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An Exploration of Encounters Between People with Lived Experience of Mental Illness and Police Officers

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By

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ABSTRACT

Understanding the ways police officers and people with lived experience of mental illness interact during mental health calls is imperative to improving the outcomes of these encounters. Despite increased attention and public calls for change, little is known about the complex ways police officers and people with mental illness interact during a mental health crisis. To address the paucity of literature, this study sought answers to critical and under-explored areas to better understand the context and characteristics of these interactions.

The overarching research question for this study was: How do people with mental illness and police officers experience interacting with one another during a mental health crisis? Specifically, this study asked participants to expand on their descriptions of the context and characteristics of incidents, interventions and outcomes, their perceptions of officer roles, their perception of the dangerousness of these encounters, and what they want others, including each other, to know.

This study used in-depth interviews conducted with 18 participants from across Canada including 13 people with lived experience of mental illness, and five police officers. Transcribed interviews were analyzed using NVivo version 12 software.

Findings from this study illustrate the complexity and diversity of these interactions as well as the similarities and differences in experiences described by both groups. Findings from this study can be used to further develop policy, practice, and research, that includes people with lived experience of mental illness in meaningful ways.

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CI	Crisis Intervention
CIT	Crisis Intervention Teams
CRT	Crisis Response Teams
ECT	Electroconvulsive Therapy
MI	Mental Illness
NCR	Not Criminally Responsible
PwMI	People with Mental Illness
PwLE	People with Lived Experience
SC	Social Constructionism
SRO	Single Room Occupancy

CHAPTER I: INTRODUCTION

Despite research indicating that people living with mental illness are no more likely to commit criminal acts than people without a mental illness, contact with police officers is high among this population (Brink et al., 2011; Coleman & Cotton, 2014; Huey et al., 2021). The frequency of contacts has been attributed to many factors including deinstitutionalization, poorly-funded and fragmented community-based mental health and social services, intolerance of social disorder, and co-occurring substance use disorders (Brink et al., 2011; Fischer et al., 2006; Hoffman, 1990; van Dorn, et al., 2012; Whitaker, 2019; Yohana, 2013).

Throughout the literature concerning police interactions with people with mental illness during times of crisis, there is a tendency to overlook numerous complex factors that lead up to police encounters with people with mental illness (PwMI) and a tendency to focus on behavioural and diagnostic characteristics of encounters (Frederick et al., 2018). While it may be tempting to reduce these interactions to deinstitutionalization and symptoms of mental illness, these overly simplistic reasonings overshadow the complexity of these interactions resulting in incomprehensive and ineffective supports for people experiencing a crisis.

Policing Mental Illness

Police officers routinely interact with people with mental illness in their work, a trend that has been observed in many developing countries worldwide (Bittner, 1967; Wallace, 2020; Wood et al., 2020). Institutionalized approaches to responding to people with mental illness have existed since the 19th century and they continue as a dominant approach to responding to people with mental illness in crisis today. Illustratively, police

officers assume expanded functions of maintaining social order in responding to individuals experiencing mental health crises (Brink et al., 2011, p. 11). In this capacity, police officers have a lot of discretion and hold significant decision-making power when it comes to assessment, intervention, and the outcome and impact experienced by people with mental illness.

Police officers have limited options when it comes to supporting people with mental illness and have expressed the challenges they face operating in this role including longer periods of time waiting for assessments, being questioned or not listened to by mental health providers, and bringing people to the hospital only to have them discharged leading to the "revolving door"

that requires police officers to deal with the same people time and time again (Engel and Silver, 2001). The public has also become aware of the serious limitations of police response to people with mental illness in times of crisis. Reactions to the outcomes of interactions between police officers and people with mental illness and an increase in public consciousness has brought awareness to violence, use of lethal force, and racism, in Canada and the United States (Ben-Moshe, 2020).

Within the literature, rates of criminalization, injuries, and fatalities of people with mental illness at the hands of police officers have been documented (Ben-Moshe, 2020, Slate, 2017). Although people with mental illness (PwMI) are no more likely to commit violent acts than people with mental illness, they are vastly overrepresented in the criminal justice system and have faced injury and death at the hands of police officers both in custody and within the community (Slate, 2017).

Despite information indicating that most people with a mental illness will never perpetrate a criminal or violent act, current estimates indicate that 7% of police encounters involve contact with an individual with mental illness, and three in ten individuals with mental illness (30%) have police officers involved in their trajectory (Brink et al., 2011; Hacker & Horan, 2019; Slate, 2017). People with mental illness (PwMI) experience higher levels of arrest, criminal charges, and custodial rates than people without mental health issues (John Howard Society 2012). In Canada, mental health issues are estimated to be two to three times higher among prisoners than in the general population (Webster, 2019).

Although encounters between PwMI and police officers rarely end in violence, recent and mounting evidence of the injuries and fatalities sustained at the hands of police officers has brought increased attention to the role police officers occupy in responding to mental health calls. Of the 460 fatal encounters with police officers between 2000 and 2018 in Canada, an estimated 70% involved a person with mental illness (Marcoux & Nicholson, 2017). While estimates vary, some authors indicate an individual with mental illness is killed during 25-50% of all fatal police encounters (Hacker & Horan, 2019). Further research indicates that people with untreated mental illness are 16 times more likely to be killed during a police encounter than individuals without a diagnostic label (Fuller et al., 2016).

These encounters are especially dangerous for members of Black and Indigenous communities (Shadravan et al., 2021). An analysis of cases involving deaths by police officers in Canada conducted by the Canadian Broadcasting Company (CBC) in 2020, found that Black and Indigenous people were overrepresented in police fatalities and

were twice as likely to be killed during these encounters. While interest and awareness in this area have grown among the public and within the literature in recent decades, this is not a novel issue for the family members, advocates, and communities of those impacted by these occurrences (Quiring, 2021).

The Dangerousness Myth

When discussing mental illness and interactions with police officers, it is important to address the longstanding myth that people with mental illness are more dangerous than people without a mental illness. Despite this powerful and longstanding narrative, people with mental illness do not encounter police officers or the criminal justice system due to mental illness alone (Mulay et al., 2016). Research has demonstrated that there is no empirical support for an association between violent crimes and mental illness (Applebaum et al., 2000; Douglas et al., 2009; Joseph, 2014), and studies have shown that only a small portion of crimes are related to psychiatric symptoms (Mulay et al., 2016; Peterson et al., 2014). Rather than implicating mental illness as the cause of police contacts, research suggests that many risk factors are associated with violence (Engel, 1977; Langman, 2017; Van Brunt & Pescara-Kovach, 2019). Clearly articulated by Van Brunt and Pescara-Kovach (2019):

> [These] Overly simplistic portrayals of those struggling with mental health issues as directly causing targeted violence are unfounded and insulting. These individuals are not more dangerous than the general population (p. 53).

Stigmatizing beliefs that people with mental illness are dangerous are often perpetuated by the mainstream media which shares tragic incidents involving people living with mental illness representing them as violent, aggressive, uncontrollable, and

unpredictable. Increased discussion and coverage of violence and mental illness found within the media, governments, agencies, and psychiatric and penal institutions have led to beliefs that people with mental illness are deviant, unruly, and unpredictable (Daley et al., 2019). Despite these exaggerated portrayals, research indicates that people with mental illness commit crimes for the same reasons as people without mental illness and these encounters rarely end in violence (Dvoskin et al., 2020). Antithetically, people with mental illness are more likely to become victims of crime than perpetrators (Ghiasi et al., 2022; Kerr et al., 2010).

Within the mainstream media and throughout the literature, as it concerns police interactions with people with mental illness, the voices of those experiencing this phenomenon and the key factors leading up to these events, including social and cultural contexts, are often overlooked (Joseph, 2014). This serves to individualize the crisis attributing it to diagnoses and symptoms. These (mis)representations spark reactions that place blame on the perpetrator's mental state and lead to public misperception and fear of people with mental illness. This, in turn, perpetuates the narrative that people with mental illness (PwMI) are dangerous (Pescosolido, et al., 2019).

Common constructions of people with mental illness, often focused on deviancy and control, become deeply embedded in societal beliefs subsequently impacting the perception and treatment of PwMI. For example, in the context of policing mental illness, police officers might respond with increased force if they believe PwMI are unpredictable and dangerous or if they anticipate violent behaviours. These types of stigmatizing beliefs among the public consciousness are resistant to change. Despite

contradicting evidence, even science and statistics cannot correct the rhetoric that links violence to mental illness (Pescosolido, et al., 2019).

Problem Statement and Research Aim

Police officers routinely interact with people with mental illness in their work, sometimes with dangerous consequences; however, despite increased attention to the issue and public calls for change, little is known about the ways police officers interact with people with mental illness (PwMI) in crisis (Huey et al., 2021). Further, the voices of people with lived experiences have not been adequately explored throughout the literature.

Research into these interactions has increased over the past two decades but unlike the present study, much of the research concerning these encounters is quantitative and focused on the impacts of police training. A recent systematic review of qualitative studies concerning people with lived experience of mental health-related crises, their families, and first responders, included 79 studies- only two of which involved the narratives of PwMI (Xanthopoulou et al., 2022).

While not included in the review, some authors have explored the rich narratives of people with mental illness (PwMI) who have interacted with police officers during a mental health crisis (for example, Livingston et al., 2014 and Wittmann et al., 2021); however, paucity of studies continues to exist as it concerns the expressed opinions of police officers and PwMI regarding their perceptions of one another and the role of police officers in responding to PwMI in crisis, the outcomes of and impact of encounters, and the in-depth analysis of contextual and causal characteristics of crises.

In response to these limitations, this work sought to develop knowledge surrounding the multiple complex factors involved in these encounters beyond symptoms and diagnoses. As others have pointed out, the current research surrounding these encounters lacks the details of complex characteristics and systemic issues surrounding crisis events (Morabito, 2007). Overlooking these factors has resulted in frameworks and conceptualizations that offer a surface-level understanding of these interactions and minimize the impact of longstanding systemic prejudices and factors such as homelessness, gentrification, poverty, and the rise of disorder-focused policing that aims to "push people who are deemed disorderly or disruptive out of public spaces" (Frederick et al., 2018, p.17).

Novel ways of viewing these crises, departing from the reductionist tendency to attribute crises and the focus of intervention to mental health symptoms, are needed to better understand this issue. Including the voices of people with lived experience, both police officers and PwMI, is integral for developing a deeper understanding of these incidents and improving these interactions. As stated by Wood and colleagues (2017):

> It is time to take a 21st-century look at the broader context of police interactions with persons affected by mental illnesses and their implications for advancing practice in this area (p.83).

Research Questions

The following research questions guided this study: How do people with mental illness and police officers experience interacting with one another during a mental health crisis?

Sub-questions included:

- What perceptions do both groups hold of one another and of the role officers occupy in supporting people with mental illness experiencing in times of crisis?
- What do participants perceive of the dangerousness of these interactions?
- What do participants want others to know about these interactions?
- What future directions do participants believe would improve the outcomes of these interactions?

Research Approach and Theoretical Orientation

Historically, medicine and the law have been called upon to resolve problems. Within the context of police interactions with people with lived experience of mental illness (PwLE), there is evidence of a traditional medical approach and a reliance on institutional means to address problems (i.e., through policing, psychiatry, and hospitalization). This traditional model of responding to people with mental illness has existed since the late 1800s and continues to present power imbalances and limitations in both practice and research today. These approaches limit participant involvement and have been critiqued by those accessing mental health care (Baker & Pillinger, 2020; Boscarato et al., 2014). Despite this, these approaches continue to be revered as central to mental health support (Nelson et al., 2000).

The biomedical model has provided a dominant framework for mental illness that views mental illness in reductionist and predominantly medical terms (Jacobs, 2015). Within this approach, "aspects of human experience and behaviour are categorized as symptoms of a biomedical illness and attached to the accepted truth that these symptoms represent a disease that must be treated" (Joseph, 2014, p. 281).

Traditional positivist approaches are often used to frame and conceptualize interactions between police officers and PwMI in research and practice through the language, interventions, and trajectories of these encounters. Through language, and within research and practice, frameworks used to explore these interactions are reflective of this paternalistic culture (Jacobs, 2015). Descriptions of the contexts surrounding these interactions commonly involve symptomology and diagnoses overshadowing key factors such as housing instability, social isolation, and food insecurity. This serves to individualize and homogenize the experience of people living with mental illness muting the multitude of complex factors that surround the individual in crisis.

Traditional structures of "support[2]" that focus predominately on addressing the label of mental illness have historically impeded progress in this area and are incongruent with social justice and anti-oppressive practices as problems are seen as inherent deficits (LeFrançois et al., 2013). With this focus on inherent symptoms and pathologies, problems are reduced to the individual in crisis and are not attributed to other impactful factors. Within this model, correcting physiological problems becomes more important than addressing contributing social and political conditions (Joseph, 2014). According to Morrow and Malcoe (2017), reducing these occurrences to the single narrative of psychological suffering, individualizes, ahistoricizes, and apoliticizes pain and distress, muting important issues that underlie social suffering.

Evidence of the oversimplification of the context of these interactions, and a reliance on traditional approaches is also found throughout the reporting of contacts. Throughout practice and research, police officer reports of PwMI are considered objective and factual, albeit reporting is often based on the subjective experiences of

police officers who determine a person to be mentally ill based on their own construction of how they believe a person with mental illness behaves. These constructions of what is *normal* and what is characteristic of mental illness and the subsequent actions taken in response to these assumptions, are not only unreliable, they are dangerous. These actions uphold misinformation that solidifies societal beliefs that PwMI behave unacceptably, therefore justifying police intervention. These views minimize the impact of larger factors involved in crisis that reside outside of the individual who may be experiencing distress.

Social Constructionism

Exploring this complex issue warrants an epistemological framework that departs from the narrow and simplistic views of these interactions expanding on often overlooked factors involved in these occurrences. A Social Constructionist (SC) approach was a useful framework for this study as it departed from traditional models, allowed for the multiple subjective realities of people with lived experiences of these encounters, and facilitated a deeper understanding of the multiple complex factors that contribute to crisis events. Table 1 outlines positivist and constructivist aspects as they relate to this study and previous work in the area.

Table 1

Aspects of Positivism and Constructivism Relevant to the Study

Positivism	Constructionism
Epistemology: Objectivist; "true" findings	Epistemology: Transactional/subjectivist; Multiple realities; Created findings
Inquiry aim: Explanation; Prediction and control	Inquiry aim: Understanding; Reconstruction
Expert: Professional	Expert: People with lived experience
Language and framing: Patient, subject; Symptoms, diagnoses; Treatment non-compliance; Problems inherent and individualized	Language and framing: Person/people with lived experience; Survivor Multiple factors; Systemic and structural; intolerance for social disorder; Lack of support
Methodology: Chiefly quantitative	Methodology: Qualitative
Values: Excluded; Researcher's influence denied	Values: Researcher's values are included and explicitly stated; Reflexivity is used throughout the research process

**Derived from Guba and Lincoln, 1994*

Social Constructionism can be used to explore how the meaning and experience of mental illness aree shaped by social and cultural systems (Conrad & Barker, 2010). There are multiple roots of social constructionism with important foundations of SC emerging in the 1960s and 1970s. Researchers have examined the construction of social problems and how labeling and concepts of deviance apply to people with mental illness (Spector and Kitsuse, 2001; Lemert, 1967; Schur, 1971.) Research suggests that the way society identifies and responds to people with mental illness is due to their construction of whether a person's behaviours align with what is considered "normal" within society at the time (Collins & Furman, 2005; Galanek, 2013).

According to SC theory, what society labels as abnormal and deviant, are related to the historical, societal, and cultural context in which people are experiencing these interactions (Gergen, 2015; Dewees, 1999; Sahin, 2006). Becker explored how societal reactions and labelling contribute to the construction of deviant identities (1963). Once defined as abnormal, society assumes that intervention, often medical attention, is needed to return someone to a state of normalness (Farone, 2002).

Friedson (1970), argues that, like deviance, social constructions are based on categories of what is considered acceptable or normal. The common portrayal of people with mental illness as deviant and unruly signifies a construction that has developed among public consciousness. The beliefs and attitudes that society hold about particular labels, including mental illness, impact how they treat people with mental illness and lead to policies concerning appropriate response. Friedson (1970) spoke of the consequences of labels urging awareness of "how signs and symptoms get to be labeled or diagnosed as an illness in the first place" (p. 212). Constructions of mental illness may lead to biased treatment and stigmatization within various settings resulting in further marginalization and exclusion. These constructions, often tethering mental illness to medical and institutional interventions, lead to narrow solutions to extremely complex problems.

Gergen (1985) noted that the concept of mental illness is reflective of culture and history, and that without considering these elements, disease cannot be fully understood. Gergen (1985) posits that constructions of mental illness have evolved throughout history, are always changing, and are a social construction of reality. Some researchers have explored the social construction of mental illness (Horwitz, 2012; Thompson, 2010; White, 2017). Szasz (1961) coined the "myth of mental illness," positing that people who

have a mental illness are experiencing “problems in living.” In Szasz's view, concepts of mental illness are passed off as "scientific categories" when in reality, they are judgments that lead to uses of power by those deemed to be authorities. An example of this occurs with the development and widespread use of the Diagnostic and Statistical Manual of Mental Illness (DSM). Mental illness is often framed in terms of the (DSM), which focuses on categorizing symptoms and providing labels for abnormality. The DSM is used to determine what is considered normal and abnormal within institutional settings including hospitals and court systems. According to Horwitz (2012), the DSM’s definitions “pervasively confuse problematic but natural human emotions which develop as responses to stress with mental disorders” (p. 559).

Interactions between police officers and people with mental illness are complex and cannot be comprehensively understood unless we are willing to explore constructions of mental illness, how they are developed and maintained, and the power they hold. Social Constructionism provides a valuable framework for viewing police interactions with people with mental illness and the conceptualizations of these roles, with respect to the social, cultural, and historical contexts in which they occur. In light of these complexities, it is evident that focusing on one aspect of this context, mental health labels, is insufficient in understanding the experiences of police officers and people with mental illness who interact during times of crisis and the options that are offered in response. An understanding of the constructions individuals hold of one another helps us to understand how people interact with one another. The beliefs that people hold about police officers may impact their interactions with police officers and the beliefs and attitudes they hold about people with mental illness may impact how they treat people

with mental illness. For example, if police officers believe that people with mental illness are dangerous, they may treat them as such, removing their freedoms and privileges and responding with force. Similarly, if people with mental illness do not like the police or do not believe the police are there to help them, they are unlikely to respond positively to their approaches.

Through this lens, we begin to understand the complexity of these interactions including how mental illness and conceptualizations of crisis are framed and understood. This approach recognizes that mental illness is not solely a biological or individual issue, but is also influenced by social and cultural factors including the societal attitudes, stereotypes, and stigma surrounding mental illness. Social constructionism offers a broader lens that can shift the focus of the crisis away from the individual in crisis and refocuses the issue on the reality of larger social and systemic issues. This theory provides a more comprehensive understanding of these interactions that accounts for the underlying social dynamics that influence police contact with people with mental illness and the complexity surrounding this phenomenon.

Statement of Positionality

Researchers bring certain beliefs and philosophical assumptions to their studies, and oftentimes, these views are deeply ingrained and instilled through education and experiences (Denzin & Lincoln, 2011). Since these assumptions have the potential to influence the philosophies, beliefs, and approaches one brings to a particular endeavor, it is important to make these assumptions and subsequent interpretative frameworks explicit (Denzon & Lincoln, 2011). Acknowledging, declaring, and addressing positionality is

especially important in the qualitative tradition whereby information is viewed through a subjective lens.

The role of the researcher as the primary data collection instrument necessitates the identification of personal values, assumptions, and biases at the onset of a study (Creswell, 2017, p. 205). Qualitative research is interpretive, and the researcher is involved in "sustained and intensive experiences with participants" (Creswell, 2017, p. 183). This leads to strategic, ethical, and personal issues that must be accounted for during the qualitative research process (Locke et al., 2013). With this in mind, it is important to explicitly identify and reflect upon the positionality of the researcher and engage in ongoing reflexivity throughout the research process. Reflexivity was a practice employed from the planning phases through to the end phases of the study and will be returned to in later sections of this work.

Positionality requires researchers to acknowledge how their worldview, experiences, and beliefs impact their research given that these positions impact decisions made throughout the research process (Holmes, 2020). I approached this research through various lenses and identities. I identify as a crisis worker, a social worker, an advocate, and an ally. My experience as a crisis worker inspired me to pursue research within this context. After nearly a decade of working in the field, I observed many limitations in the ways people with mental illness (PwMI) are responded to during times of crisis. As a social worker with previous research experience, I decided to explore this issue further through this research.

As a social worker, I have responded to various mental health crises in the community. I have worked within interdisciplinary teams comprised of nurses,

psychiatrists, social workers, police officers, and case managers, to facilitate positive outcomes and to support individuals with mental illness, whether perceived or diagnosed, during times of crisis. I have seen interventions and outcomes within psychiatric and legal institutions. I have observed the challenges that many professionals and people with lived experience of mental illness face during these interactions. I have seen how this issue is challenging for both police officers and PwMI.

I have participated in training courses alongside critical response teams comprised of police officers. I recall a particular four-day police training event designed to address crises among people with mental illness in high-risk situations including risk to self and others and in hostage and barricade situations. In this training, actors were brought in to play the role of PwMI who were exhibiting symptoms of mental illness and re-enacting crisis situations requiring de-escalation and urgent response. During this training, I was immersed in a theatrical (mis)representation of how PwMI were constructed to behave. These deeply disturbing portrayals were unlike the experiences that I had in the field. As a social science researcher, I was acutely aware of the dangerous undertones and power of these portrayals.

In training, I have learned about the common traits of PwMI and the behaviours one should expect if they encounter someone with certain diagnoses. I was particularly struck by the hostage-barricade scenarios that linked dangerous people with mental illness (specifically, people with schizophrenia) in the context of negotiations with the police. I knew that this very situation reflected the perpetual stereotyping of PwMI and was a subtle and 'invisible' form of discrimination and power even though it was disguised as a normative and proactive practice.

While I am acutely aware of the challenges associated with the current model of crisis intervention, I am aware that, during times of crisis, police officers may be the only option available. This is especially true for people living in rural communities and in locations where 24/7 mental health support is unavailable.

As a frontline worker and researcher, I believe there is a need for reform in current crisis response models and in the way we perceive these occurrences. Specifically, I believe progress would be made by "shifting the paradigm" (as Nelson and colleagues referred to in 2001) in mental illness from the traditional medical and institutional models of care which have been revered and heavily relied upon in times of crisis. I am confident that people with mental illness (PwMI) are experts in their experiences and that they possess the strength and insight to contribute to knowledge in this area.

My professional experiences have allowed me to see both the strengths and limitations of different structures of support for those living with a mental illness. For example, in some situations, hospitalization and medication may be beneficial following a crisis; however, in other cases, medication may serve as a temporary solution to problems that are situated at structural and societal levels and not within the individual. Similarly, in some cases, a diagnosis may result in an individual gaining an understanding of their experience and may lead to opportunities for support that an individual without a diagnosis would not be eligible for. Conversely, a diagnosis may be used to individualize issues through pathologization leading to further segregation of people with mental health diagnoses.

Given my previous experience within this context and in alignment with the tenets of qualitative methodology, it has been important to reflect on my own beliefs and values as well as my position of privilege as a white female. Given my race, I am less likely to experience the negative and sometimes fatal outcomes that are the result of police contact with members of racialized communities. Reflecting on my position as a researcher was an ongoing process throughout the study and is revisited throughout this work.

Research Assumptions

In this study, the following assumptions were made: It was assumed that participants would have narrative accounts of their experiences and would be willing to share these experiences. It was assumed that the instruments used (semi-structured interview guides) would elicit reliable responses and would engage participants in a meaningful way.

It was assumed that participants would provide honest answers to the questions asked. Given the current context of police interactions with people with mental illness and the documentation of negative outcomes surrounding these events, it was anticipated that participants may have negative experiences to share. It was also assumed that although media portrayals of the negative outcomes of these interactions prevail, the questions would elicit responses from participants with diverse experiences (both positive and negative) and that they would be willing to provide details about these interactions.

It was assumed that, given the controversy surrounding this issue and the sensitive nature of the topic, conversations would require empathy, patience, and understanding. It was assumed that relationships and rapport and the development of a safe space to share these stories, would need to exist between the researcher and the experts- those with lived

experience. The global pandemic impacted many individuals and organizations. The assumption was made that the impact of the pandemic would be felt by researchers engaging in fieldwork and by participants who generously shared their stories during unprecedented times.

Conceptualization of Language and Key Terms

It is necessary to address the conceptualizations, language, and key terms used throughout this work. The first reason for this is to address conceptual and methodological challenges within historical and contemporary research. As discussed in chapter two, many authors fail to provide conceptualizations of mental illness or crisis. Further, terms like "[serious] mental illness," and mental health issues, are not clearly described and there is no clarification of whether the officer made the determination based on behaviours they believed to be consistent with a diagnosis or whether a person *actually* had a diagnosis at all.

This lack of clarification has not only caused inconsistencies throughout the literature, it has also served to perpetuate societal constructions of mental health and mental health crises that may not be reflective of these experiences. Another reason for the importance of clear conceptualization of language is to address that few studies have acknowledged how research within the area of policing mental illness has the potential to shape people's perceptions of people with mental illness or the views of people in crisis. The very coupling of mental illness and policing invokes imagery of major violent scenarios covered by the media linking violence and danger to both police officers and people with perceived mental illness.

Researchers hold significant power in shaping the view of mental illness (Frederick et al., 2018). The language and terminology used within academic discourse, including this work, have the ability to shape perceptions and responses to mental health issues influencing policymakers, service providers, media, and the public (Frederick et al., 2018).

Thus, this work aimed to provide clarification around key terms, knowing that in the pursuit of defining and responding to current issues within mental health systems, researchers play a crucially important role. A list of the key terms used throughout this dissertation is found in Appendix A.

Dissertation Overview

This dissertation presents a study exploring the experiences of police officers and people with mental illness who interact in times of crisis. Chapter one explored the background and context of police encounters with people with mental illness and presented the purpose of the study. The following chapter will review the literature surrounding these encounters including the debate surrounding the frequency of these incidents, characteristics and call types, and the models of response that are used to address these calls. The outcomes and experiences of these encounters as described in the literature, are further explored. Chapter two concludes with the importance and relevance of the present study.

Chapter three describes the methodology and outlines the research design and procedure, including data collection and data analysis, and describes how trustworthiness and credibility were achieved and maintained. A discussion concerning ethical considerations concludes the chapter. Chapter four describes the findings from this study

and outlines major themes. The final chapter of this dissertation explores similarities and differences between participant groups and suggests implications for practice, research, and policy.

CHAPTER II: LITERATURE REVIEW

The following chapter will review and critique the empirical research exploring interactions between police officers and people with lived experience of mental illness (PwMI). Specifically, this chapter will present relevant literature surrounding the context of these interactions, the implementation, and the effectiveness of crisis response models (CRMs) including Crisis Intervention Teams (CITs) and co-response models, the outcomes of interactions, and participant experiences.

Given the importance of language and frameworks used in this discourse, there will be conscious and focused discussion of the language and frameworks used throughout the literature to describe these interactions. The chapter will conclude with a summary of the limitations of the current research and will discuss the importance of the present study.

