In Crisis: Vancouver's Mental Health Crisis Response Model and Where to go From Here

by

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Abstract

Car 87/88 is the mobile unit in Vancouver that responds to persons experiencing a mental health crisis. However, they have not had the capacity to meet demand, leaving the majority of mental health crisis calls to uniformed officers to attend. Substantial investment from the City of Vancouver to create and expand existing response services has provoked questions about the role of police in mental health response in the city. This capstone examined the existing evidence regarding the effectiveness of police-based mental health crisis response models, such as Car 87/88, the co-response model specifically, non-police alternatives and the key findings that indicate more positive outcomes. Co-response was confirmed to be a common model but the variations in model application and lack of standardization have resulted in insufficient evidence to determine whether the model is effective. It was correlated with improvements in some key metrics, such as arrest rates and involuntary hospitalizations but many results were mixed, and isolating influencing factors were limited to speculation. Interagency collaboration, police culture and service-user input were identified as influential elements contributing to outcomes and in need of consideration in program design and implementation. Literature regarding non-police-based response models was minimal although evidence indicated potential demand for these services. Application of the learnings to the Car 87/88 program demonstrated that the claim of Car 87/88 as successful could not be substantiated with the evidence available. The creation of a non-police de-escalation team as part of new investment appears to align with recommendations that co-response teams be implemented with other programs to form a mental health continuum of care. Recommendations reinforced the importance of incorporating evidence in program design, staff training, and the decriminalization of service-users for improved relationships and outcomes.

Keywords: Car 87/88, mental health, crisis response, police response model, co-response**.**

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Chapter 1: Introduction

In Vancouver, where police are currently the primary responders to mental health crises, law enforcement has historically taken precedence over the provision of appropriate care when people are facing a mental health emergency. Unless an officer has had specialized training or possesses knowledge of mental health services, the primary tools available to them are use of force and the legal authority to detain a person for assessment by a physician (Mental Health Act, 2023) which may or may not be the optimal course of action for the person in crisis. Car 87/88, mobile crisis units staffed by a police officer and a nurse, currently offer mental health assessment and service referral on-scene (City of Vancouver, 2023a). But with a wait time of 72 hours, sometimes with no response at all, the majority of mental health crisis calls have fallen to uniformed officers to attend, prompting appeals for increasing the service's capacity (Howell, 2021; Lindsay, 2021; Steacy, 2023).

A response to those appeals came following the 2022 municipal election with the announcement of substantial investment in, and expansion of, the Car 87/88 program as part of a larger framework for improving mental health and substance use services in the city (City of Vancouver, 2023a). While the increased funding and programming have generally been welcomed, the plan has drawn criticism for its continued police involvement and additional required capital, with some questioning the justification for any police presence at all (Boyd & Kerr, 2016; Kelsall & Beaumont, 2022; Junos, 2022; Steacy, 2023). Against the backdrop of several other Canadian communities implementing their own Car 87/88-like response models in tandem with rising mental health concerns (Basu, 2023; Ghelani et al., 2023; Knox, 2023), the consideration of the existing evidence for the effectiveness of police-based models in mental

health response, the co-response model in particular, and their alternatives has never been more critical and is precisely what this capstone project examines.

Overview

Mental illness in the community arose as a civic concern in Vancouver, and across North America, during the 1970s in conjunction with the deinstitutionalization of mental health resources (Boyd & Kerr, 2016; Dempsey et al., 2020). This phenomenon saw the closing of sanitariums and centralized residential facilities in favour of a mental health support system that would provide access to mental health care from within communities (Boyd & Kerr, 2016; Dempsey et al., 2020). Comprehensive wrap-around programming was intended to meet mental health needs at a variety of levels, including recovery and local residential treatment, while reducing the harm, isolation and stigma associated with the institutional treatment (Boyd & Kerr, 2016). However, when the anticipated funding and comprehensive programming that was designed to support this systemic transition fell short, the many people who were struggling to cope with their mental health were left in their respective communities with limited to no access to housing, resources and support, and with little means of subsisting (Boyd & Kerr, 2016).

While the closures of numerous institutional facilities impacted Vancouver, the incremental shutdown of Riverview Hospital that completed in 2012 epitomized this shift, explicitly displacing a substantial population of people grappling with mental illness onto the city streets (Boyd & Kerr, 2016). The inner-city area known as the Downtown Eastside (DTES), a low-cost neighborhood that traditionally housed labourers, immigrants and marginalized demographics, drew large numbers of this vulnerable deinstitutionalized populace and with it corresponding organizations, support services and charities to provide much-needed resources (Boyd & Kerr, 2016; Somers et al., 2016). The community, and thus the police as first

responders, became the primary access to mental health resources for people in crisis and experiencing severe symptoms or episodes (Dempsey et al., 2020; Wiebe, 2016). It was within this context of uniquely challenging conditions that Car 87 emerged.

Car 87/88

Car 87 was the first mobile response unit of its kind in Canada, initially functioning as a pilot project from 1978 until it was permanently implemented in Vancouver in 1987 (Munro, 2020). While the program is a partnership between the VPD and regional health authority Vancouver Coastal Health (VCH), it also exemplifies the police-based co-response model which pairs a plain-clothed police officer with a nurse, typically a psychiatric nurse, who together respond to callouts and provide on-site mental health support far exceeding the scope of regular police patrols (Wiebe, 2016). The nature of the service has been described as a "health response… rather than a criminal justice response" to a person in mental health crisis (City of Vancouver, 2023a, p. 4). Functioning within the operations of the Access and Assessment Centre, the health authority's gateway to mental health services, Car 87/88 facilitates assessments, referrals, access to services, medication dispensation and determination of appropriate intervention for mental health incidents (Vancouver Police Department, 2023; Wiebe, 2016). The average number of interactions was reported as eight per day, as per a city council report released January 31st, 2023 (City of Vancouver, 2023a).

The Car 87 program remained a single-car (or unit) service for over 30 years until July 2020 when a second car, Car 88, was added, enabling the service to operate throughout both the daytime and evening, seven days a week, although still only one unit is on duty at a given time (Howell, 2021; Steacy, 2023). The addition of Car 88 was spurred by an appeal from 19 Vancouver agencies to the City of Vancouver (CoV) to address the risk posed by long wait times

which had been estimated from 72 hours to no response at all (Lindsay, 2021). The current average wait-time remains 72 hours despite the additional car, supporting the statement by the VPD to the Police Board that "the increased resources are still unable to meet the demand" (Howell, 2021). Ultimately, when a co-response unit is not available to attend a call related to mental health, it is typically up to uniformed officers to do so (Ghelani et al., 2023).

Criticism has continued to focus on the utility (and emphasize the irony) of a crisis service that takes three days to respond, prompting calls for greater resourcing and, most recently, heavy investment from the CoV to expand and improve response services, including Car 87/88 (City of Vancouver, 2023a; Steacy, 2023). However, this has provoked further questions about the role of police in mental health response, the power of the police to influence the mental health narrative and the subsequent direction of change of response services in the city (Kelsall & Beaumont, 2022; Junos, 2022; Steacy, 2023).

The Role of Police

The Vancouver Police Department (VPD) has historically filled the role of responding to mental health incidents with the remit of maintaining public safety and enforcing law (Wiebe, 2016). Police officers are one of only four professions in British Columbia, alongside judges, physicians, and nurse practitioners, granted the authority to detain people involuntarily for psychiatric assessment by the BC Mental Health Act (Mental Health Act, 2023), an official legal recognition of their position and responsibilities in the mental health care system. Despite forming half of the Car 87 pairing, release of information and comment about the unit to the public appears to originate solely from the VPD which regularly publishes reports of their analysis of conditions in the city and heavily influences the dominant mental health narrative in the process (Boyd & Kerr, 2016; Wiebe, 2016).

The VPD began reporting on the perceived deficiencies in mental health service capacity in 2008 and continued throughout 2013 in a series of reports (Boyd & Kerr, 2016). During a press conference for the release of the VPD's *Vancouver's Mental Health Crisis: An Updated Report*, it was announced in conjunction with the Mayor of Vancouver that the city was indeed experiencing a mental health crisis (Cole, 2013; Vancouver Police Department, 2013). The supporting data quoted an increase of 43% in emergency visits to St. Paul's Hospital by people experiencing addiction or mental illness between 2009 and 2012, among other rising metrics (Vancouver Police Department, 2013, p.1).

Recommendations included the creation of a joint treatment model between the VPD and Vancouver Coastal Health (VCH), establishing the Assertive Outreach Team (AOT) which also works closely with the Car 87 program (City of Vancouver, 2014; Vancouver Police Department, 2023). Resources were mobilized and the CoV followed in 2014 with its report *Caring for All: Priority Actions to Address Mental Health and Addictions,* outlining its strategic approach (City of Vancouver, 2014).

The VPD's portrayal of the mental health crisis has drawn scrutiny over the past 15 years, particularly regarding its framing of vulnerable populations in Vancouver's Downtown Eastside (DTES) as dangerous and violent, reinforcing stigma (Boyd & Kerr, 2016). As a concentrated center for social services and a disproportionately large population of vulnerable and marginalized peoples, the DTES also includes high rates of homelessness, mental illness and substance use (Boyd & Kerr, 2016; Dempsey et al., 2020). As these elements are often criminalized in law enforcement discourse, they can serve to justify a police-based approach in the pursuit of public safety (Boyd & Kerr, 2016; Dempsey et al., 2020). The VPD's narrative appeared to shift in this regard with the 2016 *Vancouver Police Mental Health Strategy*, and

during the opioid overdose crisis in 2017, broadening beyond an enforcement-heavy approach by emphasizing the value of community supports, access to care, community-based treatment and the need for specialized training (Vancouver Police Department, 2017; Wiebe, 2016).

