisis. While MCTs were first introduced as pilot programs in 2014, they have since spread to operate in several services across Ontario including: Toronto Police Services, Hamilton Police Services, Niagara Regional Police Services, Haldimand-Norfolk O.P.P., Brantford Police Services and Halton Regional Police Services (County O.P.P., 2016). The MCT program in the city of study was launched 9 months prior to the commencement of the

current study. Many of these services were interested in pairing police officers with mental health professionals to address identified concerns, namely: a lack of on-scene mental health assessment, lengthy hospital wait times, a paucity of connections and referrals to appropriate services, repeat 9-1-1 calls and the inefficient utilization of considerable police resources in mental health related calls (County O.P.P., 2016; De Caire, 2015; Halton Regional Police Service, 2016). The perceived benefit of MCTs is the joint element: the mental health professional on scene is familiar and comfortable with responding to mental health crisis, and provides an immediate, and presumably more accurate assessment of the problem and can offer potential ideas for resolution. The police officer can provide safety in the event of violence or danger and is duly authorized to immediately apprehend under the MHA when necessary (Coleman & Cotton, 2010; De Caire, 2015).

Typically, MCTs require only a small number of officers. For example, Hamilton Police Services use five full-time officers and Halton Regional Police Services use four officers (De Caire, 2015; Halton Regional Police Service, 2016). The officers who work on these teams are trained to de-escalate situations and diffuse crisis situations, advocate for the person or families that are in crisis, ensure completion of mental health assessments, ensure connection to mental health services and resources, and provide help and support to those involved (County O.P.P., 2016). The rationale behind this partnership is that having mental health professionals paired with officers will allow these unique situations to be approached from different perspectives (Bennett, 2015). For example, pairing law enforcement with mental health expertise can be beneficial because while some people may respond better to uniformed police officers, others are thought to respond better to a mental health worker, which can promote safer and less hostile interactions for all parties involved (Bennett, 2015). Further, sometimes the mental health

professionals can gain access to and control of situations more easily than police officers (Bennett, 2015). Other perceived benefits of the MCTs include on-scene assessments and increased support of PMI, increased diversion from emergency services towards other community services, and reduced time spent in emergency rooms for both police officers and PMI (Halton Regional Police Service, 2016; Brant County O.P.P., 2016; Bennett, 2015).

Chapter 4: Theoretical Framework

Although MCTs have begun to be studied empirically, there is a lack of the application of a theoretical lense to understand how police work with and perceive working with these teams. Drawing on such a lense could be of great value in interpreting these phenomena. In order to understand officers' perceptions of and experiences with the MCTs, a plural policing framework, herein referred to as pluralism, was adopted (Jones, van Steden & Boutellier, 2009).

Pluralism refers to the restructuring of policing whereby policing is now offered by institutions other than the state, mainly by private companies and community actors (Bayley & Shearing, 1996). Pluralism is occurring in policing as a result of the inability of police forces to meet the demands of all members of society. There are a wide range of groups in society such as the government, local communities, and business groups. The interests and perceived threats to each of these groups often conflict with one another in terms of which are most deserving of police action (Vaughn, 2007). This disagreement may cause certain members of the public to choose to "contract" certain services that are typically police-based to other groups and organizations who are capable of providing policing functions (Vaughn, 2007). As a result, the contemporary landscape of policing is changing wherein various forms of policing are being offered by institutions other than the traditional state-created police. As Crawford (2006) argues, it is now generally accepted that governments are no longer the sole providers of policing the populations that they govern. With this change, the public police, or traditional police services and officers, are experiencing a form of identity crisis trying to find and maintain their place and authority among other police entities (Bayley & Shearing, 1996). The public police are no longer confident that they are effective or efficient in controlling crime, causing them to examine every

aspect of their performance, including management, accountability, strategies and organization (Bayley & Shearing, 1996).

The End of a Monopoly

Since the 1960s, the monopoly on policing by the state has been fragmented as a result of the emergence of other forms of policing such as private security companies and volunteer community initiatives that are designed to prevent crime (Bayley & Shearing, 1996). Police services since this time have been subjected to various demands for change and reform, which has led to a shift away from the traditional command and control models that have characterized policing for most of the 20th century (Fleming & Rhodes, 2005; Crawford, 2006; Brewer, 2015). As a result of these demands for change and the previously mentioned difficulties with police officers dealing with PMI in the community, MCTs have emerged. This shift has resulted in ‘the police’ and the act of policing becoming increasingly distinct (Bayley & Shearing, 1996; Wood, 2014; Loader, 2000). Policing has become a complex division of labour conducted by public, private, and other agencies that are not part of the formalized state (Johnston & Shearing, 2003; Loader, 2000; Crawford, 2013). This trend towards plural policing has accelerated over recent decades and led several states to relinquish their monopoly over security governance (Kempa & Johnston, 2005). The pluralization of policing is now seen as necessary in order to supplement the often overburdened public police (Bayley & Shearing, 1996). In fact, governments have gone from passive acceptance to active encouragement of increased private-based policing (Bayley & Shearing, 1996). This state level encouragement highlights the need for various actors to be involved in the delivery and provision of policing.

This new organization of policing substitutes the old hierarchical models of regulation with a decentred regulation through a variety of entities that work together through networked

alliances (Crawford, 2006). The traditional style of regulation is characterized by hierarchy, rules and permanency, where police services are structured on authoritarian lines, and regulated by strict rules and legislation that place an emphasis on vertical and internal communication (Fleming & Rhodes, 2005). Decision-making within the older model tends to be rarely participative or collegial across rank lines, and routines tend to discourage innovation in order to avoid risking the reputation of the police service (Fleming & Rhodes, 2005).

While this managerial style is still very much alive, there are other forms of policing emerging as a result of the overburdening of police services. Further, research on traditional policing practices have shown traditional methods – such as random patrol and police visibility – to have limited effectiveness (Crawford, 2003). As a result of these issues with traditional policing models, there have been several calls for reform. These calls are fueled by demands for efficiency and effectiveness, concerns about the relationships between the police and the communities they serve, and organizational corruption (Fleming & Rhodes, 2005). As such, decentered regulation has become a popular model of governance, one that involves a shift in regulation from the state to other locations (Crawford, 2006).

Direct control by police services is being substituted for forms of “regulated self-regulation” (Crawford, 2003, p. 488), by harnessing the capacity of third party actors in the community (Cherney, 2008; Crawford, 2003). This form of policing means that police are contracting out policing services to actors within the community, and then regulating them, while these actors themselves are able to play a role in regulating their own behaviours and conduct in maintaining a sense of order (Crawford, 2003). Community actors, such as the mental health professionals of local community agencies have a unique set of skills that can be better utilized when they are involved in police response to PMI both on-scene and in a follow-up role. This

new type of joint regulation, as opposed to the aforementioned traditional command and control policing models, allows police organizations to recognize and respond to the conduct of those they wish to regulate in a way that harnesses the capacity for self-regulation on the part of non-police actors, that is, the MCTs (Crawford, 2006). When this joint regulation involves cooperation, more legitimate and effective regulation will be achieved (Crawford, 2006).

The New Extended Family of Policing and Developments in Policing Policy

As a result of these changes in policing, there are many new forms of public patrol programs that are designed to promote improved overall performance by the public police. Aside from community agencies and individual actors, police services are being supplemented with private security companies who have less training and power than traditional police officers, but still represent an authority figure (Jones et al., 2009). The number of employees in the security guarding sector has skyrocketed in the last 20 to 30 years, which has created a new division of labour in security (Crawford, 2006; Crawford, 2013). While this growth was initially seen by police services as something to be feared, as the sector has grown and matured governments have begun to make clear that private sector involvement in the delivery of public services is the rational response (Crawford, 2013). Not only are actors such as private security involved with the police, they are also largely involved in hospitals and schools. This involvement has progressively led to the private policing sector being seen as less threatening by public police services (Crawford, 2013).

In addition to these private security companies, there are policing agents who are not paid. One example is those involved in increasingly prevalent community crime prevention efforts (Bayley & Shearing, 1996). For example, in the United Kingdom the extended family model of security governance has been endorsed by the government. In this extended family

model, Community Support Officers deal with issues such as street patrol and are tasked with contributing to reducing low-level crime and disorder, thus enhancing public reassurance (Kempa & Johnston, 2005). Further, neighbourhood policing, a form of community policing, dedicates neighbourhood policing teams comprising police, private security and others, to apply a problem solving approach to solve local issues (Kempa & Johnston, 2005). Two-way communication between neighbourhood policing teams and communities has been found to help build trust and cooperation in order to more effectively deal with crime and disorder (Kempa & Johnston, 2005).

Harnessing the crime control capacity of third parties can involve the redistribution of responsibility by persuading various community actors and agencies to adopt practices that enhance crime prevention. For example, many retail stores have introduced measures such as requesting identification when selling spray paint in order to prevent graffiti (Cherney, 2008). This ability to harness the crime control capacity of third parties builds on Marcus Felson's (2006) idea that institutions, through their routine day-to-day activities can facilitate crime by creating the necessary conditions for it to take place. Therefore, it is in the interest of police services to make third parties active in taking precautions against circumstances conducive to criminal activities (Cherney, 2008). In addition, compared to traditional command and control policing, this third party involvement can involve a more active partnership where various agencies such as the police, local government and community agencies come together and can each assert influence over different elements of crime problems (Cherney, 2008). In the case of the MCTs, while police officers are able to maintain control over situations and be available if an arrest or apprehension is necessary, the mental health professionals offer a therapeutic element to

policing by being able to offer informed advice to both those in crisis and the responding officers.

Another justification for these partnerships is cost efficiency. Involving the private sector and other non-police actors is perceived to help police services make budgets more efficient in the wake of police budget cuts (Crawford, 2013). This type of crime prevention has been called problem-oriented policing, and has been cited to be successful in reducing several forms of crime and disorder (Cherney, 2008). In addition, third party policing enables police services to reduce crime and be more analytically informed in focusing on preventative actions (Cherney, 2008).

The fostering of community involvement and commitment creates an ‘active community’, where individual commitment is backed up by organizations in the public, private, and volunteer sectors (Crawford, 2001). This type of plural regulation has been termed “meta-regulation”, such that the central state oversees plural regulatory practices (Cherney et al., 2006). While state and local governments as well as police services are still largely responsible for supervision and the direct provision of policing, policing activities are now undertaken by services and organizations beyond governments and by citizens below governments (Loader, 2000). As previously described, in mental health calls for service police officers supervise the interactions, but activities such as talking to a PMI and understanding what they are experiencing that were once carried out by the police, are now being done by the MCTs. Further examples of this type of policing by citizens below government include applications such as neighbourhood watch schemes that have been increasingly encouraged by governments (Loader, 2000). This shift and mobilization of policing within society has led to individuals and communities being seen as capable of crime prevention via their self-calculating and risk-monitoring characteristics (Loader, 2000).