Prevalence Rates and Incident Characteristics

A scoping review of peer-reviewed research conducted in 2017 examining the Canadian policing literature from 2006-2015, found an increase in research concerning interactions between police officers and PwMI in crisis, adding that the increase in research in this area should not be surprising given repeated claims that policing of persons with mental illness places a “huge burden” on policing resources in addition to the high rates of individuals with mental illness who are killed in police lethal force cases, a topic that has generated significant media interest (Huey, 2016, p. 11).

Current prevalence rates in Canada range from 1-30% of contacts (Coleman & Cotton, 2014; Huey et al., 2021; Livingston, 2016). Within the United States of America (USA), 7-30% of police calls involve someone with a mental health issue (Coleman &

Cotton, 2010; Watson et al., 2010). In the United Kingdom (UK), estimates of police incidents linked to mental health crises range from 2% to 50% (Puntis et al., 2018). These international trends continue in Australia where police officers spend an average of 10% of their time responding to calls involving PwMI (Godfredson et al., 2011).

The ranges illustrated in contact statistics reflect both a reality and a challenge within current practice and research: Conceptual and methodological inconsistencies in how mental illness is defined, and how data is collected and analyzed, make it difficult to map the size and scope of these encounters (Huey et al., 2021). These limitations have also led to disagreement on whether the frequency of interactions between PwMI and police officers is increasing (Huey et al., 2021).

As illustrated in the range of contact statistics (for example, within Canada 1-30% of all contacts involve someone with mental illness (MI) [Huey et al., 2021]), when it comes to establishing the prevalence rates and the extent to which Canadian police officers engage in calls involving people with mental illness, estimates vary. This trend does not solely exist in Canada but is reflected in contact statistics worldwide. As such, it is difficult to decipher how prevalent these calls are due to the difficulties with how police data are both collected and used (Huey et al., 2021).

Charette and colleagues (2014) conducted a retrospective quantitative analysis of police interventions drawing from data from police reports in 2006 and estimated mental health calls as comprising 4.4% of all service calls in Montreal; however, this data was derived from only three days of police reports with a relatively small sample size (n = 272). Recently, researchers have determined that mental health-related calls can cluster

temporarily and spatially (Vaughan et al., 2019), thus the dates examined in many studies may not accurately reflect the actual prevalence of these occurrences.

Cotton and Coleman (2008) have conducted a significant amount of research on police encounters with people with perceived mental illness (MI) within Canada and have reported these contacts to comprise between 7-15% of all service calls. This data is based on questionnaires and interviews with police personnel, but, as with other research in the area, there is no way to confirm whether these calls were mental health-related or based on officer perceptions of calls.

Some authors, albeit few, have used self-reported data from people with mental illness to capture a more accurate portrayal of these occurrences. Using self-reported data extracted from Statistics Canada's Canadian Community Health Survey (2015), Boyce et al. found that an estimated 18.8% of all service calls involved people with mental illness. In an earlier study, Brink et al. (2011) used self-reported data gathered from focus groups (n = 19), in-depth interviews (n = 60), and surveys (n = 244) with people with mental illness in British Columbia (BC) and determined rates to be an estimated five percent.

Problems with how police have historically recorded data have created methodological challenges for contemporary scholars which are reflected in the range of prevalence rates from an estimated 1-30% (Huey et al., 2021). In an examination of the limitations in knowledge surrounding these contacts, Huey and colleagues note that mental health prevalence rates will also vary by location as a result of population characteristics and the ability of PwMI to access services.

A further area of contention concerns whether police contact with people with mental illness (PwMI) is increasing. In the 2018 annual report by the Ontario Provincial

Police (OPP), it was noted that there was an annual increase of 10% in the volume of mental health-related calls, an increase that was consistent over the previous two years. In smaller communities in Ontario including Chatham-Kent, Timmins, and Camrose, police services reported similar increases (Huey et al., 2021). Vaughn and Anderson (2019) reported that calls involving PwMI were increasing by as much as 9.7% in police services in British Columbia (BC). However, the reason behind the increase in contacts is unknown. As Huey and colleagues note, "definitional changes and awareness of the issue by police officers may or may not be at play here, but alternatively, it could be due to social changes, population growth, and other macro and micro impacts unrelated to (yet impacting) policing. As such.... pinpointing whether police contacts with PwMI are in fact increasing is not possible at this point..." (2021, pp. 433-434).

In one of the largest mixed-methods Canadian studies, Brink and colleagues (2011) provided socio-demographic information for self-reported data surrounding contacts between police officers and PwMI and found that most participants were unmarried (survey: 82%, *n* = 201; interview: 92%, *n* = 55), experienced low income (survey: 80%, *n* = 196; interviews: 90%, *n* = 54), and were high school or equivalent educated (survey: 73%, *n* = 177; interview: 73%, *n* = 44). Less than half of the participants (survey: 21%, *n* = 51; interview: 48%, *n* = 29) indicated they were currently engaged in some form of paid employment. Almost two-thirds of interview participants (63%, *n* = 38) reported lifetime experiences of homelessness which has been supported by other researchers who contend that people without permanent shelter are more likely to be seen in public spaces and are more likely to be seen as occupying positions of social disorder (Huey, 2007). Furthermore, people who experience homelessness may be more

likely to engage in survival tactics such as petty theft, which may account for the increase in contacts among this population (Schulenburg, 2016).

Brink and colleagues found that lifetime experiences of non-violent (77%, *n* = 46) and violent (72%, *n* = 49) victimization were prevalent among interview participants, but more recent experiences (those that occurred within one year), were reported by fewer than one-quarter of participants (22%, *n* = 13). Most interview participants had perpetrated non-violent (60%, *n* = 36) or violent (53%, *n* = 32) criminal acts in their lifetime. As with other research in this area, Brink and colleagues found that participants were more likely to be the victim, rather than the perpetrator, of a violent act in the past year (*p* = .006) (p. 21). As mentioned earlier, Brink and colleagues based their research on self-reported data and the authors did ask participants to disclose their mental health status. Schizophrenia (survey: 25%, *n* = 61; interview: 33.3%, *n* = 20) and bipolar disorder (survey: 42%, *n* = 103; interview: 33%, *n* = 20) were the most commonly self-reported primary diagnoses, followed by schizoaffective disorder (survey: 14%, *n* = 35; interview: 25%, *n* = 15) (p.22).

Canadian research on contacts between PwMI and police officers is scarce, and research regarding police contact with PwMI who are also members of minority or equity-deserving groups is even less developed; however, we can assume that contact among this population is increasing based on research showing a steady increase in forensic admission in Ontario between 1987 to 2012 of non-Caucasian backgrounds (Huey et al., 2021; Penney et al., 2019). Shore and Lavoie (2019) addressed this gap in knowledge by examining the ethnic composition of PwMI who encountered police noting that 14% were non-white despite comprising only 10% of the population in the area

studied. Shore and Lavoie (2019) also noted that PwMI who were white, were 6.6 times more likely to receive a community mental health referral than members of an ethnic minority group.

Further gaps exist in what is known about Indigenous PwMI and contact with police. In 2020, Huey noted that there were only eight published, peer-reviewed studies on Indigenous policing. An exception to this is the work of Kiedrowski et al. (2016) who examined issues related to police mental health response within Indigenous communities in Canada. This study surmised that Indigenous police services were positioned to fail due to lack of funding, difficulties in retention and recruitment, significant rates of mental illness, and disproportionately high levels of suicide and substance use (Kiedrowski et al. 2016). In a search of police annual reports for statistics related to mental health calls in Indigenous police services, Huey et al. (2021) located 16 Indigenous police services. Of these, only five provided statistical information on their location and the population served (p. 439). Indigenous contacts with police warrant further exploration given that, despite comprising only 5% of Canada's population, 30% of Canadian prisoners are Indigenous (Al Jezeera, 2021). In Manitoba, Saskatchewan, and Alberta, this number rises to 54% (Al Jezeera, 2021). Indigenous people in Canada are more likely to be shot and killed by police. While it is difficult to track these numbers, a CTV news analysis revealed that of the 66 people shot and killed by police since 2017, 25 were Indigenous. This number may be even higher given that race and heritage are not always identified in these circumstances.

Police officers and PwMI encounter one another for various complex reasons and the characteristics of these contacts are equally complex and diverse. A review of the

literature by Brink and colleagues in 2011 in Canada, found that half of all contacts between these two populations involved "alleged" criminal behaviour. In their review, Brink and colleagues (2011) found that 1 in 5 (20%) police encounters and arrests involving people with mental disorders were concerning the alleged perpetration of a violent criminal act (Brink et al., 2011, p. 30). Forty percent (40%) of the encounters between police and PWMI involved less serious and non-violent criminal acts including theft, property damage, and disorderly conduct (Brink et al., 2011). This is consistent with Charette's (2014) finding that police interventions involving PwMI were less likely than those without mental illness to be related to more severe offences. Interestingly, interventions for these minor offences were more likely to result in arrest when they involved someone with mental illness (Charette, 2014).

Hacker and Horan (2019) reported that the most frequent scenarios involving police officers and PwMI include concerned persons (often family and friends) contacting police during a psychiatric emergency, suicidal ideation, inappropriate behaviours, or persons seeking help from the police due to "imagined threats" (p. 552).

In a mixed-methods study conducted in Chicago between 2012 and 2016, researchers confirmed that these interactions occur for various reasons. In their study of the nature of calls, Wood et al. (2020), found that police responded to calls about young people manifesting behavioural disturbances at school, families struggling to support a loved one with MI, and people experiencing food insecurity or housing instability (p. 32). In their study of 36 field observations, it was not uncommon for calls to be accompanied by substance use issues, which is not surprising given the presence of co-morbidities in justice-involved populations (Peters et al., 2015). This study was largely based on

observations and officer descriptions; therefore, it is difficult to determine whether these calls involved someone with mental illness (MI) or if the data was based on people perceived to have a MI.

In a recent examination of what is known about how police encounter people with mental illness in the Canadian context, Huey and colleagues (2021) noted three ways in which these groups interact: Conducting apprehensions under provincial and territorial mental health legislation, investigating reports of PwMI who have been reported missing, and conducting wellness checks including responding to reports of people who are considered high risk for suicide (p.427). Another Canadian study by Kouyoumdjian et al. (2019), found that of 547 individuals with mental illness, 518 had formal contact with police. Of 518 contacts, 213 were the result of victimization.

To date, little Canadian research has explored the dynamics that have led to a request for police intervention (Huey, 2021, p.436), although some studies have attempted to shed light on incident characteristics. One such study by Charette et al. (2011), found that people with mental illness (PwMI) were among those most likely to initiate an intervention (21%), followed by a relative (20%), or bystander (19.5%). In a study conducted in Ontario, Shore and Lavoie (2010) noted the most common initiator or encounters were service providers (i.e., paramedics, mental health workers, schools, and hospitals) (29%), followed by family members or friends (28%), bystanders (27%), and self (16%). In a study conducted by the Saskatoon police of the calls that came through dispatch, 42% were initiated by family members or friends (n = 191) and 13% (n = 60) were initiated by the person in crisis (Saskatoon Police Service, 2019).

The characteristics and call-types described throughout the literature and often serve to provide simplistic reasonings for why people with mental illness encounter the police. With a focus on mental health status, these disclosures often overshadow the many other complex factors that contribute to crises. The reporting and quantification of mental health statuses often attribute certain characteristics to people with mental health diagnoses and serve to homogenize descriptions of people with mental illness and their experiences. Previous research and practice have socialized this practice by focusing on symptoms of those in crisis and basing trajectories in medical models; however, findings from this and previous studies reveal, this leads to a narrow and simplistic understanding of these issues and lead to negative experiences and consequences for people in crisis.

Crisis Response Teams and Co-Blended Models

Research has focused extensively on Crisis Intervention Team (CIT) programs which provide training for officers to increase their knowledge about mental illness and change their attitudes toward people with mental illness (PwMI) (Compton et al., 2014). While CIT models vary, many are based on the Memphis Model which was developed following the death of an individual with mental illness at the hands of police officers. CIT models often involve 40 hours of training by mental health professionals and advocates (Rogers et al., 2019; Rohrer, 2021).

CIT programs are widely accepted and implemented in North America and there are currently 2645 local and 351 regional CIT programs in the USA (Rohrer, 2019; Watson et al., 2010). CIT content was developed by the University of Memphis and includes content concerning the history and overview of CIT, education on mental illness (including identifying signs and symptoms), risk assessment and intervention,

developmental disabilities, substance use disorders, auditory hallucinations, legal issues and departmental processes, a panel of consumers and families impacted by mental illness, community resources, and role play exercises that include de-escalation of crises (Rohrer, 2019; Watson et al., 2010).

Studies regarding the effectiveness of the CIT model have failed to produce consistent results. In a study of 586 officers (251 trained in CI), CIT training revealed a significant impact on officers' knowledge of mental illness, attitudes toward people with mental illness (MI), and social distance and stigma toward people with MI (Compton et al., 2014a). A further study examining 91 CIT-trained officers found officers with training were less likely to arrest people with perceived MI (Compton et al., 2014b). Morabito and colleagues (2012) found that officers with CIT training were less likely to use force on people with perceived mental illness. Compton et al. (2014b), found that officers were more likely to refer a person perceived to have a mental illness to a mental health service provider following training. Watson et al. (2010) did not find a significant difference among trained officers, and noted officers were more likely to arrest individuals with co-occurring substance use disorders.

A Canadian study conducted by Kerr and colleagues (2010) revealed that CIT training did not affect injuries in police encounters with people perceived to have a mental illness. The study suggested that, at higher levels of resistance, when CIT training is no longer effective in reducing force, the likelihood of injury increases (Kerr et al., 2010). A further criticism of CITs is that, within Canada and in the USA, the implementation of the program varies. To date, there is no standardized CIT program and departments are often able to determine what CI approach to utilize, how many officers

to train, and the hours and components of training. Further, many officers report not having specific training related to responding to people experiencing a mental health crisis (Compton et al., 2017; Lane, 2019). One study found that, in large departments in the USA, only 20% of officers have training (Compton et al., 2017). With 20% trained, these officers only responded to 20% of calls involving people with mental health issues (Reuland et al., 2010). Having officers on call who are trained and able to respond is not always feasible.

While changing attitudes toward PwMI is not an explicit goal of CIT training, officers' perceptions of mental illness stigma are acknowledged throughout training. For example, some lectures based on the Memphis Model 40-hour training curriculum highlight the importance of discussing the negative beliefs of PwMI who use psychotropic medications (Haigh et al., 2020). Some authors contend that given the inconsistent findings concerning the effectiveness of CIT training, factors- such as mental illness stigma that may contribute to the (in)effectiveness of these interactions should be examined; however, to date, there is a paucity of empirical research examining the stigma held by law enforcement officers toward PwMI to date (Haigh et al., 2020, p. 46). Haigh and colleagues (2020) examined whether CIT training affected levels of mental illness stigma among 185 officers in four police departments in Connecticut. The authors used surveys to determine levels of stigma using phrases like "People with mental illness tend to neglect their appearance" and "When I am around someone with mental illness, I worry they might harm me." Survey results indicated that there were no significant differences in the levels of mental illness stigma between CIT-trained and untrained officers.

An alternative to having trained officers respond to calls involving PwMI, co-response teams, also referred to as blended models, are another widely accepted approach to crisis intervention (Reuland, 2010; Rohrer, 2021; Watson et al., 2010). Co-response teams include mobile crisis intervention and comprise police officers and mental health professionals (e.g., a social worker, a nurse, a mental health counsellor, or a psychiatrist) (Bailey et al., 2018; Morabito et al., 2018). Co-response teams have proven effective in reducing the negative outcomes associated with interactions between police officers and people with perceived mental illness (Morabito et al., 2018; Rohrer, 2021). In one study of 1127 incidents responded to by the Boston Police Department's co-responder unit, only 0.8% of the calls (9 of 1127) resulted in an arrest. Similarly, Steadman et al. (2000) found that 5% of interactions between people with perceived MI and police officers ended in arrest. A significant benefit of having a police officer partnered with a mental health professional includes increased referrals to mental health services (Steadman et al., 2000). One study found that 78% of the Knoxville co-responder program resulted in referrals to treatment services (Steadman et al., 2000). Interagency collaboration and increased information sharing between agencies have also been noted as positive outcomes of this approach (Bailey et al., 2018; Rohrer, 2021).

While authors have found this collaborative model effective, feedback from PwMI who have interacted with this model during a crisis disagree. A study by Boscarato and colleagues (2014), using information gathered from people with lived experience of mental illness (PwLE), found that participants noted the still have a police record with the embedded model and that the process may actually take longer to resolve. Further, the degree of success of these models depends on well-coordinated and timely responses

which may be difficult, and not always possible between agencies (Boscarato et al., 2014).

In the most recent and largest systematic review and meta-analysis of police response models conducted by Seo and colleagues in 2021, police response models including CITs and co-response models were found to offer only a moderately effective solution for processing incidents with PwMI. The meta-analysis included 42 studies from across the world including Canada, the USA, the UK, Australia, and Africa. While the findings from Seo et al.'s study found crisis response models improved "officers self-reported changes in officer perception" or "self-reported changes in PwMI perception" outcomes (e.g., attitudes toward PWMI and perceived procedural justice of PwMI), police response models had little impact on observed officer behaviour outcomes including reducing arrest rates and excessive use of force (2021, p.1).

Despite providing police officers with training in de-escalation and skills in confronting people with MI, these programs are often ill-integrated into the wider mental health care system and serve as a "check box" for police agencies. Still, police CITS and co-response models involving the police, continue to be a dominant model of CI. Of greater concern, few departments track program outcomes and many lack clear benchmarks for measuring success.

Outcomes of Interactions

Informal outcomes, responses that do not involve transportation to institutional settings and may include support from family and friends, are listed as a preferred method of crisis resolution by those experiencing a crisis throughout the literature (Watson & Wood, 2017; Xanthopoulou et al., 2022). However, this is a lesser-examined

outcome of interactions between police officers and PwMI. One exception is the work of Boscarato et al. (2014) who examined the lived experiences of PwMI. Boscarato and colleagues (2014) found that of the 11 participants with lived experience included in their study, all but one preferred informal crisis support from family and friends. The study also confirmed that quite often, informal supports were unavailable causing participants to deal with the issue alone or seek out formal support. Boscarato et al.'s findings indicate that, the formal responses they most preferred involved general practitioners, mental health case managers, and the emergency department (2014). Participants in this study unanimously indicated they would never call the police to solve their crises.

While Boscarato et al.'s (2014) study examining narratives of PwMI found that PwMI reported received formal CI, other studies, report that many mental health-related crises are solved at the scene. For example, Bailey and colleagues (2021) examined 1426 events over two years in a large Midwestern city in the USA and found that most events (*n* = 784, 55%) were solved at the scene, followed by immediate detention (*n* = 384, 26.9%), voluntary transport (*n* = 200, 14%), and arrest (*n* = 58, 41%).

Studies concerning call dispositions involving PwMI and police officers fail to yield consistent results. In a systematic review of 11 studies on contacts between police and individuals with MI, half of all police encounters involving an individual with MI resulted in transport to the hospital or referral to services (McNeilly, 2017). This same review of studies ranging from 1986 to 2010, found that on average, approximately two in five (40%) of interactions were resolved by police using informal means.

Commonly cited outcomes of police contact with PwMI are transport to treatment and transport to jail (Ritter et al., 2011). Police make the decision to transport to hospital

or jail based on factors such as whether the person is exhibiting violence, whether the person was taking prescription medication, or whether the person is showing signs of mental illness or substance abuse (Ritter et al., 2011). After making this initial assessment, police officers must further assess the availability of treatment services in the community, which is based on the degree of knowledge that officers have about the mental health system (Morabito, 2007; Ritter et al., 2011; Teplin & Pruett, 1992). These decisions are also based on the demeanor of the person in crisis, the officer's own personal characteristics, and the type of offence in question (Ritter et al., 2011). Ritter and colleagues (2011) analyzed CIT officer reports (n = 2174) during a five-year period using hierarchical logistic and multinomial regression analyses to compare transport to jail, hospital, or not transported at all. The results revealed that calls dispatched as suspected suicide were more likely to be diverted to treatment than to jail. Further, data indicated that calls dispatched as disturbance, suspicious person, assault, or suspicion of a crime were less likely than a mental health call to be transported to service (Ritter et al., 2011).

Ritter and colleagues (2011) found that officers who determined that PwMI were demonstrating areas stressed in CIT training, including substance use, adherence to medication, signs, and symptoms of mental illness and/or physical illness, and violence toward self and others, were associated with an increased likelihood of transportation to treatment.

A study by Lord and colleagues (2011) examined the nature of interactions between police CITs and the outcomes of these calls. Using quantitative methods, the researchers examined a large sample of reports of cases of CIT interaction of crisis

among those with MI (*n* = 3635). Results indicated that calls were most often diverted to hospitals and/or crisis units when they involved violent, intoxicated, psychotic, mood-disordered diagnosed, and in need of urgent care (Lord et al., 2011). Of the sample, 25% of calls involved diverting the individual from their current setting to the hospital. Further results indicated contacts most often involved males. As with other research in this area, there was no control group, and the data was collected from a single location. In a study by Short et al. conducted in 2014, most cases (*n* = 2552, 97.7%), involved police officers who were responding to an unplanned call for assistance (p. 339). In most cases, the individual was brought to the hospital emergency department (77.6%, *n* = 2025). Individuals were also brought to psychiatric facilities (8.3%, *n* = 217), and the police department (5.6%, *n* = 146).

Despite programs including Crisis Response Models which are designed to divert PwMI from jail, research indicates that approximately one in seven, or 14% of contacts involving police and PwMI result in an arrest (McNeilly, 2017). Police have been said to serve as gatekeepers to institutions, whether medical or judicial. One study found that one in three individuals who were transported to hospital emergency rooms in psychiatric crisis, was taken there by police (Teplin et al., 2005). Research examining the formal and informal accounts of these interactions has failed to account for the various factors leading up to a crisis event, often focusing on immediate and disorder-based causes including substance use and presumed mental health diagnoses. Studies are often based on the impact of CIT training and fail to account for various other complex factors surrounding t these encounters.

Research concerning the outcomes of interactions has also failed to account for the long-lasting impacts of these encounters specifically, from the first-hand accounts of those involved. Formal outcomes, for example, when individuals are diverted from jail and brought to the hospital, are often viewed as a positive outcome despite this experience resulting in a person's loss of power, and freedom.

Experiential and Perceptional Accounts of Police Officers

The perceptions that the police and people with mental illness have of one another can influence the nature and quality of their interactions (Brink et al., 2011, p.7), yet few authors have examined the facets of these complex interactions through an in-depth qualitative analysis.

Much of the research concerning the perceptions of police officers and PwMI concerns their attitudes toward the effectiveness of crisis response models and training. Seo and colleagues (2021) found that as of 2021, only four studies had examined frontline officers' perceptions of CIT models (Bonfire et al., 2014; Ellis 2014; Ritter et al., 2011; Wells & Schafer, 2006). All four studies found that officers reported positive perceptions of CIT models. Officers reported that: CIT training enhanced their confidence and preparedness when dealing with people perceived to have MI (Bonfire et al., 2014), improved officers' attitudes, perception, and knowledge of PwMI (Ellis, 2014; Wells & Schafer, 2006), and was effective in diverting PwMI from the criminal justice system to mental health treatment facilities, minimizing encounter times, increasing preparedness, and meeting the needs of PwMI (Ritter et al., 2011). Seo and colleagues expanded this research by examining the perceptions of police chiefs' favorability toward police response models (including CITs and co-response models). They found that police

chiefs (n = 190) showed favourable attitudes toward police response. The analysis also showed that nearly half (49.5%) of police chiefs in the sample reported that their department did not operate a PRM (Seo et al., 2021, p.808).

In a study by Soares and Pinto da Costa (2019) examining 10 police officers with an average of 22.6 years of experience in law enforcement, police altered their behaviour to become more empathetic and comforting to people perceived to have a mental illness. Findings indicated that officers felt dealing with these individuals was challenging and time-consuming. Police officers in this study perceived individuals with mental illness to be dangerous, unpredictable, and without discernment (Soares & Pinto da Costa, 2019). Similar findings were found in a study by Lane (2019) that examined online discourses surrounding mental health issues on an online policing forum. The author found that officers thought mental health-related work was incompatible with police work unless there is was need for physical restraint (Lane, 2019).

Further findings from this study suggested that police officers delegitimized mental health problems and that, in some instances, officers deemed the person in crisis to be attention-seeking and wasting police time (p. 433). Lane's study highlights how police perceive people experiencing a mental health crisis and their role in these events. Lane's work highlights the assumed socially constructed nature of social categories and acknowledges how discourses are used to build up "mentally disordered identities" (2019, p.431).

Throughout the literature police report that these interactions are challenging and frustrating. Short and colleagues (2014) found that police find calls involving people with mental illness (PwMI) take up a significant amount of time and resources. Further studies

have noted the "conflation of mental health and moral deviancy" and skepticism regarding the authenticity of crises among people with MI in discussions among police officers (Lane, 2019, p. 433). The results from Lane's study are not surprising given that, historically, there has been resistance by police officers toward their role in the management of people with MI (Bittner, 1967; Short et al., 2014).

Experiential and Perceptional Accounts of People with Mental Illness

In the only qualitative systematic review of stakeholders involved in a mental health crisis in the community, Xanthopoulou et al. (2022) reviewed 79 studies concerning the experiences of people with mental illness (PwMI) and first responders. Of the studies included, most explored the perspectives of police (n = 35), followed by paramedics (n = 13), persons with MI (n = 15), carers and family members (n = 8), and other stakeholders (n = 8). Most studies were conducted in the United Kingdom (UK) and the USA (n = 22), followed by Australia (n = 15), and Canada (n = 11). The analysis included one study each from New Zealand, France, Sweden, Ireland, Ghana, Slovenia, Portugal, and Guyana. The review yielded 15 studies that involved the perspectives of PwMI, only two of which were conducted in Canada (Brink et al., 2011; Mahmuda et al., 2020).

Brink et al.'s 2011 study is the largest qualitative study in Canada with 60 people with lived experience sharing their perceptions and interactions with police. The second largest qualitative study included in the review from Canada regarding consumer experiences is Mahmuda et al.'s 2020 study explored the narratives of 10 participants using semi-structured interviews via a grounded theory approach. Common themes derived from the systematic review included acknowledging versus

criminalizing mental illness, legitimacy, and stigma, first responders' capability; and skills to deal with mental health crises, and the impact of response on companions: Involvement hindering versus facilitating response. Participants indicated their mental health crisis was not taken seriously by police officers.

As evidenced by Xanthopoulou et al., (2022) in their qualitative systematic review, few studies have examined how people with mental illness perceive their experiences with police officers during a mental health crisis. While not included in Xanthopoulou and colleagues' review, Evangelista and colleagues (2016) addressed this gap by conducting in-depth interviews with 12 people who had interacted with a co-response team between June 2013 and March 2015. Results indicated that this model was regarded as beneficial by PwMI and was a preferred response during times of crisis (Evangelista et al., 2016). Including PwMI in developing a care plan was also associated with positive experiences. When asked how they felt things could be improved, participants indicated further training and follow-up care would improve interactions. PwMI also expressed a desire to have access to support that reduces public scrutiny and the visible attendance of police (Evangelista et al., 2016). Limitations of this study include a small sample size. Further, there is room for improvement as it concerns the use of language and inclusivity. For example, the authors note that a high number of PwMI were excluded due to inaccurate contact details "which is reflective of the transient and unsettled nature of the clients engaged by services" (Evangelista et al., 2016, p. 275). The authors also tend to focus on challenges as opposed to strengths. The authors posit that "this high level of non-participation in the work and social relationships is consistent with the level of disability commonly observed in patients with severe mental illness who can

access crisis services" (p. 375). Like other research in the area, there is no way to confirm that there is an actual diagnosis or to ascertain the degree to which the crisis was a result of that diagnosis or other situational and/or systemic factors.