Yet concerns arose again in 2022 by a report commissioned by the police department commenting on the costs and administration of social services in Vancouver, thus impacting on public safety, with particular emphasis on the DTES. The scope of the report and subsequent commentary extended beyond that which was typical for the VPD, provoking strong skepticism of its findings and criticism of what some perceived to be a political agenda in justification of higher budgets (Howell, 2022b; Lindsay, 2022). An "unprecedented" endorsement from the Police's Union of the municipal ABC Vancouver party and mayoral candidate Ken Sim further stoked concerns of police backing a political candidate and party to maintain their stature (Kulkarni, 2022; Lindsay, 2022). The party's campaign platform pledged to hire 100 mental health nurses and 100 police officers, and support an expansion of Car 87/88, to address public safety concerns, further committing Vancouver to a police-based model for mental health crisis response (Junos, 2022; Kelsall & Beaumont, 2022; Lindsay, 2022; City of Vancouver, 2023a).

Expansion & Progression: Car 87/88 and More

Following the election of numerous ABC council members and Ken Sim as city mayor in October 2022, the motion to enact the platform commitment of 100 mental health nurses and 100 police officers was passed as planned (City of Vancouver, 2023b). However, an announcement was made the following February that diverged from Sim's original messaging, detailing a more complex plan that included a novel non-police de-escalation team (City of Vancouver, 2023a; Thibault, 2023). A $2.8 million grant would be provided by the CoV to VCH in support of Phase 1 of the proposed *Urgent Mental Health and Substance Use Service Enhancements Framework*

that was designed to align with the goals of both agencies and the VPD and is expected to be implemented in 2023 (City of Vancouver, 2023a). The grant is expected to increase in the following years to a potential $8 million annually as the implementation of subsequent phases of the framework continues (City of Vancouver, 2023a).

This framework initially focuses on the enhancement of response services with the addition of 58 FTE positions in a range of disciplines to support the specified programming (City of Vancouver, 2023a). 10 of those FTE positions are currently dedicated to increasing Car 87/88 capacity while the remainder will go to expanding the Assertive Outreach Team (AOT) (2 FTE) and triage support staff (2 FTE), strengthening Indigenous services across all of the framework's services (12 FTE), and the establishment of a moderate (non-police) de-escalation service (32 FTE) (City of Vancouver, 2023a). The latter program is expected to serve people who are not in a high level of mental health crisis and facilitate access to a range of appropriate supports in the community, marking a new chapter in the city's mental health response narrative (City of Vancouver, 2023a; Thibault, 2023). Nonetheless, the additional funding required for the VPD to hire 100 new officers was also approved despite the Car 87/88 expansion only requiring 10 of the new hires and with no additional officer pairings indicated with the other programs in the framework (City of Vancouver, 2023b; Steacy, 2023).

Car 87/88 has been the official mental health crisis response service in Vancouver for more than 30 years and as a cornerstone of the new framework, will expand to what generally equates to 10 additional pairings of nurses and police officers. In his campaign, Mayor Ken Sim referred to Car 87/88 as a "made-in-Vancouver approach that has been successful since 1978," but just what exactly qualifies as success in this context and how it is being measured remains vague and anecdotal (City of Vancouver, 2023b). Despite several references to being an

evidence-based program, no concrete data or actual evidence, save for its longevity, have been provided to support this claim or to support its effectiveness (ABC Vancouver, 2022; Junos, 2022; Kelsall & Beaumont, 2022).

Since becoming a hot campaign topic, Car 87/88 has generated greater scrutiny of the police-based co-response model in general and its appropriateness for addressing mental health calls; people have publicly questioned whether law enforcement should have a role in mental health response at all (Ghelani et al., 2023; Junos, 2022; Steacy, 2023). According to the VPD, less than 6% of calls attended by the unit in 2022 involved detainment under Section 28 of the Mental Health Act, a statistic that has lent credence to the questioning of police presence (Steacy, 2023). Concerns have also emphasized the VPD's ability to influence mental health policy and programming in the city, and their direction of the mental health narrative through an enforcement lens that tends to criminalize mental illness (Boyd & Kerr, 2016; Dempsey et al., 2020; Junos, 2022; Lindsay, 2022; Steacy, 2023). Nonetheless, VCH has stated that their clinicians would not respond to serious mental health crisis incidents without the presence of police, highlighting the importance of safety in response work (City of Vancouver, 2023a).

Amongst the competing concerns, interests and opinions regarding Vancouver's mental health crisis response approach, it is clear that the service could not have continued as it was and that change had been long overdue. Understanding the body of evidence that does exist about police-based mental health response models, the alternatives and subsequent implications can only serve to better shape the change that is coming for healthier outcomes for all.

Purpose Statement

The purpose of this capstone is to determine what the existing evidence says about the effectiveness of police-based mental health crisis response models, the co-response model

specifically, non-police alternatives and what the key findings are that indicate more positive outcomes. It examines the existing research regarding police-based mental health crisis response models, with particular focus on Car 87/88 and the co-response model, for evidence of their effectiveness, benefits and deficiencies, and important issues of police involvement that are relevant to Vancouver. Non-police alternatives are also explored as well as the identification of gaps in the body of research and key findings that can contribute to improving the response model in Vancouver are summarized.

Contribution to the Field

The portrayal of Car 87/88 in the political discourse of the 2022 Vancouver municipal election campaigns and framing of mental health crisis response through police-based lens revealed the general lack of awareness regarding what evidence actually exists regarding this subject and the utility of collating the findings. The research produced by this capstone is intended to provide a summary and analysis of findings from the existing body of evidence regarding police-based mental health crisis response models, with particular focus on the co-response model, including their relative effectiveness, deficiencies and what contributes to each of those factors. Recommendations for improving the co-response model, non-police alternatives and outstanding issues will also be examined.

The findings are intended to be used by administrators, elected officials and policymakers, primarily at provincial and municipal levels of government, health care and law enforcement to develop mental health crisis response services that can better meet demand and generate greater positive outcomes. They can inform discussion, policy, program planning and investment decision making regarding the growth and direction of mental health crisis response resources. Both non-police and police response workers can use this information to increase their

understanding of the system in which they operate and improve communication with their coworkers and service users. The findings can also be used to support advocacy for mental health response and resources by workers in community health and emergency services, organizations that support vulnerable populations, and family and friends of individuals with mental disorders or who experience mental health crises.

Reflexivity and Positionality Statement

My interest in this topic and approach to the research have been heavily influenced by my social location, worldview, and professional experience. I am a 42-year-old white, straight, cisgender, middle-class woman who was raised in a stable home with a supportive family and have benefited from the numerous privileges afforded to me as a result. As a member of many dominant groups, I have enjoyed the support and ability to pursue multiple post-secondary degrees, the mobility to travel and live abroad, the opportunities of many different jobs, including multiple careers, and relative financial security. These freedoms, in addition to a solid grounding in socialist principles and passion for community, fostered my constructivist socio-political views and commitment to social justice which underpins my perspective on the nature of this problem and my engagement with it.

I first became aware of Car 87/88 as a shelter support worker in Downtown Vancouver during the height of the COVID-19 pandemic. Many people who had been homeless and living in encampments in a number of Vancouver city parks had been forcibly relocated to temporary housing and shelter projects. Homelessness and the lack of an address poses challenging barriers to accessing mental health resources and many of the residents I supported were not directly engaged with support teams that could be called in the event that a particular person was in crisis. I was therefore instructed to call Car 87 in those circumstances, only to be repeatedly met

by a voicemail service and unreturned calls. It was exceptionally frustrating; I wondered why the service deemed most appropriate for the situation was so unresponsive, leaving the police as the only option but one that ran the risk of escalating the person in crisis as well as other residents. I did not understand how this inconsistent patchwork of supports served to improve people's well-being or positively addressed the mental health and overdose crises.

In late 2021, I joined VCH as an allied health worker in a downtown community health centre and gained further insight into the benefits, limitations, and obstacles to the provision of, and access to, appropriate mental health resources for people in crisis in in Vancouver. I worked alongside members of the ACT team, coordinated with Mental Health and Substance Use departments, and supported people who had a variety of experiences with Car 87/88 as a service.

I therefore come to this topic as someone who has engaged with this issue in a professional capacity, both externally as well as from within the health authority that is a partner in the service. Particular caution has been taken to mitigate the appropriation or assumption of the voice and experiences of service users and non-dominant groups, in this case those experiencing or having experienced mental health crises, by more privileged and powerful groups and have extended care to the manner in which the ideas and experiences of all relevant stakeholders have been represented. Through my capstone project, I endeavor to address some of my own personal questions regarding how the current service model might improve to better ensure that people in mental health crisis receive efficient and appropriate care.

Anecdotally, my own interactions with police in this context have been mixed. As a support worker, I have interacted with a few highly skilled and well-informed police officers who were able to de-escalate and assess situations in a manner that seemed to result in positive outcomes or productive engagement with appropriate resources for all concerned. Conversely,

and in most police interactions, uniformed officers tended to escalate situations where people would end up being arrested or escorted away with negative consequences. While it may or may not have been appropriate for them to do so, it was my observation that the former approach, or engagement with a mental health worker in lieu of a police officer altogether, was far more productive, with long-term implications such as stronger trust and relationship with systems in place, and more positive outcomes for clients.

Definition of Terms

Co-Response

A police response model in which police officers and mental health clinicians collaborate to respond to mental health crisis incidents (Seo et al., 2021a). Collaboration can manifest in multiple forms, e.g. one police officer and one clinician in-person response, mental health professionals providing remote support to onsite officers, multiple health clinicians travelling with one officer, etc. (Bailey et al., 2018). Co-response is commonly referred to in UK literature as "street triage" (Parker et al., 2018, p. 4).