In addition, in recent years there has been a marketization of policing in which the police have been more active in buying and selling services (Crawford, 2013; Crawford, 2006). For instance, police services can contract out police officer time for functions such as security for football games, and they can also establish accreditation schemes where non-police organizations are given limited powers to contribute to community safety (Crawford, 2013). The increasing use of CCTV security systems has allowed governments to police from a distance, and more indirectly (Loader, 2000). Together, these factors have drastically changed the role of police services and the way they operate.

A New Form of Regulation: Nodal Governance

At the centre of all forms of regulation and governance is the issue of control. Regulation involves activity that looks to control, direct, or influence the behaviour and the flow of events (Crawford, 2006). Regulation is responsive when those in power recognize and respond to the conduct of those they wish to regulate in a way that considers the capacity for self-regulation (Crawford, 2006).

There have been many calls for reform of current forms of regulation fueled by demands for efficiency and effectiveness, as well as concerns about relationships between police services and the communities they serve (Fleming & Rhodes, 2005). One form of governance that has emerged in part due to these calls for reform is nodal governance (Dupont, 2004). In this model, the traditional public police are seen as one node amongst many (Crawford, 2006). Along with the public police, several other private and community actors also delivering policing services can make up high functioning networks (Shearing & Johnston, 2010). Networks are made up of resource-dependent organizations characterized by diplomacy, trust and reciprocity (Fleming & Rhodes, 2005). For example, in handling PMI in the community the police are one node, the

MCTs are another, the hospital is another, and various community services and resources make up others. Together, all these nodes make a network aimed at handling and responding to the needs of PMI. The concept of nodal governance is meant to convey the idea that policing, its functions, and their various organizing nodes can now be thought of as “plural” (Dupont, 2004). A network has several nodes, but has no center or main actor, making all nodes equally responsible for crime prevention and security (Loader, 2000). The nodes that make up networks of policing actors may be large or small, and can be comprised of individuals, groups, organizations or states. They may be tightly or loosely connected, and may engage in similar activities or be specialized to undertake specific tasks (Shearing & Johnston, 2010).

The result of this nodal governance is a growing trend towards a more decentralized, horizontal and networked delivery of law enforcement (Dupont, 2004). As Shearing (2001, p. 261) explains, “effective and efficient governance requires the mobilization of a network of capacities and knowledges located within [a] variety of institutional nodes”. Thus, traditional policing methods of working vertically through formal command structures are increasingly becoming irrelevant (Giacomantonio, 2014).

Policing agencies within these networks have been called “brokers”, because they are responsible for connecting external institutions to crime control goals and the promotion of collective responses to opportunities for crime often arising through legitimate activity (Cherney et al., 2006; Brewer, 2015). The state and policing agencies in this model are responsible for monitoring the direction of regulation, and correcting deviations (Crawford, 2006). This model can be extremely effective when these regulatory institutions of control respond to the regulatory capacities of third party actors and are explicit about the direction and goals of crime control (Crawford, 2006). This pluralism shifts the police role from first responder to administrator

involved in distanced governance and linking service providers in an effort to address community safety issues (Brewer, 2015). By working together, and having MCTs available on-scene, more mental health service providers may be involved and utilized due to MCT expertise and familiarity concerning available treatment and resources in the community. In addition, this shift to pluralistic policing assumes that coercive sanctions are inefficient and ineffective, and instead emphasis is placed on voluntary compliance and self-regulation among the parties (Crawford, 2006). Nodal governance is perceived to be more effective than command and control models of policing because when actors voluntarily engage in governance, it can be assumed that they are more committed to its success.

Networks involving resource-dependent organizations are characterized by multi-agency partnerships which are flexible, cooperative agreements based upon the needs of a given community (Fleming & Rhodes, 2005; Hope, 2005). Multi-agency consultation, rather than single agency consultation, between parties such as police authorities, health services and marginalized groups has shown success in inspiring citizen engagement in pluralised policing approaches (Kempa & Johnston, 2005). These policing networks are informed by specific, local crime problems to select and implement objectives, targets and prevention measures (Hope, 2005). Stakeholders must debate and be empowered to shape policing issues, both at the micro and macro levels, in order to achieve an inclusive nodal policing arrangement (Kempa & Johnston, 2005).

Further, networks are characterized by diplomacy, trust and reciprocity. At the heart of inter-organizational networks, diplomacy refers to management and ongoing negotiation of issues in the community (Fleming & Rhodes, 2005). Trust is thought to be the most important aspect of networks and the main coordinating mechanism. Shared values and norms, along with

an appreciation for differing organizational cultures amalgamates the complex set of relationships present (Fleming & Rhodes, 2005). Finally, reciprocity is important and often a difficult obstacle for police services to overcome. This difficulty can be problematic because many situations, such as care of the mentally ill, require cooperation among many agencies, including the police. When each involved actor does their job properly, they are able to share resources such as staff, information and expertise (Fleming & Rhodes, 2005). In order to develop trust, diplomacy and reciprocity, it would seemingly be important that police officers have positive perceptions of the mental health professionals. Fostering such a perception would likely depend on their ability to build rapport with these individuals on a personal level.

One potential hurdle to developing trust, diplomacy and reciprocity is information sharing, which is a major barrier in police practice (Lyons, 2002; Sanders & Henderson, 2013; Sanders 2014). In this networked or nodal model, plural policing providers must come together in horizontal partnerships in order to create a co-production of security and safety deliverance (Crawford, 2006). This perspective emphasizes the importance of non-state authorities and their relations with state-centered initiatives for understanding contemporary crime control and policing (Crawford, 2006).

This trend towards pluralization has, and will continue to have implications for police practice and policy. In fact, it is possible that police services have in part contributed to this process because it ultimately benefits them by assisting them in carrying out functions (Cherney et al., 2006). As police services continue to recognize the benefits of plural policing and nodal governance, crime prevention and the delivery of once exclusively police services will be increasingly enhanced.

Relationships in the Extended Family of Policing

Despite this rise in authority figures that are not police officers, it is not always clear how the relationships and partnerships work between police officers and other governing bodies, such as police officers and mental health workers (Diphoorn & Berg, 2014). While there is some empirical evidence that points to some of the successes of the MCT program as a whole, it is unclear how officers actually work with and perceive the mental health professionals. The idea of pluralism in policing is a matter of supplementing the public police with other private and public policing services, while still allowing them to maintain their recognition as protectors of the public good (Vaughn, 2007).

Most of the current literature indicates that the relationships between the private police and public police can be characterized as either a competitive or a collaborative model (Brewer, 2015). Policing research has often concluded that the convergence of public and private police within a security network is typically characterized by competition, competing values and mistrust (Brewer, 2015; Crawford, 2006) However, when a collaborative relationship is fostered the private police can function as the eyes and ears and work to support the public agenda (Diphoorn & Berg, 2014). Although the MCTs do not necessarily fall under the umbrella of private police in the same manner as security guards, MCTs are still working to supplement officers because they are taking on some responsibilities expected of officers in responding to mental health calls. In such a partnership, the difference between a cooperative and competitive relationship has drastically different implications for policing. While a cooperative relationship might lead to enhanced care for PMI, a competitive relationship might cause a lack of coordination and productivity. As a result, it is worth uncovering which model is operating in the

collaboration between the MCTs and police services because of the divergent consequences each would have for policing in a given community.

Research has also shown that there are several relational stages that tend to develop between public and private policing (Diphorn & Berg, 2014). Usually there is an initial denial by the public police in acknowledging the existence of private policing. This denial then transforms into competition and hostility, which is then followed by partnerships that employ a strict hierarchical structure such that public police are “senior” and private police are “juniors” (Diphorn & Berg, 2014). The private police (i.e., ‘juniors’) have been found to view the relationships more favourably and are interested in assisting in the community (Diphorn & Berg, 2014). On the other hand, public police officers often claim that private police companies withhold information and statistics from them, and provide false information to further the poor reputation of the public police (Diphorn & Berg, 2014). Finally, there are several incidents where the division of labour between the various groups has created tension when information is not shared sufficiently (Diphorn & Berg, 2014). This group tension is more reminiscent of a relationship reflecting competition, one that could eventually turn into a collaborative relationship if both groups recognize the value and importance of the other (Diphorn & Berg, 2014). It is presently unclear at what stage MCTs and police are located in this relational process, or how they function working together.

The Role of Police Cultures

Police cultures can be extremely useful in understanding how police officers interact with various groups and people in the community (Loftus, 2010). Networks consisting of public and private actors require agencies to work together in order to achieve both their own goals as well as collective goals (Whelan, 2016; Whelan, 2017). One of the most significant relational

properties of networks are occupational cultures, which can develop through shared experience, associated values and norms, and social interaction (Johnson et al., 2009). One such occupational culture is police culture, which has two major components: the image police officers have of themselves as impartial and professional crime fighters, and a set of beliefs and behaviours not explicitly described in agency manuals or value statements (Hall, 2002). Policing involves multiple networked private, public, and community police actors who are interconnected, yet often have different cultures (Giacomantonio, 2014). The degree to which various actors are able to cooperate to coordinate resources and information, despite these differences, can have significant implications for operational efficacy (Giacomantonio, 2014). An “us and them” mentality is common in police culture; however, networks are about creating partnerships that best address the needs of society (Fleming & Rhodes, 2005). Culture involves beliefs, values and attitudes that are often shared by network members, or differentiated between actors (Whelan, 2017). The culture of police services shapes how officers interact with others, and often conflicting occupational cultures can present problems in the relationships with other actors (Whelan, 2017). It is unclear whether MCTs are able to fit within the police culture, or if they have a culture unique to their mental health background that conflicts with that of the officers.

Police organizations tend to be secretive and suspicious of outsiders, which makes trust an important aspect for developing a strong and high functioning network (Whelan 2016; Whelan 2017; O’Neill & McCarthy, 2014). This suspicion and cynicism towards partnership working are often due to a reluctance by officers to relinquish their own cultural values (O’Neill & McCarthy, 2014). Further, skepticism towards working with community agencies often arises from officers’ perceived incompatibility between community agencies’ style of work and their own. Typically, community agencies work style is described as process-based and dependant on

negotiation while police officers' style is more reliant on taking charge of situations (O'Neill & McCarthy, 2014). Finally, there appears to be a relative lack of order and hierarchy in partnerships, which often runs counter to police organizational structure and practice (O'Neill & McCarthy, 2014).