Earlier work by Boscarato and colleagues (2014), examined consumer experiences of formal crisis-response services and preferred methods of crisis interventions. Their work included 11 consumers aged 22-58 who indicated they had experienced symptoms of mental illness for 13.27 years on average (Boscarato et al., 2014, p. 289). While the study sought primarily to explore consumer experiences with joint police and mental health service crisis response, the authors found that most participants were unable to comment on how effectively the services worked together because the agencies presumably interacted and coordinated their response before arriving at the scene; as such, the concept of collaboration was difficult to understand, and the participants' intense distress at the time of the crisis prevented them from knowing how the agencies interacted (Boscarato, 2016, p. 289).

The narratives of participants resulted in five themes: response speed, humane treatment, feeling threatened by personnel, over-reactive police interventions which exacerbated the crisis, and disjointed responses and lack of onsite collaboration. Participants in Boscarato and colleagues' (2014) study indicated that timing of response was crucial in crises and while most participants found the police responded promptly, one participant waited 45 minutes at a police station before the crisis team arrived. Another participant noted their symptoms of mania escalated while waiting in a police cell for mental health professionals to arrive. Some participants indicated they felt they were genuinely listened to and treated in a non-judgmental and non-threatening manner.

Others noted they felt frightened by the police due to their uniforms, weapons, and authority. Numerous participants noted they were treated roughly by police and subjected to non-lethal weapons (e.g., tasers). Most felt "reactions had been disproportionate to the risk they posed" (p. 290). Despite the small sample size, this study is one of few in this area that departs from the professional perspective.

In a Canadian study using a participatory action research (PAR) model, Brink et al. (2011) used a mixed-methods approach to examine how individuals (n = 304), with mental illness, encountered police officers and how they perceived these encounters. Using semi-structured interviews and surveys, researchers determined that most participants held positive attitudes toward the police but that this varied based on individual officers and individual events (Brink et al., 2011).

Although this study found that participants did not hold negative attitudes toward police, compared to the general public, participants' attitudes toward police performance were more negative. These findings suggest that the negative perspective about police may result from a combination of factors such as direct experiences interacting with the police (e.g., in the context of an alleged criminal act), feelings of powerlessness, co-occurring substance use problems, and marginalized social locations (e.g., high rates of poverty, unemployment, homelessness, and victimization) (Brink et al., 2011). Almost half of the participants in the survey stated that they wished the situation had been handled more effectively; however, further details regarding how participants feel things may be improved are needed (Brink et al., 2011).

Brink and colleagues (2011) examined quantitative and qualitative data to determine service user perceptions of their contacts with police. Using a five-point scale

to rate participant experiences from “very dissatisfied” to “very satisfied”, the researchers found mixed results but noted that service users generally felt satisfied with their encounters with police (53%, *n* = 41) as opposed to those who were generally dissatisfied (37%, *n* = 29).

The authors noted, “the lowest-rated items tended to be those involving situations in which the participant was engaging with the police in the context of suspected criminal behaviour or activity” (Brink et al., 2011, p. 55). The results of interviews indicated that 30% (*n* = 15) of service users felt their mental illness had a positive influence on their encounters with police. Nearly the same number of participants (32%, *n* = 16), felt their encounters with police were negatively impacted by their mental illness (Brink et al., 2011).

Further evidence of variance among experiences was found in Livingston’s (2016) study of 60 individuals with mental illness who had interacted with police in Vancouver, Canada. Most of the sample, (*n* = 43, 72%) reported they were generally satisfied with how the police officer(s) handled their most recent interaction. Livingston (2016) found that a slight majority (*n* = 30, 51%) rated their previous experiences with the police as positive; with 32% (*n* = 19) indicating that their previous encounters with the police were negative (p. 334).

In an earlier study, Watson and colleagues (2008) examined the perceptions that individuals with mental illness (*n* = 20) held of police. The authors found that participants felt fearful and often humiliated during interactions with police officers. Some participants reported both physical and verbal abuse by officers. The results also indicated that the way police officers treated the individuals in these situations mattered.

Fairness and respect were shown to affect the outcome of interactions leading to more positive experiences (Watson et al., 2008).

The perceptions that participants hold about one another and of their interactions with each other vary, and research indicates that not only do perceptions vary between individuals and events- they even fluctuate within a single interaction (Brink et al., 2011; Jones & Mason, 2002). Due to varied and inconsistent findings and the complexity of the issue, more research in this area is warranted. Specifically, the details and experiences of people living through these encounters would develop the current body of literature.

Language and Frameworks Used in the Literature

The growing body of literature concerning interactions between police and people with mental illness (PwMI) has resulted in various terminology, frameworks, and definitions surrounding these occurrences (Frederick et al., 2018). Most often, this has been given limited attention despite its larger implications. As Frederick and colleagues note, it is important to highlight the variance and use of the language as it relates to these encounters for theoretical and methodological purposes (2018, p. 3). It is also important to examine the language and frameworks surrounding these encounters and their contribution to the discourse surrounding mental health.

In a scoping review of 92 articles about police responses to mental health crises published over a 17-year period (2000-2017), Frederick and colleagues (2018) found 17 different frames used to explain the current context of these interactions and 23 different terms used to describe people with mental illness.

Frederick and colleagues (2018) found that criminalization, described as the overrepresentation of people with mental illness in prisons and jails, was the most

common frame employed in the research (used in 48% of the articles). The next most used frame was deinstitutionalization and "a framing emphasizing police as a common frontline response to people in crisis (used in 32% of the articles) (Frederick et al., 2018, p. 10). Crisis-focused framing was used in 26% of articles and was often used in articles focusing on the evaluation of CITs (Frederick et al., 2018, p. 11). Twenty-three percent (23%) of the articles examined employed multiple frames (deinstitutionalization, crisis, and criminalization) and 21% of the articles offered no framing or context for discussion (Frederick et al., 2018).

Of the 92 articles reviewed, only a small portion (9%) directly discussed stigma or discrimination. Other systemic factors such as gentrification (2%), homelessness (16%), inadequate support (17%), or disordered policing strategies (11%), demonstrated reduced attention (Frederick et al., 2018).

The analysis reported 23 different terms used to describe people with lived experience of mental illness (PwLE). The most used term by large was "person with mental illness" or a related term (used in 96% of articles). The term "mentally ill" was also used frequently with 94% usage across articles with 751 occurrences (p. 11). The next most common term was "people in crisis" (used in 72% of articles with the usage of approximately 155 occurrences), followed by "consumer" (66%), subject (61%), and "people with serious mental illness" (58%). Many articles did not provide a direct definition or operationalization of PwMI. The investigators found a "significant amount of overlap in terms of the definitions and operationalizations, but also differences in terms of the illness listed" (Frederick et al., 2018, p. 14).

The variation in language and topic framing has important implications. Methodologically, the variety of terms used (often interchangeably) raises concerns about the extent to which groupings can be treated as constituents of the same population (Frederick et al., 2018, p 3). For example, is a person in crisis the same as a person with mental health issues? Not all people who are in crisis have a mental health diagnosis. Further, some articles rely on police labelling of persons with mental health issues; however, police do not have the knowledge or capacity to make these assertions, and often, it is unknown if the person involved truly has a mental health diagnosis. Further, the context of crisis is diverse and may include other factors including lack of housing and access to appropriate support.

The work of Frederick and colleagues (2018) highlights an important and often forgotten area of exploration into these occurrences. As the authors concede, the terms and frames we use can shape the construction of the problem and the proposed solutions (p. 4). In the process of defining and outlining the context of these interactions, researchers play an invaluable role and hold a certain amount of power to shape the perception surrounding these interactions. Labelling people in crisis as being mentally ill further stigmatizes and depersonalizes the issue and leads to negative outcomes for those involved. It also perpetuates the ongoing discrimination of people with mental illness (PwMI). The tendency to frame these occurrences as individual problems or crises related to the inherent nature of the illness overlooks predominant systemic issues such as poverty, stigma, lack of access to support, and social isolation. It also perpetuates the notion that people with mental illness are dangerous and unpredictable, thus warranting police intervention.

The authors reflect an ongoing propensity to individualize crises and blame problems on factors attributed to mental illness while glazing over crucial factors such as homelessness, poverty, and disorganized policing strategies (Frederick et al., 2018). This creates a common narrative in the literature and society that the authors eloquently summarize:

> Around the 1960s, mental health hospitals started to close and legislation around commitment changed. These changes led to an increase in individuals with mental illness in the community. Untreated mental health needs within this population led to a crisis and increased police contact, which frontline officers have not had the training to manage, particularly with limited options for resolving these calls outside of arrest or apprehension. These factors combined led people who might otherwise be in a hospital to end up in the criminal justice system (Frederick et al., 2018, p. 16).

This narrative, while prominent in the literature, is problematic and over-simplistic and overlooks that most people with mental illness are unlikely to require hospitalization or have contact with the police because of their diagnostic label. Offering a broader and more thoughtful narrative has the potential to combat these problematic and discriminating beliefs. Frederick and colleagues (2018) highlight the dangers of the variance of terms and frameworks surrounding police interactions with people with mental illness as illustrated in the literature, but they also highlight the work of other authors who have documented "the successful interactions that can extend from the ability of officers to recognize "chronic vulnerability" and to "negotiate provisional outcomes" (p. 17).

There are two issues with this. First, this assumes that people with mental illness have "chronic vulnerabilities", which further perpetuates the notion that people with mental health issues are predisposed to negative symptoms and neglect to focus on individual strengths. It also fails to consider that these "chronic vulnerabilities" exist outside of the individual experiencing a crisis and fails to consider the many strengths these individuals have. Second, this fails to account for the dangers associated with having police officers using their power to "negotiate provisional outcomes." This is problematic as it assumes officers know how to make appropriate decisions related to a person's well-being and mental health. This echoes the sentiments of authors who have referred to police officers as gatekeepers (for example Rasmussen, 2020). This statement holds police officers responsible for facilitating positive outcomes, thereby removing decision-making power from the individual experiencing a crisis. In response to these concerns, this study used language that reflects multiple factors that reside outside of the individual in crisis and that account for various complex and systemic issues within a broader system. This is described in greater detail in Chapters four and five,

Limitations of Previous Research

A review of the research demonstrates the limitations and challenges of current knowledge concerning police interactions with people perceived to have mental illness and the need for this study and future research.

First, there is a lack of standardized terms in the literature as it concerns mental illness, crisis, crisis teams, and distress. The absence of clear and operationalized terms makes it difficult to ascertain the degree to which a "crisis" or "distress" is indeed the result of mental illness and vice versa. Much of the literature is based on the subjective

experiences of police officers and whether they deem certain physical and behavioural characteristics to be proof of a mental health diagnosis. Furthermore, the various frames used to contextualize the issue make it difficult to gain a holistic understanding of these interactions, and often very narrow and rigid reasons are offered as reasons for these interactions.

An additional limitation is that a large amount of the literature is focused on police perspectives of these interactions. Further, most of the research has focused on the quantitative impact of police training, often with contradictory findings. With few exceptions, a large amount of the research has omitted the narrative accounts of PwMI and how they may be empowered within this context. Despite an increase in information in this area, little is known about how participants feel about the role police officers occupy in this domain, the outcomes and short and long-term impact of these interactions from the perspective of those involved, and the perception of dangerousness among participants involved in these encounters.

Much of the literature is grounded in traditional positivist frameworks of mental illness. The literature continues to provide simplistic and narrow explanations for the frequency of these interactions (for example, deinstitutionalization), and individualizes and pathologizes people with lived experiences of mental illness. Many studies continue to focus on the challenges associated with perceived diagnoses and the symptoms that may or may not accompany them. Within this view, people with mental illness are apt to experience challenges due to their inherent vulnerabilities and not due to social and systemic structures that have served to oppress PwMI throughout history.

Summary and Importance of the Study

The present study moved away from the limiting and narrow conceptualizations of this issue. This work positioned those with lived experience as experts and empowered them to share their stories in the lesser-explored narrative tradition. This study sought explanations beyond the narrow framing that has oversimplified and pathologized these occurrences and muted important factors that exist beyond the individual. This study sought to better understand police contacts with people with mental illness looking beyond symptoms and diagnoses and allowing for a deeper understanding of the multiple complex factors that contribute to these encounters.

This study asked questions that have been less explored in the literature including perceptions of risk and dangerousness, perceptions of one another, and suggestions for future directions. The study sought rich details of experiences including the impact and outcomes of these interactions.

A specific and strategic methodology was chosen for this study to address gaps in previous research. Through a qualitative approach, this study provides a rich analysis of these interactions which will be described in greater detail in the following chapter. This work has important implications for social workers who understand the limitations of focusing on only one aspect, for example, diagnoses and symptoms, when responding to people in crisis. Social workers understand the importance of interdisciplinary collaboration, advocacy, the impact of stigma, and the need for advocacy. Social workers often work directly with people with lived experience of mental illness and those in crisis and can contribute to the field in a research and practice capacity. An understanding of the phenomenon of police interactions with people with mental illness in times of crisis

may assist social workers who may work directly with people with lived experience of mental illness in times of crisis.

CHAPTER III: METHODOLOGY

Research Design

In response to conceptual and methodological gaps in the literature, this study employed a qualitative design and drew from aspects of grounded theory in a constructionist framework (Charmaz, 2014). A qualitative approach to inquiry was selected given the paucity of voices from people with lived experience of these interactions throughout the literature, and in order to elicit rich descriptions of interactions between police officers and people with lived experience of mental illness (PwLE) through one-on-one in-depth interviews with participants. As indicated in earlier sections, positivist methodologies such as survey data and labelling, limit an understanding of the complexities of these interactions. In order to collect rich and descriptive information, qualitative methods were employed.

The study design was based on Charmaz's (2014) approaches to Constructivist Grounded Theory (CGT). Charmaz's constructivist approach to grounded theory (GT) departs from the rigid, rule-bound, and prescriptive traditions of Classic and Straussian methodology and philosophy (Kenny & Fourie, 2015) thus allowing for an open and flexible approach that would leave space for a comprehensive understanding of the experiences of people with lived experience of mental illness and police officers.

Constructivist Grounded Theory, presented by Charmaz, a student of Glaser, offers a third adaptation of GT, resisting concrete and prescriptive approaches to coding that serve to confine the researcher's creativity (Charmaz, 2008). Charmaz argues the importance of flexibility, tolerance for ambiguity, and openness to emergent categories. Constructivist grounded theory aligns with the philosophical underpinnings of this study

described in chapter one and departs from earlier versions of GT which Charmaz argued were closely related to traditional positivism assuming "an objective, external reality" (Charmaz, 2000, p. 510). Constructivist grounded theory (CGT) offers a valuable framework for understanding mental illness by acknowledging the subjective nature of experiences and allows flexibility in data collection and analysis enabling researchers to adapt their approach to capture the unique and diverse experiences. CGT has implications for critical inquiry with the goal of democratic social reform (Charmaz, 2017), which applies to this work as change is needed within the domain of practice and policy surrounding policing mental illness.

Procedure

To maintain quality throughout the work, a strategic and procedural approach was used throughout the research design and implementation process based on the work of contemporary grounded theorists (Charmaz, 2014; Sbarini et al., 2011). The first step of the process included the development of an open and flexible research question to guide the work. The overarching research question was: How do participants describe their experiences of interacting with one another during a crisis? This question was used to develop further questioning that would elicit details that have not been previously addressed or require further development throughout the research (this is expanded on in later sections).

Designing the Interview Guide

In-depth interviews (IDIs) elicit rich information about personal experiences and perspectives while allowing for spontaneity, flexibility, and responsiveness; however, their implementation requires a considerable amount of time and effort (Russell et al.,

2005). To elicit rich narratives from participants, semi-structured, IDIs were used with both participant groups.

In designing the interview guides, the work of Deborah van den Hoonaard (2019) was used. van den Hoonaard's (2019) contemporary work provided detailed information on how to design an interview guide and how to effectively conduct interviews. This included how to conduct follow-ups (Appendix B), how to transcribe interviews, and considerations for electronic and online data collection. In addition to the work of van den Hoonaard, the project also drew from Kvale's (2007) work regarding the construction of interview questions and interviewing skills.

Two interview guides were created, one for participant group one (people with lived experience of mental illness) (PG1) (Appendix C), and the second for police officers who comprised participant group two (PG2) (Appendix D). The interview guide for PG1 consisted of socio-demographical questions (gender, age, ethnicity, education, and geographical location), one question concerning the use of language interview was added to the interview guide at the earlier stages following a review of the literature concerning language and frameworks and following discussion with one of the participants. This is discussed in greater detail in chapters one, two, and four. This question allowed participants to determine their preferred language and served to empower and offer choices to people with lived experience of mental illness (PwLE). For example, participants were asked about their preference for terms. One participant provided the suggestion to use the language of "people with lived experience of mental illness" as opposed to "people with mental illness." Additional participants were asked

what they felt about that terminology and many agreed that the language better described their experience.

Questions that sought to explore the description of encounters included: "What was the reason for the encounter?", and "What occurred during the interaction?" Prompts were used to obtain specific details regarding incident characteristics including how many officers arrived, what they did when they arrived, and the outcomes of the encounter.

Six questions pertained to perceptions of officer roles in responding to PwLE including the ways police respond differently to PwLE, why these occurrences have the potential to end in violence, why PwLE are sometimes seen as more dangerous, and in what circumstances if any, they believe police officers should become involved. Three questions explored future directions including what PwLE want police officers and others to know about these interactions and how these encounters may be improved.

The interview guide for police officers (participant group two [PG2]) was comprised of similar demographical questions including age, gender, ethnicity, rank and/or role within the department, and length of time in service. Police officers were also asked about their training, including what training they have had and whether they believe their training has been sufficient.

The greater portion of questions concerned the details of encounters. Questions explored incident characteristics including the types of calls they have responded to involving people with mental illness (PwMI), how many officers arrived at the scene, what they are hoping to accomplish when they arrive, outcomes of encounters, how these calls differ from non-mental health-related calls, and aspects of interactions considered

positive or negative. Officers were also asked for details of their attire (plain-clothed or uniformed), and their vehicle (marked or unmarked police vehicle).

Officers were also asked about their perception of preparedness in dealing with people with mental illness (PwMI). This included whether officers have received training, and what type of training they have received, and what they wish they knew about working with PwMI. Additional questions examined the perception of police role in supporting PwMI including whether they think police officers should occupy this role, and in what circumstances, if any, they should become involved.

Two questions examined the perception of people with mental illness including whether they believe calls involving PwMI are more dangerous and why these encounters have the potential to end in violence when they involve someone with a mental illness. Three questions examined future directions including what police officers wish the public knew about working with PwMI, what they wish PwMI knew about their role in supporting them, and how they think these encounters may be improved.

Determining Inclusionary Criteria

To participate in this study, participants in group one (people with lived experience of mental illness) were required to: (1) have interacted with police officers for a mental health reason within the last two years, (2) have interacted with police officers in Canada, (3) be over the age of 18 at the time of the interaction, (4) speak English, and (5) be willing and able to provide consent for an audio recorded interview. Participants of all genders, ethnicities, religious affiliations, economic classes, and from all provinces, were invited to participate in interviews.

Participants from group two (police officers), were required to: (1) have interacted with people with a mental illness while on duty within the past two years, (2) have interacted in this capacity within Canada, (3) speak English, and (4) be willing and able to consent for an audio recorded interview. Participants in group two were welcome regardless of their rank or length of time in service. Retired officers were also welcome to participate if they had interacted with people with mental illness while on duty within the last two years.

Research Ethics Board Review Process and Considerations

An application was submitted to the Research Ethics Board (REB) at the University of Windsor in February 2021. The application included sampling and recruitment plans, data collection instruments, and ethical considerations. Clearance for the project was received in March 2021 (REB#21-026). Data collection began in April 2021, and was completed in August of 2021.

Sampling and Recruitment

The initial research plan sought to interview two participant groups (people with lived experience of mental illness [PwLE] and police officers) with matching sample sizes for both participant groups (an equal number of PwLE and police officers). However, recruitment resulted in participation from both groups with over-sampling of the former (PwLE). Difficulty in recruiting police officers may be attributed to many factors including fear of financial or social losses that police officers may face in participating. Some officers who had worked with the researcher indicated they were not comfortable participating given they are already facing scrutiny for the work they do and that this is further complicated as “it is done differently in every department.” The

unprecedented pandemic posed additional challenges to researchers engaging in field work during the peak of COVID-19. Attempts were made to address low levels by engaging in various recruitment strategies and attempting to target more participants from group two. This was a very overwhelming time for people and may have contributed to participation levels. In total, 18 participants, 13 people with lived experience of mental illness (PwLE) and five police officers, consented to share their stories.

To recruit participants from across Canada, the study used sampling strategies that encouraged diversity, promoted accessibility, and allowed for sharing. Purposive sampling was used to find participants who had direct lived experiences of interacting during mental health crises. This approach was used deliberately as it was the most likely strategy to receive answers to the research questions.

An additional sampling strategy was snowball sampling. This method allowed participants to be recruited to the study via word of mouth whereby participants informed other potential participants of the study and encouraged them to participate. This method proved the most successful and when asking participants to disclose how they heard about the study they often reported they had heard about it from someone else. This was especially true for members of participant group two as an officer in Ontario shared a recruitment posting throughout her contact list in the police department.

Participants were also recruited through social media platforms and by e-mailing or telephoning police departments, grassroots agencies, and mental health organizations. The researcher searched online for directories of mental health agencies and organizations, support groups, and police departments across Canada. Attempts were made to contact an equal number of agencies across provinces for both participant

groups. To track recruitment and targeted outreach (attempting to fill gaps in geographical recruitment), a recruitment tracking table was created in a Google document which contained agency names, provinces, cities, name of the main contact, if available, and method of contact available (for example, social media, email address, telephone). The dissertation committee also suggested venues for contact and assisted with the distribution of recruitment materials to known contacts and on social media platforms.

Recruitment flyers were created using the Canva app and were created based on universal learning and accessibility approaches. Clear and consistent font style, size, and colour, were implemented in creating the flyers, and simple non-colloquial language was used. Flyers were posted online on Reddit, Twitter, Instagram, and Facebook. Postings were made on Facebook pages for mental health support groups and sent via direct messages to mental health agencies and police departments (albeit fewer as there were fewer social media avenues available for police departments), for permission and ability to post (Appendix E).

An Instagram account was created titled “Canadian Crisis Research” and hundreds of mental agencies and support groups were followed and contacted. The account acquired 65 followers and tags were created to promote sharing of the study. Overall, the most popular method of contact with the researcher was through e-mail which garnered the most direct contact with participants. Facebook was the second most common method of contact via direct messages received in response to recruitment postings on support group pages. Reddit was used by one participant. Most participants in participant group one reported they heard about the study through social media platforms

(Instagram, Facebook, and Twitter). Police officers responding to the study, reported word of mouth and social media postings had drawn their attention to the study.

Recruitment flyers were sent to agencies, via e-mail or social media platforms, who were encouraged to share via their social media platforms and/or within their agencies in hallways and waiting areas. Recruitment materials, including the email script sent to agencies and recruitment flyers, are found in Appendix E. Despite contacting numerous mental health agencies in Canada, many did not respond to communication with the researcher. This may be due in part to the pressure put on individuals and agencies during the context of the global pandemic. This was a very stressful time for many who were trying to pivot as a result of shifting demands.

Due to the context of the global pandemic, many agencies were not offering services in person; therefore, web-based recruitment was most effective. It is also noted that this may have contributed to lower participation. Agencies that were more apt to participate in recruitment strategies were grassroots organizations and advocacy groups. Furthermore, it was noted that agencies in the Eastern provinces (namely, Nova Scotia and Newfoundland), were more agreeable to sharing recruitment flyers on social media platforms resulting in participation from people with mental illness in the Eastern provinces.

Police departments and government mental health agencies were less responsive to recruitment inquiries. One large police department in Ontario asked the researcher to send an application to their department's ethics board noting it would involve a lengthy wait (up to and likely more than, six months) and would involve careful review and possible omission and revision of research questions. As a result, this avenue was not

pursued. Following snowball sampling, one officer from a mid-sized city in Southwestem Ontario sent an e-mail to their mailing list within the police department which resulted in contacts from multiple police officers within that area.

A further concern was noted by officers who showed an interest in participating but feared voicing their opinions would put them at risk noting that their vocational obligations were already highly scrutinized placing them at risk both personally and professionally. One participant noted that some police services may be unwilling to respond due to a "firewall" of sharing information:

> I think that's something that always comes up is our own firewall, our own sharing of information. It's so difficult because every service is doing things a little bit different."

The officer added that since so many agencies are doing things differently and there is no standard of practice, it puts them at risk for not doing what others are doing.

The recruitment postings and materials asked participants to connect with the researcher directly via email and an e-mail address was created for the sole purpose of the study (crisisresearch@uwindsor.ca). Once participants contacted the researcher, study information and consent forms were e-mailed for review. The researcher went over this information with participants via telephone before the interviews to assure an understanding of what the study entailed as well as to gather informed consent via audio recording.

The decision was made to include an automatic e-mail response to respondents who contacted the researcher via e-mail to report their interest in participating. An automatic message was set up in Microsoft Outlook that thanked participants for their

interest, advised that the e-mail account was not monitored 24/7, and that it was not a crisis service. The automatic message also contained a 1-800 24/7 crisis hotline number if they required immediate assistance. The decision to include this information was made given the nature of the subject and the possibility that people intending to speak with the researcher may have experienced a recent crisis and/or may be experiencing distress at the time of contact. This decision was made to protect participants and avoid any harm that may arise should they reach out expecting an immediate response. Participants were also offered follow-up resources if needed and were encouraged to reach out to the researcher if they had any further questions following the interviews.

In the e-mail script, participants were asked to advise of their availability. An interview schedule was created using Microsoft Word to track contact information and schedule participant interviews (Appendix F). This proved helpful in managing interviews across various time zones and documenting who had an interview scheduled, who was pending schedule, who had confirmed interviews, and who had yet to respond to the e-mail sent in response to the initial contact. Once a time and date were established for the interview, the researcher connected with participants via a secured video platform of their choice (Zoom or Microsoft Teams) or by telephone, at their preference. The researcher first offered to call the participant noting that as an alternative option, they could call the researcher themselves. This option was included to allow for privacy if the participant was uncomfortable sharing their contact information but also to attend to any accessibility concerns.

Only one participant in participant in group one opted to participate via the secured-video platform noting he would like to see the person he was speaking with. For

this interview, both cameras remained on but only audio was recorded. All other participants (n = 17) opted for telephone calls. Consent was thoroughly reviewed and recorded via audio recording as all interviews were conducted remotely. The researcher informed participants when the recording would commence and when it ended so that they were aware of when they were being recorded and when they were not.

The researcher confirmed and reviewed the study information and informed consent form with participants to assure they understood the study and to answer any questions they had before presenting the questions. This not only ensured a thorough understanding of their rights, but allowed space and time to develop rapport and not rush into questioning to avoid feeling as though they were being interrogated. Given the sensitivity and gravity of these experiences, it was important to create a safe and welcoming space where participants could share their stories; thus, it was important not to rush into questioning.

Theoretical Saturation

Saturation is a methodological principle that has attained widespread acceptance in qualitative research and, while there are various conceptualizations of saturation, contemporary theorists posit that saturation should be operationalized in a manner that is consistent with the research questions (Saunders et al., 2018, p. 189). Saturation has been described as a criterion for discontinuing data collection and is often considered an essential methodological element in qualitative research (ibid).