Car 87/Car 88

Mobile crisis teams in the City of Vancouver that comprises a police constable and a psychiatric nurse that provides on-site assessments, interventions and referrals in response to individuals experiencing a mental health crisis and is a partnership between the Vancouver Police Department and Vancouver Coastal Health (Vancouver Police Department, 2023).

Mental Health Crisis

The presentation of severe or intense mental distress in an individual that may pose potential risk of harm to themselves or others; behaviour can range from an acute anxious or depressive state to psychosis to suicidal thoughts (Fraser Health Authority, n.d.).

Mobile Crisis Team

A type of co-response team comprising at least one mental health professional and at least one police officer that travels together to respond to dispatched calls regarding cases of mental distress or acute mental health crisis, enabling onsite qualified mental health assessment and referral (Cotton & Colman, 2010, p. 308).

Persons in Mental Health Crisis (PMHC)

A person demonstrating behaviour that is impacted by mental illness or distress and that influences the person's behaviour in a manner that prompts engagement or interface with police or emergency services (Iacobucci, 2014). Mental health is explicitly specified in this term to differentiate from persons in crisis which may not necessitate mental health response. Various terms are applied for this purpose in the literature including persons with mental illness (PMI) or (PWMI), and emotionally disturbed persons (EDP) (Bailey et al., 2018; Seo et al., 2021b; Shapiro et al., 2015). There is no differentiation in the cited works in this paper between a person with the appearance of mental illness and a person with a formally diagnosed mental disorder.

Police Response Model

Any team staffed partially or fully by police, that applies specialized training or structure, for the specific purpose of responding to mental health crisis incidents; used synonymously in this paper and in the literature with the term *police-based response*.

Service-User

A person who is a direct recipient of responder services, also referred to in the literature as a consumer (Kirst et al., 2015; Lamanna et al., 2018; Wood & Watson, 2017).

Chapter Layout

Chapter two examines the existing body of literature regarding police response models in the mental health context with particular focus on the co-response model as it reflects the Car 87/88 structure. The chapter beings with the emergence of police involvement in mental health crisis response and descriptions of the two primary police response categories: crisis intervention and co-response. This is followed by an exploration of the body of evidence regarding the effectiveness of the co-response model and the challenges identified by researchers to producing conclusive results. Consideration is given to the important issues that interact to influence co-response performance and outcomes, such as interagency collaboration, police culture and service-user input. The literature regarding non-police mental health response alternatives is also examined before summarizing the recommendations from the research on co-response models as to how effectiveness can be better determined, and implementation of the model improved.

Chapter three is a discussion that applies the learnings from the literature review to the context of Car 87/88 and Vancouver's current mental health crisis response landscape. The questions posed at the beginning of the project, such as whether or not co-response is effective and what role the police have in mental health crisis response, are answered so far as the body of evidence provides and what that means for the programs, systems and perceptions that are already in place. The chapter concludes by highlighting key areas for further investigation and consideration.

Chapter 2: Literature Review

Police as Mental Health Responders

The police have a mandate to enforce and maintain law, uphold public safety and prevent crime, and the tools at their disposal have been deigned to achieve those objectives (Dempsey et al., 2020; Police Act, 2022). Whether they are encountering a robbery or a mental health crisis, their means have historically been the same, ranging from warnings and fines to arrest, jail time and use of force (Dempsey et al., 2020; Shapiro et al., 2015). The rise in police encounters with person(s) in mental health crisis (PMHC), as deinstitutionalization progressed through the 1980s and sufficient corresponding community resources failed to materialize, saw those traditional tools and training falling short (Cotton & Coleman, 2010; Shapiro et al., 2015). Greater numbers of people with mental health concerns were being sent to jail, becoming entangled with the criminal justice system and harmed through use of force and stigmatization (Dempsey et al., 2020; Koziarski et al., 2021; Lamanna et al., 2018). In some places, arrest and charging a PMHC with a crime was perceived as the only means by which they might access relevant treatment (Semple et al., 2021; Wood & Watson, 2017). Police simply did not have the expertise to appropriately manage or assess a PMHC, nor the breadth of knowledge required to make referrals to suitable resources (Wood & Watson, 2017).

Recognition of these facts, coupled with a number of notable deaths of PMHC during police interactions, generated actions through which various trainings, programming and policy evolved to address and improve how PMHC were supported (Cotton & Coleman, 2010; Dempsey et al., 2020; Koziarski et al., 2021; Shapiro et al., 2015). Providing police with the power to detain a person who is suspected to be a danger to themselves or others under mental health legislation was thought to address these problems and was widely implemented across

North America (Dempsey et al., 2020). Enactment of this power involves police escorting the PMHC, voluntarily or involuntarily, to a hospital emergency department where they can be assessed by a physician who in turn has the power to certify them, if necessary, for specific treatment (Mental Health Act, 2023). Waiting for assessment can take many hours resulting in higher emergency room volumes while it may not have been the most appropriate option for the PMHC in the first place (Dempsey et al., 2020; Lamanna et al., 2018).

As the time and costs devoted to PMHC interactions increased, so too did police collaboration with other professionals across a range of disciplines in an effort to expand capacity (Dempsey et al., 2020; Wood & Watson, 2017). This shift toward greater cooperation with other community agencies has been supported by the trend in contemporary policing away from the traditional reactive strategy to a more proactive stance (Cotton & Coleman, 2010; Dempsey et al., 2020; Wood & Watson, 2017). New approaches, chiefly in the form of response models, emerged to enable first responders to anticipate and more appropriately meet the needs of service users (Koziraski et al., 2021).

Police Response Models

A variety of police response models have arisen to address incidents involving PMHC and whilst they may have their own acronyms and particular make-up, most fall within two broad categories: crisis intervention and co-response (Parker et al., 2018; Seo et al., 2021b). There is some overlap in their methods, numerous co-response teams employ training from the most popular crisis intervention model, and both share many of the same goals, such as reducing arrest rates, diverting PMHC away from jail and facilitating access to resources however their approaches can be quite different (Bailey et al., 2022; Shapiro et al., 2015). Yet, it is critical to

examine both categories when endeavouring to understand the effectiveness of one, as research findings for either can inform on directions for improvement and growth.

Crisis Intervention Models

By far the most common and well-established police-based crisis intervention model is the crisis intervention team (CIT), a form of pre-arrest diversion, which was one of the earliest police response models to be developed in the late 1980's following a police incident involving the death of a PMHC in Memphis, Tennessee (Boazak et al., 2020; Parker et al., 2018; Seo et al., 2021b). An extensive training program was subsequently designed to equip officers with the skills and knowledge to better understand, manage and assess interactions with PMHC and facilitate engagement with mental health and medical resources through consultation with the respective practitioners, (Seo et al., 2021b; Parker et al., 2018; Bailey et al., 2022). CIT units consist of specially-trained uniformed officers with practiced skills and knowledge of relevant resources and how to access them that enable the determination of an appropriate course of action for a PMHC (Dempsey et al., 2020; Seo et al., 2021b).

The CIT has become the most common model type in the US while the training is considered to be the standard for police working with PMHC, both within and outside of North America (Boazak et al., 2020; Dempsey et al., 2020; Seo et al., 2021b). It has been widely adopted both in its full form as well as forming the foundation for customized training; the VPD has modelled its own mental health training on the CIT program (Dempsey et al., 2020; Koziarski et al., 2021). Variations of the CIT model often include shorter versions of the training, such as reduced hours or a more locally applicable focus and are commonly deployed in smaller or more rural locations where larger programs are either not required or unable to be sufficiently resourced (Seo et al., 2021b).

Official training consists of about 40 hours and includes treatment facility and resource site visits, role-play, collaboration with practitioners and service providers, interactions with PMHC, and education in recognizing behaviours and other indicators of mental health disorders (Dempsey et al., 2020). Nonetheless, despite the enormous popularity of the training, adoption of the CIT response model itself has been relatively limited outside of the US (Koziarski et al., 2021).

Research evaluating CITs has found that implementation of the model can lead to increased engagement in mental health programming for service users although this may be contingent on access to, and the extent and quality of, available resources (Bailey et al., 2022). CIT officers tended to perceive improvements of their own knowledge, skills and comfort in handling incidents with PMHC (Marcus & Stergiopoulos, 2022; Seo et al., 2021b). Officers also reported enhancement of collaborative relationships between police, health care and justice agencies (Marcus & Stergiopoulos, 2022). Yet both systematic and rapid reviews of the literature determined that there were measurable, albeit small, impacts of the model on elements such as arrest rates, injuries and applied force, and little to no effect on general outcomes regarding the mental health crises (Marcus & Stergiopoulos, 2022; Seo et al., 2021b).

The CIT model may dominate in the US but beyond its borders, more collaborative models are preferred with that of co-response reining supreme, particularly in Canada (Koziarski et al., 2021; Puntis et al., 2018; Shapiro et al., 2015). Explanations for this preference refer to the significantly lower concerns and incident rates involving firearms outside of the US, as well as the lower rate of deaths of PMHC during police incidents in Canada, leading to greater acceptability of involvement from non-enforcement agencies in mental health response interactions (Cotton & Coleman, 2010; Koziarski et al., 2021). Thus, while CIT training

continues to be considered "Best Practice" and globally popular in educating and preparing mental health response teams (Wood & Watson, 2017, p.6), the execution of the team is more commonly to follow a co-response model.