While the formal aspect of networks such as written agreements are important, the informal aspects which are based on trusting relationships and the commonalities between those involved can be just as imperative (Whelan, 2016). Trust, which is developed over time and fostered through shared experiences, helps networks function (Whelan, 2016). Consistency in staff is a valuable attribute for networks to possess, because actors are able to develop better relationships and build interpersonal trust with one another (Whelan, 2016). Finally, inclusivity in terms of involving all actors in regular interaction is important to maintain trusting relationships (Whelan, 2016).

Gender and Policing

An important issue within policing that cannot be ignored in the current discussion is the role of gender and how it intersects with policing. It is well established that women have been underrepresented as police officers (Franklin, 2007; Workman-Stark, 2015). In fact, while women make up just over 50% of the population in Canada, in 2014 women accounted for only 20.6% of police officers (Workman-Stark, 2015). Within policing, the "cult of masculinity" has been referred to as the most prominent feature of police culture (Brown, 2007; Prokos & Padavic, 2002; Workman-Stark, 2015). Masculinity is defined as, "a socially constructed set of values and practices that glorify status, aggression, independence and dominance" (Franklin, 2007, p. 13). Policing culture perceives policing as a dangerous, masculine occupation, where aggression, violence and danger are thought of as fundamental (Brown, 2007; Franklin, 2007;

Workman-Stark, 2015). Further, policing culture promotes masculine values which engender particular views of the roles for which men and women officers are believed to be most suitable (Franklin, 2007). Male officers perceive they are best suited for “masculine” tasks involving strength and power, viewing “feminine” tasks as those that involve empathy, compassion, trust and relationship building (Workman-Stark, 2015).

Further, police culture reinforces masculinity by viewing an ideal police officer as a strong brave man (Workman-Start, 2015). Male police officers equate men with guns, crime fighting, fights, and a desire to work in high crime areas (Prokos & Padavic, 2002; Workman-Stark, 2015). Conversely, social service aspects of policing are perceived as feminine work, with male officers equating women with social work, emotion, and the domestic realm (Prokos & Padavic, 2002). Male officers perceive these social service aspects of the job as feminine work in an attempt to preserve the masculine image of a physical crime fighter (Prokos & Padavic, 2002; Franklin, 2007; Workman & Stark, 2015). It is important to consider this gendered aspect of police culture given that police calls for service involving PMI are often made up of work that may be considered social service work. This aspect of handling the concerns of PMI could have implications for how police officers view these calls and the MCTs.

Currently, there are gaps in our understanding concerning how police services generally, and individual police officers specifically, work together with MCTs as they jointly respond to mental health calls. It is presently unclear how they share responsibilities and interact with one another, and also how they view each other and their respective roles. I argue that the MCTs, given their role as a supplemental tool at the disposal of the police, likely fit the role of the “juniors” who are favourable of their partnership with the police and are eager to help in any way they can. It is beneficial to gain insight into which duties police officers typically defer to MCTs.

Such delegation is likely dependant on officer understanding of the expertise that the mental health professionals are able to offer.

Research Gap

In sum, there is a lack of scholarly research available centered on new plural responses in policing, particularly in the domain of policing PMI. Given their growth in recent years, groups such as the MCTs are deserving of research attention. There is limited research currently available on how police officers in smaller police services work with the MCTs when faced with a mental health crisis where resources are limited. While there are insightful quantitative reports that analyze the effectiveness of MCTs operating at several police services, they focus on limited aspects such as number of calls responded to, length of hospital wait times, and diversion rates (County O.P.P., 2016; Halton Regional Police Service, 2016). Presently, there is a lack of qualitative research that explores and makes sense of how these partnerships are working on the ground in practice. Given that MCTs are still in their infancy, there is a need for observational research carried out directly in the policing field to explore the collaborative work of police and MCTs. As such, the present ethnographic study was undertaken to explore police perceptions and interactions with MCTs in a city in Ontario.

Chapter 5: Methodology

Ethnography

The present study comprised an ethnographic case study including field observations of frontline police officers and MCT workers managing mental health calls for service in a mid-sized city in Ontario. Field observations were conducted by three researchers participating in “ride-alongs” with police officers. Ethnography enabled an in-depth understanding of how officers perceive and collaborate with MCTs. The advantage of this first-hand interaction with police officers is the gaining of a more comprehensive understanding of participants’ motivations, beliefs and behaviours (Tedlock, 2003). The purpose of ethnography is not for the researcher to be in a position of authority or to influence the participants, but rather to be credible in relaying the observations and their stories (Gallant, 2008). The ethnographic approach is unique in that it allows researchers to immerse themselves into a setting in order to try and become a part of that setting as much as possible (Marks, 2004). Further, in the case of policing research, ethnographic research is valuable, as it helps explore police culture, which is itself key to determining several aspects of police practice. Understanding officers’ deeper cultural values requires intense and continuous engagement with them in their environment (Marks, 2004). This immersion allows the establishment of rapport, and the ability to participate in experiences involved in the topic to be studied, while observing patterns in how individuals behave and respond to various situations (Marks, 2004).

Case Study Context

To assist in filling these gaps in knowledge, a medium sized city (Population: approximately 100,000) located in Ontario was chosen to study these phenomena. The city in which the ethnography was undertaken was selected because of its size as well as its increased

focus on mental health concerns in the community (City Community Safety and Crime Prevention Task Force, 2011). Between January 1, 2014 and June 15, 2014, the service received 400 calls that involved a citizen living with mental illness (Shore, 2015).

The city has a land area of approximately 70 square kilometres and is made up of an equal number of males and females, a trend that remains fairly constant throughout each age bracket. English is by far the most commonly used language (86.4%), with the remainder of the population speaking either French, Aboriginal languages, or one of a variety of other languages (City Website, 2016). The city has a diverse ethnic makeup, with over 130 ethnic backgrounds living in the community. Visible minorities makeup just under 10% of the population, and Native Americans make up approximately 5% of the population. The police service is a mid-sized service that receives approximately 25% of the city's budget. It is made up of about 170 sworn officers (6% females), with seven officers being visible minorities, three of whom identify as Aboriginal (City Police Service, 2015). The identity of the police service and MCT organization was kept confidential to protect the identities of the participants.

MCT Program

The MCT program examined in the current research involves a collaboration between the police service, the local healthcare community as well as a local community services agency and consists of three MCTs. There is one team referred to here as "MCT-Joint" which involves a male police officer partnered with a specially trained female mental health professional. Together, riding in a police cruiser, MCT-Joint responds to 9-1-1 Person in Crisis Calls. The other two MCT units, referred to as "MCT-Single", are made up of two mental health professionals (one male, one female) who respond to requests for police assistance with Person in Crisis Calls when MCT-Joint is already engaged or not working. Both of the MCT-Single

units contain one mental health professional and are dispatched from the local community services agency in an unmarked vehicle, to meet officers on scene and offer assistance. While MCT-Joint and MCT-Single are often on-duty and dispatched concurrently, both MCT-Single units are never dispatched simultaneously because they share one unmarked vehicle. All three mental health professionals wear vests indicating that they are part of the local community services agency. Regardless of which MCT unit is involved, an assessment of the person in crisis is completed by the mental health professional to determine appropriate supports. The client is then connected to these supports with the assistance of outreach workers employed at a local community services agency, in order to reduce repeat 9-1-1 calls (County O.P.P., 2016). In addition to responding to calls, the MCTs also go out into the community to assist with follow-up in the days and weeks after a police-PMI encounter and check in on individuals to ensure their well-being. This after care is another effort that has helped reduce 9-1-1 calls and crisis situations (Peeling, 2016). These MCT services are available Monday-Friday from 9:00am-12 midnight. A five month “pre-implementation” phase was undertaken in the service wherein key indicators (discussed below) were recorded to evaluate program success.

The pre-implementation evaluation identified the following successes of the program: substantial reductions were seen in the number of Persons in Crisis being taken to the hospital as well as reductions in wait times at the hospital. Further, mental health assessments were completed at the scene and police resources were utilized more efficiently to deal with issues of criminality. Finally, clients received the appropriate supports once they were either released or had been diverted from hospital care (County O.P.P., 2016). A former local community agency director had stressed that the value in diverting calls from the hospital to community agencies is patients are given the support they need to more effectively address their issues (Peeling, 2016).

The early successes of the MCTs have been seen in services besides the city of study, with the Halton Regional Police Service also citing officer wait times decreasing significantly, as well as increases in emergency room diversion rates. Together these diversions and wait reductions led to 110 officer hours being saved in January 2016 alone (Halton Regional Police Service, 2016; Lea, 2016). As these programs have continued to develop and become more widespread throughout Ontario, some services have looked to expand the MCT program. Speaking to the early successes of the MCTs, Hamilton Police Services has expressed a desire to expand to 7 days a week (De Caire, 2015). Enhanced availability of MCTs is important given that many mental health crises occur during weekends and in the hours when the MCTs are not typically operating.

Experiences in the Field

While the data was collected by three researchers who participated in ride-alongs separately, the following are my personal experiences in the field. During data collection, I encountered some challenges, but there were also aspects that proceeded better than expected. In some of the ride-alongs, the officers were rather skeptical of the study and requested a detailed description of the research as well as the consent form they were being asked to sign. Having a strong knowledge of the study details, as well as the non-invasive and non-critical nature of the research was helpful in putting these officers at ease. Rapport building in all the ride-alongs went better than I expected, as most officers were quickly willing to talk with me and assist me in answering any questions I had. When this rapport was built quickly during the beginning of the shift, it assisted in the officers more willingly signing the consent form. I believe asking them questions about themselves and their backgrounds, as well as stating my desire to pursue a career in policing helped this process. In the field, it was often challenging to take detailed notes due to

the fast paced nature of the shift. Often, there were long breaks between calls, whereas other times several calls came in one after another which made it more difficult to recall exactly what occurred. Fortunately, the officers were required to take detailed notes as each call unfolded, thus allowing time for me to write field notes. Most officers were extremely helpful in assisting me in recalling missed details.

Any potential ethical dilemmas in the field were overcome by erring on the side of caution. When the MCTs arrived they often were required to enter private residences. Most times officers would wait outside during parts of these interactions, so I would wait with them in order to avoid breaching the privacy of the individuals. Further, if an officer felt a situation was unsafe for me, or a citizen asked that I not be present, I would oblige and wait in the cruiser. Finally, details such as personal information and specific locations were anonymized to ensure the confidentiality of all participants.