There is no current consensus regarding the appropriate sample size in qualitative research; however, some researchers have provided suggestions. For example, Creswell

(2019) recommends between five and 25 participants, while others have determined saturation to occur when no novel themes occur in the data (Guest, et al., 2006).

For this study, data was collected until theoretical saturation was achieved. It is noted, however, that reaching data saturation is often subjective, non-linear, gradual, and unfixed (Aldiabat & le Navenec, 2018).

Theoretical sampling was used to saturate the properties of categories, identify variations in processes, clarify the relationship between emerging categories, and improve the study by specifying relevant properties in categories and increasing the parsimony of theoretical statements (Charmaz, 2014). Theoretical saturation involves the "conceptualization of comparisons of these incidents which yield different properties of the pattern until no new properties of the pattern emerge" (Glaser, 2001, p.191). While the sample size for this study was not large, as previous authors concede, other considerations supersede the sample size.

The trend of non-emergent themes has been supported by Urquhart (2013) and Given (2016). In alignment with aspects of Kathy Charmaz's (2014) work concerning grounded theory, an open and flexible approach was taken when considering saturation whereby the use of reflexivity, intuition, and guidance from other grounded theorists and experts in the field assisted in determining theoretical saturation for participant group one. Participant group two was under-sampled due to the challenges presented during the recruitment phase as outlined previously; however, recurrent themes from participants in group two did emerge and are the focus of discussion in chapter four.

Interviews

Interviewing and recruitment occurred simultaneously for both participant groups. In-depth interviews (IDI) have been described as one of the most powerful tools for gaining an understanding of experiences and exploring topics in-depth (Fontana and Frey, 2000).

While the length of the interviews varied, most interviews were completed within 45 minutes to an hour. Two interviews were substantially longer (one and a half hours and two hours). Interviews with people with lived experience (PwLE) were longer than interviews with police officers. PwLE had more information to share when describing the factors leading up to and during their encounters with the police and the impact of their encounters. All of the interviews were conducted by the researcher as no research assistants were employed in this project. Interviews were recorded using an Olympus digital voice recorder. Interviews were conducted in private locations so that no one could hear conversations.

Interview questions evolved based on emerging themes and in response to participant feedback. The consultation of multiple guides to developing and implementing effective interview guides was important as this study focused on an important, controversial, and sensitive topic. Due to the sensitive nature of the topic and the potential for the questions to evoke negative memories from participants, strategic and methodical considerations were implemented. For example, having appropriate follow-up measures, for example giving participants time to ask questions at the end, providing them with contacts for additional community in-person and telephonic support if needed and encouraging them to connect with the researcher with any further questions

or concerns following the interview, ensuring that participants were well-supported throughout the process.

It is important to note that much of the discussion of intensive interviewing reflects a North American context; therefore, while elements of intensive interviewing were drawn upon, careful consideration of participants and contexts were explored throughout the development of the interview guide as well as the interviewing process.

A sensitive approach, a casual and non-threatening demeanor, and self-disclosure of interest and experiences led to meaningful discussions with participants. Using the same language as participants and drawing from principles of empowerment and advocacy helped to ease suspicions and position participants in an expert or consultant role. Participants expressed that this was comforting to them and that they wished more researchers and service providers would engage in this approach.

Participants were not provided with a copy of the interview protocol in advance; however, in hindsight, this may have been beneficial to allow participants time to reflect on their answers and to make participants feel more comfortable sharing their stories. All participants were asked whether they had any concerns or questions about the consent and interview process before commencing the interviews. Before commencing the interviews, the interviewer also took time to explain their position and interest in the area. This often involved answering the question “Are you a police officer?” Upon confirming that the researcher was not a police officer, many participants in participant group one (PG1) expressed relief. Given the dual roles of the researcher as a social worker and a crisis worker, rapport was established with both participant groups early in the process.

Revisions to Interview Protocol

The initial interview protocol included a lengthy introduction that explained the consent and interview process and included a thorough oral explanation of participant rights and risks. The initial plan was to read the introduction verbatim as part of the interview to ensure participants understood their role and their rights. The researcher orally improvised the introduction many times, and after the first interview, it was determined that the lengthy introduction took up too much time and was often unnecessary as participants were given a letter of information about the study and a letter of consent before scheduling the interview.

Most interview questions were read in order and as written in the interview guide; however, participants often answered questions ahead of time while describing the context and details of their interactions with police. In several instances, it was necessary to change the order of questions and add additional probes and prompts to obtain information that was not covered. Questions were added to the interview guide based on feedback from participants and based on themes that emerged throughout the interview process. For example, the questions *"*Is there anything else I have not asked that you think might be important?", and "Do you have any advice for me as I continue to interview others about their experiences?" were included to add more depth to the analysis and to allow participants the opportunity to provide their feedback and insight into the study. While participants did not add any additional questions, they did encourage the researcher to stay in touch with participants as they have invaluable knowledge in the area and to keep in mind that it takes a tremendous amount of courage to share this information with a stranger. As mentioned earlier, they also reminded the

researcher of the courage and strength it takes to share these stories and the challenges she could expect trying to mobilize the work. This is explained in greater detail in chapter four.

Participants in participant group one (people with lived experience of mental illness) spent a considerable amount of time setting the context for the interactions. Therefore, it was important to examine the factors leading up to the interaction rather than dive into the crisis event. As a result, more time was devoted than originally planned to examine the history leading up to contact with the police and the complexity of encounters. It also became apparent early on that developing a rapport with participants was particularly important for them to feel comfortable enough to share their stories. As will be discussed in greater detail in Chapter 4, many participants described their experiences as embarrassing and "the worst thing that has ever happened" to them. As such, rather than structuring the interview as step-by-step questions, participants were encouraged to share their stories and the researcher then prompted the participants to share more details to fill gaps in areas that were not covered. This helped to build rapport as participants were not made to feel like they were being interrogated allowing them the power to lead the discussion.

It also became apparent early on that asking participants about the "reason" for their encounter with police officers served to minimize multiple complex factors leading up the crisis. Therefore, the researcher allowed for an open conversation from the start and allowed space for the participants to share their history leading up to the encounter and expand on what was going on in their life during that time.

Due to the conversational nature of the interviews and the need to establish a relationship with participants before asking sensitive questions, the interviews often lasted longer than anticipated. Participants wished to vent their frustrations with the medical, mental health, and criminal justice systems. Some participants reflected on the impact of medication and lengthy hospital stays. Participants were not rushed and were allowed time to discuss their experiences. Techniques commonly used in the field by social workers, such as redirection, validation, and supportive listening were implemented at times.

Field Notes and Memos

Detailed notes were maintained from the early stage of research design through to data analysis. Memos contained all information, insights, or impressions, that arose during the various stages of the research project.

Memos also helped to organize thoughts and to contribute to the reflexive journal that was maintained throughout the research. The field notes and memos captured sensitizing concepts, inquiries, and ideas, that occurred throughout the data collection phase. Memos helped keep track of ideas throughout the research process and facilitated reflexivity and the recognition of how one's own experiences may impact the data and participant encounters with the interviewee (van den Hoonaard, 2019).

Memoing occurred throughout every stage of the research process and helped keep track of key insights, engaging in reflexivity at various stages, capturing non-verbal communications throughout interviews, and tracking inquiries to later discuss with committee members or other participants. Memos were kept in a confidential notebook

and were referred to in the data analysis phase through a constant comparative approach. Examples of memos are found in the findings section.

Sensitizing Concepts

A sensitizing concept is a broad term said to have no definitive characteristics (Charmaz, 2014; van den Hoonard, 1997). Grounded theorists use sensitizing concepts as tools for developing ideas about processes as a guide to inquiry (Charmaz, 2014). In this project, sensitizing concepts served as a point of departure that guided the study while providing a "loose frame for looking at these interests" (Charmaz, 2014, p. 31). Specifically, I began with an interest in the experiences of PwLE who have had contact with police officers during a mental health crisis and how they perceived these encounters.

These guiding interests and sensitizing concepts served as a starting point for developing ideas, refining the interview guide, and developing a theoretical understanding of the experiences under investigation. While many researchers begin their research with a "sound footing in their discipline" (Charmaz, 2014, p. 31), such vantage points may cause the researcher to focus more on some areas and ignore others. As such, drawing on Charmaz's work, I treated earlier perspectives with scrutiny, avoiding methods that may preconceive data. I relied on an open-ended interview guide to avert forcing responses into narrow categories (Charmaz, 2014, p. 32). I used memoing as a tool for examining my own beliefs and expectations. I also included participants throughout the process to incite a broad understanding inclusive of various experiences and perspectives.

Data Analysis

The data collected was analyzed drawing from Charmaz's (2014) approach to constructivist grounded theory using NVivo software (version 12). The data analysis phase consisted of a review of both interview data and memos, in the form of field notes and dated journal entries.

Table 2

Components of a Grounded Theory Study

Component	Stage	Description
Openness	Throughout the study	Inductive analysis
Analyzing immediately	Data collection and analysis	Researchers do not wait for data to be collected before starting data analysis; The analysis must commence as soon as possible and continue in parallel to data collection to allow for theoretical sampling
Coding and comparing	Data analysis	Data analysis relied on coding and comparing; data were transcribed and coded as close to the data collection as possible to keep a close connection to data and while data was fresh in the researcher's mind; the researchers break data down into smaller components and compare data with data and case with case to understand any variations
Memo-writing	Data collection; analysis; development of substantive theory	Memo writing occurred throughout the project and helped stimulate thinking and record data and insights gathered throughout the process
Theoretical sampling	Sampling and data collection	A theoretical sample is informed by coding; comparison, and memo writing and is used to help develop a substantive theory; often interpreted when no new themes are emerging from participants
Theoretical Saturation	Sampling; data collection; analysis	In theoretical saturation, all concepts in the substantive theory are well understood and can be substantiated by the data

Production of substantive theory	Analysis and interpretation	This theory is considered fallible and dependent on context (is not finite)

Derived from Sbaraini et al., 2011

Following data collection, individual interviews were transcribed verbatim and reviewed several times for familiarity by the researcher. Reviewing the transcription while listening to the audio recordings allowed the researcher to gain familiarity with the content and ensure the interviews accurately captured even minute expressions. This was particularly important given most interviews were conducted over the telephone which did not allow the researcher to capture non-verbal cues and nuances from participants. Concurrent with the process, field notes and memos were considered. Important notes and ideas captured at particular moments during interviews were reflected upon. Memos that appeared in hard copy in a research journal were added to transcripts through track changes in a Word document. Examples of memos are found in chapter four.

Once all interviews were transcribed in Microsoft Word, each document was labelled, saved, and uploaded to NVivo as separate files. Data types for this project included documents (e-mail correspondence and field notes) and interview transcripts. Units were set to "people" within the system and various attributes (for example, gender, age, and education) and were added to files. Files were labeled using participants' alpha-numeric identifiers (for example, participant one in participant group one was coded as PG1-1). While NVivo captured these individual attributes and attached them to their respective file, the researcher maintained a hardcopy of participant demographics to maintain closeness to the sample and to reflect on the unique characteristics of each participant.

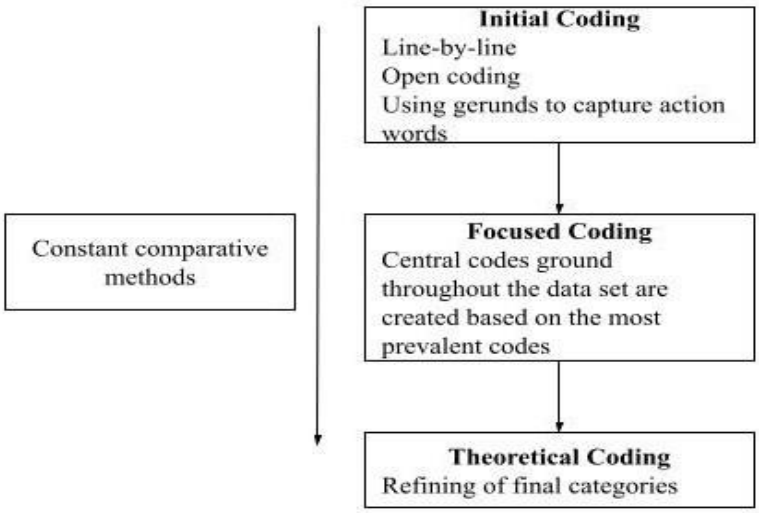
In addition to NVivo 12 software, all transcripts were printed, and spontaneous initial coding was completed in the margins during initial line-by-line coding. A coding manual was also created using a password-protected excel sheet to review codes and categories, ensure all data was accounted for, and ensure goodness of fit between codes and categories. The coding manual was compared to the codes created within NVivo. Codes were revised and refined throughout the process. A sample of the coding manual is found in Appendix G.

Coding

Coding in grounded theory is the process of defining what data is about (Charmaz, 2014). Coding involves "categorizing segments of data with a short name that simultaneously summarizes and accounts for each piece of data" (ibid, p. 111). According to Charmaz (2014), coding is a pivotal link between collecting data and developing theory. Through coding, researchers can define what is happening in the data and what it means. Charmaz encourages flexible, direct, simple, and spontaneous coding in her constructivist approach to grounded theory. Figure 1 illustrates the coding process.

Figure 1

Coding Process



Initial Coding

The early phases of coding involved constructing initial codes. Here, codes were constructed by actively naming data. Given the constructive nature of the approach to grounded theory selected, it is noted that the codes were reflective of the language, meanings, and perspectives used by the researcher. Thus, the codes derived by the researcher reflect the grounded theorist's actions and understanding (Charmaz, 2014).

Initial coding consisted of spontaneous, line-by-line, open coding. Codes were not developed in advance; speed and spontaneity were used to encourage and spark creativity in thinking in earlier stages of coding. Throughout the coding process, data was analyzed and organized into smaller pieces. Initial coding focused on actions in each set of data (gerunds) which reduced tendencies to code for types of individuals rather than what is happening (Charmaz, 2014). Charmaz encourages researchers to code using action words or gerunds (ending in "-ing"). Initial coding sought gerunds while staying as close to the

original transcript as possible, moving toward higher levels of abstraction as the coding process progressed.

Figure 2

Initial Coding

Examples of Initial Codes	Initial Narrative Data to be Coded
Not being able to work Being in pain Trying to cope Getting no help	I couldn't work. I was in pain all the time. So, I was trying to cope and getting no help with that (Jade*).

*"Jade" is a pseudonym.

Constant comparative methods formed the basis for the analysis. Data were compared with other data to find similarities and differences, and incidents were compared with statements and incidents in other interviews. These constant comparative methods continued throughout the analysis phase with earlier interviews compared with later interviews.

Focused Coding

Following initial coding in NVivo version 12, all earlier (initial) codes were reviewed. Codes that were redundant or that were better described as sub-codes were situated under larger codes. These codes were reviewed and reflected upon with the researcher considering emerging patterns and frequently appearing codes. Focused coding involves using the most important or frequent earlier codes to sift through and analyze substantial amounts of data (Charmaz, 2014, p.138). This phase of coding involved making decisions about which initial codes best captured the data accurately and completely. Focused coding was completed in NVivo. Like initial coding, focused coding remained an emergent process whereby unexpected findings emerged while comparing codes and data with each other.

Theoretical Coding

Theoretical coding in grounded theory as described by Charmaz, involves the process of identifying and developing concepts and categories that emerge from the data during the research process. Like initial and focused codes, Theoretical coding helps in understanding the relationships between categories and facilitates a coherent theory based on the data collected.

Theoretical coding was the final stage of analysis. The core categories were established, and subcategories were linked. Connections between categories were created and refined by a selective coding process (Charmaz, 2006). Categories were then linked and integrated to create inductively driven theory (Charmaz, 2012, p. 132).

Theoretical coding was used to take categories and concepts and further develop a better understanding of the relationships between emerging themes. This is expanded upon in the findings section and is relevant to the theoretical framework developed based on the findings and illustrated in the discussion section.

Trustworthiness and Credibility

Optimal strategies for achieving trustworthiness and rigour were implemented throughout this study. The concept of rigour is well-supported in qualitative research in the field of social work (Creswell, 2019; Lietz et al., 2006). Establishing techniques to manage bias throughout the process legitimizes qualitative findings. Reflexivity, the use of an audit trail, triangulation, member checking, and addressing preconceptions, were utilized throughout the study, and are described below.

Reflexivity

As discussed in chapter one, ongoing reflexivity is an important component of qualitative research**.** Reflexivity is defined as the "active acknowledgment by the researcher that [their] actions and decisions will inevitably impact upon the meaning and context of the experience" (Horsburgh, 2003, p.308). Reflexivity is important because it allows the researcher to reflect on their social location and how it may interfere with the research process.

One strategy to incorporate reflexivity from the onset was the development of a research journal as suggested by one of the committee members. From the beginning of the study, a research journal was used to track progress, notes, memoing, and reflexivity, including key insights, feelings, and challenges that occurred throughout the process. The journal was used to document ideas, thoughts, feelings, and emotions that arose during the project. The journal was not only used to document ideas throughout the data collection phase but was also used throughout the literature review stage to encourage thoughtful reflections regarding positions and arguments occurring in articles.

Maintaining an Audit Trail

The use of an audit trail during the data analysis phase was another strategy used to manage threats to trustworthiness. The audit trail described the research procedures throughout the process and included a description of reflexivity at each phase. The researcher diligently described the research decisions that were made throughout the work and provided details regarding the justification for selections. This not only increased transparency, but also allowed me to critically review selections when

versatility was present. The audit trail contained dates, documents, memos, and excerpts from the research journal and was stored in a password-protected Word document.

Triangulation

Triangulation is used as a qualitative research strategy to explore validity through the convergence of information from different sources (Carter et al., 2014). Denzin (1978) and Patton (2002) identified four types of triangulation: (a) method triangulation, (b) investigator triangulation, (c) theory triangulation, and (d) data source triangulation. The four types of triangulation were used in the study.

The first strategy of triangulation, method triangulation, involves the use of multiple methods of data collection about the same phenomenon (Carter et al., 2014; Polit & Beck, 2012). This type of triangulation includes interviews, observation, and field notes. Throughout the study, interviews were conducted with participants. Observations, including verbal and non-verbal (during video recordings), were captured. Memos and field notes were used to capture key findings, themes, similarities, and differences. Implementing these various methods provided more depth to the study and allowed the researcher to use multiple methods to establish recurrent concepts about the shared phenomenon.

Investigator triangulation involves the participation of two or more researchers in the same study who provide multiple observations and conclusions (Carter et al., 2014). While not directly in contact with other researchers, this type of triangulation was used as the researcher sought other works by other authors in similar and dissimilar fields (social work, nursing, policing, and more) to elicit confirmation of findings and different

perspectives leading to the breadth of the phenomenon of interest (Carter et al., 2014; Denzin, 1978).

The heterogeneity of the sample increased data source triangulation which involved the collection of data from different types of people. Including people with lived experience of mental illness with varying differences, despite a shared experience of interacting with police during the crisis, in addition to police officers with varying years of practice and training, allowed the researcher to gain multiple perspectives and lead to the validation of data through recurrent thematic concepts.

Peer debriefing and consistent dialogue with committee members to determine whether the data analysis was a trustworthy representation of the themes identified were also used (Lietz et al., 2003). Attention was given to the historical context and critical relation of the research topic so that the researcher could better understand the history of oppression and the context for the information that was shared (Fawcett & Hearn, 2004). In doing so, the researcher departed from their preconceptions of the issue and was able to embrace the unique experiences of others.

Member Checking

Member checking was used to check in with participants to confirm and maintain accuracy. This occurred through follow-up calls with participants during the data analysis and provided authority to the participants' perspectives (Padgett, 1998). Participants provided validation and challenged aspects of the data to meet their perceptions. They also identified areas that were missed or misinterpreted, therefore increasing the accuracy of the analysis.

Prolonged engagement throughout the process encouraged participants to gain rapport with the researcher and led to more meaningful discussions and a clearer understanding of concepts. Having participants engage in this process augmented participatory elements of the research and allowed reflexivity through dialogue. An example of member checking and the corresponding memo that was taken as a field note during a follow-up call with a participant is found in Figure 3.

Figure 3

Member-Checking Memo

Entry date: August 3rd, 2019 ***Follow-up Call with Jeanne****
Jeanne mentioned she was a psychiatric survivor of three decades. I realized after our discussion that I had not explored the terminology she used and given my intentions to develop knowledge and better understand the impact and use of language within this context, I felt the need to reconnect with her to better understand what she meant by the term. This was a term I was originally going to use throughout the work but decided it may not accurately describe all participants or their experiences. Further, after discussion with committee members, it was determined that this might lead to confusion as not all participants would know what this term meant; this may especially be the case for police officers. Agreeably, it seemed more appropriate to give participants a choice in how they were described. This was the first time I had heard someone refer to themselves as a *"psychiatric survivor"* outside of the literature, although the term *"survivor"* had come up in other interviews with participants. I regretted not asking more about why she chose that language. I e-mailed Jeanne to set up a phone call to clarify a few things. She was happy to do so, and we set up a day when she was home. At the time of the call, she was in good spirits and had her grandchildren over. She stated she refers to herself as a *"psychiatric survivor"* because she is recovering from long-term damage both physically and mentally from the *"care"* she received in the "mental health system." She stated she lives with tardive dyskinesia, akathisia, and cognitive disabilities from drugs and ECTs. She said her experience caused her a great deal of *"trauma."* The impact of her decades-long experience within the mental health system is something she lives with every day. It has impacted her job, relationships, and overall quality of life.

*"Jeanne" is a pseudonym.

Ethical Considerations

The study considered research, clinical, and Social Work ethics. Before commencing the study, Research Ethics Board (REB) clearance was obtained and

resources including interview guides were provided to the panel for review. The researcher completed the Tri-Policy Statement: Ethical Conduct for Research Involving Humans training (TCPS2) and adhered to the foundation of TCPS2, the value of respect for human dignity expressed through the core principles of respect for persons, concern for welfare, and justice. REB approval was granted before engaging in recruitment processes.

All risks and benefits were carefully considered in this study. While the risks were low, there was a risk of psychological harm whereby participants may have felt anxious and/or distressed before, during, or after the interview. To mitigate these risks, the researcher built a rapport with clients through a caring and compassionate approach, disclosure of personal and professional interest(s) in the study and ensuring that all participants were aware of their rights and responsibilities, and risks as participants. Measures were also put in place to provide appropriate follow-up care to participants. Participants were provided with a list of contacts should they require any additional follow-up support and were encouraged to contact the researcher, research supervisor, or the REB in the event they had questions or concerns.

Considering potential risks, participants were also made aware of the potential benefits of participating in the study, including having an opportunity to share experiences, the advancement of knowledge, and the opportunity to contribute valuable information to this underexplored area.

In addition to research ethics, social work ethics and values were considered throughout the project. The primary investigator is a Registered Social Worker and adhered to the code of ethics outlined by the Canadian Association of Social Workers in

addition to the guidelines outlined by the Ontario College of Social Workers and Social Service Workers (OCSWSSW). As such, there were limits to confidentiality. Disclosure of confidential information is required to prevent serious injury or harm to participants and or others. Participants were made aware of the extent of confidentiality during the consent process.

CHAPTER IV: RESULTS

Participant Group One- People with Lived Experience of Mental Illness

Profile of Participants

Thirteen people with lived experience of mental illness (PwLE) participated in the study comprising the first participant cohort (referred to as participant group one [PG1] throughout the work). Each participant was assigned an alphanumerical identifier and a pseudonym to protect their confidentiality.

Gender, Age, and Ethnicity

Most of the sample were females (*n* = 8; 61.5%), followed by males (*n* = 4; 30.7%), followed by one individual who identified as non-binary (*n* = 1; 7.7%). Table 3 presents the demographic characteristics of participants in group one and their self-reported history of contact with police for mental health-related reasons. Most participants in PG1 were between the ages of 26-33 (*n* = 4, 30.8%). Diversity was observed across both participant groups. Participants ranged in age from 21 to 77 (*M* = 40) at the time of the interview. Eligibility criteria for participation included people who have interacted with police officers within the last two years; thus, all interactions had occurred within two years of the ages stated by participants. Most participants reported their interaction with police occurred within a year of the interview although some participants indicated they had more than one lifetime encounter with police for mental health-related issues.

Most participants in PG1 identified as White (*n* = 11; 85%) with two participants identifying as Indigenous (15%). A lack of diversity across the sample means the study lacks input from the most at-risk populations including members of racialized

communities. Focused and purposive sampling from equity-seeking populations would augment future work in this area. One learning that occurred in hindsight was that the researcher should have asked participants who identified as Indigenous which Indigenous community they are members of to avoid pan-Indigeneity or cultural homogenization. This should be a consideration in future research. The researcher did reach out to find out this information following the interviews and managed to reconnect with one participant who clarified they identified as Metis. The researcher could not reach the other participant who identified as Indigenous to clarify what Indigenous community they were a member of.

Unsolicited Physical and Mental Health Status Disclosure

As discussed in earlier sections of this dissertation, medical, and individualized views of crises dominate the literature surrounding interactions leading to narrow, simplistic, and oppressive understandings of these encounters. In the early stages of the study, the decision was made to challenge the simplistic and narrow narrative that Frederick and colleagues (2018) highlighted and provide deeper descriptions of encounters from the view of those who have experienced them. Thus, early in the study, a conscious decision was made to avoid asking participants about their mental health status.

The decision not to ask participants about their mental health status was intentional. However, in the interest of developing knowledge of the degree to which these health disclosures were made *without solicitation*. While cognizant of the potential to perpetuate the stigma that accompanies the perception of these diagnoses, this information is presented in Table 5, noting these status disclosures should not serve as a

generalization of what these diagnoses look like. As the next section will highlight, all participants attributed multiple factors to their crisis, and mental illness was not listed in isolation by any of the participants.

The most widely referenced mental health status disclosure was psychosis (n = 6), followed by anxiety (n = 4), followed by schizophrenia (n = 4). Insomnia was mentioned by three participants. Pain was also mentioned by three participants. Paranoia, an extreme form of anxiety, was mentioned by two of the four participants who felt anxiety contributed to their experience with the police. Two of the individuals with anxiety also reported having a weapon at the time of the incident. Both participants indicated they had knives on them for protection at the time of the incident. They both denied any intent to harm themselves or others but felt they felt the need to have the weapon to keep themselves safe. This is expanded upon in later discussions regarding dangerousness and perceived risk.

Geographical Location

Five participants in PG1 had interactions with police in Ontario. Three of five participants lived in smaller communities (populations under 10,000) at the time of the incidents. Four participants indicated their encounters occurred in Eastern Canada (Nova Scotia and Newfoundland). These participants connected with the researcher after a mental health agency in Nova Scotia shared the recruitment flyer via their social media accounts. Incidents were also reported in British Columbia, Alberta, and Manitoba. One participant chose not to disclose the province they interacted with police in. This information could be beneficial for future research that examines the composition and

availability of resources in rural versus urban settings and the level of police service (for example, municipal versus provincial) in the area.

Education

Members of participant group one (PG1) reported high levels of education. Five individuals had a university education. Two participants reported having graduate-level education. Six participants indicated they had college degrees and two reported their highest level of education was high school. The large number of participants who reported having a post-secondary degree may be due to an interest in research; some participants shared they had engaged in research in the past.