The Co-Response Model

The co-response model is cooperative by nature, typically featuring a plain-clothed police officer and a mental health clinician responding together and managing mental health incidents on-site (Marcus & Stergiopoulos, 2022; Seo et al., 2021b). This team is designed to mitigate escalation during a mental health crisis, free up uniformed officers for law enforcement duties, and divert PMHC away from the justice system and emergency rooms by providing them with a greater range of options to support their mental welfare (Shapiro et al., 2015). The police officer has typically undergone CIT training, or a relatively equivalent program, while the attending clinician, often a psychiatric nurse, brings skills and expertise that can directly address the mental health needs of a PMHC (Ghelani, et al., 2023; Puntis et al., 2018). In contrast to a police-only team, co-responders offer assessments, referrals, medication support and access to resources (Lamanna et al., 2018; Shapiro et al., 2015).

Considerable variation exists between teams under the co-response umbrella due to the specific needs and resources of a given location and population (Ghelani et al., 2023; Seo et al., 2021a). Most teams are considered secondary response units, attending calls dispatched only after uniformed officers have already assessed a situation for risk, such as the mobile crisis intervention teams (MCIT) in Toronto and the mobile crisis assistance team (MCAT) in Minneapolis (Ghelani et al., 2023; Kirst et al., 2015). Some units however do provide primary response, contacted directly by the public or police and dispatched directly to an incident, such as Vancouver's Car 87/88 and some types of "street triage", as they are called in the United

Kingdom (Ghelani et al., 2023; Puntis et al., 2018). Some units are based out of a single location while others have multiple teams working out of numerous sites, such as the MCIT in Toronto (Lamanna et al., 2018).

The number of teams and operating hours have been found to vary widely across the teams examined in the literature, with none in Canada operating on a 24-hour schedule and only one informal 24-hour on-call unit (Ghelani et al., 2023; Koziarski et al., 2021). While most programs have set hours of operation, some are fluid or operate as-needed (Koziarski et al., 2021). British co-response teams that operated less frequently demonstrated greater variety in their operating hours, with only two phone-based services responding on a 24-hour basis (Puntis et al., 2018).

Teams can also vary in the types of clinicians and number of agencies involved. The MCAT as well as the Police, Ambulance, Clinician Early Response (PACER) teams in Australia are examples of models consisting of more than two professionals, including paramedics and a behavioural health clinician in the team instead of a nurse (Bailey et al., 2018; Heffernan et al., 2021). Others include a social worker as the primary clinician (Ghelani et al., 2023). It is also not uncommon for American and UK co-response units to feature remote clinicians, reached by phone, in place of on-scene attendance (Horspool et al., 2016; Seo et al., 2021a).

Co-response is the leading police response model outside of the US, although teams can be found in numerous American cities, and is the predominate model in Canada, the United Kingdom (UK) and Australia (Bailey et al., 2018; Koziarski et al., 2021; Puntis et al., 2018; Shapiro et al., 2015). Within Canada, various formal and informal arrangements exist throughout the country, with both RCMP and local law enforcement, and officially designated co-response teams feature in Toronto, Halifax, Peel, Windsor, St. John's, Sherbrook, Hamilton, Regina,

Saskatoon, Victoria and, with the first co-response unit in the country, Vancouver (Ghelani et al., 2023; Koziarski et al., 2021; Northcott, 2020).

Despite Car 87/88 having operated in Vancouver for over 30 years, and Toronto's MCIT for over 20, the bulk of research regarding police response models, and co-response in particular, emerged within the last 10 years (Ghelani et al., 2023; Lamanna et al., 2018; Parker et al., 2018). The longevity of the programs has long been touted as justification for implementing the model in other cities and regions notwithstanding a dearth of evidence supporting its efficacy (Ferris et al., 2001; Ghelani et al., 2023). Nonetheless, police spending, scope of powers and use of force have come under greater scrutiny over the last several years with the *defund the police* campaign, prompted by Black Lives Matters movement and other cases of excessive use of force involving BIPOC, that seeks to divert funding for enforcement into the broader community and social supports (Ghelani et al., 2023; Koziarski et al., 2021). The treatment of vulnerable and marginalized peoples by the police has become more contentious, with the public and municipalities demanding stronger evidence and demonstrable results to justify police strategies and funding (Koziarski et al., 2021; Shapiro et al., 2015). Subsequently, literature exploring how effective the co-response has been at meeting its objectives has experienced a surge over the past 5 years, generating some productive findings.

Evaluation of the Co-response Model

Effectiveness

Police-based response models were found to share many of the same goals, those overarching being the increasing of police efficiency by responding to mental health incidents with sufficient knowledge and skills to result in the redirection of PMHC away from jail and toward appropriate mental health resources and programming (Bailey et al., 2022). More

granular goals included reduced arrest rates, aversion from the justice system, reduced crisis escalation & injuries, cost-effectiveness, reduced hospital admissions, and reduced health care assessment and handover time (Bailey et al., 2018; Lamanna et al., 2018; Kirst et al., 2015; Shapiro et al., 2015; Koziarski et al., 2021; Marcus & Stergiopoulos, 2022). In addition, co-response in particular tended to include the quality of officer training, PMHC crisis outcomes and wellness, interagency relationships and mental health resourcing, availability and access in the community as part of program objectives (Koziarski et al., 2021).

Co-response teams demonstrated greater performance on numerous factors compared to police-only teams, including both CIT and teams with no specialized training (Marcus & Stergiopoulos, 2022; Seo et al., 2021b). Several studies identified lower arrest rates and shorter interaction times on-site, and potentially reduced injury rates although results on this are generally mixed, compared to those of uniformed officers (Kisely et al., 2010; Lamanna et al., 2018; Marcus & Stergiopoulos, 2022; Puntis et al., 2018; Shapiro et al., 2015). One meta-analysis found that co-response teams had longer on-site interaction times when compared to other police response models however this could have been due to on-site assessments and facilitation of engagement with other appropriate resources in lieu of detainment and hospital visits (Seo et al., 2021b).

A study out of Indianapolis indicated that co-response could result in the reduction of initial arrests for PMHC yet those same service-users were found to engage more frequently with first responders over the longer-term (Bailey et al., 2022). Frequent repeat service-use of co-response teams was reported in multiple other studies (Lamanna et al., 2018; Puntis et al., 2018). Bailey et al. (2022) posited that this may have been an effect of co-responders frequenting particular areas that exhibited higher demand, a form of selection bias, or that contacting

emergency services was understood by service-users to be the gateway to support. The same study also identified that arrest rates by co-response teams of Black service-users were lower in comparison to police-only units and that interactions with co-response may result in lower re-incarceration rates of that demographic (Bailey et al., 2022).

Law enforcement officers that participated in surveys regarding police response models reported positive enhancements of their own perceptions toward PMHC and mental health incidents (Seo et al., 2021b). Nonetheless, a review by Shapiro et al. (2015) found that numerous police officers did not believe that the co-response model had a material impact on statistics such as time onsite or number of arrests. In a qualitative study of street triage in the UK, a greater number of interviewed mental health professionals than police respondents considered the program to be of benefit to service users (Horspool et al., 2016). Notwithstanding, co-response was generally considered to enable more joint decision-making, thereby reducing inappropriate use of mental health legislation, greater interagency understanding and sharing of information (Horspool et al., 2016).

Detention for sectioning under mental health legal mechanisms was consistently demonstrated to be significantly less frequent for co-response teams although the difference in rates varied (Marcus & Stergiopoulos, 2022; Seo et al., 2021b; Shapiro et al., 2015). Results also reported fewer involuntary escorts to the hospital, indicating greater cooperation of service-users to be transported for further evaluation or treatment (Dempsey et al., 2020; Ghelani et al., 2023; Puntis et al., 2018). Shorter assessment times by, and more rapid handovers to, hospital staff were reported when co-response teams were involved, possibly due to earlier assessment in the field completed by mobile clinicians (Ghelani et al., 2023; Shapiro et al., 2015).

Early research emphasized that findings regarding hospital admissions, whether they were lower with co-response teams, were conflicting although later research demonstrated notable reductions in both hospital visits and admissions when compared to police-only teams (Dempsey et al., 2020; Lamanna et al., 2018; Marcus & Stergiopoulos, 2022; Shapiro et al., 2015). Various explanations for the previous conflicting findings referred to the dispatching of some co-response teams specifically for the accompaniment of people to hospital for involuntary sectioning, the proficiency of co-response clinicians to more appropriately assess when a person is in need of hospital admission, or that uniformed police may request co-response teams to avoid time spent in the emergency room when a hospital visit is suspected (Lamanna et al., 2018).

Studies that examined public and service-user experiences found that the co-response model was generally viewed favourably by service-users and their families (Kirst, 2015; Marcus & Stergiopoulos, 2022; Shapiro et al., 2015). The inclusion of mental health clinicians in response teams has shown improved outcomes for PMHC (Koziarski et al., 2021; Dempsey et al., 2020; Marcus & Stergiopoulos, 2022). Furthermore, clinicians appeared to enhance consumer perceptions of the interactions and were appreciated for their specific knowledge, expertise and skills such as de-escalation, as well as their treatment of service-users with dignity, respect and recognition of their agency (Kirst et al., 2015; Lamanna et al., 2018; Marcus & Stergiopoulos, 2022). In contrast with police-only interactions, consumers reported not feeling criminalized by the co-response teams, instead feeling empowered and heard (Lamanna et al., 2018). Findings also indicated that co-response teams had the potential to facilitate more preferable outcomes for service-users by making more appropriate treatment referrals and one study showed improved participation in treatment (Dempsey et al., 2020; Kisely et al., 2010).