Upon the conclusion of each ride-along, I would thank the officer for their participation in the study and for letting me ride with them on that night. I never ran into issues on a ride-along that required me to leave before the conclusion of the shift, and all of the officers were extremely receptive to having me ride with them. In fact, most expressed willingness to let me ride with them again in the future if necessary.

Analysis

Within 24 hours of the conclusion of a ride-along, the field notes were transcribed in first person, narrative form to vividly recreate all of the events and conversations that took place. In conjunction with this transcription process, notes were included to capture significant points that may not have been explicitly stated or discussed but were deemed notable. Constructivist grounded theory guided the analysis process such that theory was constructed by analyzing the

data (Charmaz, 2014). The constructivist approach is desirable, because the data is a discovered reality, one that arises from an interactive process between the researchers and the field setting (Charmaz, 2000). In the case of the current research, the interactions with police officers during the ride alongs produced the data and thus the meanings and observations (Mills, Bonner & Francis, 2006). This data was then enriched through the field notes which are meant to add a description of the situation as well as any interactions that occurred (Mills et al., 2006). As more ride alongs were conducted and data was collected, dominant and recurrent themes were tagged with codes which were then grouped into categories (Charmaz, 2014). The research questions were in part shaped, changed and informed by the data that emerged and the way it evolved as more data was collected.

Coding, analyzing and theorizing data is a process that involves the opportunity to immerse oneself within the data to understand and demarcate the information in each transcript. In order to do this, it is important to understand the goals and research questions of a particular project (Warren & Karner, 2015). The coding process aids this immersion into the data and helps the researcher embed themselves into the narrative of the participants that produces the research outcome (Charmaz, 2000).

The data for this study comprised the transcribed narratives. Notable observations were extracted from these narratives in the form of excerpts that were 1-3 sentences in length. Once a pool of these observations was compiled, they were assessed using incident-by-incident coding, which was undertaken in order to find similar perceptions, feelings and occurrences throughout the data. These similarities were then grouped into five broad codes such as perceptions of MCT program effectiveness and police perceptions of MCT staff. The broad codes were then broken down further to create the final themes and sub-themes that make up the results section. It was

apparent that the major themes of Mobile Crisis Team Member Skill Sets, Practical Collaboration in the Field, and Implications at the Hospital were extremely dominant and necessary to include. Based on these major themes, emergent sub-themes such as hospital wait times, use of resources and diversion, and decision to involve the MCTs were placed under the appropriate major theme.

In addition to the use of constructivist grounded theory, conceptual elements of pluralism from the policing context were used as a framework to interpret how duties conventionally considered policing duties are being deferred and shared with external groups, specifically the MCT and hospitals. The study was designed to answer the following research questions and as a result guided the analysis process:

Research Question 1: How do frontline police officers engage with the MCTs?

During the ride-alongs conducted for data collection during this ethnographic study, observations were made to understand how officers utilize and collaborate with the MCT mental health professionals. A focus of this research question was to determine how officers communicate with and practically involve MCT workers when responding to a mental health related call.

Research Question 2: What are police officers' views and reactions to MCTs in managing mental health calls?

The study was designed to examine how police officers react to individuals involved with MCTs and their function as a whole. It was hypothesized that while they may be extremely willing to work with mental health professionals and ask for assistance, officers may be apprehensive to collaborate if they perceive themselves as being able to handle a mental health call on their own.

Research Question 3: How are persons in crisis managed during mental health calls? What do officers focus on as important?

Given the expected differences in occupational culture between police officers and mental health professionals, understanding what officers view as most important in a mental health call is valuable insight. Officers may have very different and more criminal justice related resolutions to situations, whereas the mental health professionals could be more willing to exercise therapeutic options such as counseling.

Research Question 4: How are citizens transferred to direct or follow-up mental health services?

One key potential benefit to involving the MCTs on scene during mental health calls is the ability to more efficiently and effectively connect citizens with mental health issues to appropriate resources. Given the mental health professionals' expertise on the resources available in the community, it is important to understand how they, with the assistance of the officers, ensure citizens access mental health services.

Research Question 5: How do frontline police officers share and divide duties with MCT workers?

In line with the pluralism literature, it is important to know what duties police officers perceive as legitimately being their own, and which they perceive as being duties that the mental health professionals can manage. It is possible that there are certain responsibilities that officers view as "police work" and expect to carry out themselves, whereas other duties may be viewed as "non-police work" and officers are willing to delegate to the mental health professionals.

Gaining Entry and Conducting Observations

Gaining access into the police service of study was easily achieved through the working relationships and collaborations established between the police service and my supervisor Dr. Lavoie. All three researchers entered the research field after receiving institutional ethics approval (REB #4284). Between July 2016 and October 2016, approximately 140 hours (14 shifts, total of 10 hours per shift) of field observations through ride-alongs with police officers were conducted by the three researchers. I collected roughly 70% of the data, although all the data was analyzed concurrently. All researchers rode on different days and were a part of shifts that ran from 16:00-2:00 across all platoons of the service, and included involvement in most aspects of the officer's shift. We attended parade prior to each shift where officers were made aware of notable occurrences in the community. During parade, we were paired with an officer. During each shift we attended calls, unless the officer felt it was too dangerous, ranging from domestic disputes to attempted suicides, well-being checks, and trips to the hospital. On several occasions a MCT-Single unit arrived on scene which provided valuable data on how they interacted with officers and proceeded to handle each call. Following each call, we attended debriefings with the officers. The MCTs also attended if they were present during the incident. These debriefings were a rich source of data as officers would discuss their concerns, and reflect on the call and what they like and dislike about the MCTs and their involvement. This immersion into the routine activities of officers in the field allowed the collection of first-hand experiential data on how police officers and MCTs interact in the frontline context.

The collected data were comprised of narratives that captured all events and behaviours associated with a mental health crisis encounter. Field notes were hand-written in a notepad in the cruiser following all calls for service and during discussions with officers while patrolling.

These notes were extremely thorough and included details on all incidents that occurred throughout the ride-along, whether or not it was related to police interactions with PMI or the MCTs. In order to put participants at ease, officers were informed that they could view these notes at any time, though only one officer expressed interest in viewing them, and this was only out of curiosity. Field notes were comprised of detailed comments that included observations on reflexivity, setting, police or MCT actions, rationales provided during debriefing at the end of each call, and details on the interactional processes that take place between police officers and the MCTs when responding to calls that involve a person who is in mental distress.

Chapter 6: Results – Mobile Crisis Team Skill Sets

Based on the analysis of the field notes derived from the ride alongs, three dominant themes emerged. These themes include the MCT skill sets, practical collaboration in the field and implications at the hospital. The first theme centered on the perceived value of the MCT staff's unique set of skills and knowledge involving mental health compared to police officers, who see themselves as less knowledgeable in this domain. As a result of this unique skill set, police officers engage in pluralistic policing by allocating a portion of responsibility to MCTs during mental health related calls. While officers value the MCT's knowledge of mental illness and applicable community resources, officers are frustrated with the lack of authority that MCT-Single (i.e., unit of a sole mental health professional) can exercise when an officer is not present. This chapter will outline the major sub-themes that fall under mobile crisis team skill sets, followed by a discussion of how this theme can be understood in the realm of pluralistic policing.

Knowledge of Mental Illness and Appropriate Response

The first dominant theme was officer perception that MCT workers were better equipped to manage the concerns and issues of PMI compared to police officers when safety was not a concern. Officers frequently feel they are inadequately prepared to handle mental health crises and often become frustrated in trying to provide PMI with access to services and resources in the community (Hails & Borum, 2003). Officers consistently spoke highly of the skill sets of the MCT workers. One officer praised the ability of the mental health professionals to de-escalate and make people more comfortable,

...the mental health workers are phenomenal for calming people down and giving them a more relaxed environment to talk to and in – Ride Along 404.

Often times citizens are fearful of talking with police, a fear that can be exacerbated during a mental health crisis, where police officer uniforms and authority figures are triggering (Bennett, 2015). Having a mental health worker on scene offers officers versatility and an alternative way to gain control of situations (Bennett, 2015).

When interacting with a PMI who is experiencing a crisis, officers are sometimes unsure whether they should apprehend the individual or not. This situation often results when officers determine that the client does not clearly meet the Mental Health Act criteria, but still feel that the client is unsafe in the community. In these so-called “borderline cases”, the MCTs can assist officer decision-making and alleviate officer concern by eliciting relevant information from the client, sharing a risk assessment with the officer, and negotiating a plan to keep clients safe if they remain in the community. As one officer says, “what [MCTs] are great for is 50/50 calls when [officers] are not sure if an apprehension is necessary” – Ride Along 403. Similarly, another officer showed his appreciation and willingness to allot responsibility to the MCTs when dealing with a mental health crisis:

“It is always nice to have trained guys [i.e., MCT mental health professionals] in borderline cases. That’s all they deal with [mental health crises]. They know better than I do.” – Ride Along 801

This officer displays his understanding that while he may see a mental health crisis occasionally, the MCTs deal exclusively with these types of situations. In addition, the previous officer’s use of the term “borderline cases” shows the value of allowing the mental health professionals to make decisions that may change the outcome of a mental health call to be more effective.

Ultimately, in many situations the officers recognize that their counterparts are more knowledgeable than themselves with respect to mental health calls. One officer aptly summarizes

this when he, "...discusses how important he thinks the MCT workers are because they are better equipped and more knowledgeable on what a client needs..." – Ride Along 403. Following the actual on-scene interactions, the mental health professionals know not only what support a PMI may need; but, more importantly, what resources are available to them. Officers value this support because they do not want to leave a PMI in the community if they fear the client may be unsafe. Having a mental health professional who can actually engage clients with services and follow-up with them helps alleviate this fear.

Use of Resources and Diversion

The perceived ability of MCTs to divert PMI away from costly and time-consuming emergency services and the criminal justice system and instead allow for community resources to be utilized was another recurring theme. Having MCTs on-scene more readily connects the mental health professionals to clients and allows them to establish follow-up plans. Establishing a follow-up plan means the mental health professional is able to contact citizens following a mental health crisis in order defuse the crisis situation (Hamilton Police Services, 2016). This often includes linkage to community service agencies and crisis support (Hamilton Police Services, 2016). One officer stated that in his experience,

Less than half [of clients] are actually following up with services. MCTs can follow-up with these guys directly and kick their butts to go to their appointment.
– Ride Along 803.