Table 3

Demographic Characteristics of Participant Group 1

Identifier	Pseudonym	Age	Gender	Ethnicity	Highest level of education
PG1-1	Jeanne	42	Female	White	High school
PG1-2	Lorraine	66	Female	White	High school
PG1-3	Doug	77	Male	White	Undergraduate degree
PG1-4	Jade	40	Female	Cree Metis	College diploma
PG1-5	Frank	50	Male	Indigenous	College diploma
PG1-6	Jessica	35	Female	White	Undergraduate degree
PG1-7	Justin	39	Male	White	College diploma
PG1-8	Kate	27	Non-binary	White	College diploma
PG1-9	Richard	45	Male	White	College diploma
PG1-10	Ashley	26	Female	White	Undergraduate degree
PG1-11	Kim	21	Female	White	College diploma
PG1-12	Keith	29	Male	White	Master's degree
PG1-13	Alexis	26	Female	White	Master's degree

History of Contact with Police

A large portion of the sample, (n = 9; 69%) reported that the event they described was their first interaction with police for mental health-related reasons. Three participants

(23%) reported having two-lifetime contacts with police for mental health issues. One participant reported eight-lifetime contacts with police for mental health-related reasons.

Contact Locations and Initiators of Contact with Police

There was diversity in terms of the locations where participants described their encounters with police occurred. More than half of the participants in PG1 indicated their encounters with the police occurred in their homes. The second most common location was on-campus (one in on-campus housing), followed by on the street. Other locations included a church and a restaurant.

Participants described contact locations as indiscreet and noted that multiple onlookers, including neighbours and bystanders, witnessed the interactions. Participants described that the location of the incident changed as trajectories included transport to the hospital or jail. Transportation emerged as a theme among participants. All but one interaction was solved informally with the participant left at the scene. This will be described in greater detail in the outcomes section. Table 4 illustrates initiators of contact with police and contact locations.

Table 4

Contact Locations and Initiators of Contact with Police

Locations	Initiators of Contact with Police
Home Street On-campus Campus housing At a restaurant On a remote backroad At church	Self Family member Friends Crisis Hotline Therapist Neighbour Restaurant employee Bystander Pastor Firefighter

Most participants indicated the police arrived following a call made by others. Participants indicated that the call was made to the police by family members (namely, mothers). Other initiators of calls to the police included telephone crisis lines, therapists, friends, a pastor, a neighbour, a restaurant employee, and an on-duty firefighter who was responding to an unrelated call.

Two individuals indicated the interactions were self-initiated through direct contact with police. Two participants indicated the police were called by telephone crisis hotlines after they reached out for help. Both participants felt their interactions were the result of misunderstanding and an incorrect evaluation of risk on the part of the person who called the police. Two additional participants indicated a similar trend existing with their therapists who called the police after misinterpreting the level of risk.

Two individuals who interacted with police officers on campus indicated that the police were called by their friends who were also on campus with them at the time. One individual reported the police were called by a restaurant employee while they were out for dinner. This participant also described a misunderstanding involving the employee who was waiting on them. This theme of misunderstanding and misinterpretation of risk is further discussed later in the chapter. One participant was found by chance amid a suicide attempt on a desolate road when an on-duty firefighter intercepted him on his way to an unrelated call and proceeded to call the police. Other initiators of contact with police were a pastor at church, and a neighbour.

Interactions and Interventions

Most participants were unable to elaborate specific details related to the composition of the crisis team (whether those who responded were crisis-trained officers,

blended/co-model teams, or other). Six participants indicated they had two police officers respond. Four did not recall if there was more than one officer there. Frank stated that he has had multiple officers attended his home over multiple encounters indicating the number of officers increased with time: “At first, started sending a couple, then eventually they would send the whole brigade.”

Some participants could not recall, or were unaware, of the composition of the crisis team that arrived. Jessica indicated that in one of their previous encounters there may have been a nurse there, but she was unsure. This inability to recall events may be due to the overwhelming nature of the encounters and/or the lack of introductions by first responders who may or may not appear in uniform.

Paramedics were involved in three incidents described by participants. In these situations, participants expressed positive attitudes toward paramedics. One spoke about a time when EMS were involved to assess them following a call their mother made to the police. Another stated both the police and EMS responded to a call on campus. In both situations, the police took over involvement once it was determined that EMS was not needed. Further formal response teams included the campus police who were involved alongside the Calgary police in an incident that occurred on campus.

Participants indicated they felt embarrassed and ashamed by the presence of police during these situations due to the overt presence of police officers. Many commented that they were worried about what neighbours and onlookers might think. Ashley remarked that even attempts to send unmarked cars and plain-clothed officers are not helpful as it is not difficult to see it is an officer: “I’m not stupid, we can see the boots and I know what an unmarked car looks like…I know you’re a cop.”

This same sentiment was shared by another participant below who shared that even with a mental health professional accompanying a police officer, they know the officer is the one in control. Participants were unable to elaborate on what specific intervention strategies were used.

Thematic Findings

Facing Multiple Complex Challenges

Participants in this study voiced a variety of complex layering and co-occurring challenges that occurred leading up to contact with police. Many participants stated that there was "a lot going on" at the time of the interaction with police and that various factors were causing stress. Rather than describing a single isolated event, participants described a combination of complex factors that interacted and escalated over time preceding the interaction with police. This theme encompasses the range of multifaceted difficulties that participants described leading up to their interactions with police. An overview of these factors is found in Table 5.

Participants prefaced their interactions with the police stating, "There's a story leading up to that" (Jade), or "It's a long story" (Jessica) indicating there were surmounting issues and lack of support leading up to encounters. The complex and layering factors that led to contacts with police were described in detail by participants. Richard spoke about not being able to access support for his basic needs and the frustration this caused leading up to and during the event: "There was a lot going on. I was barely making ends meet and I didn't know if I would have enough food to feed my family." In the following excerpt, a participant with the pseudonym Lorraine describes her experience leading up to the interaction:

> I was going through a hard time with my mother dying, and not having a job, and not having money, stuff like that, it was stressful for me, and I was fighting with my daughters. It was a bad time in my life.

Kate described various co-occurring and multiplying factors that eventually led them to contact the police:

> I just came out to my parents and there was a lot going on with my family at the time, my brother was dealing drugs again. Things were really stressful at work too, and then my friends abandoned me. I tried to commit suicide and was hospitalized for a bit and then after that is when the police encounter happened.

Kate was struggling to find support for their housing situation. They were also experiencing food insecurity and were denied support by community organizations based on the inability to meet eligibility criteria. Kate spoke of the gravity of their situation preceding the incident: "I was starting to starve in my apartment, and I only had a little bit of food I could get every two weeks from the food bank." Richard was also struggling financially and stated he: "was barely making ends meet and I didn't know if I would have enough food to feed my family." The multiplicity of factors was also demonstrated by Jade:

> When this chronic pain disorder hit me, I had a complete breakdown one day. I was on long-term disability, and I was trying to get back to work, but I ended up failing at that, and disability said, "no, we don't believe you can't work, you can work." So, I was in a spot where I wasn't working. I wasn't getting paid. I was trying to appeal that decision and dealing with that. I was still trying to get into the pain clinic and waiting for that referral to go through. I was in a very bad low

point, and I was extremely depressed and in severe pain with severe insomnia.

Severe.

Table 5

Factors Involved in Encounters

Factors	
Unfulfilled basic needs	Lack of income Housing instability Food insecurity
Mental health disclosures	Psychosis (including visual and auditory hallucinations) Anxiety PTSD Depression Paranoia Schizophrenia Suicidal ideation Self-harm ideation Flashbacks Obsessive compulsive disorder Bipolar disorder Dissociative identity disorder (DID)
Physical health disclosures	Insomnia Pain Eating disorder Chronic fatigue
Familial conflict	Fighting with parents Estrangement from children Unacceptance from parents Incarceration of a family member
Relational conflict	Separation from partner Dispute with non-family members (neighbours/friends) Abandonment by peers Stalking by an ex-partner
Lack of support	Lack of informal support from friends and family; lack of connection; Social isolation Lack of formal support including government assistance and access to healthcare
Trauma or major life event	Death of a family member. Life-altering surgery. Coming out to family and friends

	Recent and life-changing diagnosis
Issues of Access	Lack of transportation Not able to meet eligibility criteria for programs and services

Familial conflict including fighting between parents and children, was described by multiple participants. Doug had a falling out with his father who told him he was not good enough and did not meet up to his expectations as a son. Lorraine stated both of her daughters had quit speaking to her at the time and she had found estrangement very difficult. Kate, like others, was also experiencing the impacts of ongoing discrimination. She stated their parents were not accepting of their gender and sexual orientation leading to estrangement. Strong emotions were associated with these interactions. Commonly expressed emotions included shame and embarrassment, fear, anger, shock, and confusion. Participants spoke of the severity of the interactions using language like "intense" (Kate), and "traumatic" (Justin).

These complex and layering challenges described by participants, demonstrate the stressful situations that people were experiencing at the time of the interaction with police and illustrate the need for comprehensive solutions to crises. Narrowly attributing a crisis to one aspect of the encounter, overshadows the multiple factors leading to contact with police. This is expanded on in Chapter five. Failure to address these multiple co-occurring factors though supports and resources that were found appropriate, adequate, and considered effective by those in crisis, resulted in overall negative experiences and frustration with various systems.

Lacking Support and Resources

In the face of numerous challenging co-occurring factors going on in their life, participants expressed not feeling supported. Simply stated by Doug: "There are just not enough resources for people with mental illness." Participants spoke in detail about the lack of support they were experiencing and described not having their needs met. This lack of support was experienced holistically; participants expressed lack of support at all levels including lack of access to basic needs like income, housing, food, and shelter; lack of informal support and connection, including support from friends, family, and community members; and lack of support within the medical and mental health system.

Participants were experiencing a lack of informal support including lack of support from parents, siblings, partners, friends, acquaintances, colleagues, and neighbours. This lack of connection led to feelings of frustration leading up to and during encounters. Lack of connection with others was expressed by participants who felt estrangement and lack of support from family and friends. Participants also reported being denied government funding, and lack of food and shelter.

Participants reflected on not receiving adequate support for their mental health issues at the time of the interaction with police officers. Frank had struggled within the mental health system for years. He was connected with a therapist who did not help him and fought constantly to receive proper support that met his needs. Frank indicated that he did not find mental health services supportive as they did not accept his definitions of coping. He was eventually banned from the community mental health agency in his community and left without support.

Lack of adequate and effective support caused frustration among participants. Keith was awaiting support from a therapist but was on the waitlist. He was not receiving support in the meantime. He stated he was frustrated with the system. Doug reported his psychiatrist had become a "pill pusher" adding they do not give him enough time during appointments. He stated: "My psychiatrist talks to me for half an hour on the phone every four weeks, well what are you doing the rest of the time? That's not enough." Doug felt "the whole business of mental health that needs a rethink." Jeanne had a further critique of the medical system: "The meds they give you are junk. They don't work."

Feelings of frustration and distrust for the system were fueled by not having access to support, not feeling like support was adequate, feeling like mental health providers were not helping them, and "falling through the cracks." Participants expressed the lack of and/or inadequate[1] support including not having access to, or limited access to, therapy or proper medication.

Frank felt like the crisis workers were not properly trained or able to help, reporting that they had called the police on him multiple times. Jade shared the same experience of having the police called on her by crisis lines which she found embarrassing, unhelpful, and ultimately ineffective.

Participants were dissatisfied with the mental health support they received and felt disempowered by mental health providers. This loss of power extended into the interaction with police officers by which time participants had already been "let down" by the system and were frustrated. Participants expressed similar dissatisfaction of their

[1] Defined as not often enough or ineffective.

experience with police officers as they did mental health providers indicating they would not listen to them, misinterpreted their risk, and were improperly trained.

Feeling Disempowered and Treated like a Criminal

Participants experienced a loss of freedom and power as a result of interacting with police officers. This happened in several ways such as through being restricted physically, being denied their autonomy, and being yelled at. This power dynamic was further exacerbated as participants were not allowed to share their side of the story which caused a diminished sense of power and agency.

Jade described the loss of power she experienced during her interaction with police when she was forced to attend the hospital. Despite experiencing chronic pain, Jade was not allowed to find a spot that was comfortable to her:

> So, it was an all-day event, it started in the morning, and it was in the evening, so probably, I stayed there for six to seven hours in a plastic chair…they weren't gonna let me leave and I asked them "is there somewhere I could lay down" and they said "no."

This loss of power had several negative consequences including feelings of fear, intimidation, and reduced trust in police officers. These experiences had long term impacts on participants which is described later in this chapter. Participants described police officers as figures of authority who had the power to make decisions on their behalf. Doug sated, "The police become involved and become an authority figure." The authority to take away freedom and power was described by Lorraine who said, "You don't argue with cops- they have a form. They're there to get you- there's no negotiating." Jade had experienced this firsthand: "They said, "You're not going

anywhere, we're taking you [to the hospital]." Participants did not have the power to go against the police, as stated by Alexis: "You can't defend yourself when you deal with the police."

Many participants expressed they felt scared and intimidated during contacts. Jeanne stated: "I played dead in the car. They took me over to somewhere to get checked over first. I don't remember where I went, I was too afraid to open my eyes." Fear was also experienced by Kate who only called the police to ask a question when they decided to attend their apartment unannounced, "I thought they were coming to hurt me. It was very scary."

Multiple participants were not permitted to access their belongings during encounters. For example, Kate and Keith were not allowed to get their cell phones during the interaction. Keith, Jessica, and Jade were not allowed to get items of clothing. Jade wanted to change from her pajamas to something more appropriate to wear to the hospital but stated: "They wouldn't let me go upstairs to change because they thought I would get something to hurt them. They hauled me out in my pajamas." Jessica noted she wanted to get her coat because the interaction happened during the winter, but she was not provided the freedom to do so.

Participants reported they were treated like criminals during their encounters. Jeanne, who was transported to jail and held there until a bed opened at a psychiatric hospital, stated she had her personal belongings taken from her and was dressed in criminal attire: "I was treated like a criminal. I was thrown in the back of a cop car. They had to check me over. They took my things and put a yellow jumper on me." Ashley

stated that she was treated like a criminal as soon as the police arrived at her door. She stated they screamed "Open the door! Calgary Police! Open the door!"

Participants felt they were treated unjustly and made to feel like they had done something wrong. Justin stated he felt like "the bad guy" adding, "they made me feel like I was unruly." Kate had her things rummaged through and stated the police "rooted through my stuff, even my fridge." Ashley had a similar experience: "They were fully-uniformed, full vest, boots, stomping around. They made me sit down while they were still standing up, it's like WE are in control here."

Many of these participants were reaching out for help only to be treated as though they had committed a crime (only one participant did engage with police due to criminal behaviour). Participants indicated they had commands yelled at them, had force used on them, were put in handcuffs in the back of a cop car, and in some instances brought to jail. Participants experienced this behaviour as "over the top", "intense", "extreme", and "unnecessary." In the following transcript, Keith describes his experience:

> I tried to be compliant, but they think I'm being resistant. Like, can I adjust this seatbelt, or can I get some clothes if we're going to the hospital? And they refuse, and I know they think I'm trying to grab a weapon, but I don't own anything. And I get they have to be hyper-vigilant but then they get really aggressive and pin me to the ground.

Participants described that the experience of loss of power and treatment like a criminal extended to transport to the hospital. Justin described his hospital stay as like being prison: "I ended up having to stay at the hospital. It's like a prison. They lock you in. It's not a fun thing." In the hospital, participants described further loss of freedom

such as not being able to leave, being told when to eat, whether they could have a cigarette, when and how many visitors they could have, and what they had to do while in the hospital. Lorraine, who had been found not criminally responsible for the incident that occurred during her interaction with police, spoke about her experience in hospital and in the penal system:

> When I was in the system, I was forced to inject with Risperidone. I had to do pee tests every week for five years because I smoked marijuana. I wasn't allowed to drink alcohol. It was awful being at the Centre because you can't go outside, and I am a smoker [cigarettes] and I couldn't do that. While I was in court, I had to sit in a jail cell all day long and wait for my court case to come up. There's a lot of rough people in there [jail], and I'm a senior, and it was a shock to me to see what they're up to in jail. And it's very noisy in jail. I was in isolation for a while… It's the pits.

Some participants indicated that it felt like they were being penalized for reaching out for help, which led them to a loss of power and mistreatment. This is especially concerning in the long-term as some participants indicated they would be unwilling to reach out to the crisis lines, therapists, or police if they experienced a similar crisis in the future as a result of how they were treated. These experiences led to a great deal of frustration with the system.

While most participants described their interaction with police officers to involve mistreatment and disempowerment, two participants, Doug and Lorraine, found the experience positive because they were treated with kindness and connected to supports.

Despite being "hogtied" during the incident with police and spending time in jail, Lorraine stated it was a "good experience":

> It was a good experience. Once I got to Waypoint centre, I got two nurses who come to see me once a week and they give me my injection once a month and we interact. [My worker] comes to see me each Tuesday and we go for a walk in the park... And I get a rent subsidy. So, I am glad I went through the whole thing because it helped set me up to have subsidy on my rent.

In this excerpt, Lorraine describes the experience with police officers to have been positive overall and even expressed that she was happy to have gone through "the whole thing." This is interesting given that the incident did result in the participant being charged and going to jail before being found not criminally responsible (NCR). Despite their expression of a negative experience during the encounter, including use of force during detainment, and loss of freedom during their time in jail which she shared was a negative experience. When reflecting on the incident, she still felt this was a good experience and that she is "glad" to have gone through as it led to supports, she did not previously have.

Losing Your Voice: (Mis)Communication and (Mis)Understanding

Most participants in this study found it challenging to communicate with police officers and they highlighted the importance of sharing their side of the story and feeling understood. Many participants perceived that they were not fully understood, listened to, or believed by police officers and crisis teams. Challenges in effective communication and understanding lead to misunderstandings and inappropriate responses in some circumstances. Frank stated that despite communicating with crisis teams that he did not

pose a risk to himself, the police were called. Jade tried to explain that she was not a risk to herself but was forced to attend the hospital with the police. Justin stated he was unable to tell his side of the story. These actions taken led participants to believe police officers did not care and did not want to be there. Keith felt like he was a "blight on their shift." Jade stated, "They don't want to be there", Alexis stated she does not think anyone with a weapon is there to help.

Jeanne stated that the police "don't know how to talk or treat the person. They don't know how to communicate with us." During the interactions with police, participants did not get a chance to tell their side of the story, were not listened to, and were not believed. Justin described his experience at a restaurant with multiple onlookers present:

> And I started talking to tell my side of the story and he shouted at me, "Woah, hey!" and I realized, "Oh my God, I'm the bad guy. This guy thinks I am a threat." So, I backed up and I said, "I'm not out of my mind." I've seen the show COPS and I thought, "I'm going to be in big trouble here." And everyone was watching, but the officers wouldn't hear my side of the story. Everyone was huddled around me. It was the worst day of my life" (Justin).

Kate was also misunderstood and felt communication was lacking when they called the police to ask a question which led to an unsolicited wellness check:

> I started to have flashbacks about something that happened to me back in junior high [school], and I called the police to ask a question. I was reliving the flashback, and it was coming out when I was talking to them… […] … they

wanted to come over and talk to me, and I told them I didn't want to talk in person, I was just asking a question.

Despite telling crisis workers, therapists, and the police that they were not a risk, they were not listed to. This lack of communication and loss of voice experienced by participants in group one, led to negative experiences that often made the crisis worse. Justin described how communication may be hindered when both parties are in an "amped up state." He mentioned that he only hopes that if he were in a situation where a gun was pointed at him, that he would understand enough to act accordingly: "I can't imagine having a gun pointed at me in a psychosis, like, "we just want to talk to you!" I would hope I understood that."

This discussion impacted me as multiple participants had mentioned that in these intense situations, they often felt there was a lack of communication and misunderstanding. Reminiscent of Frank's comment of these encounters, one must ask, "Who is putting who at risk" in these situations. Justin pointed out how these misunderstandings have the potential to become dangerous. Figure 4 outlines the memo I wrote following the interview with Justin.

Figure 4

Memo Excerpt

Entry date: July 20th, 2021 ***"Justin," PG1-7***
Today speaking with Justin, he said something that really struck me. Many participants have spoken about the intensity of these situations. During these encounters both parties are often *"amped up"* as Justin put it, overwhelmed and overstimulated, trying to juggle a multitude of complex and co-occurring issues (mental health, physical health, familial and relational breakdowns and more), and the last thing they need is a police officer who is intimidating and carrying a weapon, directing them**,** and causing further embarrassment. Justin stated that in a state of psychosis, people already feel like everyone is out to get them, everyone appears to be *"your enemy",* as he put it. He added that he just hopes that if a police officer ever did point a gun at him, that he would understand. This was such a painful reality and made me feel terrible. The thought that Justin expressed was a reality for him especially as he is living in a rural community where police officers are likely to respond to a mental health crisis. I believe this highlights the importance of having people like Justin share their stories with police officers to let them know how the experience made them feel and how it impacted them in the long-term, and to educate about how misunderstandings can occur when both parties are *"amped up" and* the potential to misunderstand one another is high.

Participants highlighted the challenge of being misunderstood by both mental health professionals and police officers who did not give them a chance to tell their side of the story. This misalignment between what participants felt was the issue and what they required both leading up to and during the interaction led to inappropriate responses and missed opportunities for effective interventions. For example, Jade stated she was not suicidal when she called the crisis line and while she tried to explain how her chronic pain, lack of formal supports, and the risk of losing her job was the reason for her crisis, these factors were overlooked, and the focus became her state of mental health. Jade described that despite trying to communicate this to the crisis worker, the hospital, and the police, her needs were overshadowed by a persistent and incorrect focus on her perceived risk.

With these discrepancies between what service providers and those accessing support deem to be the main factor and focus of response, it is important to consider the multiple and layering factors as presented in the multifactorial model of crisis. It also points to the importance of communicating effectively with people who are in crisis and considering what they feel is the reason for the call and the focus of the intervention.

An overview of helpful and unhelpful aspects of these encounters is found in Table 6 and relates to key findings that outline participants' experiences. For example, a major theme of feeling unheard and unsupported were reported as unhelpful negative aspects of encounters.

Table 6

Helpful and Unhelpful Aspects of Encounters

Helpful Aspects of Encounters	Unhelpful Aspects of Encounters
Validation Feeling heard; able to tell their side of the story; having their feelings and experiences validated; feeling understood **Empathy** Showing kindness; listening empathetically **Officer Approach and Behaviour** Calm; patient; Officer body language- arms not crossed; hands where they can see them; relaxed demeanour and stance (thumbs in vest); Buying food for them if transported Engaging in general conversation; "Talk shop" **Connection to Support**	**Unvalidated** Not listened to; not allowed to tell their side of the story; not taken seriously; dismissed **Officer Approach and Behaviour** Body language that is authoritative or threatening (arms crossed or hands on hips); posturing; unintimidating. Raised voices, yelling, shouting Causing a scene; rushing; joking with fellow officers; "preaching" about what the person in crisis should or should not do

Connecting to support; providing resources; following up after the incident	

Experiencing Disproportionate Response to Perceived Risk

Participants were made to feel like they were dangerous and stated that the responses by police were unnecessary and "extreme." Participants spoke about trying to negotiate their level of risk with police officers and mental health professionals but not being believed. Frank stated that he had called the crisis hotline only to have his mental illness "weaponized", against him. He stated that the crisis line's "constructs of safety" were applied to him even though they did not fit his beliefs or circumstances. As a result of this misalignment, police officers were sent to his home during his child's birthday party. He was banned from the Canadian Mental Health Association which he reported was the result of a misunderstanding in which he feels he was wrongfully perceived as dangerous.

Similarly, Jade accessed the crisis hotline to vent about the multiple challenges in her life. When the crisis worker found out that Jade had a weapon in her home, she immediately assumed Jade was at risk to herself. Jade tried to defend herself to no avail: "I told them I had my husband with me. I was not a threat to myself." Nonetheless, police were called to her home, and she was brought to the hospital against her will.

Participants described feeling like the response from police officers was "over the top." Ashley stated police were banging on her door and shouting. She stated the response was "extreme" and added, "I'm five feet tall, 80 pounds with an eating disorder at the time. I was not a threat. It did not help the crisis."

Participants described officers in terms of authority and intensity. Justin stated the officers were "amped up." Most participants felt police officers overreacted and caused a scene which worsened their experience. Participants discussed feeling as though police officers were loud, directive, overly assertive, and used body language and physical force that was intimidating. Most participants felt this was unnecessary and made matter worse.

Frank used language to describe officers such as "militarized thugs" and "hired muscle." He was met with force and brought to the hospital because he was perceived as dangerous. He believed this was due to the dangerous things that had happened to him in his life and his multiple complex diagnoses.

The actions taken by police officers and mental health professionals made participants feel further disempowered and ashamed. Jade was not able to go upstairs and change because they thought she might grab something to hurt them. Frank said they sent a "brigade" of officers to his home. Frank was aware that he was perceived as dangerous:

Participants were treated as if they were a risk to themselves and others. Frank stated:

> Eventually, my therapist got scared of me, scared of what I am, scared of my violent upbringing. Totally misunderstood what I had to do to survive. And because I used self-harm as a coping mechanism, the mental health and addictions industry turned around and weaponized safety against me. Even though what I was doing was what I knew, for lack of better terms, was safe for me. Apparently, what I consider "safe" is so outside of their industry's classification of "safe" that they weaponized safety and that's what they would use to always send the police to come get me…. […]… I was doing what I was supposed to do. I was using my

> supports while I was in crisis and all they would say is, "This guy is a risk, DANGER, DANGER."

Frank's statement is reflective of the incongruence among concepts of safety. What Frank believed was keeping him safe, was interpreted as dangerous by others. This speaks to the construction and subjectivity of these concepts. This differential treatment and the stigma that surrounds people with mental illness were reflected by others who stated they think the police are afraid of people with mental illness. Jeanne stated: "They feel threatened by us, that's what I am gathering, I don't know if it's true, but that's just my opinion. They're afraid." Frank added a similar sentiment:

> Nothing scares me and that's the scary thing for them, they know they can't use their fear tactics on me, so they use their armies. When they beat someone like me that's fine… I'm not intimidated and that's what scares them. Most of them know I'm a walking dead man.

When asked to clarify "walking dead man", Frank indicated that because of what he has been through and how he currently feels, he feels he has nothing to lose. He felt the police knew that and were afraid of how he might behave as a result.

Use of force was also described as a disproportionate response by participants. Kate stated:

> My hands were completely empty, and they shot me with the Taser then they threw me to the ground and stepped on my back while the needles were still in me. They pressed down right on my back and handcuffed me. They brought me out in the hallway of my apartment and the one officer started skiffing me, checking for other things, he ended up groping my genitals. It was disgusting. It

was the most violating thing I ever felt. He dragged me off the wall and took me to the ambulance and it ended up leaving a blood smear on the wall.

Further use of force occurred during the process of trying to get handcuffs on people or trying to get them into the police car. Jeanne stated: "They pretty much beat me up. I had sleeves of bruises on my arms." Frank stated: "They hogtied me and threw me in the back of the car. I have taken so many cheap shots by the police- boots to my ribs." Lorraine said, "They had to manhandle me to get the cuffs on."

Involvement with the police as described by participants was often not for criminal reasons and most often did not involve risk of danger as expressed by the participant. However, in some instances, a misunderstanding of risk, meant that the person in crisis was considered a danger to self or others as determined by the professional (for example, by police officers, therapists, or crisis teams). Table 7 presents danger to self, danger to others, and property damage.