The co-response model has indeed been shown to achieve improvements in a number of factors and outcomes integral to mental health crisis response. Seo et al. (2021) stated that police-response models were a "moderately effective" approach for managing encounters with PMHC but that results were highly variable per model applied (p. 12). However, the ultimate question of whether or not the co-response model is effective, particularly in increasing the efficiency of mental health crisis response and redirecting PMHC toward appropriate mental health treatment and resources over uniformed officers, could not be resolved with the results generated to date (Bailey et al., 2022; Ghelani et al., 2023; Marcus & Stergiopoulos, 2022; Parker et al., 2018; Puntis et al., 2018). Evidence of the specific elements and optimal conditions that combine to produce effective mobile crisis response was still insufficient although the body of research has identified the challenges to adequately addressing this problem (Ghelani et al., 2023; Marcus & Stergiopoulos, 2022; Shapiro et al., 2015).

The Problem of Effectiveness

Ferris et al. (2001) were among the earliest researchers to highlight the problem of determining effectiveness of mobile crisis psychiatric teams, emphasising the substantial body of case studies and deficit in analyses of outcomes that could be applicable on a larger scale. Program decisions at that time were therefore relying on largely anecdotal rather than empirical evidence, thus necessitating methods for assessing efficacy and the research to test them going forward (Ferris et al., 2001). Substantial progress, and research, has certainly been achieved in the over-20 years since the Ferris et al. publication (2001).

The second wave of studies and meta-analyses that arose in 2018, informed by the larger body of research than what was available in 2001, attempted to navigate these issues to produce

more robust results yet despite generating substantially more material, the one consistent finding across all of the co-response literature was the need for more specific research to generate a larger evidence base that could facilitate more robust and applicable effectiveness findings (Bailey et al., 2022; Cotton & Coleman, 2010; Ghelani et al., 2023; Kirst et al., 2015; Kisely et al., 2010; Koziarski et al., 2021; Lamanna et al., 2018; Lancaster, 2016; Marcus & Stergiopoulos, 2022; Parker et al., 2018; Puntis et al., 2018; Seo et al., 2021b; Shapiro et al., 2015). At the heart of this problem is the complex nature of the co-response model itself which has many moving parts, competing interests and high variability.

Co-response may be a common model but the variations in model application and lack of standardization have added further difficulty to making comparisons and generalizing findings (Ghelani et al., 2023; Kisely et al., 2010; Koziarsky et al., 2021; Parker et al., 2018; Puntis et al., 2018; Seo et al., 2021a). While co-response was correlated with improvements in some key metrics, such as arrest rates or involuntary hospitalizations, results were often mixed and isolating the particular influencing factors such as policy, service or program changes were not possible and limited to speculation (Lamanna et al., 2018; Parker et al., 2018; Puntis et al., 2018; Marcus & Stergiopoulos, 2022; Seo et al., 2021a). Seo et al. (2021a) found that contextual factors were salient in conducting effectiveness analysis as the size of effect varied by country and several studies emphasized that differences in sample size made comparison difficult (Puntis et al., 2018; Seo et al., 2021a).

Consistency and Access to Data

Research using objective statistical measures to determine effectiveness of response models was found to be lacking, especially outside of the US, including typical policing metrics as well as demographic and subjective data regarding service users and sociopolitical context

(Seo et al., 2021a). This reflected a second common finding across the literature: lack of consistent, complete data of sufficient quality (Bailey et al., 2022; Kisely et al., 2010; Lamanna et al., 2018; Puntis et al., 2018; Seo et al., 2021a). The general lack of individual and comparative data, and lack of randomized control trials further limited analysis of effectiveness despite relatively widespread implementation of both CIT and co-response models (Lamanna, et al., 2018; Puntis et al., 2018; Parker et al.; 2018).

Access to the data required to sufficiently inform research is granted by the gatekeepers, in this case law enforcement agencies and health authorities, that have discretion over what data they collect, how it is collected and whether or not it will be shared. Obtaining police and health data tended to be problematic and where a data set was available from one program, it was often lacking for another making accurate comparisons impossible (Bailey et al., 2018; Ghelani et al., 2023; Kisely et al., 2010; Lamanna et al. 2018; Puntis et al., 2018). Use of force and injury statistics were consistently reported to be unavailable, if collected at all, as were data for mental health referrals and treatment follow-through (Bailey et al., 2018; Ghelani et al., 2023; Kisely, 2010; Lamanna et al., 2018).

Findings from a study examining police calls involving mental health by Koziarski et al. (2022) suggested that data collection methods could be updated to better capture social issues as well as crime. Despite being disproportionately affected by police action, data regarding interactions with BIPOC and LGBTQ2SIA segments were lacking to non-existent (Bailey et al., 2018; Ghelani et al., 2023). Data collected on co-response teams was regularly reported to have been more consistently available than police-only data (Ghelani et al., 2023; Lamanna et al., 2018; Marcus & Stergiopoulos, 2022).

Service Variability

The variability in the models and how they operated, such as structural differences between services, customized service design for location, knowledge and capacity for service referral, and adequate staffing and scheduling, posed further complication in comparing data (Ghelani et al., 2023; Horspool et al., 2016; Koziarski et al., 2021; Lamanna et al., 2018; Marcus & Stergiopoulos, 2022; Shapiro et al., 2015). Programs differed in the scope of their core offerings, such as intensive servicing of particular high-demand areas, relationship building in the community, continued engagement with service-users or facilitation to various resources (Shapiro et al., 2015).

The differences in operating hours, staffing, area of jurisdiction and team capacities also demonstrated the relationship between co-response program resourcing, response times and their ability to meet call demand (Kirst et al., 2015; Koziarski et al., 2021; Lamanna et al., 2018). Response times for co-response teams varied and have typically been longer than uniformed officer response, potentially impacting on outcomes as the competencies of those first on the scene can significantly influence what follows, potentially shaping outcomes and convoluting findings (Koziarski et al., 2021; Lamanna et al., 2018; Marcus & Stergiopoulos, 2022; Seo et al., 2021b).

The majority of programs were secondary responders, but some were also primary and included in the same samples, limiting the generalization of findings (Ghelani et al., 2023; Koziarski et al., 2021; Lamanna et al., 2018; Marcus & Stergiopoulos, 2022). While potential relationships were demonstrated between outcomes for de-escalation, arrest, injury and use-of-force, and the skills and approach of responders, specific causal factors were not able to be

isolated and may subsequently affect additional outcomes, such as hospital visits, justice system and treatment engagement (Lamanna et al., 2018; Marcus & Stergiopoulos, 2022).

Furthermore, when units were operating during designated hours but already engaged and not able to respond to additional calls, uniformed officers were required to follow through to completion or respond instead (Koziarski et al., 2021; Kirst et al., 2015). Limited operating hours also resulted in traditional police having to respond to calls that were more appropriate to the co-response teams that occurred at times outside of the scheduled hours (Koziarski et al., 2021).

Understanding the historical limitations of the data and the variability of key features can help tailor future research to produce more consistent and specific findings while potentially facilitating the identification of causal relationships. It can also inform agencies regarding which aspects of programming to standardize and what data could be the most useful to track and collect, in order to enhance effectiveness of program design and execution (Shapiro et al., 2015). Integrating evidence-based learning into policy and program development is critical to improving the effectiveness and efficiency of co-response models and as this model is a mechanism of multiple components within the social services systems, uptake of evidence by other parts of the system are critical to valuable change (Cotton & Coleman, 2010; Shapiro et al., 2015). Furthermore, understanding how the mechanism in question is impacted by influential components within that system, and how they interact with each other, is critical to improving its functioning (Cotton & Coleman, 2010). Researchers have highlighted interagency collaboration, police perspectives and culture, and service-user experience as the important components and interactions to productive co-response implementation.

Critical Co-response Interactive Components

Interagency collaboration

A consistent viewpoint among interviewed stakeholders held that agencies worked better together when explicit communication protocols were established and awareness of roles and responsibilities among participating organizations were clear although more often than not, these elements were a work in progress (Bailey et al., 2018; Kirst et al., 2015; McKenna et al., 2015; Parker et al., 2018). There was minimal inclusion in the co-response research of corresponding yet relevant agencies, such as those involved in emergency care or substance use services, however, lack of knowledge by hospital, treatment centre and other social services program staff about the service was common and identified as a hinderance to service reach (Bailey et al., 2018; Kirst et al., 2015; McKenna et al., 2015; Parker et al., 2018; Shapiro et al., 2015). Recommendations to address these issues included stronger education and publicity to both external agencies and the public as well as relationship building by co-response teams with the organizations with which they most frequently interacted (Ghelani, 2022; Kirst et al., 2015).

Information and perspective sharing were identified as substantial facilitators to successful implementation, as was the sufficient provision of mental health program and service options to which PMHC could be referred by the team (Bailey et al., 2018). Additional barriers included the competing financial and staffing needs of policing and mental health services, and the shifting of strain that occurs with creating new teams and increasing referrals when capacity does not correspondingly increase (Horspool et al., 2016; Kirst et al., 2015; Koziarski et al., 2021). While the breadth and nature of community mental health services were also typically beyond the scope of reviewed research, the importance of adequate and accessible treatment and community resources to which co-response staff could make referrals and with which service-

users could follow-up was consistently emphasized (Bailey et al., 2018; Horspool et al., 2016; Kirst et al., 2015; Koziarski et al., 2021; Shapiro et al., 2015).

The most commonly discussed relationship in the co-response literature reflected the typical representation of professionals in the partnership: law enforcement and mental health agencies (Kirst et al., 2015; Parker et al., 2018; Shapiro et al., 2015). This pairing was frequently cited as a critical element to achieving greater treatment and resource-oriented outcomes instead of arrests and unnecessary hospitalizations as well as creating positive service-user experiences (Kirst et al., 2015; Koziarski et al., 2021; Parker et al., 2018; Shapiro et al., 2015). A prevalent perception was that expertise from both disciplines combined to best serve the needs of service-users while officers gained experience and knowledge about PMHC and appropriate management of mental health incidents (Kirst et al., 2015; McKenna et al., 2015).