Due to their workload, police officers are generally unable to follow-up with individual citizens to ensure they are utilizing appropriate services. In their current role, the MCTs are able to be involved with PMI both on-scene and in this follow-up role, which creates a more efficient system for all parties, and better rapport and relationship building between the client and the

mental health professional. Clients who have been connected to services and follow-up to ensure barriers to service use are removed are less likely to experience crisis and require future police services.

Several officers spoke to the priority they placed on diverting individuals away from expensive emergency systems and towards the resources available within the community. One officer spoke to how beneficial this diversion can be for both police officers as well as PMI:

[This officer] feels that the priority is to get officers back on the street [to return to their patrol duties]. He reports that there has been 93% diversion of clients away from emergency services at the hospital [and presumably into community treatment/services]. – Ride Along 801

While this particular statistic regarding diversion rates is reported only by this officer, and is higher than the 74% reported during the program's pre-implementation period (County O.P.P., 2016), it speaks to the perceived success of the MCT program. A decline in the number of clients transported to the hospital takes a tremendous burden off both police and hospital resources, while also increasing the chances of the person maintaining their liberty in the community and connecting with community services. Returning officers to street patrolling is notable, as officers perceive their legitimate job to be "crime fighting" and law enforcement as opposed to being frontline mental health workers. This perception is made clear when one officer, "...refers to the officer on [MCT-Joint] as a 'useless cop' now that he's [on the MCT]" – Ride Along 802.

Officers perceive the MCT officer as useless as they do not view mental health work and riding with mental health professionals as being a part of their duties as a police officer.

Having the MCTs to rely on gives officers an alternative to taking PMI to the hospital. One officer said, "there are times when you know you don't have to go to the hospital, rather you

can get MCT to give referral to services [for clients]” – Ride Along 803. Prior to the implementation of these teams, officers’ options were to either bring PMI to the hospital, or leave them in the community and risk the likelihood that the client will engage in self-harm, harm to others, or re-involvement with police. As a result, most officers chose to apprehend to assuage concerns about police liability. However, a study prior to the introduction of the MCTs at this police service found that 40.8% of apprehensions under the MHA resulted in the PMI not being admitted to the hospital (Shore, 2015). This high rate of unnecessary apprehensions highlights the discrepancy between what behaviour police officers consider worthy of apprehension compared to that considered by hospital staff (Shore, 2015). Apprehension is stigmatizing to the client and deprives him or her of liberty. Having MCTs reduces over-apprehension of PMI and the corresponding negative effects on the client. Officers perceive that they no longer have to resort to an apprehension solely to avoid re-involvement with PMI or avoiding liability.

Individual MCT Staff

When speaking specifically about the three mental health professionals and one police officer who comprised the MCTs, there was an overall positive officer perception of them, describing them as “really good people, who are easy to get along with, and very easy to work with” – Ride Along 403. There were notable departures from this positive view, suggestive of sub-cultural bias and officer need to become more familiar with the MCTs. One officer made a statement about the police officer who rides with the MCTs, stating, “the officer doing the MCT is well suited for this as he was a social worker prior to being a cop, ‘so he was always more of a social worker – he had a different approach to these calls’” – Ride Along 600. This statement, although not expressed by all officers, speaks to sub-cultural differences between the police

officers and the MCT members. This quote in conjunction with the “useless cop” quote discussed above demonstrates an “us” and “them” mentality – where police are perceived to do the real work – the crime fighting, and the MCTs do the less legitimate work – the social work piece. Despite the fact that the uniformed officer riding with the MCTs has the same authority as any other police officer, he is viewed primarily as a “social worker” and demoted to a “useless cop”. During this same ride along, another officer expressed his belief that the mental health professionals like being on the MCTs because, “they think it is cool because they get to be with the ‘cops’” – Ride Along 600. These feelings expressed by some officers show that there are still perceived differences in the abilities and legitimacy of each party. Officers who felt this way still saw boundaries in terms of what is considered police work and what are considered the duties of a social worker.

Another officer felt initially that the MCTs were not a good idea, but eventually came to like them, perhaps indicating the importance of in-the-field collaboration:

He told me he was highly opposed to the teams at first but that they have grown on him both because of their function as well as the people. He says all the people involved are very nice and easy to work with, and it is positive to have them on scene to help assess a mental health call. – Ride Along 401

This statement shows the need for the officers and mental health professionals to get to know each other to develop rapport and appreciate each other’s skill sets and roles. The vast majority of officers felt as though the workers were easy to get along with, very helpful, and proficient at getting citizens to respond to them as a result of building rapport and trust.

Roles and Responsibilities

Despite most officers reporting they valued their interactions with MCT staff, there were frequent frustrations regarding the limitations of units of a lone mental health professional (MCT-Single), specifically concerning power and responsibility. Many officers expressed that a benefit of MCT-Joint (officer and mental health professional) was the ability to relieve officers from monitoring apprehended clients at the hospital. Officer relief reduces officer wait times, returns them to the street to continue patrol and alleviates an accumulation of police resources “grounded” at the hospital, thereby hindering their ability to enforce the law in their assigned zone.

Due to internal policy, two officers are mandated to be present at the hospital for each apprehended client. Mental health professional-alone units therefore cannot relieve officers and are perceived as little use at the hospital once an apprehension has taken place. One officer, “...expressed his frustration with the MCTs relieving an officer. He explained to me that [MCT-Single units] cannot relieve officers from the hospital, only [MCT-Joint] can do this (because a uniformed officer is involved)” – Ride Along 401. Similarly, an officer stated that he “...doesn’t understand why [the MCT-Single worker] was needed at the first call [at the hospital] because he [the mental health professional] is unable to do anything (i.e. relieve the officers), so he was essentially just standing there for the duration of the call” – Ride Along 407. Thus, while MCT-Joint was consistently perceived as being an effective system, many officers pointed to a lack of understanding why MCT-Single units were dispatched, particularly to the hospital, and questioned what more such MCTs could offer other than on-scene consultation.

While there was consistent frustration regarding the constraints of MCT-Single units, most officers spoke to the benefit of having MCT-Joint on duty during their shift. One officer

explained that he, "...does not interact much with [MCT-Joint] because they typically will take all the mental health related calls when they are working" – Ride Along 403. Having a police officer and a mental health professional riding together at all times was seen as beneficial because the two were constantly in collaboration and had the requisite authority to handle various mental health calls.

Discussion

This first theme can be understood through the lens of pluralistic policing. The ability for police officers to govern at a distance means they are still heavily involved in calls for service, but they are able to extend their realm of influence and divert some responsibility for undertaking policing activities to the MCTs, who are not part of the police service (Garland, 1996). In having the ability to lean on the MCTs, police officers are contributing to the process of pluralization, a model that is an asset to them and their ability to carry out what were once exclusively policing duties (Cherney et al., 2006). In handling PMI in the community, police officers are only one node amongst many (Crawford, 2006), and are willingly shifting from first responders to actors involved in distanced governance (Brewer, 2015), by connecting PMI in the community with MCTs and thus other mental health resources. As the literature suggests, police officers are diverting their duties and responsibilities to the MCTs. They do not see mental health calls as traditional and legitimate police work, or even work that they are trained or qualified to handle (Borum, 1998). Instead they see mental health calls as time consuming, liability issues and are thus naturally eager to divert this work to the MCTs who are trained and trusted by officers.

In policing, culture is one of the most significant relational properties that often determines police officers' ability to build relationships with partner organizations (Whelan,

2017). Historically in policing, different and often conflicting occupational cultures have presented problems in building relationships with other actors (Whelan, 2017). While the police officers and MCTs appear to value and respect one another, there are still perceived differences in the value of the work each party does, possibly due to a cultural divide. Specifically, officers see their own work as more legitimate. They believe that the MCTs aspire to be like them and have a perception that all actors outside of the police service wish they were police officers, viewing themselves as “senior partners” and others as “junior partners” in partnerships with non-police agencies (Diphorn & Berg, 2014). Further, officers who departed from the overwhelmingly positive views of MCT staff is suggestive of these culture boundaries and biases towards non-police actors. Police officers historically have not believed that actors outside the policing profession could assist them in performing their duties (Terrill, Paoline & Manning, 2003), and thus perceive themselves as being superior to these actors. Much of this stems from an “us vs. them” outlook that has long characterized police officers’ relationships with those outside of the policing profession (Terrill et al., 2003).

Trust and reciprocity are thought to be the central properties to effective and cooperative relationships within high functioning police networks (Whelan, 2016; Whelan, 2017; Fleming & Rhodes, 2005). As police services continue to evolve and recognize these promising opportunities for partnerships with non-police agencies, cooperation and collaboration with one another will continuously be enhanced (Sarre & Prenzler, 2011). As was seen first hand during ride-alongs, trust, cooperation and collaboration are continuously fostered as police officers continue to work with and develop rapport with the MCT members.

Chapter 7: Results - Practical Collaboration in the Field

A second theme comprised collaboration of police officers with the MCTs in the field. Working together was viewed to be affected by factors such as officer understandings of the MCTs intended function and the availability of the teams when needed. Overall, officers and the MCTs were able to effectively collaborate and communicate by recognizing the importance of one another. However, a lack of a clear policy on how to utilize the MCTs, along with a paucity of available MCTs was found to at times hinder effective collaboration. Throughout this chapter, the major themes related to practical collaboration in the field will be examined, followed by a discussion on how a pluralistic framework can assist in understanding police-MCT collaboration in the field.

Decision to Involve

A dominant theme observed in the field was officers describing situations where they would and would not involve the MCTs, which was based on officer perceptions of MCT purpose. The majority of officers felt that the mental health professionals were best suited for situations where officers were unsure of the best course of action. However, if the officers came to a conclusion that an individual must be apprehended, most were hesitant to involve the MCTs. In one conversation, an officer,

...tells me when it is cut and dry that he is going to make an apprehension there is no need to call the MCT because they know they are going to the hospital regardless... - Ride Along 403

Thus, most officers did not see the value in calling the MCTs when a hospital transport was needed. Instead, one officer stated that the MCTs, particularly MCT-Single units (which do not have officers assigned to them) are,

...ideal when not making a mental health apprehension, because it allows the officers to get back on the road and the citizen in need to get someone to talk to as quickly as possible. – Ride Along 402

The above statements show that most officers view the mental health professionals as being useful in terms of acting as an on-scene social worker who can talk to non-violent individuals. However, they were not viewed as decision makers in terms of whether or not an apprehension was necessary.