Table 7

Danger to Self, Others, or Property

Characteristics	Number (%)
Danger to self	
No thoughts of self-harm or suicide	11
Suicide attempt	1
Thoughts of self-harm	1
Danger to others	
No thoughts of harm to others	13
Damage to property	1
Weapon*	
Knife	2
Lighter	1

**Weapons were reported as a means for self-defense/protection in most reports with the exception of one disclosure in which the threat was made to burn down the complex they were living in.*

As stated in earlier sections, unfounded linkages have been made to people with mental illness and dangerousness. None of the participants in participant group one (PG1) described any thoughts of harming others during their interaction with police. Of the 13 participants in PG1, one participant reported thoughts of self-harm which were shared with the crisis line, and another indicated they had an encounter with the police during a suicide attempt that was intercepted by a firefighter responding to an unrelated call. Two participants mentioned having a knife on them for self-protection. Another participant indicated they used a lighter to attempt to set fire to their apartment; however, this attempt was not made to intentionally hurt anyone inside the building.

Participants demonstrated some ambivalence when discussing whether people with mental health issues are dangerous, but many were quick to highlight stigma and the higher risk posed to PwMI by others. Participants indicated people with mental illness are not more dangerous; however, as evidence of the construction of beliefs surrounding people with schizophrenia, the term did come up when this question was asked. For example, Jeanne, when asked if PwMI are more dangerous stated:

> I don't know. There's definitely a stigma out there. People with schizophrenia are known to be more dangerous than the rest of us, but I don't think that's the case because I don't think people with schizophrenia are any more dangerous than anyone.

This notion of "the rest of us" is interesting here as it shows the separation and division between diagnostic signifiers. When the participant says, "more dangerous than the rest of us," referring to PwMI it demonstrates that certain diagnoses are seen as more severe and dangerous than others. Lorraine stated initially that PwMI are not more

dangerous but then added: “unless they have schizophrenia and are in an episode.” This participant, diagnosed with schizophrenia herself, believed that in some situations, for example, if someone is off their medications, they would be dangerous.

Most participants in group one indicated that they do not believe people with MI are dangerous. They were aware that stereotypes exist tying people with mental illness to dangerousness. Doug stated: “It’s a popular stereotype, in fact I belong to a support group, and I can tell you that most schizophrenics are more of a danger to themselves than anybody.” Most participants were aware that rather than perpetuate violence, people with mental illness are more likely to become victims of criminal activity.

Jade pointed out that “you don’t have to have a mental health issue to have a temporary lapse in mental health. Anyone has the capacity [to become dangerous] under high stress.”

Jeanne shared an impactful statement: “I’m not a dangerous person. I’ve just had dangerous things happen to me, how does that make me a dangerous person? It doesn’t.”

Enduring a Lasting Impact

Participants in this study reported the interactions with police to be an intense and traumatic experience. For most participants, there was not a positive impact as a result of the interactions with police. These interactions left lasting impacts on participants lives and strong emotions and consequences were associated with these encounters. Some participants referred to the events as life-changing. Jeanne stated: “I was sexually molested when I was younger, and this was worse than that.” Jeanne describes that the interaction was traumatizing and something she will “never forget.”

This sentiment was shared by Ashley who stated the encounter "was the worst day of my life." Justin described the long-term impact of the encounter stating: "The impact of it? It changed my life. Like, I live with my parents. I'm in the old room I used to be in as a kid right now. Every day is a reminder of how it happened." Jade stated: "It was very traumatizing for me."

Lorraine indicated she was unable to keep her job as a result, given that she could not maintain a clear criminal record check. Frank indicated they lost their family and friends when the police showed up at their child's birthday party when they called a crisis line while in distress.

The distress and consequences of the interactions with police officers impacted participants beyond the interaction. In some cases, this led to ongoing fear and distrust of the system. For example, Kim says she will never call crisis support lines again. Frank has lost faith in the system altogether and feels it traumatized him. Jessica does not trust police officers and feels like they may be watching her.

Participants described further stigmatization and elevated states of crisis following interactions with police. Keith reported that both he and his parents lost friends following the incident with the police. Many described the humiliation and shame that these interactions caused. Participants felt that they were not treated humanely or treated with empathy by within the system. Reflecting on his experience within the mental health system, Doug stated: "the whole business of mental illness has a long way to go before we can come up with humane and effective treatment."

Many of the immediate impacts that the encounter had on participants, for example fear, distrust, and shame, permeate into long-term impacts for PwLE. Table 7 outlines the impact of these encounters.

Table 8

Impact of Encounter

Impact
Embarrassment and shame
Estrangement from others including friends, family, neighbours, and colleagues
Loss of freedom
Feeling like a criminal
Frustration
Fear: Fear of police; Fear of crossing the border; Paranoia; Feeling like they are being watched; Afraid to reach out for help
Distrust of police and service providers
PTSD
Police record**

** Immediate outcomes also manifest as long-term outcomes as participants reported that the impact of the encounter causes an immediate breakdown in relationships and ongoing fear and shame that exists following the encounter.*
***A police record is different from a criminal record as it refers to having their information on file or a record of their contact with police without formal charges or a criminal record.*

Kim indicated they felt afraid of the police and scared to reach out for help from crisis teams or therapists following the incident. Jessica indicated that, following the incident, she feels like the police are always out to get her and panics every time she sees a police car. This has further implications for people in crisis, as they may not reach out for help or confide in service providers if they are fearful that the police will be called.

> … it draws a lot of attention and adds a lot of stress. Because people see it and see there's a bunch of cops coming to the house and dragging someone out and that raises emotions, tensions. My parents said they felt very judged, and people shamed them after [the incident]. We had cops show up and then had to explain to

> neighbours what's going on because people think we're running a drug ring out of our house.

Many participants indicated that their encounter with police arose as a misunderstanding and they feared that, at any time, this could happen again, and they would be subject to having to prove that they were not dangerous or unstable. Jade noted that she was afraid to cross the border because she did not know if her police record would show up when she attempted to get into the United States.

Multiple participants indicated that, since the incident, they are afraid to seek help, specifically from health care providers for fear of being misunderstood and deemed at risk. Participants who had the police dispatched by a therapist or crisis hotline, indicated they would not use these supports again. Another participant indicated they would lie to a health care provider if they asked about their mental health status for fear that saying the wrong thing could get her "locked up."

Helping Yourself and Helping Others

While the literature concerning interactions between people with mental illness and police officers has focused on the negative aspects of these experiences, participants in this study demonstrated resilience and a desire to help others which can be seen as some of the strengths that people with lived experience of mental illness possess. Many participants indicated that they have sought their own knowledge and information and have used this insight to help themselves, and others. Doug stated:

> You have got to help yourself. Don't wait for other people to do it for you- not family, not psychiatrists, not other people, do everything you possibly can to help yourself.

Alexis felt that her interaction with the police and her experience in the hospital motivated her to pursue an occupation in the helping profession. Jeanne stated that she feels it is her job to help others: “That’s my job now, so people can see what they’re going through. You have to go through it to understand. I want to bring light to the darkness.” Doug stated: I’m a Schizophrenia survivor and it’s became my mission in life to learn as much about schizophrenia as I can so I can help others.” All participants had a strong desire to help others and to help themselves. They demonstrated resilience and they found ways to take back control in their lives by finding ways that met their criteria as helpful including alternative ways to deal with their mental health.

Participants described gaining and sharing knowledge with others about mental illness and their experience. Some have appeared on radio talk shows, podcasts, and participate in community initiatives and support groups on and off-line. Participants offered advice to others who have had similar situations. Richard wanted people to know that they should fight for their mental health and advocate for themselves:

> When you get down to it, it’s your life that’s on the line so you better fight really hard for it. If you don’t have your mental health, you, can’t really do much without it. So, it’s important to work on it as much as you can.

Frank shared a Similar sentiment: “If there’s one thing I have learned it’s that you have to help yourself. Don’t wait for others to do it. Not your family, not psychiatrist. Do everything possible to help yourself.” Participants took it upon themselves to find help outside of the medical model and seek alternative support. Alternative support, including accessing support groups online or in person, listening to podcasts, attending church, seeking spiritual guidance, meditating, reiki, and music, were reported as helpful by

participants. A further strength is the degree of insight these participants hold, and are willing to share, about the negative and positive aspects of encounters and subsequent outcomes. The participants have helped us to hear their experiences of interacting with police officers, an essential element in understanding police responses to those with mental illnesses.

Participant Group Two- Police Officers

Profile of Participants

Gender, Age, and Ethnicity

Of the five police officers that participated in this study, four were female (n = 4; 80%). Collectively, the years in service totalled 106 years, with an average reported years in service of 21.2. Most participants were white, with the exception of one participant who identified as Asian. Participants ranged in age from 35 to 51. Participants in PG2 were not asked to indicate their level of education, as it was assumed that all would have at least a post-secondary education to become an officer. Some participants shared this information with the interviewer despite not having been asked. For example, one participant in PG2 indicated that she had a degree in Psychology which she felt helped her in the work she does in the field when she encounters people with mental illness. Three officers worked in Ontario. One officer worked in British Columbia, and another participant was currently working in Nova Scotia but had experience working all over Canada including in remote Northern locations. Table 9 illustrates the demographics of Participant Group 2.

Rank, Training, and Years in Service

Most participants worked as constables. A Chief and a sergeant also shared their experiences. Officers had experience in diverse environments including within smaller rural communities and large urban areas. One officer indicated he worked in a remote location where the nearest hospital was two hours away and accessible by only by plane.

Training among officers varied. Officers who worked on a crisis team indicated they had extra training which entailed the use of firearms, use of force, and mental health

(Carrie). Connie reported she had taken online crisis training which focussed on different types of mental illness and how to recognize signs and symptoms. Most of the officers indicated they received some training; however, Dan stated he had not received training on how to deal with someone with mental health issues in 25 years. Carrie felt that the pandemic impacted training:

> You can speak to training and education, or practical skills, we only do so much training and the training is limited. And now with COVID it has been even condensed down further.

Table 9

Profile of Participants in Group 2

Alpha- numeric Code	Pseudonym	Age	Ethnicity
PG2-1	Carrie	50	Caucasian
PG2-2	Dan	51	Caucasian
PG2-3	Shannon	35	Caucasian
PG2-4	Deb	43	Caucasian
PG2-5	Connie	39	Asian

Location of Encounters

Participants in group two described working in rural and urban areas with advantages and disadvantages comprising both locations. In rural communities, officers felt they had more time to spend with people in crisis and were able to get to know the people they routinely work with. Officers also experienced challenges working in remote and rural locations where there are less services available for people with mental illness in times of crisis. Dan was tasked with flying for two hours to transport people with

mental illness (PwMI) to the nearest hospital. He felt there was an advantage to knowing the people you are responding to and having a historical context for the calls.

Officers found work to be challenging in larger areas where people are transient. They do not get to work with the same person more than once and lack information about them that may be helpful in times of crisis. Officers in larger areas reported the availability of resources not reported in smaller communities including a drop-in crisis centre and 24/7 crisis teams.

Call Types and Frequency

All participants in group two mentioned that dealing with people with mental illness was a major aspect of police work. Dan stated, "It's very difficult to separate mental health from police work, the two of them are one of the same." Deb stated: "At the end of the day, people who go into crisis are going to try one number- and that's 911."

Officers noted that they feel that the frequency and severity of calls have increased during the pandemic. Officers recalled the different types of calls they respond to, and many indicated it was difficult to focus on one or two encounters as most calls involve someone perceived to have a mental illness. When asked how officers knew the calls involved someone with mental illness, they indicated they made the determination based on symptoms or information they received from dispatch. When asked about the types of calls they have been involved in with people with mental illness, participants indicated there were many calls that ranged in diversity. Connie indicated that these calls are one of the most common calls for service and indicated it is hard to focus on just one:

Interviewer: Can you tell me about the types of calls you've responded to?

> Connie: Many calls… I couldn't- that is probably one of the largest percentages of calls for service. I have vast experience with it. I will try to focus on one or two.

Dan, stated: "Wow, I have been to literally hundreds and hundreds. It is very common."

Similar to the multiple factors involved in calls expressed by participants in group one, participants in group two expressed multiple components of crises including mental illness, housing instability, relational issues, familial conflict, and hostage and barricade situations.

Officers indicated that they respond to "frequent flyers" or people who are well known to police and who have regular contact with police. They offered reasoning for these reoccurring calls, including not getting the services they need and not being supported by informal or formal means.

Connie made a differentiation between what they referred to as "legitimate" versus "minor "calls. The former included substance use issues while the latter included dealing with youth in crisis who are fighting with their parents. This differentiation of severity and legitimacy of the crisis was voiced by other officers. Shannon described an "obvious" crisis:

> There are obvious ones, someone is threatening suicide or actively in a crisis right? It could be passive suicidal ideation, it can vary from a day-to-day battle or some sort of mental health issue they had their whole life, or even recently. So, it could be something small or something very large.

Officers appeared to understand that the crisis was not sudden and that it was the result of a history of complex factors. Some expressed that they knew people were not

getting the supports they needed leading up to a crisis. Shannon described how a history of trauma could have impacted the crisis and how her view has changed since she first started policing.

> … There's always something that's led up to this, whether it happened years ago, or childhood trauma, there's always something that's come on. For me, having done this for a bit, I have different coloured lenses on when I go to these calls. When I first started, we just dealt with what's going on "right now", but now having done this for a while, I wonder what happened prior to this? What brought them here and try to figure out how I can get help for them?

Thematic Findings

Experiencing Challenges on Multiple Fronts

Participants in group two expressed that working with people with mental illness was challenging and led to frustrations. They were also experiencing challenges with the medical and mental health system, and the legal system relating to these calls.

Many officers described the challenges of working with people with mental health issues. Largely, this was attributed to symptomology and difficulties concerning their behaviours relating to mental health. Officers felt these calls took more time to resolve and required more officers. Some experienced difficulties communicating or "getting through to" (Connie) people with mental illness. Carrie mentioned, "they become focused" and cannot be reasoned with.

The challenges and frustrations officers voiced were largely targeted at the lack of resources available and the overall lack of support for officers responding to calls and for people who are in crisis. These sentiments reflect those of participants in group one who

described various complex challenges and lack of support. The challenges described by officers are found in Table 10.

Table 10

Challenges of Calls Involving People with Mental Illness

Challenges Officers Encounter when Responding to Mental Health Calls
Communication: Person in crisis is unwilling to engage; Verbal de-escalation strategies are ineffective **Lack of Resources:** Calls require more officers and more time than usual; not having mental health professionals available 24/7; lack of resources and training for officers; lack of alternative options for supporting people with mental illness in crisis **Police role:** Having to make assessments quickly and under pressure; Public scrutiny; Not being heard in the hospital; young and inexperienced officers

Officers also expressed challenges within the medical, mental health, and legal systems. Officers described frustrations within the hospital setting including lengthy wait times, not being listened to, and treatment of people with mental illness and officers by hospital staff. Carrie stated:

> It used to be when you went to the hospital the psych nurse, or the doctor would listen to what you have to say and the grounds for us being there. Especially if there's a background. Now they don't give you time or listen.

Carrie felt that officers are often responsible for doing tasks that are outside of their vocational duties. She described how hospital staff ridiculed the person they brought in and that she felt she had to stand up for them. Connie, Shannon, and Dan felt that, in the hospital, there is a lot of violence which they indicated would be reduced if it were not for the long wait times. Dan shared a story about not being heard and having to follow a doctor's orders despite knowing better:

> I brought a woman in because she was mentally ill and we handcuffed her she was screaming, we brought her to the hospital, and the doctor said "constable I think you're upsetting her" and I said, "Sure, I agree with that" and he asked me leave but he asked me to take of the handcuffs off and I said "oh doc I don't think that's a good idea" and he said "I'm the doctor here and you'll do as I say!", so I said "fine I'll go grab a coffee from the cafeteria and wait" and I didn't make it 30 feet down the hall before I heard crashing and banging and whatever. They should listen.

Shannon shared that she was frustrated and unheard at the hospital as well. She said it is frustrating because "the physician on scene doesn't see them like they were on scene, and they don't listen." She felt that physicians do not care. She added that the only time she has seen a response from physicians at the hospital was when violence at the hospital occurred. Shannon shared the frustration of not feeling supported by hospital staff because they do not see the same behaviours that the officers see at the scene so they do not respond the way they should.

Officers shared frustrations of bringing people to the hospital only to have them released. Dan cried when recalling a story about bringing someone to the hospital for suicidal ideation only to have them released and complete suicide upon discharge demonstrating the impact that these incidents have on them. Officers knew that the hospital was not a positive trajectory for people in crisis and that most did not want to be there. Carrie was aware that there were no other options and that both officers and people with mental illness found this frustrating. She added that sometimes people in crisis are not given genuine care which makes things worse.

Carrie shared her frustrations with what she had witnessed with people in crisis and hospital staff. She stated she has taken people to the hospital and witnessed them being treated unfairly. This experience was frustrating for officers who were also aware that people in crisis do not have their needs met in hospital.

Frustrations with the judicial system were also discussed. Officers spoke about bringing people with mental illness in crisis to the courts and the implications and outcomes of this. Connie stated there is no framework or procedure regarding this and spoke about feeling as though they are failing people. Officers stated they try to advocate for people and try to get people in crisis the help they deserve but that this is a difficult task.

Challenges associated with the criminal justice system in the context of these calls were also shared. Connie did not want to bring people to jail and spoke about the ineffectiveness of carceral approaches. Deb shared similar sentiments and stated:

> And to bring them before the courts- why would I wanna do that? Because what is the outcome? And what and where? There's no framework and no procedure on their end.

Officers were acutely aware of the challenges of police responses to people with mental illness. They blamed the current system and spoke about the lack of resources available to people in crisis.

Lacking Support and Alternatives

The officers in this study were aware that having police respond to people with mental illness in times of crisis and the pathways that are the result of interactions were not ideal; but they knew that during times of crisis there may be no one else available.

Connie stated: People are like, call the social worker, well their team ends at 8, so now what?"

The unavailability of support after-hours and the limited options of where to bring people during these times were mentioned throughout multiple interviews. Officers were aware that even basic needs were not being met. Connie stated: "There are no places where their needs are met. They're not eating, there's no shelter, no places to get clean or have a shower."

Carrie felt an alternative to current models may involve the development of a centre or a "hub" where police officers could bring people in times of crisis that would be available 24/7. Carrie felt this option was a better option than bringing people to the hospital. Dan also shared the need for an alternative beyond the hospital. He spoke of the caveats of bringing people in crisis to the hospital where they are removed from their families. Dan reflected on the complexity of the situation:

> There are no easy solutions and very little services available to them; we try to put a band aid on as much as we can but there's usually only 1 mental health worker and if a person was significantly traumatized, we could fly them to Winnipeg or Ottawa and there they have access to psychiatrist and treatment, but then you're removing them from family and support and putting them in mental hospital so it has a lot of, you know, difficulties attached.

Most officers supported a blended model and felt that responses to these situations should involve a collaborative approach between professionals. Officers also spoke about the benefit having a registered nurse (RN) would add to these encounters but also spoke to the feasibility of this:

> I know some larger cities have done it- teamed with a Mountie in a crisis car. If you get a suicidal male on a bridge, those calls will go to that car and an RN is in the car with you as you go to the call, so you have a mental health worker; that would be awesome. But, of course it's not feasible because we don't have enough nurses to begin with but if we could wave a magic wand, I would love to have a nurse with me as I arrive at calls (Dan).

Shannon supported a blended model but was also aware of the limitations of this alternative approach and the perceptions people hold of police as it relates to provision of help:

> Maybe if more people knew the service was there. Even with so much visibility and media about it, there's still people who just don't associate police with being the people to help.

Both Dan and Carrie noted that shared information between professionals would help. Dan stated they are "getting better at sharing information, so there's no disconnect."

While some spoke about the limitations associated with bringing people in crisis to the hospital, some appeared to conform to the belief that psychiatric hospitals offered a solution to people in crisis. Carrie said she wished there were still psychiatric facilities available in communities and spoke about how people with mental illness who live in the communities fall victim to drug dealers who prey on them. Connie reflected on the days when the former psychiatric hospital was still in operation in her community. She recalled there were better supports for people with mental illness when it was open.

Officers spoke of the government's role in providing alternatives and supports. Connie referred to the current context as a "crisis" and acknowledged the deficit of addressing root causes:

> I feel like we need a village, in order for us to get on board and get the federal government to recognize that this is a crisis and that we are not getting to the root [of the problem].

Carrie mentioned the need to show the provincial authorities data pertaining to the number of mental health calls they are receiving and hoped that would lead to more support and training. She advocated for a "whole team" who would have training and work specifically with this population. She also mentioned the need for more seasoned officers, noting that she believes many officers are young and inexperienced. She referred to them as "green and without life experience," and thought they were "mission focused." She felt this could be problematic when responding to people with mental health issues in the community, specifically those with suicidal ideation.

Police officers expressed that they were lacking support for themselves too. Dan stated there is an overwhelming number of officers in his department alone that are off on stress leave. Carrie and Connie noted this as well. Dan stated he feels that the stigma surrounding mental illness and mental health support for officers has improved but that there is still a lot of work to be done.

> If you did a study of how many officers in service are actually off on stress leave or medical leave or sick leave you would be blown away. I know what our numbers are and it's astronomical. It's concerning and it's disturbing. (Dan).

Perceiving Risk

Perceiving risk was a theme that arose in some aspect in all five interviews with police officers. Officers described risk in multiple areas including the risk associated with responding to mental health calls and the risk of people with mental illness, the risk posed to the community, and risk to their public image.

Officers expressed that they felt people with mental illness were more dangerous and that these calls have a higher probability for violence when they involve someone with mental health issues. Carrie stated people with mental illness have a "tenure for violence" signifying a direct link to people with mental illness and violence. Carrie stated that people with mental illness pose a threat that "nurses shouldn't have to deal with." Shannon also seemed to imply that police were there to mitigate risk when she spoke about her role supporting a nurse on a mental health crisis team. She stated that she was there to "protect the civilian" referring to her nurse partner. Dan referred to these calls as "High risk. High frequency." Carrie used this same language when she spoke about mental health calls describing them as "High risk."

Carrie held further beliefs about people with mental illness that she believed the interviewer may have been aware of:

> You might have heard- when people are mentally ill, more often than not, they don't feel pain like the average person does, you know so sometimes if I used just an arm bar it doesn't work as effectively so you have to step it up a little bit because what works on person A doesn't work on person B.

Carrie, like other officers in group two, described people with mental illness as unpredictable, unreasonable, and violent. Deb, who had recently started on a crisis team, indicated that this position was the most violent position she has occupied in 19 years.

Deb, Carrie, and Connie spoke about being injured by people with mental illness in crisis. Connie indicated she had her glasses punched off her face. Others reported being spit at, lunged at, and swung at. Some officers thought that the determination of risk was based on symptoms, noting some diagnoses and symptoms pose a greater risk than others. Officers shared that people with depressive symptoms are less violent than someone who is experiencing "violent hallucinations" (Connie), "hearing voices" (Dan), or "bipolar" (Carrie).

The risk of weapons also arose in discussions about people with mental illness in crisis. Dan stated that, in his experience, people "with drugs" often have weapons augmenting the risk. Connie also spoke about the involvement of weapons in these encounters:

> A lot of times there's weapons involved, for example, suicide, especially in the prairies there's a lot of rifles, it may be in their lap or in their mouth, and I have to be aware that's a loaded rifle and as much as the mentally ill person is a victim of circumstances and not thinking straight, you still have a loaded weapon and you're not thinking straight so you might use that on me or someone else- it's a whole different feel.

Most participants agreed that use of force was more common when it involved someone with mental illness. Some officers expressed that they did not want to admit it and that it varied depending on the circumstances. Dan stated if he had to rank use of

force, people who are under the influence of alcohol would pose the highest risk and require use of force, and people with mental illness would be in second place. Dan added: "And if you have a drunk mentally ill person, they go to the top of the list." Connie felt that force may be necessary to prevent the person from causing harm: "Sometimes you have to use force and it's difficult because you want to help them, and you have to prevent them from hurting someone." Two officers spoke about the optics of use of force appearing worse than it is.

Perceptions of risk were often grounded in stigmatizing beliefs about people with mental illness including their tendency for violence, their unpredictable nature, and their inability to reason. These beliefs may have actually led to increased risk to people with mental illness as officers described use of force as a justifiable response.

A further risk expressed by participants in group two was the risk posed to communities. Connie felt that these incidents require more officers which takes officers off the road. Risk of violence and violent behaviours within hospital settings were noted as well.

Officers also spoke about how they are viewed in society and the risk to their reputation. They appeared to care about the risk these encounters posed to their image and the risk of not acting quickly due to being afraid of how it may be received by the public. Officers reported they felt like they were working under a microscope considering events involving police officers and people with mental illness. Carrie referred to the murder of George Floyd which occurred at the hands of a police officer in the United States in 2020:

> A lot of police, given the current political state- even with Floyd[2], are fearful of putting hands on people, and sometimes that's the fastest way to get them help. If you're in a medical crisis, something like excited delirium, and you're already in a medical crisis, and we take longer and longer and stall, they're less likely to survive the outcome.

This sentiment was shared by other officers who stated that some officers may be afraid to respond due to public image and being blamed. Deb stated:

> If police are more fearful and do it safely and tactfully, that's the better outcome and some people don't realize that. And then you have to think- what are the people saying or seeing? Is everyone gonna blame me?

Being afraid to do their job and facing public scrutiny were concerns expressed by other participants in group two. Officers noted fear and scrutiny made situations where assessments and response were already complex and time sensitive more difficult. Some officers expressed that they are put in difficult circumstances, which sometimes results in vilification . Dan expressed his view about an incident involving a 26-year-old Indigenous woman who was shot and killed by police during a wellness check in New Brunswick. He stated that officers are often put in these positions and have to make difficult decisions. He spoke of the impact these responses have on officers:

> I think of that poor Mountie in New Brunswick who got called to a wellness check, and I know no more than what you do from reading in the paper other than he was called to go check on this woman, and she comes out with a knife, and is not responding to commands, and God, I'm glad it wasn't me, because I don't

[2] The officer is referring to the death of George Floyd who was murdered by a police officer during an arrest in Minneapolis, Minnesota on May 25th, 2020.

> know what I would've done differently than him. He's become vilified. I'm not taking sides, but he was put in a horrible position and if anything, at this point he needs mental health help to get through what he's going through.

Officers shared similar views around the public and not being able to do their jobs properly because they are "under a microscope" or because of the community influence. Officers felt that they were perceived negatively in the mainstream media and by the public.

Officers indicated that, when they are attending a scene and the public is recording them on cellular devices or crowding around them, it makes it difficult for them to control situations and poses a risk to the community. Dan shared a story in which he was responding to a mental health call on a busy street when a crowd of onlookers of about 50 people were yelling and making their job difficult. The officer shared that these onlookers made the situation much worse and heightened the risk for all involved.

Wanting to Help

Every officer in this study voiced a desire to help people in crisis. Although in some circumstances they demonstrated discriminatory practices and held stigmatizing beliefs about people with mental illness as described in the last section, participants in group two voiced that they were trying their best and felt like they could contribute to change.

Carrie shared: "We're doing the best we can to respond to these very complex calls." Deb stated:

> I feel like we can contribute to change. We can be a safe person for them."

Officers wanted the public and people whom they deal with during times of crisis to know that they are there to help and that they do not want to use force, or for anyone to get hurt. Carrie wanted people with mental illness to know they are not there to judge them*:*

> We're not judgmental in their mental health. Admitting you have mental health is still-they're ashamed, so a lot of the time they say, "I'm not mental, I don't have an issue" I wish they could realize that it's not a judgement we are there to help."