Yet there was an identified lack of evidence regarding what makes for effective collaboration and a common issue was lack of clarity regarding roles and responsibilities within the team (Bailey et al., 2018; Kirst et al., 2015; Parker et al., 2018; Shapiro et al., 2015). Some challenges were attributed to conflicting objectives between the professions, for example health and well-being versus enforcement of law and order, resulting to differences in approach during an incident, such as assertion of control over a situation or service-user (Kirst et al., 2015; Lamanna et al., 2018; McKenna et al., 2015).

Clear procedures, strong communication and shared responsibility for decisions were considered key to improving collaboration within the team as well as clear understanding of the mandate and functions of the program itself (Kirst et al., 2015; McKenna et al., 2015). Shapiro et al. (2015) suggested the fostering of a sense of partnership versus ownership of a co-response program to relieve tensions (p. 617). Interdisciplinary training to educate staff about each other's

roles, program aims and mechanisms was also recommended in the findings (Bailey et al., 2018; Kirst et al., 2015).

Nonetheless, differences in professional culture were emphasized as a significant factor with both police and clinicians feeling excluded from both their own and their colleague's discipline, police officers in particular experiencing substantial stigma from within their own stations for taking on mental health-oriented roles (Bailey et al., 2018; Kirst et al., 2015; Shapiro et al., 2015). While official communications and support from the system agencies to normalize unconventional roles and skills were identified as actions that could reduce or mitigate such barriers, the issue appears to be primarily rooted in attitudes toward mental health historically embedded within policing culture (Bailey et al., 2018; Wood & Watson, 2017).

Police Culture

Prevalent police attitudes toward PMHC interactions have been shaped by the ways in which the gap in mental health services created by deinstitutionalization have added complexity, responsibility and new demands to their traditional roles (Wood & Watson, 2017). Mental health work was not considered legitimate police work which included more keeping of the peace and problem solving with force, negotiation or arrest used to regain control over challenging situations (Wood & Watson, 2017). Officers quickly went from maintaining public order and safety to being considered "de facto mental health providers" as mental health crisis incidents substantially increased through the 1970s and 80s (Wood & Watson, 2017; Cotton & Coleman, 2008, p. 2). Arresting those with seemingly unmanageable behaviours due to mental illness could conclude an incident, satisfy the public and reduce potential risk of harm in one swift action (Dempsey et al., 2020; Wood & Watson, 2017).

As systems moved to address this shift by adjusting laws, creating service agreements and constructing new models of mental health crisis response, police were expected to collaborate and share responsibility in new ways that also changed how they were expected to interact with PMHC (Cotton & Coleman, 2010; Wood & Watson, 2017). This transition has demanded that police release the customary adversarial position toward people they interact with and embrace a more protective stance, a repositioning that essentially expands the police remit and who they should be protecting (Wood & Watson, 2017). It has also required officers to reframe their perceptions of mental illness and people with mental health conditions beyond the limitations of social stigma (Ghelani et al., 2023; Wood & Watson, 2017).

Mental illness has been, and continues to be stigmatized, perceived as an indication of moral deficit, deviance or unworthiness (Jauch et al., 2023; Lane, 2019). As mental illness is also correlated with criminalized circumstances such as homelessness and substance misuse, these socially unacceptable stereotypes perpetuate the criminalization of mental illness (Boyd & Kerr, 2016; Jauch et al., 2023). While PMHC represent a small proportion of overall incidents, they have been shown to require more police time and resources than calls with no obvious mental health element and behaviours caused by mental health conditions can be misinterpreted by police without mental health expertise as resistant or hostile (Charette et al., 2014; Lamanna et al., 2018). This can perpetuate the belief that PMHC are dangerous or higher risk, potentially justifying stronger application of force and contributing to the disproportionately high population of people with mental health conditions being incarcerated or engaged with the criminal justice system (Dempsey et al., 2020; Lamanna et al., 2018; Lane, 2019).

Officers who have undergone CIT training for co-response teams have shown positive changes in their perspectives toward PMHC yet mental health stigma persists within law

enforcement, impacting both service-users and the officers that work with them (Bailey et al., 2018; Boyd & Kerr, 2016; Lane, 2019). Police who joined mental health teams have reported being treated as pseudo-police, made to feel that their work was less legitimate than traditional policing or not wearing the uniform was showing disloyalty to the badge (Bailey et al., 2018; Lane, 2019). While issues embedded in a professional culture are complex, extend into wider society and can be slow to adjust, researchers asserted that legitimization of mental health roles and clarification of mandates by law enforcement administration, indeed of all the organizations involved in the respective programs, would be critical to facilitating organizational change (Bailey et al., 2018; Lane, 2019). Messaging and education that normalizes the guardian role and mental health response as an integral part of contemporary police work would be expected to benefit not only the officers working on co-response teams but the staff they interact with and the service-users themselves.

Voice of the Service User

Despite the body of literature including some qualitative studies that incorporated service-user feedback, the voice of the service-user in the macro discussion of co-response effectiveness was considered by researchers to be relatively small (Marcus & Stergiopoulos, 2022). The information that was collected was minimal, tending to reflect service-user experiences of interacting with police-based and co-response teams, and what they felt was or was not working for them in relation to the treatment they received from co-response staff (Kirst et al., 2015; Kisely et al., 2010; Lamanna, et al., 2018; Mckenna et al., 2015; Shapiro et al., 2015).

Overall, feedback indicated a preference for co-response teams over police-only units, citing superior de-escalation, listening and assessment skills, stronger expertise regarding the

service-users' mental health needs and a decriminalized approach when mental health clinicians were part of the team (Kirst et al., 2015; Lamanna et al., 2018; Marcus & Stergiopoulos, 2022). Public respondents were generally positive about their interactions with co-response staff and expressed beliefs that their engagement with the team led to more optimal outcomes than with police only (Ghelani et al., 2023; Kirst, et al., 2015; Kisely et al., 2010; Lamanna et al., 2018; Semple et al., 2021). Conversely, the presence of police in uniform, unnecessary use of handcuffs and misinterpretation of mental health behaviours as hostile were elements referenced by service-users that contributed to escalation and feelings of criminalization, emphasizing the importance of plain-clothed officers and a decriminalized, person-centered approach (Lamanna et al., 2018; Lane, 2019; McKenna et al., 2015).

Understanding a consumer's experience is typically critical to improving the service they are receiving yet input regarding the impact of the co-response model on criminalization and the needs of service-users in crisis, from their own perspective, have been sparse (Heffernan et al., 2021; Lamanna et al., 2018; Marcus & Stergiopoulos, 2022). One study that highlighted the needs of service-users with psychosis during a mental health crisis illustrated how outcomes can be influenced by how needs are met during an interaction (Farrelly et al., 2014). For example, a sense of agency was reported to be important to respondents and when hospital admission was recommended, most chose voluntary compliance to preserve a sense of control (Farrelly et al., 2014). Comprehensive research concentrated on service-user experience, specifically in the context of co-response, could be used to inform program design and responder training to better meet the needs of PMHC and their preferred outcomes (Ghelani et al., 2023; Kirst et al., 2015; Marcus & Stergiopoulos, 2022; Parker et al., 2018). It could also amplify the voices of groups

who are traditionally marginalized and excluded from official systems and activities (Boyd & Kerr, 2016).

Qualitative feedback suggested that service-users were pleased with the range and depth of resource knowledge and referral options presented by co-response clinicians although there has been little to no statistical reporting to specify and quantify this information (Bailey et al., 2018; Kirst et al., 2015; Kisely et al., 2010; Lamanna et al., 2018). The body of evidence has been lacking in quantitative data that can support more generalizable results (Ghelani et al., 2023; Kisely et al., 2010; Parker et al., 2018; Punits et al., 2018). Data related to referrals, recovery, engagement with treatment, outpatient and follow-up services were cited as of particular interest and service-user experience of these resources may provide insight into their efficacy (Bailey et al., 2018; Bailey et al., 2022; Ghelani et al., 2023; Kisely et al., 2010). Obtaining complete health data was found to be challenging due to confidentiality and consent issues while administrative data can be subject to human error (Kisely et al., 2010; Semple et al., 2021). Considering that a significant component of effectiveness for co-response models is contingent on service-user outcomes, the lack of data and input from this segment exposes a substantial deficit.

Non-Police Models and Approaches

Police-based models have dominated mental health crisis response in North America and many Western countries, yet a plethora of non-police models exist, albeit with little evidence to verify their efficacy (Marcus & Stergiopoulos, 2022). Non-police crisis response models have typically been small-scale endeavours, developed by the community to meet their specific needs with limited resources (Marcus & Stergiopoulos, 2022). Types of non-police models have included community civilian mobile crisis teams, units comprised of medical responders, mobile

teams for youth in crisis, home-based crisis resolution, and crisis telephone lines (Dempsey et al., 2020; Marcus & Stergiopoulos, 2022). Some civilian mobile teams also provide other social service support such as food and shelter resources for the homeless (Dempsey et al., 2020).

Mobile teams have been known to be either primary or secondary responders, depending on the nature of the call and often work with emergency services in the area to divert calls of lower risk away from police (Dempsey et al., 2020; Marcus & Stergiopoulos, 2022). In their review of non-police initiatives, Marcus & Stergiopoulos (2022) found that these models did request police back-up with varied frequency, which was potentially due to triaging of calls, how they were dispatched and by whom.