Despite this tendency to not involve the MCTs after the decision had been made to apprehend an individual, some officers felt that the MCTs were helpful in determining whether an apprehension was in fact necessary in the first place. In one example, “[The officer] also mentioned that most of the calls he would have apprehended have been identified as fine by the MCT cars” – Ride Along 600. This statement is particularly interesting in light of the above quotes because it contradicts the notion that the MCTs have no use when officers decide an apprehension must be made. Many times officers tend to over-apprehend to avoid liability issues and out of concern for an individual. Police officers often have a misconception that those who are mentally ill are more dangerous than they are (Cotton, 2004), which likely contributes to this over-apprehension. The MCTs can demonstrate to officers that despite being ill, it is possible for some PMI to stay in the community safely when they are connected to services. Certainly there are situations where an individual must be apprehended immediately for safety reasons. However, as the above excerpt shows, if the MCTs are not being called *before* an officer decides to apprehend, there is no opportunity for the mental health professional to make an assessment and contribute insight into whether an apprehension is in fact the best course of action.

Lack of Resources leading to Limited Collaboration

Although the introduction of the MCTs to this police service has led to several early successes, such as, increased diversion of PMI from hospital, enhanced efficiency in processing PMI and decreased hospital wait times, one continuous barrier was a lack of community resources. While limited resources can be expected in a smaller service, still in the infancy of this program, it is a problem nevertheless. The main issue appears to be a lack of available MCTs. One officer simply stated, “It would be nice if each platoon had an MCT” – Ride Along 802. During the field observations, there appeared to be a lack of availability of mental health personnel on the part of both the police service and the community agency providing the mental health professionals.

Further, consistent across all the ride alongs was a belief that the value and potential of this program lies in the MCT-Joint units, where an officer and mental health professional respond in one cruiser. One officer felt that, “...the [MCT-Single units] are certainly useful, but further resources would be best used in expanding the number of teams that contain both an officer and a mental health worker” – Ride Along 407. Adding to this, another officer pointed out that having only one officer-mental health professional tandem can be problematic since, “tying up [MCT-Joint] does not help because then they are unavailable for 4 or more hours while they are waiting in the hospital” – Ride Along 401. These statements show that officers value the MCTs and desire more teams to be available to them.

Related to this issue is the lack of MCT availability due to limited operation times. Officers reported that in some cases they wanted a MCT for assistance, but, “...the main reason the Mobile Crisis Teams were not called was because they were not working” – Ride Along 402. As a result of this shortcoming, officers stressed “...the importance and need for extended hours

and more staff on the MCTs” – Ride Along 403. It is noteworthy that opportunities for diversion or connection to resources are being missed as a result of the MCTs either being unavailable or off-duty. With the teams only working weekdays in the daytime hours and until 11:00p.m., calls that occur on the weekend and outside of these hours are largely responded to by officers alone. This limited MCT availability during specified periods of time is problematic, because as one officer said, “...unfortunately most mental health calls take place outside of those hours” – Ride Along 402.

Communication in the Field

Another recurring theme was officers reporting a collaborative relationship between themselves and the MCT members. The officers were typically willing to either divert responsibility to the MCT members, or in many cases, the two officers and the mental health professional discussed what they felt was the best course of action. In one ride-along when responding to a call involving a young, mentally unstable male who was unwilling to accept assistance from the hospital, MCTs, or available community resources, “the [MCT-Joint] officer, the mental health worker and my officer [had] a conference on what to do” – Ride Along 801. Observations similar to this collaborative discussion were common, and appeared to be the most frequently used approach.

While these types of conferences and discussions usually came towards the end of a call after situational information was collected, initially the officers were often willing to allow the mental health professional to talk to PMI, assess the situation, and discuss client’s options going forward. In one call the officers stood off to the side for much of the time, and,

[the MCT-Single worker set] up a follow up plan with [the client] where he will call her in the morning to make sure she has called her family doctor and to set up

a follow up visit. She says she has dealt with [the officer and mental health worker of MCT-Joint] a few times in the past and she loves talking to them because they put her at ease. – Ride Along 406

This observation is telling for two reasons. First, it shows the benefit of having a mental health professional on scene. Officers do not have the time or resources to follow up with clients to ensure they are taking their medication or have spoken with their family doctors. Through the MCT program, officers perceive that citizens are given extended care from a mental health professional following the incident. Second, it shows that compared to police officers, PMI often prefer to deal with the MCT members because the mental health professionals are comforting. This feeling of comfort is likely a result of the mental health professionals being sympathetic towards mental illness due to a greater knowledge of mental health. In addition, PMI seem to view the MCTs as less threatening since they are not police officers.

Additionally, officers spoke to the MCT's ability to enhance care for PMI by ensuring all parties involved are better connected and communication is more consistent and efficient. One officer spoke to this by discussing the MCTs in conjunction with a newly introduced mental health screener. This screener is used by police officers to collect information when encountering a PMI and transmit the screener to the emergency department in the event of an apprehension. This particular officer felt that, "the communication between all parties is much better, and it is easier to admit persons with a mental illness when everyone is on the same page" – Ride Along 404. With better communication between all parties involved in care, police officers spend increased time on the road patrolling because PMI are managed more efficiently at the hospital. In addition, the MCTs are able to ensure that PMI have stream-lined access to the after-care and

resources they require. Finally, communication between police and MCTs can help with preventing future mental health crises by identifying at risk individuals.

Liability, Policy Clarification, and Safety in the Field

A final dominant subtheme of practical collaboration in the field involved confusion around who ultimately has the final decision on how to proceed and who assumes responsibility for a citizen once a police officer leaves the scene. One notable example of confusion around who makes the final decision occurred when a patrol officer did not agree with the opinion of the MCT member concerning disposition of a case, but was unsure of who had the authority in terms of overriding the decision of the other. This particular officer stated that,

Sometimes the [MCTs] make a call that I just don't agree with. In fact, the other day, I was at a call and was going to apprehend but MCT said not to. I went along with their call, but I didn't agree with it. When I came back to the station I asked the Staff Sergeant 'who has the authority?', 'who makes the final decision?', because you know there are a lot of times I just don't agree with them. The Staff Sergeant said 'You are the police officer so you have the authority – you can make the call and you can disagree, but at the end of the day, you are in charge'. –
Ride Along 600

This observation not only shows the need for a clearer policy so that officers know they are in charge and have the final decision, but also emphasizes the power hierarchy. Although the MCT member may be perceived as more knowledgeable in certain mental health related situations, the officer still arrives at their own conclusion based on their experience and is in control of the situation. The officer may disagree and ultimately override the MCTs assessment. While the mental health professional may be better equipped in understanding mental health concerns,

police officers are the experts in law enforcement. Often times in mental health crises there is a legal component as well, that officers are better suited to make decisions about. Officers have superior knowledge regarding when to apply the MHA police powers section in the event of an apprehension.

Another important issue that involved both policy clarification and liability, was confusion regarding when an officer can leave a client with an MCT member or the hospital staff, and who was responsible should something go wrong. One officer felt that having the MCTs arrive on scene was valuable, “because it allows the officer to comfortably leave the scene and know that the mentally ill individual is in good hands and will not do anything to harm themselves or others” – Ride Along 402. However, contradictory to this statement, another officer was uneasy leaving citizens with the MCT members because,

...there is no policy around WHEN to stay (with a client). This is true in cases where the officer calls in [a MCT-Single unit], and they determine there are no grounds [to apprehend]. The MCT worker might want to stay to chat with the client. We assess if there is danger, and we leave if they are harmless. One of these days someone (e.g., an MCT worker) is going to get killed and we’ll lose our job – there is no policy here to refer to. – Ride Along 802

The difference of the previous two excerpts is notable. The first shows that the MCTs can be valuable for enhancing the safety of clients and providing officers with the confidence to leave the scene, while the second shows that due to a lack of formal policy around when an officer can do so, the safety of the mental health professionals and the liability of officers can be jeopardized. While in most situations officers felt that if they had made an assessment that a citizen was not a threat they could comfortably leave, the lack of policy around what would

happen if they made this assessment, left, and then something was to happen is clearly problematic. Further, it appears that in some situations officers are forced to remain on scene simply because of a lack of policy around these types of situations. This demonstrates that a primary concern of officers is liability. Their liability over a client in crisis is assuaged when responsibility is diffused to an MCT; however, liability increases when officers perceive that they are leaving the MCTs in a potentially unsafe situation.

Discussion

This collaboration between the MCTs and police officers can be aptly understood through a pluralistic framework. At times, officer decision-making remains reminiscent of the more traditional policing structure wherein decision-making tends not to be participative. This traditional policing structure is used in order to reduce the risk of being held responsible for making a mistake (Fleming & Rhodes, 2005), which officers often utilized when deciding whether or not to make an apprehension. Despite this current shortcoming in terms of policy, effective collaboration between officers and the MCTs appears to be made possible as a result of both groups recognizing the value and importance of the other (Diphoorn & Berg, 2014). This recognition is essential to creating an effective partnership because effective care of PMI requires cooperation between all involved agencies along with all parties doing their jobs properly (Fleming & Rhodes, 2005).

Effective partnerships between police services and community agencies are characterized by resource-dependent relationships (Fleming & Rhodes, 2005; Hope, 2005), meaning both the MCTs and the police service must rely on one another given the limited resources each have at their disposal. Instead of solely relying on the criminal justice system, police officers are now able to utilize the assistance of non-state organizations (Garland, 2001), such as MCTs to fulfill

their duties. Although police officers are still largely responsible for supervising interactions, policing activities such as mental health calls for police service are now being undertaken by other services and organizations situated within the local community (Loader, 2000).

Although it is desirable to create a more efficient system for police officers by ensuring they are free to patrol and engage in law enforcement activities, it is also imperative to enhance care of citizens. To achieve both of these goals concurrently, effective inter-organizational networks must be fostered, which is done by negotiating and managing the roles of each party in situations involving PMI (Fleming & Rhodes, 2005). While collaboration is present, the current relationship between police officers and the MCTs is reminiscent of Diphorn and Berg's (2014) "junior partner model", where the police act as "senior partners" while other policing organizations, in this case the MCT, act as the "junior partner". The police still hold the ultimate authority and decision-making power, while the role of the MCTs is to assist them whenever needed.

Chapter 8: Results - Implications at the Hospital

The data revealed a third theme enveloping the perceived impacts of MCTs on officer experiences at the hospital such as reduced hospital wait times and enhanced collaboration with hospital staff. Officers did not all agree in terms of the effectiveness of reducing wait times at the hospital. Further, several officers expressed negative relationships with the hospital staff. These negative relationships appeared to be partly alleviated by MCT staff who were able to relate to and speak a common language with the nurses. Finally, many officers expressed similar issues at the hospital as in the field, namely concerns around liability due to a lack of a clear policy for leaving PMI at the hospital. This chapter will highlight the major themes pertaining to implications at the hospital, concluding with a discussion interpreting the findings through the lens of pluralism.