In some cases, officers felt as though they had to advocate for people with mental illness in crisis at the hospital and with various community agencies to get help. Dan shared that they recognize there are some "bad apples", referring to police officers who may not have the best intentions of people with mental illness in crisis in mind; however, he shared that many officers aim to help others and put their lives on the line in many calls:

> In good faith, these are officers who signed up because they want to keep people safe. And the goal is to try to break down barriers with a community. I am not standing up here defending officers who do something bad. There are bad apples among everything and every once. I just think people don't see all the good that we do and that's the problem. You know, our officers are doing good work every single day. Every day they come in here and they put their life on the line.

CHAPTER V: DISCUSSION AND CONCLUSION

The findings of this study illustrate both the diversity and complexity of interactions between police officers and people with lived experience of mental illness (PwLE). The findings from this study challenge the simplistic and often stigmatizing views that have been presented in the context of police contacts with people with mental illness. Findings advance what is known about what is often referred to as "mental health crises" and illustrate the importance of acknowledging the many factors that contribute to these events.

Findings from this study illustrate that there are both similarities and differences in the ways police officers and people with lived experience of mental illness (PwLE) perceive and experience these interactions. The findings lead to recommendations at practice, policy, and research levels and have direct implications for social workers.

Call Types and Frequency

In alignment with previous literature, participants with lived experience of mental illness reported interacting with police for multiple complex and co-occurring reasons. Similar to findings from Brink et al. (2016) and Wood et al. (2020), participants in this study reported that they were experiencing various biopsychosocial issues with or without support at the time of contact with police. In alignment with previous research, these interactions were most often not the result of criminal acts nor were they due to mental illness alone. Participants indicated that in the time leading up to their contact with the police, they were experiencing homelessness, social isolation, familial conflict, and other complex challenges. These findings point to the importance of addressing multiple key factors that contribute to a crisis rather than focusing on the mental health

label as the main reason for contact; especially when the person in crisis has indicated that is "the tip of the iceberg" or a "snapshot" of what is occurring in their lives at the time. This is expanded on in the conceptual framework presented later in this chapter.

Like findings from previous researchers (for example, Bittner, 1967; Wallace, 2020; Wood et al., 2020) police officers reported responding to mental health calls as a common occurrence and a regular part of police work. Like previous research, police officers find this challenging and time-consuming work. Some officers reported they did not have specialized training for these roles and many voiced frustrations in this capacity.

Facing Multiple Complex Challenges

Participants in this study were experiencing various complex issues and lacked support at the time of contact with the police. In alignment with previous research, these interactions were most often not the result of criminal behaviour nor were they due to mental illness alone. Participants indicated that in the time leading up to their contact with the police, they were experiencing homelessness, social isolation, familial challenges and more. These findings point to the importance of considering multiple key factors that contribute to a crisis rather than focusing on the mental health label as the main reason for contact. Alexis referred to this label as "the tip of the iceberg" representing what Justin described as a "snapshot" of what was occurring in their lives at the time.

Frederick and colleagues (2018) examined the frameworks and language used to describe the context of police interactions with people with mental illness throughout the literature. Frederick et al. (2018) found a tendency to reduce causal reasons for these interactions most often to deinstitutionalization and symptoms of mental illness. Mill and

colleagues (2017) described this same propensity to describe and respond to crises with a focus on mental illness while muting other key factors such as stigma and lack of support. By perpetuating this universalizing and homogenous story about mental illness and crisis, there is a muting and erasure of a "multitude of alternative ways of understanding distress in diverse contexts" (Mills, 2017, p. 104). While well-intended, these approaches focus on symptoms of mental illness and risk, locating the crisis inside the person in distress while overlooking and failing to address important issues like lack of income, housing, or formal and informal support. These responses impose a single and overly-simplistic narrative that blames the crisis on mental illness and does little to address the actual causes of distress experienced by the person in crisis.

Within this study, participants described multiple layering and complex reasons for interactions with police officers. Rather than provide a simple "reason" for the interactions, and in contrast to prior studies that focus on mental illness as the reason for contact with police, none of the individuals with lived experience of mental illness indicated their mental illness alone was responsible for the crisis. In some instances, officers were aware of the complex challenges experienced by people with mental health issues, and they knew there was more to address than the mental illness label; however, they lacked support and alternatives to address these concerns beyond institutional means.

Narrow Solutions to Complex Problems

Findings from this study suggest that better options are needed for both police officers and people with mental illness during times of crisis. Participants were offered narrow solutions to complex problems. Most participants stated they were transported to

the hospital by police following the incident despite indicating that the cause of their crisis did not require hospital intervention. While hospitalization is often seen as a positive outcome throughout the literature, most participants indicated they did not like going to the hospital. Two participants noted it was better than going to jail. Most participants who were brought to the hospital following their encounters with the police, indicated they did not find the hospital to be a good experience. Common critiques included further loss of freedom and autonomy (including losing their telephone privileges, not being allowed to have visitors, being unable to leave as they pleased, being treated like a child, having nothing to do while there, and not feeling heard. All of these circumstances made them feel worse.

Another negative outcome of encounters experienced by participants was arrest. Four participants indicated they were arrested following their encounter. Of these four, all were brought to the hospital following detainment. One was charged and later found not criminally responsible (NCR).

For two participants, jail served as a temporary holding place before they were transported to the hospitals. Both of these participants indicated their events happened in rural areas and they had to be transported later to larger hospitals outside of their region. This speaks to the lack of services in rural communities.

As described in Chapter four, participants felt the response was unhelpful and unnecessary. Many indicated it was the result of a misunderstanding. Some participants indicated that the outcome of the encounter left them in a worsened state The solutions that were offered to participants in group one did not resolve the issues they were experiencing because focused the intervention on mental illness while overlooking other

central issues in a person's life. Further, the interactions that occurred with the police perpetuated the negative experiences including lack of support, loss of power, and frustration, that they were already facing. The interaction with police added further stress, fear, and shame that led to negative outcomes and lasting impacts.

Addressing Complex Needs: Reframing Crisis

All participants were experiencing multiple complex and layering factors including physical and mental health status, lack of informal and formal support, and situational stressors, preceding interactions with police officers. Alexis spoke about these complex and layering factors stating that mental illness and what police officers are seeing at the scene is "the tip of the iceberg." She added: "Officers don't see that they see that moment. They don't know there was 15 years prior when we could've housed them, given them clothes, income support."

Interviews with participants illustrated that the term "crisis," often used to describe a particular "mental health crisis" or crisis event throughout much of the literature, is insufficient and ineffective in defining interactions. First, there is a multitude of co-occurring factors involved in the encounters that exceed the constructs of mental illness. Second, the encounters described by participants were not always considered a crisis for participants during or up to the time they encountered police. Police officers held the power to determine the legitimacy of crises which stripped people in crisis of any power and autonomy over their circumstances.

. This parallels the work of other researchers who have found that rarely do people interact with police for mental health reasons alone (Mullay et al., 2016). Through the emergent design of the study, the interview guide evolved to leave time and

opportunity for participants to share what was occurring in their lives leading up to the event. Leaving this space allowed participants to share what was going on in their lives at the time of the encounter. Given this space, participants told the story of how they found themselves in the circumstances of interacting with police including details about their history and previous experiences and the multiple, co-occurring factors that existed at the time of the event.

All participants in group one (PG1) (n = 13) indicated they were experiencing multiple challenges leading up to and at the time of the crisis. None of the participants implicated mental illness alone as the cause of the encounter. The issues participants were facing required complex and comprehensive supports that police officers cannot provide.

Research tends to situate issues at the individual level and attribute problems to the "mental health" status of the person in crisis. Often, having the very label of "mental illness" overshadows other key issues that are co-occurring in one's life at the time of the incident and as such, common trajectories such as hospitalization, become regarded as an effective solution. This was the case in this study although not a preferred solution by PwLE.

As mentioned earlier in the study, the decision was made to depart from the traditional medically dominated discourse surrounding these encounters. As such, participants were not asked to disclose their mental illness. This is novel to crisis research as it concerns interactions between people with mental illness and police officers. Much of the current literature surrounding police contacts with PwMI focuses on the "mental health" aspect of the crisis while overlooking various other key factors that may hold more importance for the person in crisis.

People with a label of "mental illness" interact with the police for many reasons and just because they have a mental illness, does not make the crisis a mental health issue. For example, while all participants participating in the study identified as having a mental health diagnosis, none of them indicated this was the reason for the call. This is not to say that there are not instances when mental illness is a factor in mental health calls; but, labelling a crisis a "mental health crisis" because a person has this label, misses the mark and leads to ineffective responses.

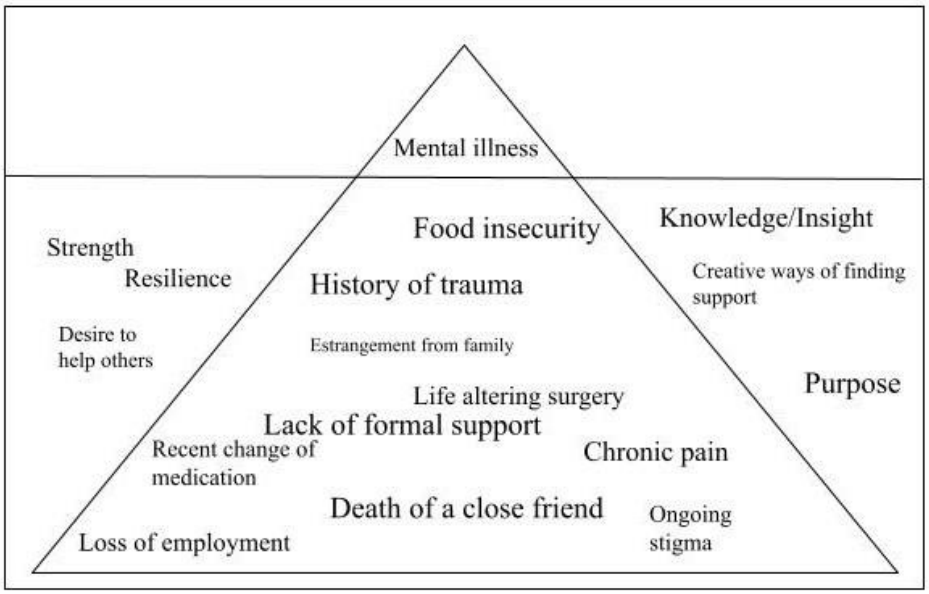
An obvious disconnect occurs with the overshadowing of the mental health labeling when it relates to mental health calls. Using language that departs from traditional and positivist views of crises when it relates to someone with a mental health diagnosis may serve to shift the understanding and responses to these situations. Responding to the label of mental illness and not addressing other factors is disempowering and ineffective and led to worsened, and often longstanding impacts for people in crisis who required comprehensive support at the time of contact.

Rather than implicating their mental illness as the cause for the encounter with the police, participants described circumstances that would be more appropriate to refer to as a "housing crisis" or a "relational crisis" than a mental health crisis. Within these descriptions, participants described factors such as lack of basic needs, mental and physical health conditions, family and relationship conflicts, lack of informal and formal support and major life events, yet the interventions they were offered, most often transport to the hospital, did not respond to their concern. They often reported feeling misunderstood and disempowered.

Figure 5 reflects the many factors that contributed to crises that were experienced by participants in group one. The tip of the iceberg reflects what is often what officers see when they respond to crises and what they choose to address when responding. This model encourages a deeper understanding and consideration of multiple factors that influence crises beyond the label of mental illness.

Figure 5

Factors Contributing to Crises



While current responses to these encounters typically focus on the mental health status of the person requiring support and include trajectories such as going to the hospital, this only addresses one issue that may or may not be a "crisis" for the person in need of support. As Ashley stated, addressing issues at this level "solves the problem for them, not us[3]." Further, discrepancies in what both parties consider to be a crisis, and subsequent institutional responses (like hospitalization and carceral[4] approaches), have

[3] "Them" is used by the participant to refer to police officers.

[4] Carceral is defined as relating to arrest and jail.

proven ineffective and disempowering by people with lived experience (Joseph, 2014) and should not be revered as a central approach to mental health crises.

In response to findings from this study and in alignment with previous literature that illuminates causes beyond mental illness alone (for example Mills, 2017), this model highlights a variety of factors that make up a crisis. This framework encourages a broader understanding of multiple, complex, intersecting factors that contribute to these interactions and the limitations of disregarding countless co-occurring stressors in the pursuit of addressing mental health concerns.

Given the multiple layering factors that contribute to a crisis state, approaches should address comprehensive factors. If someone in crisis indicates they are experiencing homelessness and social isolation, transport to the hospital is unlikely to resolve the crisis for them. Participants in both groups indicated these were not positive outcomes and, in some cases, made the situation worse.

In the events described by participants, their needs were often not considered. They were not provided the opportunity to engage in the decision-making process. This loss of power led them to feel as though they were criminals and led to negative and lasting impacts as described in Chapter four. During crises, timely action may be required, and, as a result, it may be difficult for officers to fully understand the complex history leading up to the event. For a response to be effective for the individual in crisis, officers should understand there is a bigger picture than what they see when they attend a crisis, and the label of "mental illness" may only be a fragment of that experience. The image outline in Figure 5 was described by Alexis who noted that mental illness is "just the tip of the iceberg." Justin shared a similar view stating police officers on the scene are

only seeing a "snapshot" of what is going on. As the figure depicts, many co-occurring issues may be happening and the intensity or degree to which those factors are impactful, and debilitating is subjective. For example, while ongoing stigma is a factor someone in crisis may be experiencing, they may not place as much weight on it as the history of trauma they have experienced.

While less explored in the context of interactions with police, people with lived experience have unique strengths and insights that should be explored and drawn upon during times of crisis. With a focus on the negatives, it is important to acknowledge the knowledge and abilities people in these situations have despite their circumstances. For example, the ability to find creative solutions to manage their conditions, the desire to help others, the ability to find purpose and derive meaning from their circumstances, and the knowledge and insight they have regarding what works and what does not work for them are strengths that should be considered. Understanding and effectively responding to people in crisis requires consideration of the multiple, complex factors that contribute to crisis events.

Outcomes and Impact

A lesser explored area throughout the research concerns the outcomes and impacts of police encounters with people with mental illness in crisis. Most participants with lived experience stated that the interactions with police made things worse than before the crisis and left them with longstanding problems.

Many people with lived experience (PwLE) described feeling like a criminal and expressed a loss of freedom and power during the encounters. These findings align with previous research which found that negative perspectives regarding the police resulted

from “a combination of factors such as direct experiences interacting with the police (e.g., in the context of an alleged criminal act), feelings of powerlessness in relation to their mental illness (e.g., mental health-related police apprehensions), co-occurring substance use problems, and marginalized social locations (e.g., high rates of poverty, unemployment, homelessness, and victimization)” (McNeilly, 2014, p. 86).

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The exchanges people with lived experience had with officers mimicked the same frustrations and perpetuated the unmet needs they faced prior to contact adding more issues to their already complex situations. When police officers treat people in crisis like criminals, do not listen to them, and further disempower them, it creates a cycle that returns them to a previous state of feeling unsupported and adds another layer of stress and problems to the multitude of issues they are already facing leading to a worsened state. In this study, participants reported experiencing a multitude of complex problems and lack of support which led to stress and crises. Preceding contact with police, PwLE feel unsupported, experienced discrimination, and felt further frustrated and disempowered. The interactions with police contributed to a loss of power and

discrimination which augmented these feelings leaving them feeling worse and without support.

Participants described positive interactions and outcomes as involving compassion, validation, empathy, and allowing space to feel heard. Acts of service including kind gestures were also mentioned as positive for people during times of crisis. Participants also reported they wished to be connected to support and receive follow-up after the interaction and a desire to be heard and allowed to share their story. They mentioned several helpful aspects of encounters (Figure 6) that would lead to positive interactions.

A Mutual Understanding

An interesting finding that arose from this study is the similarities shared by both groups. Despite having very different experiences, police officers and people with lived experience of mental illness in this study shared similar constructions of reality which are explored in the following section.

Lacking Support and Resources

Both groups agreed on the lack of support and funding for people experiencing mental health issues. Both groups also spoke of the lack of training and the challenges with current models of support. Both groups acknowledge and understand the limitations of current approaches and recognize the need for change. In this study, police officers and people with lived experience of mental illness (PwLE) believed the current structure of support offered to those in crisis is not working and they seem to agree on the reasons for this. For example, both groups stated they felt there are not enough formal and informal supports which leads people with mental illness to experience a crisis. Both groups

mentioned a need for more resources, including more funding and more trained mental health professionals.

Both groups understood that the hospital is not a positive outcome and both groups understood that this was a temporary solution that was frustrating for police officers accompanying people with the hospital and for people with lived experience of mental illness (PwLE). Participants in both groups were aware that neither the officer nor the person in crisis wanted to interact with one another and they seemed to understand each other's frustrations, many of which were the same.

Police officers and PwLE experienced challenges and frustrations with one another, with the mental health system, specifically with the hospital, and with the lack of support available. Both spoke about not feeling heard at the hospital, not being taken seriously at the hospital, and having to wait long periods only to be discharged without resolve.

Both groups spoke about the limitations of training and the importance of a collaborative approach. Both groups mentioned the police had no choice but to attend calls involving people with mental illness due to lack of 24/7 supports. Both groups experienced the impact of these encounters in negative ways. For example, Dan cried when he reflected on the interactions he had with PwMI who had completed suicide following their interactions. However, interactions were described as having a much greater and longer-lasting impact on people with lived experience (PwLE).

Unheard and Unsupported within Multiple Systems

Throughout this study, people with lived experience of mental illness shared their frustrations within multiple systems and reported feeling unheard and unsupported by

police officers and mental health professionals. Police officers shared this same frustration and noted that they also felt unheard in certain situations. For example, officers reported that when they brought people in crisis to the hospital, they were dismayed to find out that the person was only going to be released. They stated that they were frustrated by not being listened to in the hospital. Like PwLE, they shared that they were frustrated by lack of resources and support, and lengthy wait times.

Feeling unheard and unsupported appeared throughout numerous transcripts in both participant groups. In participant group one, participants with lived experience of mental illness (PwLE) felt that they were not heard by people they sought help from leading up to and during the crisis. In several instances they voiced that they were misunderstood. Other participants spoke about how they were not listened to by the crisis line, their therapists, the police or in the hospital setting.

These feelings of not being heard were also expressed by officers who indicated that when they get to the hospital with people in crisis, they are not listened to by hospital staff. Both groups felt there is A lack of support for PwLE voicing that there is not adequate support available 24/7 and nowhere to go during times of crisis. Officers knew that there were gaps in current systems and expressed this in their descriptions of what should be done to improve these interactions.

Both groups were aware that the hospital is not always a good option but knew that in many cases, there were not many other choices. Both groups found it challenging to communicate with one another and expressed instances when they felt they were not listened to. Police officers also noted that they themselves have needed mental health

support or have known colleagues who required support and did not receive it, demonstrating first-hand experience with the lack of support and services themselves.

Both participant groups vented about frustrations with the government and spoke about changes that need to be made. When officers spoke of challenges, they often directed their frustrations toward various systems and not at people with mental illness. Participants with lived experience expressed challenges and frustrations with the way they were treated by police officers. Often times, they were already at a point of frustration and felt let down by service providers or informal supports before interacting with police. The arrival of police who were unsupportive and demanding, added a deeper layer of challenges. Frustrations and challenges have been outlined in previous research, yet the implications of these shared challenges and frustrations as well as the suggestions for what aspects need to be changed, have not been explored.

Fear and Risk

People with lived experience of mental illness voiced that they feared police during and after their interactions. PwLE shared fears of losing a job, loss of relationships, fear of what others, including friends and neighbours, would think. Dan and Jessica felt extreme paranoia arose from the incidents. The fears expressed by those in group one were diverse. Kate thought the police were there to harm them and was too afraid to open the door. Jade is afraid to cross the border as she is not sure if she has a police record. Jessica feels like the police could come to her home at any given time without reason. She feels nervous when she sees police cars and police officers in the community.

Police officers also expressed fears, but they were not related to physical injury or dominance by PwLE. Police officers spoke about being afraid of what people thought about the responses they take. They mentioned the fear of "putting hands on people" (Carrie). Some thought it posed a threat if response is delayed as a result of worrying how they might be villainized based on their response.

Understanding the experience of fear is important within this context. If people with lived experience of mental illness fear police, they may not be receptive to their help. Further, if they fear police following incidents, they may not reach out to police when they do need them.

Stigma and Scrutiny

Both groups expressed aspects of public scrutiny and stigma as well as stigmatizing views about one another. Both felt they were viewed negatively based on the roles they occupy in society and the constructions that people hold about their status in society. It is important to note that participants in group one felt this stigma was related to the views society holds about people with mental illness, while participants in group two felt they were viewed negatively by the way they were perceived in mainstream media and the public.

Police officers spoke about the ways their job was made more difficult by the public and mainstream media. They were aware that people do not want them involved in this capacity. They spoke about being under the public's watch and that, in some cases, this impacts the ability to do their job. They spoke about the mainstream media's role in perpetuating the stigmatizing views of police as they operate in this role. Some brought up the media coverage of recent contacts between police and people with mental illness

that resulted in death by officer. The results from Lane's study are not surprising given that, historically, there has been resistance by police officers toward their role in the management of people with MI (Bittner, 1967; Short et al., 2014).

People with lived experience of mental illness (PwLE) experienced scrutiny and stigmatization during their interaction with police. They were treated differently because of their symptoms and were scrutinized by friends, family, and neighbours. Jessica mentioned the impact the encounter had on her after neighbours witnessed their interaction. Keith stated his parents were even treated differently following the encounter that occurred when police were called to their home.

Stigmatizing beliefs about one another were shared during the interviews. This was evident in the language they used to describe one another. Some people with lived experience overtly stated they did not like police officers. Others used language such as "government muscle", and "militarized thugs." Police officers did not overtly state they do not like people with mental illness, but in some statements, stigma was evident; for example, beliefs that people with mental illness are more likely to be violent, dangerous, and unpredictable.

Interestingly, both groups perceived one another as dangerous and unpredictable. They both find each other difficult to communicate with and found these interactions challenging and frustrating. Some officers admitted they shy away from interactions involving people with mental illness; notably, for people with mental illness, this is not an option.

It is not surprising that both groups have constructed beliefs based on their encounters with one another. Both groups stated they have experienced violence from the

other and were aware of the perceptions of their roles in society. Participants in both groups had experienced violence from the other which may solidify their stigmatizing views of each other.

Differences Between Participant Groups

There were differences in the ways police officers and PwLE described these experiences. Police officers did not describe fear and shame in the same ways PwLE of mental illness did. Rather, their focus surrounded the complexity and frustrations within their role. In many cases, police officers see themselves as advocates for people with mental illness; Carrie stated, "If we don't advocate for them, who will?" People with lived experience (PwLE) did not share this same sentiment.

Police officers did not describe the same level of fear following these interactions. They feared for their public image in some instances, but they did not fear losing their relationships, families, jobs, or for their safety in the same ways that PwLE did. Police officers did not mention a loss of power or freedom; however, they did feel like they were not heard by hospital staff which may reflect some loss of power.

Self-stigma was not expressed by police officers like it was by people with lived experience (PwLE). While many in group one were ambivalent about whether people with mental illness may be more dangerous, police officers were confident in their answer that people with mental illness are more dangerous. They also admitted these calls are more likely to involve the use of force although some indicated they did not want to admit it. Others clarified it appears worse than it is.

Participants in group one engaged in more detailed interviews that lasted longer than interviews for participant group two. While the length of questions was similar,

people in group one (PwLE) spent a greater amount of time sharing what led up to their encounter with police officers. They also spoke longer about the impact these encounters had on them.

Participants in group one often described these encounters as misunderstandings. They used words like “intense”, “traumatizing”, “excruciating”, and “humiliated” to describe their experiences, while police officers used language that was less intense to describe these interactions such as “complicated,” and “frustrating.” Table 11 illustrates the similarities and differences between both groups.

Police officers and people with lived experience of mental illness differed in their construction of crisis and obvious discrepancies existed throughout the interviews in defining and experiencing crisis. A further difference is the level of power that [police officers hold that people with lived experience of mental illness do not have in these situations. The differences described by participants relate to the construction of reality.

Table 11

Similarities and Differences Between Participant Groups

Similarities	**Differences**
Frustrations with systems Frustrations with lack of support (believe that change is needed; 24/7 support; trained professionals; alternative to hospital) Not feeling heard by others Experiences of stigma and scrutiny by each other, by the media, and by society Fear of judgement by others Risk of violence and injury Challenging interactions Views of what change is needed Collaborative approach is needed Do not want to be there Frustrated by each other Feel the other is not listening to them	Loss of freedom and autonomy No criminal record/police record Loss of power Loss of freedom Intensity of language when describing interactions Level of fear Embarrassment/shame Impact of encounter Self-stigma Ambivalence about whether people with mental illness are dangerous

Limitations and Delimitation

As with other qualitative studies, the findings from this study were non-generalizable; however, the rich narratives provided by the participants contribute to the current literature and provide deeper insight into an under-explored area. While the sample size was small, there is richness and diversity in the expressed experiences of participants.

While the study sought to match sample sizes for both groups, people with lived experience of mental illness and police officers, the sample size for the former was more than twice the size of the latter. Only five police officers participated in the study and while themes did emerge among the five officers in this study, these finding are not generalizable. Further, the second participant group was composed largely of females (80%) although police is a historically male-dominated institution. This may have been because more females were comfortable sharing their stories or had an interest in the subject. The sample was also largely composed of Caucasian participants. Research indicates that this issue disproportionately impacts Indigenous and racialized communities. It is imperative that future research seeks to develop knowledge about the individuals and communities most impacted by this issue.

The context of the global pandemic posed limitations. This may have contributed to low sample size as many participants tried to navigate unprecedented circumstances. Due to the pandemic, interviews had to be completed virtually as social distancing requirements did not permit otherwise. Some participants may not have liked talking on the telephone or being recorded. To address these issues, participants were given a choice

to participate using various modalities including Zoom, Microsoft Teams, or via telephone.

This study contributed to the conceptual and methodological limitations of previous research and offered people with lived experience of mental illness, and police officers, the opportunity to have their voices heard. This work also responded to gaps in previous research by examining aspects of these encounters that have been less explored and offering explanations for encounters that reside outside of the individual in crisis including systemic and structural issues. In doing so, this work departs from the traditional narrative that positions the blame on the individual and crisis while overlooking factors outside of symptoms and diagnoses.

Implications for Practice

Based on contemporary literature, the findings of this study, and the conceptual model presented throughout the dissertation, important implications are presented for practice, research, and policy. As discussed in the beginning chapters, the inclusion of people with lived experience of these interactions in literature and in practice is rare; however, there is value in including people with lived experience in practice and in training as they have first-hand knowledge about these interactions which has the potential to improve outcomes for police officers and people with lived experience of mental illness who interact during times of crisis.

Participants in this study described effective communicative strategies such as empathetic listening, lowered voices, and giving people a chance to tell their story. They also made suggestions for officer behaviour including relaxed stances, keeping their hands away from their weapons, approaching the situation with less intensity, and giving

people their distance. Some participants also mentioned that more discreteness would help the situation, for example unmarked police cars and non-uniformed police. Some participants mentioned the importance of having a trained mental health worker alongside a police officer; although, some participants mentioned the clothing police officers wear and accompaniment by a mental health professional does not make a difference.