Furthermore, the review revealed general satisfaction by service-users of non-police crisis response services with particular emphasis on home-based crisis resolution and its responsiveness to cultural and family needs, and the support and choice offered by mobile teams (Marcus & Stergiopoulos, 2022). Overall results regarding diversion from Emergency Departments were mixed with some indication that non-police models decreased the number of admissions to hospital (Marcus & Stergiopoulos, 2022).

Non-police mental health crisis response models are vastly underrepresented in the literature and are in need of more in-depth research, particularly in comparison with outcomes from police-based models (Ghelani et al., 2023; Kirst et al., 2015; Marcus & Stergiopoulos, 2022). In fact, researchers and interviewed stakeholders of police-based studies suggested that non-police models were an important component of an effective crisis response system and recommended further study, development and assessment (Ghelani et al., 2023; Kirst et al., 2015; Marcus & Stergiopoulos, 2022).

Summary of Recommendations

Literature exploring the mental health crisis co-response model and its effectiveness has expanded the evidence base in recent years, generating results that indicate that it does achieve at least some of the intended goals of aspects of the program, despite insufficient findings regarding its efficacy in meeting the primary goals of increasing efficiency of police costs and time, reducing criminalization of PMHC and providing appropriate referral and treatment options to support their mental welfare (Bailey et al., 2022; Ghelani et al., 2023; Marcus & Stergiopoulos, 2022; Parker et al., 2018; Puntis et al., 2018; Seo et al., 2021b). In reporting on the current state of evidence, researchers have generated recommendations for how program implementation and performance might be improved.

Shapiro et al. (2015) identified what they suggested were two critical components, or mechanisms, that underpinned the successful achievement of two of the co-response model's objectives: diversion of PMHC away from the criminal justice system by reducing arrests and diversion from hospitalization by facilitating engagement with community health and social services. Reducing arrests would be supported by a combination of strengthening police training, relationships between health sector colleagues and organizational support, bolstering awareness about the mental health, the co-response program and appropriate circumstances in which to leverage its services (Shapiro et al., 2015). Diverting PMHC away from hospitals to health and social supports would be facilitated by enhancing collaborative relationships between police and mental health clinicians that foster linkages and awareness of the program among community agencies, enabling easier access to referred treatment and support services (Shapiro et al., 2015).

Shapiro et al.'s (2015) conceptualization illustrated the systemic nature of the co-response model, its complex linkages and multiple components that both influence and

complicate change. In addition to Shapiro et al. (2015), several authors emphasized the value of the co-response model as one part of a larger supportive system of health and social supports for mental health that would include community-based and civilian initiatives (Ghelani et al., 2023; Kirst et al., 2015; Lamanna et al., 2018; Marcus & Stergiopoulos, 2022).

Recommendations for implementation included standardization of co-response program features and staff training (Shapiro et al., 2015; Seo et al., 2021b). More comprehensive training was also suggested to include the scope of work for the team and individual roles, responsibilities, priorities, enhanced mental health education and skills practice, both for co-response staff and for the wider police force although the extent of training for officers that are not part of mental health teams was undetermined (Ghelani et al., 2023; Kirst et al., 2015; Seo et al., 2021b; Shapiro et al., 2015). Greater training and organizational support for stronger collaborative relationships were considered to potentially facilitate better cross-disciplinary understanding and appreciation for each other's professional cultures, enabling smoother working relationships and service delivery (Ghelani et al., 2023; Kirst et al., 2015; Lamanna et al., 2018; McKenna et al., 2015).

Recommendations for research development included more comparative before-and-after studies capturing problematic attitudes toward PMHC and interdisciplinary cooperation, and direct comparisons of outcomes between primary and secondary co-response teams (Bailey et al., 2018; Koziarski et al., 2021; Marcus & Stergiopoulos, 2022). More definitive evidence regarding use-of-force and rates of injury between co-response and police-only teams is critical to addressing claims that co-response reduces criminalization and harm of PMHC, used to justify investment in co-response programming (Ghelani et al., 2023). Ultimately, the evidence base for such claims is currently insufficient and efforts persist in generating stronger findings that can be

generalized, applied and tested to the benefit of PMHC and the systems and communities that support them.

Chapter 3: Discussion and Application

Car 87/88: Effective or Not?

A primary objective of this capstone project was to discover what the literature reported regarding the effectiveness of the co-response model against the backdrop of Car 87/88 having been described as "successful" in support of a recent significant boost in investment in both the program and the Vancouver Police Department (VPD) (City of Vancouver, 2023b). The common finding across the reviewed literature was a lack of consistent and comparable statistical data relevant to determining effectiveness of the models, making it difficult to justify the application of any particular model over another, with the exception that an organized police-response model of some kind may be more effective than not having one at all (Seo et al., 2021b). Too much variation in how the model has been applied in different locations and insufficient data have generally prevented most findings from being applicable at a larger scale.

Effectiveness in this case refers to the achievement of a number of objectives, i.e. increased police efficiencies, more appropriate meeting of service-user needs and improved referral outcomes, each of which are contingent on numerous factors that must work as a whole. There were very few controlled studies and complexity of the systems within which a co-response model operates in the real world made it difficult for researchers to isolate variables and subsequently causal relationships (Lamanna et al., 2018; Marcus & Stergiopoulos, 2022). Although there was evidence that the co-response model influenced certain metrics more positively than police-only teams, such as arrest rates, interaction times and numbers of involuntary escorts to hospital, these are smaller components that contribute to the larger goals and more research is needed to complete the picture. Ultimately, the effectiveness of the co-response model, the basis for Car 87/88, has not yet been proven.

Regarding the effectiveness of Car 87/88 itself, as a stand-alone program, effectiveness or "success" is even more uncertain as no data or research specifically related to Car 87/88 was unearthed, nor has any known report on program outcomes been released publicly by either the VPD or Vancouver Coastal Health (VCH). As the oldest co-response team in Canada, possibly even in North America, the potential to contribute to the body of evidence with a substantial amount of historical data has been rich, yet the program is merely referenced in numerous articles as a description of its service and longevity, with one publication having reported on anecdotal negative reviews of the program by service-users (Kisely et al., 2010; Koziarski et al., 2021; Lancaster, 2016; Shapiro et al; 2015). It appears that an enormous opportunity for insight and learning has been omitted in Vancouver, an oversight that cannot go unnoted.

Improving Measurement for Success

To measure any amount of success or improvement, there must be historical and existing data or recorded conditions with which to compare. Since the declaration in 2013 of a mental health crisis in Vancouver, a paucity of data has been provided to demonstrate positive change with the plenty of indications to the contrary. Indeed, the *Urgent Mental Health and Substance Use Service Enhancements Framework* that is to expand mental health services in the city, including Car 87/88, has been funded by the CoV to address substantial recognized deficiencies that have persisted in the mental health support system (City of Vancouver, 2023a). The creation and expansion of these services provides ample opportunity to build in the reporting, data collection, and protocols and procedures that researchers have suggested are necessary to track and evaluate progress.

The co-response literature has provided an abundance of direction on what data to collect, which aspects of the program could be standardized for more comparable results and where

resources might be focused to strengthen programming for improved outcomes. This would permit agencies to better assess the success of their own programs while generating valuable material that could inform the larger research base. Current Mayor Ken Sim stated that the new mental health services framework presents an "opportunity to set a new standard in North America" which would necessitate best practices in data collection, reporting and consistent evaluation to come to fruition (City of Vancouver, 2023b).

Evidential Proof

Consulting the current co-response findings would enable the VPD, VCH, CoV and other allied organizations to leverage existing evidence to intentionally structure their relationships, design programming and provide critical services for improved outcomes. While it is unknown how much evidence has been incorporated into the new framework, it evolved out of the original proposal to expand the city's co-response program with 100 additional nurse-police pairings, a strategy that is not supported by the literature. Rather, scholars have recommended that expansion of co-response be implemented in conjunction with other non-police programs across the continuum of care, such as preventative community-based services that engage people prior to escalation, and treatment and referral services that support PMHC in the long-term (Cotton & Coleman, 2016; Shapiro et al., 2015). The new framework and its subsequent phases appear to align more closely with the recommendations in the literature, such as creating a non-police de-escalation team, and while Vancouver's mental health system may still be closer to reactive than proactive, at this point it appears to be moving in a positive direction.

Such strategic changes and the associated costs are further validated with the application of an evidence-based approach, strengthening organizations to better withstand scrutiny over their spending and decision-making (Koziarski et al., 2021). A lack of legitimate justification can

lead to funding constraints such as those experienced by the VPD in 2020 (Koziarski et al., 2021). The Vancouver city council voted to limit what was budgeted for police funds to more than $5.5 million under the amount requested by the VPD for the 2021 year (CBC News, 2022). Despite council attributing the cut in spending to restrictive pandemic costs, the vote occurred during the height of the *defund the police* movement when debate surrounding police resourcing and over-reach was contentious (CBC News, 2022). The VPD was ultimately granted the remainder of the requested funds on appeal to the Government of British Columbia in 2022 however these events reflect an increasing need for transparency and accountability from law enforcement in Vancouver and across North America (CBC News, 2022). Validating co-response programming with current evidence can serve to legitimize the police's approach and the funding required to support it (Koziarski et al., 2021)

Agency Collaboration and Culture

The latest expansion of mental health crisis response services in Vancouver will see greater mixing of health care and police staff on the job, a move intended to improve service performance and outcomes but not if teams are insufficiently supported. Organizational buy-in and backing for the inclusion of mental health response in mandate and practice have been recommended for legitimizing programs and roles associated with co-response, both internally and between agencies (Kirst et al., 2015; Koziarski et al., 2021; Lamanna et al., 2018). The relationships within the co-response system that were identified as most in need of strengthening were between health care staff and police, and police in mental health roles and their fellow uniformed officers (Bailey et al., 2018; Kirst et al., 2015; McKenna et al., 2015; Wood & Watson, 2017).