Wait Times

A dominant theme present throughout the ride alongs was the perceived improvements in wait times at the hospital before and after the implementation of the MCTs. The majority of officers had relatively positive things to say about the improvements in hospital wait times. One officer stated that, "...his wait times at the hospital have been really reduced" – Ride Along 600. Another officer cited specific lengths of time, saying prior to the introduction of this program he experienced,

...a minimum 4 hour wait at the hospital, whereas he says he experiences 1-1.5 hour waits now. He attributes this decrease to a combination of the [mental health screener] and [MCT-Joint] having the ability to relieve officers sometimes. – Ride Along 405

While the field-note excerpt above speaks to reduced wait times, it also highlights officers' feelings about a lack of resources and a need for more officer-mental health professional tandems to be able to relieve them from the hospital.

Interestingly, while the feedback was mostly positive in terms of reductions in the amount of time spent waiting at the hospital, there were some officers who disagreed. One officer felt that, "...the wait times are better sometimes but there are still extremely long waits and it is uncommon to be there [at the hospital] for less than a couple hours" – Ride Along 402. While significant reductions in hospital wait times may have been supported in the statistics analyzed in the pilot program (County O.P.P., 2016), this sentiment speaks to the fact that there are still some instances where officers are facing very lengthy wait times due to individual incidents being diverse, or lack of availability of MCTs.

Another interesting factor that may affect how long officers are waiting at the hospital is the attitudes and effectiveness of the hospital staff. While the following observation echoes a decrease in wait times, the officer speaks about the hospital staff:

"My officer tells me that the hospital wait time depends a lot on who is working." – Ride Along 404

The perception that wait times are dependant on who is working speaks to the fact that there are additional factors that contribute to hospital wait times other than just the availability of the MCTs. For example, if hospital staff have negative perceptions of police officers or do not see mental health or getting officers back into the community as a priority, wait times will be longer.

Collaboration with Hospital Staff

A second subtheme related to the hospital was officers expressing frustration with the hospital staff. One issue was a lack of reciprocity in terms of helping one another. Several

officers felt that the hospital staff often did not show the same sense of urgency as themselves. One officer voiced this frustration, discussing how he, "...was annoyed by the fact that when the hospital calls the police they rush there to help, but the hospital does not do the same" – Ride Along 401. As a result of this perceived imbalance, officers occasionally displayed animosity towards the hospital staff, something that appeared to have negative implications on the working relationships between the two parties.

Despite these negative feelings towards hospital staff, many officers were clear that not all hospital staff cause them to have negative experiences when arriving with an apprehended individual. After waiting with an officer for a very short period of time before the doctor arrived to assess an individual, the officer noted that it had been,

...an extremely short amount of time for the doctor to come in, and it is only because it is that doctor working. They complain that the other doctor [is not as reliable]. It is clear that their experience at the hospital is very much dependent on who is working at that particular time. – Ride Along 403

This excerpt shows the frustration that the officers feel towards certain hospital staff. Not only are officers' wait times being affected by ineffective collaboration between officers and the hospital staff, but there was a perception by some officers that patient care was being sacrificed by nurses who were not as invested in promptly assisting officers and getting care for individuals with mental health problems.

Officers expressed frustration with this lack of urgency displayed by many of the nurses, with one officer stating, "...he believes patient care should always take precedent over personal biases [towards clients or officers]" – Ride Along 402. When staff at the hospital fail to do their job and admit people because they dislike a particular citizen or have negative attitudes towards

the police in general, officers are often faced with responding to that citizen over and over again because they remain in the community.

Safety and Liability at the Hospital

A common subtheme that emerged with officers was a perception that they were often playing the role of security guard, rather than police officer when at the hospital. One officer felt that, “when they [the police] wait at the hospital in [city], they are essentially just ensuring safety, something that can be effectively done by a security guard” – Ride Along 402. Officers were frustrated with being forced to remain at the hospital to provide private security, because it meant they were hindered from patrolling and ensuring community safety.

One officer gave an explanation for their role as security guard, stating that being understaffed and possessing a lack of resources is not unique to the police service. He explained that this inevitably affects the way officers are treated and processed at the hospital:

...the hospital is just like policing – they are understaffed so he believes the hospital likes to keep the officers there because they are more security for them.

He says, ‘it makes sense for them, right, because they are understaffed and they are scared of some of these people, so they want us there.’ We are their ‘defacto security’. – Ride Along 600

Despite being frustrated, this officer shows a sense of understanding that it may be out of genuine fear for safety that the hospital staff desire to have officers remain on scene.

Another issue similar to officers’ interactions with the MCTs is that in many instances upon leaving the hospital, officers spoke of a lack of clear policy for when they are free to leave the hospital after transporting an apprehended client. In one instance at the hospital, a male citizen was admitted but was too intoxicated to be assessed right away. As a result, the hospital

staff informed the officer he was free to leave because the individual would have to wait several hours to be assessed. As we were leaving the hospital,

[my officer] says that there doesn't appear to be a consistent protocol for when they [the police] can leave and the conditions around liability. He says no transfer of care was signed so what happens if the male gets up out of his bed, walks out of the hospital and in front of a car and kills himself – who is liable? – Ride Along 407

Although this individual had been apprehended and was being held at the hospital, this officer felt uneasy because of the possibility the client would leave the hospital while the hospital staff were busy, or satisfy the doctor that he was stable and safe to return to the community. As a result of the possibility of this type of situation, officers are hesitant to leave because they are unsure of the policy around who is responsible, but also because they know they will likely be called again to re-apprehend the individual and return them to the hospital.

Speaking a Common Language

A final subtheme regarding implications at the hospital is the enhanced relationships and language familiarity that the MCT members have provided. Compared to hospital staff, police officers felt they had a less sophisticated vocabulary when discussing mental health. Having a mental health professional arrive at the hospital with the officers provides someone who is able to use common medical language with the hospital staff in describing what has occurred on scene.

One officer stated feeling, “more respected when we are with the [MCTs], it's different now. It's cool when you bring an MCT worker with you [to the hospital] and you are not being shoved off like before” – Ride Along 802. Similarly, another officer, “believes that the MCT

teams are treated more favourably by the hospital staff because they can speak the same language” – Ride Along 600. The fact that the first officer refers to feeling dismissed clearly speaks to the effectiveness of having the MCT members on scene. By using medical language, the mental health professionals become legitimized in the eyes of the hospital staff as they are able to relate to the hospital subculture. This buys the MCTs, and by extension the police, currency in that the hospital staff respect the mental health professionals and value what they are saying more than previously when interactions only involved police officers. One officer felt that the, “mental health staff at the hospital seemed to be taking information from officers and the [mental health screener] more seriously” – Ride Along 801. By stating that the hospital staff are now taking information more seriously, this officer is speaking to the importance that the hospital staff place on being able to clearly understand in medical terms what has occurred and what mental health symptoms have been exhibited. Having the MCTs alongside the officers at the hospital provides them with a tool to better connect with and be understood by the hospital staff.

Discussion

The subtheme of hospitalization can be interpreted through pluralism. Although as previously discussed, the relationships between officers and the MCTs were mainly characterized by co-operation, there are incidents where tension has been created between groups (Diphorn & Berg, 2014), as was often seen between officers and staff at the hospital. Pluralistic models focus on linking service providers together to enhance the needs of the community (Brewer, 2015), though such collaboration is difficult when organizations such as police officers and hospital staff are not communicating effectively.

Much of the tension in the relationships among police and MCTs as perceived by officers appears to be as a result of a lack of resources. When officers are forced to remain at the hospital to ensure safety, they are not able to return to patrolling and ensuring safety in the community (Provincial Human Services and Justice Coordinating Committee, 2013). The inability to return to patrolling places pressure on the officers who are responsible for responding to ever accumulating calls in their assigned zone. Police officers feel obligated to assist other officers in preventing calls from accumulating, which they cannot do when at the hospital. Given that two officers must remain in the hospital when a person is transported to the hospital under a MHA apprehension, the efficiency of patrolling is consequently reduced (Provincial Human Services and Justice Coordinating Committee, 2013). One way this relationship has been improved is through the MCTs in assisting in diverting clients from the hospital when appropriate. Further, MCTs have helped reduce the barriers to collaboration between officers and the hospital staff.

The role the MCTs play is interesting, as policing scholars have often described police agencies as being the intermediary between agencies that would otherwise not be connected (Brewer, 2015). Police agencies are thought of as the “brokers” of policing networks, linking service providers in an effort to address community safety issues (Brewer, 2015). Though police do play this role between the MCTs and the hospital staff, doing so does more than simply connect the two parties. Having MCTs alongside the officers at the hospital provides police with a way to effectively relay information to the hospital staff. Further, the mental health professionals appear to act as the intermediaries in terms of building rapport with clients and having a knowledge of mental health and the available resources. Trust, along with shared values and norms are essential to effective coordination for organizations that may have different organizational cultures (Fleming & Rhodes, 2005). Having a mental health professional on scene

who shares many of the same values and norms of the hospital staff and are trusted by both these staff and the officers, is valuable for creating a better and more positive collaborative environment.

Chapter 9: Conclusion

The purpose of this study was to contribute to the limited understanding of how police officers perceive and interact with Mobile Crisis Teams and the mental health professionals of which they are comprised. Currently, many of the reports and analyses concerning police officers' interactions and relationships with MCTs are written by upper-level police service staff who may have an interest in showing that this program has been effective by having led to increased support and diversion of PMI from hospital, and reducing hospital wait times. While these reports are valuable, the current research offers objective insight into the thoughts and perceptions of the individual officers who are actually interacting with the mental health professionals in practice. Understanding these thoughts and perceptions are valuable, as they are able to offer in-the-field awareness into what officer's view as successful and unsuccessful about their practical, everyday interactions with the MCTs.

The current study found that MCT member skill sets are of major importance to police officers. Officers felt that the mental health professionals had superior knowledge of mental illness and appropriate responses to mental health-related calls compared to themselves. Often unsure of how to handle mental health calls for service, officers valued the ability to rely on the MCTs to help with making decisions on the best course of action in resolving a call. Following this process, officers viewed the mental health professionals' knowledge of available community resources as a valuable way to divert PMI from the hospital triage when unnecessary, and ensure consumers remained connected to the appropriate services. Although most officers had extremely positive perceptions of the mental health professionals as individuals, there were instances where officers portrayed a sense of superiority, which speaks to underlying sub-cultural differences between themselves and the MCTs. Overall, officers felt as though the

MCTs would be more effective if there were more officer-mental health professional tandems that could respond to mental health calls for service together. Officers frequently voiced frustration towards the lack of authority that the MCTs had when a mental health professional was responding alone. These officer perceptions are notable because they indicate that there is value in expanding the MCT program in order to continue to manage and care for PMI in the most effective way possible. Officers typically do not view mental health calls as desirable police work and consistently showed an appreciation for the assistance the MCTs were able to offer. This may be due to a lack of understanding of mental health on the part of officers and the important role they play in terms of connecting PMI with the appropriate supports, something that may be improved through increased mental health training.

Further, this research examined practical collaboration in the field to assess how officers and the MCTs worked together when handling a mental health-related call for service. Officers had different understandings of when and when not to involve the MCTs. While some officers valued the mental health professionals' ability to assist them in deciding whether to apprehend a PMI under the Mental Health Act, many typically came to the decision regarding apprehension on their own. Most officers observed chose not to summon or use the MCTs when they had already made the decision to apprehend. Additionally, at times the MCTs were not used as a result of being off-duty. This lack of availability is indicative of a need for more resources to be devoted to ensuring the MCTs are available whenever officers need assistance with a mental health related call for service. Despite these instances where the MCTs were not involved, when they were on-duty and dispatched, officers and the mental health workers appeared to have a collaborative relationship characterized by cooperation and joint decision-making. This collaboration clearly shows that it is possible for two different actors, with different goals and

cultures to build effective, productive relationships. Finally, officers appeared to be unsure about important policy and liability issues such as who ultimately makes the final decision about mental health apprehension and when an officer can comfortably leave a PMI with the MCTs either on-scene or at the hospital. These findings show that clearer policy must be laid out and conveyed in officer training in order to allow the MCTs to be used as intended, and to ensure officers are comfortable with respect to safety and liability when deferring responsibility to the mental health professionals. Further, there is a need for officers to receive mental health training on anti-stigma, how to communicate with PMI, alternatives to use of force, the Mental Health Act, and how to assess risk (Cotton & Coleman, 2008).

Finally, there were several notable implications at the hospital setting for officers as a result of the implementation of the MCTs. The most prominent sentiment expressed by officers was the perceived improvement in wait times seen at the hospital as a result of the MCTs involvement. Such a perception is significant as it allows officers to swiftly return to patrolling, where they believe they are most effective. Despite this improvement, officers typically had negative feelings towards the emergency department hospital staff who were seen as lacking urgency in assisting officers to return to patrolling by not attending to PMI promptly. The mental health professionals were seen to be helpful in assisting this tense relationship as a result of being able to describe mental health symptoms displayed by PMI in medical language to which hospital staff could relate. This intermediary role is a further benefit of the MCTs, as speaking the same language not only potentially improves client care, but eases what appears to be a tense relationship between officers and hospital staff. Lastly, similar to concerns in the field, officers were unsure about when they could safely leave a PMI at the hospital, and who was responsible in the event of a negative outcome. Officers begrudgingly felt that they were being held at the

hospital to ensure safety and play the role of security guard. Results indicate articulation of a clearer policy is needed in order to facilitate officers' comfort in leaving the hospital, and knowing when they can safely do so. Beyond this, there is a need for police services and hospitals to develop memorandums of understanding in order to enhance collaboration and give each party the ability to discuss what challenges exist for them during mental health apprehensions and develop appropriate solutions. Moreover, mental health training that focuses on the lived experiences of PMI and anti-stigma is required in order to increase officer comfort and confidence in mental health calls (Cotton & Coleman, 2013).

The present research contributes an ethnographic account of how non-police actors such as the MCTs are contributing to the policing process with respect to responding to calls with a mental health element. The study also advances theorizing in plural policing by providing much needed insight into the integration of mental health professionals as non-social control agents into plural policing networks. Much of the literature available on plural policing examines the relationships and implications of public and private police services and social control agencies. Further, an understanding of how officers perceive MCTs can offer insight into the often discussed, but little understood topic of police culture and how other actors fit into this culture. The fact that the officer on MCT-Joint is male, with the mental health professional being female is notable given the role police culture plays in viewing crime fighting as a male duty, and social service work as a female duty (Prokos & Padavic, 2002; Workman-Stark, 2015). In policing, masculine work is seen as more legitimate, with social work being devalued and perceived as feminine (Prokos & Padavic, 2002). Further, officers referring to the male officer on MCT-Joint as more of a "social worker" and a "useless cop" supports the notion that officers who do not

conform to a masculine crime fighter identity may be viewed as nurturing and weak (Workman-Stark, 2015).

As previously discussed, for much of the 20th century policing was characterized by command and control models and policing activities were undertaken exclusively by police services (Bayley & Shearing, 1996; Fleming & Rhodes, 2005). Since this time however, policing obligations and responsibilities have been fragmented to include many other actors such as community agencies and private actors (Bayley & Shearing, 1996). As a result, policing is now undertaken by several different agencies and organizations who work together and have often complex relationships (Crawford, 2006). The literature on pluralism indicates that relationships between these different actors are difficult to understand and can be described by dichotomous characterizations such as hostility or collaboration (Brewer, 2015). Policing obligations, such as managing mental health-related calls for service have been fragmented and subsequently diverted by police services to more effectively utilize resources and improve consumer outcomes. However, the way officers perceive their relationship with the mental health professionals is more collaborative than what is often described throughout the literature on pluralism. As opposed to competing for policing duties, the findings of the current study indicate that police officers are willing to collaborate with the MCTs in order to defer mental health related duties to mental health professionals who are eager to assist.

The current research is important as it contributes to the understanding of police culture and the ways in which other non-police actors can carve out a place within this culture. In the case of the MCTs, officers perceive the relationship between themselves and the mental health professionals as being characterized by cooperation, with officers typically respecting and showing gratitude for what the MCTs can offer. This positive relationship may suggest that when

officers view other actors as fulfilling a function that they cannot perform with expertise, or do not desire to perform, interactions will be constructive and friendly. Overall, officers are grateful that the MCTs can more quickly get police officers back to the “real police work” of enforcing the law.

Further, police are under much scrutiny, particularly when it comes to mental health calls, where they have received much criticism. Furthering this criticism, mistakes such as the death of Sammy Yatim have been costly. Having MCTs helps diffuse the responsibility and in many ways reduce liability. Mental health professionals are able to make recommendations such as when they feel a person can likely remain in the community safely despite feeling like they want to self-harm. In addition to these implications for officers, this perceived collaboration has implications for the consumer. MCT knowledge and consultation assists officers in making better decisions so that involuntary measures such as apprehensions that result in lengthy hospital wait times, a loss of liberty, and stigmatizing experiences for consumers in the back of a police cruiser, only happen when necessary (i.e. they are a danger to themselves or others). This avoidance of unnecessary apprehensions allows more PMI to be diverted from the criminal justice system and the hospital and towards mental health resources in the community, thereby reducing criminalization of the mentally ill (Zinger, 2012).

In addition, this research provides evidence that partnerships between police services and non-police agencies such as the MCTs are possible and can operate according to the principles of nodal governance, where the police are seen as one node amongst others (Crawford, 2006). Together, various actors, working with one another can create high functioning networks (Shearing & Johnston, 2010). In the case of police officers and the MCTs, each fulfills an important role in the handling of calls for service that involve PMI. The police are able to

provide control and authority to engage the law in these situations, whereas the mental health professionals are able to offer resources as well as on-scene assessment of PMI. Both of these functions are important, and with both groups recognizing the value of the other, policing is carried out more efficiently, and citizens, in this case PMI, are policed in a manner that is more empathetic, less stigmatizing, and safer for all parties involved.

Limitations and Future Research

The most apparent limitation of the current study is the overt nature of the research, in that the officers who were part of the ride-alongs were aware of the purpose of the research and that their actions and statements were being noted. Many times the data came from discussions with the officers as a result of a lack of mental health-related calls and involvement with the MCTs during field observations. In these situations, officers spoke of how they had used the MCTs in the past as well as their experiences with the mental health professionals. Knowing their statements were being used as data for this study, officers may have biased their responses to portray a more positive perception of their interactions with the MCTs.

This potential issue of bias is related to the second limitation, which is the limited number of mental health-related calls that were observed during the study period. While approximately 140 hours of ride-alongs is fairly extensive, the data were not comprised solely of observing mental health-related calls that involved the MCTs. Further, this relatively small sample size means limited generalizability and caution must be used in interpreting the results. Both these limitations could potentially be overcome by conducting a larger number of ride-alongs with more officers. Not only would a larger sample size include more officers' viewpoints and opinions but it would lead to more direct observation of mental health calls where officers interacted with the MCTs. Additional direct observation would likely enhance the data and

make it richer by allowing the researcher to more frequently observe how the MCTs and officers interact in practice.

Finally, using only one service can be viewed as a limitation in that other services may have different experiences interacting with MCTs. Several services proximal to the service under study have introduced some form of MCTs, and in some instances are better developed and have been operating for longer. Several officers in the current study discussed processes they knew other services used that were, in their opinion, more successful or a better use of resources. The results of the current study should be interpreted as perceptions of officers of MCTs during the critical phase of launching an MCT program.

Implications of the study are beneficial for training for police services who are in the process of planning or initiating joint police-mental health response teams. Future research could expand the scope of the current research to include other services in order to assess perceptions of MCT programs after longer periods post-implementation, as well as examine other factors of interest such as rural/urban issues, municipality size or distance to hospitals. Perhaps other services have been able to adapt or alter their use of the MCTs in a way that has made them more effective. Ascertaining this information through future research could assist services in the infancy of using MCTs by allowing them to learn from the process other services have used. Finally, a gendered analysis of police perceptions of the MCTs could offer valuable insight into police culture, perceptions of gender roles, and the role of masculinity within policing.

In conclusion, by applying a pluralistic framework to this research, it is clear that the future of policing lies in police services' ability to continue to engage community resources such as MCTs in order to supplement their own limited resources and create more positive outcomes for consumers. The current study and the MCT program serves as a framework for this

supplementation by demonstrating that police officers perceive their relationship with the MCTs as primarily collaborative and cooperative. Officers are willing to foster a positive relationship given their perception that mental health professionals can effectively assist them in policing duties, specifically the management of mental health-related calls for service.

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