In terms of health care staff and police working together, researchers and the staff themselves reported on the challenges of combining two professional cultures with conflicting mandates and how that can inhibit the relationship and preferred outcomes (Bailey et al., 2018; Kirst et al., 2015; McKenna et al., 2015; Shapiro et al., 2015). Findings recommended that more targeted training to enhance understanding of each other's roles and working cultures could align staff in knowledge and approach, serving also to reduce stigma among police staff and improve overall service delivery (Bailey et al., 2018; Kirst et al., 2015; Wood & Watson, 2017). The heavier-handed enforcement approach, representative of the historical identity central to policing culture and often at odds with the trauma-informed approach in mental health, was emphasized as problematic to co-response encounters throughout the literature (Kirst et al., 2015; Lamanna et al., 2018; Wood & Watson, 2017). This was found to reflect not only a deficiency in mental health training and knowledge but also the potential isolation by police from their own team resulting from joining another that is not considered to be legitimate (Bailey et al., 2018; Lane, 2019).

The VPD currently work with VCH on several mental health programs in addition to Car 87/88, such as the Assertive Community Teams (ACT) and Assertive Outreach Teams (AOT), as well as maintaining a Mental Health Unit as part of the police force (Vancouver Police Department, 2023). The majority of these teams are staffed by health and social service clinicians, requiring only a handful of officer roles. For example, a single liaison officer supports the six ACT teams in Vancouver and their more than 400 clients and until the new staffing comes into effect with the expanded Car 87/88 service, only one officer was required per car (ACT British Columbia Best Practice, n.d.; City of Vancouver, 2023a). Therefore, the total number of officers engaged with these teams represent a handful, a minority out of a force

numbering more than 1,300 and in a professional culture that has traditionally excluded mental health work as valid police business (Lane, 2019; Vancouver Police Department, n.d.; Wood & Watson, 2017).

Roles within these teams are typically filled by older, more experienced police who have a particular interest or skill set in working with PMHC and it is these officers who receive the comprehensive CIT training (Vancouver Police Department, 2020). All police in Vancouver are required by provincial law to complete, and re-certify every three years, a mandated Crisis Intervention and De-escalation (CID) training course that was modelled on, and ultimately replaced, a Crisis Intervention Training (CIT) program developed by the VPD in 2002 (Vancouver Police Department, 2020). The VPD CIT program was itself modelled on the Memphis Model out of Tennessee and some components of that training are still provided as a supplement to the CID course for staff who work on Car 87/88, the Mental Health Unit and other positions which have higher frequency of interface with PMHC (Vancouver Police Department, 2020). The wider research suggested that more effort is needed to shift police bias and attitudes, that inclusive messaging must be embraced from the top-down and that comprehensive training and education for all staff, not just those working directly on those programs, would contribute to improving both culture and practice (Bailey et al., 2018; Ghelani et al., 2023; Lamanna et al., 2018; Shapiro et al., 2015; Wood & Watson, 2017).

Police Attitudes and Mixed Messaging

Police feedback in the literature reported that one of the components considered most valuable during CIT training was the experiences shared by service-users themselves, providing greater understanding and empathy for what a mental health crisis is like for the people to whom they are responding (Gostomski, 2012; Thomas & Watson, 2017). Indeed, feedback from

service-users reflected an appreciation for an empathetic approach by police and greater understanding of their behaviours, leading to less criminalized feelings and outcomes (Lamanna et al., 2018; Lane, 2017; McKenna et al., 2015). Consideration for the service-user experience and meaningful inclusion of the service-user in program assessment of police response model outcomes was identified as significantly lacking in the body of evidence and integration of this perspective at all levels of program application was recommended (Heffernan et al., 2021; Lamanna et al., 2018; Marcus & Stergiopoulis, 2022). In Vancouver, understanding of Indigenous perspectives in interactions would be an essential component to incorporate.

A shift in police attitude and approach toward PMHC that is more trauma-informed, centres the service-user's experience and corresponds with those of their health care colleagues during mental health crisis response may be especially helpful as programs expand and more police are filling mental health support roles. Furthermore, it presents an opportunity for Vancouver police to foster trust with service-users at a time when relations have become particularly hostile.

The interface between police and service-users has been high for some time in Vancouver due to two other simultaneous, and not unconnected, crises: the overdose crisis and the housing crisis (Boyd & Kerr, 2016; Duncombe, 2023; Vancouver Police Department, 2017). As each issue already carries the stigma of criminalization and social marginalization while intersecting with the mental health crisis, political actions and the enforcement approach that impacts one issue then also impacts on the others, potentially affecting the trust with service-users that is necessary for both police and mental health workers to facilitate positive outcomes. In April 2023, a multi-day operation to remove homeless encampments from East Hastings Street began at the request of the CoV, without providing additional shelter to support the displaced and using

uniformed officers to execute the order (Watson, 2023). While this event was not the first decampment in the city, it was described by some to be particularly "dehumanizing" while organizations and residents in the area expressed the damaging effects such activity would have on people's mental health and their relationship with the police (Watson, 2023).

Public trust in police amongst the most vulnerable populations in the city appears quite tenuous and the decampment activities may have further entrenched a sense of criminalization among potential service-users when the CoV, VPD and VCH are attempting to implement services designed to decriminalize, all while utilizing the same police force. Such conditions lend credence to the benefit of plain-clothed officers attending to PMHC as part of co-response team, at the very least to reduce the potential for escalation while presenting opportunity for positive police interactions. Yet the opportunity may be missed if the VPD cannot embrace the guardian stance required to successfully support the broadening of its scope to include mental health support in earnest. It is thus in this socio-political climate that people have been questioning the appropriateness of police responding to mental health crises (Ghelani et al., 2023; Junos, 2022; Steacy, 2023).

Do Police Belong in Mental Health Crisis Response?

Police involvement in mental health crisis response has not been proven to be optimal but it has been proven to be most common with police-based response currently the dominant mental health crisis response paradigm in Western nations (Parker et al, 2018). They are typically the primary responders to calls involving mental health crises and, even in regions that apply the co-response model, police will most often assess an interaction first for risk prior to dispatching the co-response team (Ghelani et al., 2023). Car 87/88 is among the minority of programs that provides both primary and secondary response and although more research comparing outcomes

for each type is needed, the potential for positive outcomes is improved when the first responders on-scene are appropriately trained to handle the crisis to which they are responding (Iacobucci, 2014; Nasser, 2020).

There are clear safety benefits to police involvement in co-response and according to VCH, mental health clinicians have expressed preference for police partnership for this reason; another potential endorsement for the co-response model in Vancouver (City of Vancouver, 2023a). Yet in 2022, roughly 5% of incidents responded to by Car 87/88 resulted in detainment under the Mental Health Act, implying that a majority of the calls did not involve imminent risk of harm and may have been opportunities for a non-police crisis response (Steacy, 2023).

In Vancouver, this may be a demand that the new de-escalation team would meet although there are a number of the identified model types that are active in the province and across Metro Vancouver. For example, the Crisis Centre operates a distress line that is available to most locations in B.C. and several community-based civilian mobile response teams operate in different parts of B.C. and the Lower Mainland (Crisis Centre, n.d.; Basu 2023). The Canadian Mental Health Association operates the mobile Peer Assisted Car Teams (PACT) in North Vancouver, New Westminster and Victoria, pairing a mental health clinician together with a person with lived experience who respond to PMHC (Canadian Mental Health Association, n.d.).

Dempsey et al. (2020) suggested that ongoing investment solely in police-based response to mental health crises was akin to "treating a fever; it may temporarily alleviate the symptom but does not address the underlying illness" (p. 187). The literature review revealed that the evidence on non-police mental health crisis response models is very lean but there is clearly a role for them in the broader system of mental health crisis services and potentially a worthwhile

investment, a presumption that could be validated with more research which is certainly, in itself, a worthwhile endeavour.

Based on the presented evidence and discussion, the answer to the question of whether the police have a place in mental health crisis response would currently be: yes, but not all of the time, it depends on the circumstances. It is important to recognize that there is a difference between incidents that involve people with mental health illness and people experiencing a mental health crisis, and while criminalization has historically heightened the perceived risk of PMHC, it appears to be relatively small. That said, as long as a risk is present there will likely always be a need for police presence in mental health crisis response, but it also appears that it may not need to be as prevalent as it is currently.

Conclusions

The co-response approach that is applied to mental health crises in Vancouver is not unique nor is it outside of the norm in North America or the Western World, yet existing literature revealed little definitive evidence indicating the model's effectiveness in increasing police efficiencies, diverting service-users away from the justice system and toward more appropriate referral services that better meet their needs. These are relevant considerations when the current service model appears to fall short of the demand, particularly in Vancouver where tensions between police and potential users of the service are very high. However, effectiveness also turned out to be a rather complicated question that requires far more research than is currently available.

Future avenues for investigation that would address the gaps include specific direction for more comprehensive police mental health training, the consideration and incorporation of service-user perspectives in service design (particularly voices from Indigenous and other

BIPOC groups that are over-represented in the justice and mental health systems), optimization in interagency collaboration responsibilities and how stigma impacts policy change in this arena. Vancouver is at a turning point that could potentially mark the shift in mental health crisis service delivery representative of a more productive paradigm. That level of collaboration and support requires cooperation at all levels, including provincial and federal participation. For now, co-response is here to stay, the hope being that it will continue to evolve in a manner that best meet the needs of the people it is designed to serve.

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