Police training should include people with lived experience of mental illness and caution should be exercised when homogenizing mental health calls and diagnoses. Training should also look to multifactorial reasons leading up to crises and should include a discussion of the different views that society, and officers hold of people with mental illness, how they are constructed, and why officers should reflect on the beliefs and expectations they have about people with mental illness. Training should relocate the focus of crisis from within the individuals to outside of the individual and should highlight issues such as stigma, lack of basic needs, and lack of formal and informal support. Training should also focus on the strengths that people with mental illness possess rather than focus on the negative aspects of diagnoses and symptomology. Training should also explore officers' constructions of mental illness and their beliefs about the ways people with mental illness behave. Specifically, officers' constructions of perceived dangerousness should be examined and explored along with the implications of such beliefs and subsequent actions taken.

Within Canada, there is no standard approach to training nor is there a consistent evaluative accreditation standard that police services must follow. Future research could seek to include the feedback of people with lived experience and police officers to develop formative training and evaluative standards that could be reviewed annually.

Further, program design, implementation, and evaluation should be a consideration of future researchers who could work with police services to examine better approaches to resolving crises.

As participants mentioned, collaborative approaches should be implemented to address all areas of crisis. This includes including professionals outside of the medical model including housing workers, grief support workers, and peer navigators. Exploration into peer support programs should be implemented to examine the effectiveness of having someone with lived experience of mental illness serve as an advocate for those in crisis. People with lived experience should play an expert role as they are experts by experience and should be involved in ways that are considered meaningful to them. The Substance Abuse and Mental Health Services Administration (2022) has posted guidelines for peer support services in crisis care which includes benefits and models of peer crisis support services. Models including 24/7 crisis lines operated by peer support and professional staff and follow up supports by peer support workers are encouraged, yet these initiatives have not been universally implemented.

Covert and subtle forms of oppression within practice should also be examined. A recent initiative in Ontario has equipped nurses on a mental health crisis team alongside police officers with bullet proof vests. This has important implications and perpetuates stigma as it proposes that people with mental illness are dangerous. Further, while adding a nurse to crisis teams may be effective for some, including social workers who have holistic knowledge outside of the medical models would contribute to advancement in the field. As participants in this study stated, they have had negative experiences within the

medical system and adding a professional who operates outside of this domain may be helpful and address systemic issues that reside outside of the individual in crisis.

24/7 support should also be made available and considerations for lack of access in rural communities must be addressed. Having police serve as first responders contributes to the belief that people with mental illness require police intervention, gives police and people with mental illness no choice but to interact with one another, and leads to the criminalization of mental illness. As Jade mentioned, we will continue to see the criminalization of people with mental illness if police are the first to respond to mental health crisis.

New language surrounding the terms *"crisis"* should also be considered. First, the term itself is subjective and what is considered a crisis to one person may cause little to no distress to another. Participants noted they felt their crisis was dismissed or taken to be a sign of extreme and unnecessary risk because it was interpreted differently by others. Specifically, the term "mental health crisis" is problematic and insufficient as in many situations, the mental health status is not the main reason for the crisis. Responding to crises should include considerations of holistic support including help with access to food, housing support, income support, connection to social support, and other community supports rather than focus on addressing one component (most often mental illness). People in crisis should be given the space and time to share what issues they are facing and have a say in what support they require.

Future directions as suggested by participants in group one (people with lived experience of mental illness) are found in Table 12.

Table 12

Future Directions Suggested by Participant Group 1

Future Directions	
For police officers	Be more empathetic and consider demeanor and intensity Bring a trained professional Consider a team effort Do not act like it is ruining your day/shift. Put cameras on police officers for accountability. Do not bring marked cars; do not create a scene. Consider language barriers and possibility of misunderstandings. Do not raise your voice. Consider that people are going through a great deal of stress and may not be receiving current support.
For systemic and policy change	Preventative approaches and quality care Implementation of a government-funded advocate Approach the provincial government from the perspective of police are doing too much Provide humane care Seclusion as a last resort

Future directions as suggested by police officers are found in Table 13.

Table 13

Future Directions as Suggested by Participant Group 2

What could be done to improve outcomes?
Availability of 24/7 support
Better facilities/ Reopening of psychiatric facilities
Mental health professionals alongside the police
More training
Affordable housing
Collaboration and knowledge sharing across community members
Increasing knowledge about support available
Having access to mental health history
Having officers with prior knowledge and experience

Implications for Policy

The results of this study have implications at policy levels. First, as research and findings from participants suggest, there are many challenges that both parties face. Working with both groups (people with lived experience of mental illness and police officers), to determine revisions to policy should be a consideration.

In this capacity, participants should be able to contribute to discussions without being told what they can and cannot say and should be given a safe space to share their feedback. As mentioned by one participant in group one, while they are part of a consumer advocacy group, they are told what they can and cannot say thus limiting their participation.

Policies should be created in collaboration with various stakeholders and should be implemented consistently throughout all services and police departments. Presently, there is no standard policy governing police interactions with people with mental illness, nor is there any ongoing review or accreditation standards to adhere to. Policies should be developed, implemented, and reviewed in collaborative ways that include people with lived experience and their families. These policies should be created and reviewed continually with community members, people with lived experience, police officers, nurses, social workers, psychiatrists, and anyone else who may be involved in these capacities during crises.

Policies should focus on preventative measures that look at the multifactorial contributions to the crisis including housing, lack of formal and informal support, food instability, and stigma. Rather than focus on the mental health status of people during the crisis once the person has reached their breaking point, policies should aim to prevent and

educate the public about ways to prevent crises and should aim to empower people with lived experience of mental illness.

Measures to support people in crisis and policies outlining these processes should look beyond institutional models of support that are currently officers. These institutional approaches, including hospitalization and jail, have historically oppressed people with mental illness, and although they may be seen as a means to an end for the crisis for responders, previous research and the findings from this study, indicate that these are not positive outcomes for people with lived experience. Holistic supports, including access to basic like food and housing, and informal support should be provided. By providing support that targets only the mental health issue, we risk missing the mark.

While defunding is a polarizing topic, we cannot ignore the reminders of what can go wrong when police officers serve as first responders to people with mental illness in times of crisis. The current structure is challenging for police officers and people in crisis who lack support and alternatives to deal with these situations. Policies should aim to shift the narrative that links policing to mental illness and create systemic changes that refocus the location of the crisis away from the individual and to the broader social context. This will require difficult conversations that challenge dominant and powerful institutions and deeply embedded beliefs about people with mental illness. Reframing what a "mental health crisis" looks like is an important step in this process. We must also be cautious of approaches that appear benevolent and progressive. For example, training officers and embedding social work into police crisis models may seem like a good idea; however, when developing policies that impact people with mental illness, policy makers should avoid perpetuating the *Dangerousness Myth* (discussed in Chapter One). Further,

solutions to crises should be determined by the person in crisis, and not by those responding.

Implications for Research

Future research should aim to include people with lived experience in meaningful ways. Methodologies that incorporate active participation, for example participatory action research, would allow participants who have had these experiences, to participate in the development of research that seeks to better understand and improve the interactions between police officers and people with lived experience of mental illness (PwLE).

Focus groups that precede data collection and seek input from people with lived experience and police officers, could be used to determine what questions should be asked. Further, both groups could participate in the development of a research plan and research materials including interview guides that contain questions developed by people with lived experience and police officers who know what questions should be asked. Engaging people with lived experiences and encouraging collaboration during the research process would augment current literature and allow people who have had these experiences, to contribute to and develop progressive approaches to defining and responding to the issue that both parties face within this context.

Another key area within the literature which has been discussed throughout this work is the power of language and the role it has in shaping the understanding about these encounters. While research in this area has increased over the last two decades, few authors have examined and acknowledged how language contributes to the stigmatization of people with lived experiences of mental illness who encounter police. As illustrated by

Frederick and colleagues (2018), language within this discourse has offered a narrow conceptualization of these experiences often placing the blame on the individual in crisis.

Further, researchers have failed to explore how language within this context is subjective. For example, the use of diagnostic labels can serve to pathologize and homogenize the experiences of people with lived experience of mental illness. Future research that seeks to explore policing and mental illness should offer clear conceptualizations of the terminology and frameworks used and should also offer a preamble about the dangers of linking mental illness and policing given that people with mental illness are not more dangerous than people without diagnostic labels. Future research should also work with people with lived experience to determine the language they prefer when describing their unique experiences.

Research within this area has often focussed on symptoms and diagnoses while muting other important factors. An in-depth exploration of specific demographics, for example younger adults or older adults or people experiencing substance use issues would respond to gaps in current research. It would also be important to examine how police officers respond to these specific demographics and the variance of responses. An examination of the differences in response by senior versus new officers would also contribute to a better understanding of the approaches officers take when responding to people in crisis. This factor was noted by participants in both participant groups.

An examination of the beliefs that officers hold about mental illness would also contribute to a better understanding of these interactions. This work sought to explore the experiences of both groups while looking at the attitudes and beliefs they held about each other. Within this exploration, social constructivism served as a framework for

understanding the subjective and multifaceted views that each group held. Future research should utilize social constructivism to explore these socially constructed views and how they are shaped and the degree to which they change with experience. Future research may also examine the social construction of mental illness and how it is articulated in conversations with police officers as well as the determinations they make based on these constructions which impact the people they respond to in immediate and profound ways. The aspects could also be applied to pre- and post-crisis training for officers and mental health professionals.

Further to the note that these responses impact people in immediate and lasting ways, previous research has not focussed on the long-term impact that these interactions have on people with lived experience of mental illness and police officers. An exploration of how these interactions shape their lives both during and after the interactions and the impact these interactions have on their families and their views of themselves would lead to a better understanding of the impact and implications of these encounters. Some participants indicated that their lives were made worse following the encounter with the police.

Finally, future research should look at the similarities that these two different groups share. While it is easy to think of the differences between police officers and people with lived experience of mental illness, notably as it concerns power differentials, the findings of this study demonstrate that there are also similarities which could lead to an understanding of both parties and ways in which they may be able to relate to one another. This could add value to future practice and policy.

Final Statement of Reflexivity

Earlier in the dissertation, the initial reflectivity statement explained the researcher's perspective and how values, beliefs, and experiences impact research. This same reflexivity was used throughout the research process. For example, in the data analysis stage this process became especially important as my own views and experiences had the potential to shape the research process.

Throughout my degree, I have continuously heard and read about the importance of reflexivity, positionality, and self-care. I do not believe I truly understood the value of these concepts until engaging in this work. Memoing and journaling became important processes that not only allowed me to capture important insights about the field work I was doing, but also challenged me to examine the beliefs that I held and the position I occupied. Through conversations with participants, I grew not only as a professional, but as a person. I learned the value of reflexivity and I learned that as much as I thought I knew about my privilege and positionality, there will always be more to learn.

One example of this occurred through conversations with participants. It was the privilege I hold based on where I lived at the time of the study. If someone were to engage in cathartic behaviour amid a crisis (for example, yelling, screaming, or punching a wall) while experiencing homelessness, the police would likely be called for a disturbance. However, if I were to enact this same behaviour in my home, I likely would not have to worry about the police coming or having charges laid. This is a privilege I had taken for granted.

I knew that my work in crisis would serve me well throughout this work as I brought insight and a degree of expertise to the inquiry, but I had underestimated the

degree to which my education in social work would help me in this journey. While I avoid the term "clinical" given its close alignment with the medical model, the skills I learned as a micro-level social worker, allowed me to support participants as they shared their stories with me. Supportive listening, redirection, empathetic listening, and even the ability to sit silently with participants during periods of repose, were invaluable in forming a rapport with those who shared their stories with me.

The importance of self-care, a common suggestion given to social workers who occupy positions that often lead to high rates of burnout, was not something I valued until engaging in this work. I came to realize the value of acknowledging the impact that these stories had on me. I became more cognizant of my own emotions and the need to engage in strategies that allowed me to be an effective researcher and I learned the value of debriefing.

I also learned about the importance of establishing rigour in qualitative studies, especially when researchers are exploring areas that they are passionate about. Through discussions with colleagues and by reading about reflexivity, sensitizing concepts, and through detailed memoing, I learned how to bracket my assumptions and examine how my values and experiences had the potential to impact the data.

Conclusion

Police officers routinely interact with people with mental illness for a multitude of complex reasons. While the tendency to attribute these interactions solely to mental illness has been demonstrated throughout the literature (as Frederick and colleagues pointed out in their 2018 article, for example), participants in this study and previous literature demonstrate that these crises are the result of multiple complex and layering

factors that build up, leading to contact with police. There is a great deal of diversity in these encounters and to attribute these interactions to a simplistic narrative that mutes out the multifactorial reasons for crisis, including history, and societal views and treatment of people with mental illness, leads to ineffective responses and outcomes which perpetuates discriminating views about people with mental illness.

These experiences are frustrating and complex for people with lived experience of mental illness and police officers. Both participant groups voiced challenges of interacting with each other and within various systems. Police officers and people with lived experience in crisis are frustrated with the systems that are currently in place and both understand that policing mental illness is not ideal. Both groups voiced similarities in terms of why this approach is not ideal and what is needed for change. Groups differed in terms of their experiences of these interactions, including loss of power and feeling like a criminal, the intensity of the experience, and the impact these encounters had on their lives.

Both participant groups held stigmatizing views about the other and expressed that they experienced stigma based on the role they occupy in society. Police officers described people with mental illness based on perceptions they hold of mental illness, often based on their own experience responding to people with mental illness during times of crisis. These constructions about how people with mental illness behave, creates expectations, and leads to responses for police officers approach these situations. This homogenized views about people with mental illness, perpetuates the dangerousness myth and leads to stereotypes such as people with mental illness are unruly and unpredictable.

Despite the challenges that people with lived experience of mental illness face, they are survivors of a system that has historically oppressed them, and they possess many strengths, skills, and insights. Many have found ways to help themselves and have dedicated their time to helping others by contributing to self-help groups, serving as ambassadors, and sharing their stories with others experiencing similar situations.

These encounters are complex and challenging for police officers and people with lived experience of mental illness. Participants were profoundly impacted by these encounters. In order to better understand this issue, we need to listen to the stories of those who are experts by experience and include them in meaningful ways to reshape practice, policy, and research.

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APPENDIX A: KEY TERMS AND DEFINITIONS

Carceral

Throughout this study, carceral approaches include jail and prison.

Crisis

Throughout the literature, the terms "crisis" and "emergency" are used interchangeably, albeit some studies have differentiated between the two terms (Ball et al., 2005; Brennaman, 2012). Some authors consider the word "emergency" to be more severe than "crisis" with the need for immediacy applying to the latter (Brennaman, 2012). For example, according to Brennaman (2012), an emergency involves the risk of injury to self or others, while a crisis poses a less severe risk. Further literature has indicated that those with serious mental illness (SMI) are not offered the same crisis intervention as those without serious mental illness and as considerations of pre-existing psychopathology are emphasized often requiring hospital-based psychiatric emergency services (James & Gilliland, 2001). Throughout the literature, as in practice, crises seem to be a problem for the individual and are not taken as seriously as an emergency, which would warrant immediate, and often medically-based interventions.

In alignment with contemporary literature, this paper will use the term crisis to refer to an event that exceeds one's ability to cope and will, therefore, acknowledge that it has the potential to become an emergency in which case it is best to err on the side of caution. It is important to note that there are often discrepancies in what people consider a crisis. This is not only the case for individuals with mental illness (MI), as a crisis is a subjective state and experience. Thus, there may be a misalignment in what service users and service providers consider a crisis. This work upholds that the individual requiring

support is the expert in this situation and should have their experience(s) validated regardless of these discrepancies. Discrediting an individual's experience is not only oppressive and disempowering, but it may also precipitate a higher risk event; in other words, it may escalate a crisis state causing further distress to all involved.

A further challenge with the usage of the term crisis throughout the literature, is that little has been done to examine the extent to which the crisis is a result of mental illness (i.e., to what extent has a mental illness impacted the crisis? Alternatively, was the crisis the result of, or influenced by, mental illness at all?). Few studies have examined this complex relationship, but a person in crisis is not always a person with mental illness albeit they may be exhibiting behaviours that observers may view as congruent to their construction of mental illness or their belief of what a person with mental illness looks like.

As is much of the language surrounding this topic, the concept of crisis is socially constructed and subjective. What one person considers a crisis may cause little or no distress to someone else. This has been evidenced in studies demonstrating that people with lived experience of mental illness (PwLE) felt their crisis was not taken seriously (Boscarato et al., 2014). Other studies have reported police officers report finding people in crisis to be "attention seekers", "scrounging", and wasting police time (Lane, 2019). This has further served to disempower people with lived experience of mental illness. This paper will acknowledge and respect the right of everyone to determine what constitutes a crisis and will assume that all individuals have a right to crisis services and support, despite potential incongruences between what service providers and service users consider a crisis.

Care

The word care has been used in the literature to refer to the support(s) given to people in the mental health system. Within this context, care has not always been beneficial to the person receiving it and at times, has been asserted upon people unwillingly. Thus, the word care is used carefully with the caveat that historically, it has not always been perceived as helpful by those receiving it. As one participant noted, the care they received only served to hurt them. See also, support.

Co-response Models (Blended Models)

Co-response models refer to crisis intervention teams comprised of police officers and mental health professionals (for example, nurses or social workers).

Criminalization

Although individuals with mental illness are no more likely to commit violent or criminal acts than people without mental illness, they are vastly overrepresented in the criminal justice system. The increase in encounter statistics resulting in arrest or incarceration (often for minor offences) has been referred to as the criminalization of mental illness (Slate, 2019)

Crisis Intervention

Throughout this paper, crisis intervention (CI) refers to the approach used by police officers to address the crisis. This may include practices such as de-escalation, informal approaches (where no transport is made), and formal approaches such as transport to jail or hospital. It is important to note that various crisis intervention approaches exist and are dependent on the situation, training, and resources responders have. Within Canada, there is not one standard CI approach.

Crisis Intervention Teams

Throughout this paper, Crisis Intervention Teams refer to teams comprised of trained police officers who have participated in initiatives (often 40 hours of training) designed to respond to people experiencing a mental health crisis.

Crisis Models

Two common crisis models include crisis intervention teams (CIT) whereby police officers receive training to deal with people in crisis and co-response (also referred to as blended) models.

Deinstitutionalization

Deinstitutionalization (DI) began around the 1960s and continued internationally with many individuals with mental illness being transitioned to communities (Yohana, 2013). Historically and contemporarily, DI continues to be cited as a reason for the frequency of contacts between people with mental illness and police officers. In fact, it is the most cited reason throughout the literature for these contacts (Frederick et al., 2018). Throughout this work and in contrast to prior research, DI is considered a component, but not the main reason for these interactions. Using DI as a framework for explaining these contacts is flawed in that it fails to account for complexities of the issues and more importantly, it positions people with mental illness in the community as a central contributor to the problem when in fact, people with MI pose no greater threat to the community than those without MI.

Electroconvulsive Therapy

According to the Mayo Clinic, Electroconvulsive therapy (ECT) is a procedure, done under general anesthesia, in which electric currents are passed through the brain,

intentionally triggering a brief seizure. ECT seems to cause changes in brain chemistry that is thought to reverse symptoms of certain mental health conditions.

Encounters

Throughout this study, the terms encounter and interaction has been chosen to refer contacts between police officers and people with mental illness. This word is used in lieu of "call" and at times "crisis" as these terms appear largely in the field of policing and infer that a "call" was placed in response to a "crisis" which is not always the case. For example, not all encounters or interactions were considered a "crisis" by the person with mental illness; further, "calls" did not always occur, for example in situations where people approached police officers themselves in-person.

Institutions

Throughout the work, institutions refer to hospitals and jail settings with organizational structures and governance, rules, expectations, and that have authority over people with mental illness.

Medical Model

The medical model is used to describe the biologically-reductionist approach to understanding and responding to mental illness. Within this model, PWLE are reduced to their symptoms and diagnoses and are not understood within the social, structural, or economical contexts in which they exist. Throughout this work, it is acknowledged that the medical model, while effective for some, has served to disempower and further stigmatize people with lived experience of MI.

Not Criminally Responsible (NCR)

A person is deemed NCR when it is determined that they have committed an illegal act, but was suffering from a serious mental illness at the time that rendered them incapable of appreciating the consequences of the act. Often, a psychiatrist recommends this finding to the court after an assessment and review of the person's history, but it is the judge who makes this final determination.

People Perceived to Have Mental Illness

Much of the literature regarding police interactions with people with mental illness is based on accounts from police officers who have deemed the person to be mentally unwell because of behaviours that align with their idea of what a person with mental illness looks like. For example, if an officer responds to a scene where a person is acting in a way they believe matches identifiers for what they construct mental illness to look like, they may perceive the person has a mental illness. This has been problematic in the literature especially as it concerns police reporting of events "flagged" to be mental health related. Without the ability to determine a diagnosis, officers make decisions based on their construction of mental illness. Throughout this paper, when there is no evidence that the person indeed has a mental illness, or when the discussion concerns a socially-derived construct of mental illness, the term person perceived to have mental illness will be used to illustrate that this is based on a subjective definition of what a person with mental illness is constructed to look and behave. It is important to make this differentiation as it acknowledges that throughout the literature and in practice, social constructions of what mental illness looks like, have been used to label people in crisis and do not necessarily reflect the lived experience of those with mental illness.

People with Lived Experience (PwLE)

This term was chosen after consultation with participants with lived experience regarding their preferred terminology. Earlier work included the term person constructed to have mental illness to signify the degree to which mental illness is constructed and is the result of attributes one assigns to certain concepts. For example, much of the literature is based on constructs of mental illness and not an actual diagnosis. Research has relied on officer perception of what a mentally ill person looks like not a self-disclosed or diagnosed disorder. Previous studies in this area have used multiple words to describe people with lived experience of mental illness including subject, patient, person with mental illness, and person with mental health issues. Many of these works fail to provide a definition or explanation of terms. Throughout this work, the term people with lived experience (PWLE) will be used to refer to participants who have their own personal and unique experiences with mental illness.

People with Mental Illness

The most widely used term throughout the literature (Frederick et al., 2018), people with mental illness will be used to describe those with mental illness when used elsewhere in the literature (for example, as it concerns statistics and previous research where it is assumed a diagnosis is confirmed) with the caveat and notice that most of the literature is based on data where a mental health diagnosis has not been confirmed. For this study, which is not grounded in the medical model, a confirmed diagnosis, either self-report or professionally assigned, will not be the primary focus and will be acknowledged and only deemed as relevant as it relates to the person disclosing it. With that being said, it is acknowledged that people with mental illness is a broad term that may include people who believe they have mental illness and have not been diagnosed, or

who have been diagnosed professionally but do not believe they have a mental illness. It is further noted that many of the instances described by police officers are based on a "perceived" mental health diagnosis.

People with Lived Experience of Mental Illness

Through conversations with participants in group one, the term "people with lived experience of mental illness" arose. This term is used to describe people with mental illness, particularly when describing participants in group one, throughout this dissertation. This terminology represents that these individuals are experts by experience and are not defined by their mental illness yet do have experience with it.

Police Officers

Throughout this work, this term applies to all police officers regardless of their rank or municipal, provincial, or federal affiliation. Participants in participant group two (PG2- Police Officers) represent various ranks and affiliations including the Royal Canadian Mounted Police (RCMP), Ontario Provincial Police (OPP), and municipal units.

Recovery

While the concept of recovery has been debated, many people with mental illness, state that recovery is about "staying in control of their life rather than the elusive state of return to premorbid level of functioning" (Jacobson, 2015, p. 117). This approach does not focus on the resolution or absence of symptoms rather, it "emphasizes resilience and control over problems and life" (p. 117).

There is no single definition of the concept of recovery; however, there are guiding principles, which emphasize hope and the belief that people with mental illness

can live a meaningful life regardless of symptoms (Bonney & Stickley, 2008; Davidson, 2005; Jacobson, 2015). Recovery has been referred to as a process, an outlook, a model, a vision, a conceptual framework or a guiding principle (Davidson, 2005; Jacobson, 2015; Ramon et al., 2007), regardless of various definitions, the recovery perspective views mental illness very differently than the dominant biomedical model and psychiatric discourse. This approach focuses on the person, not the symptoms, and emphasizes that "while people may not have full control over their symptoms, they can have control over their lives" (Jacobson, 2015, p. 118).

It is important to note that the concept of recovery has been (mis)used by organizations to measure clinical improvements and has been appropriated and distorted by the mainstream thereby reducing the uniqueness of recovery processes (Jacobson, 2004); therefore, the concept of recovery that is embraced throughout this work aligns with the definition and conceptualization of the term offered by consumer-survivors and not by institutions which have used the term in an attempt to measure and quantify a unique and individual process.

Service/Support

This term is used in lieu of the term "treatment" which is largely used in medical discourse (for example in Gearing et al., 2017 and Kozlowski-Gibson, 2016). The terms "service" and "support" challenge the notion that mental illness should be "treated" or "cured", with the focus being to help or support those requiring service. The term "system" will be used when appropriate, to refer to the "system" of support that surrounds mental health service provision. This term suggests that support involves many systems, interdisciplinary professionals and considerations, and a holistic view of the

issue. For example, an individual with MI may experience a crisis because of prolonged social isolation and lack of adequate housing and may require specific "interventions" that connect them to housing and social supports. Understanding support through a systems lens depersonalizes the challenges individuals with MI face and focuses on the systems and factors impacting the individual as opposed to the individual in isolation.

Similar to the caveat outlined in the definition of the term care, support is also used with caution as there have been times when support was provided without permission and without benefit to the person on the receiving end. It has also been used to legitimize medical and institutional approaches that are incongruent with recovery.

Traditional Paradigm

Traditional paradigms or structures reflect historical and positivist views of mental illness based on the biomedical model (Neslon et al., 2001). Within this paradigm, illness is seen as an internal defect and/or deficit and is responded to with medical interventions including hospitalization and medication (Dragon, 2016). Traditional models have historically governed the treatment of those with MI (LeFrançois et al., 2013); for example, through the overreliance of medications and the focus on eliminating symptoms.

Transinstitutionlization

Transinstitutionalization has been used to describe the process of moving individuals from one institution (e.g., hospitals) to another (e.g., jails) (Barr, 2003).

APPENDIX B: FOLLOW UP RESOURCES

Canadian Mental Health Association Windsor-Essex
1-519-337-5411

Crisis Line (24/7)
1-866-299-7447

Canadian Mental Health Association Lambton-Kent
1-519-436-6100

Canadian Mental Health Association Middlesex
1-519-668-0624

Suicide Hotline (available 24/7)
1-833-456-4566 (or text "start" to 741741)

Support for First Responders in Ontario
1-800-833-677-2668

http://www.camh.ca/

https://www.crisisservicescanada.ca/en/looking-for-local-resources-support/

https://ontario.cmha.ca/documents/are-you-in-crisis/

https://www.lifevoice.ca/crisis-supports/crisis-supports-canada

APPENDIX C: INTERVIEW GUIDE PARTICIPANT GROUP 1

Interview Guide
Participant Group 1: People with Lived Experience

Consent
[ ] Consent is reviewed and documented (audio recorded)
[ ] Consent obtained to be audio recorded is documented

Demographical Questions
Gender _____ Ethnicity _____ Age _____
Location (City/town, Province; Rural/urban) _____
Highest level of education_____

Description of Encounters
1. Where did the encounter occur?
2. Who contacted police?
3. What was the reason for the encounter with the police?/ Can you describe what was going on in your life leading up to the encounter?
4. What occurred during the interaction?
    a. How many officers arrived?
        i. Were they in plain-clothes?
        ii. Were they in unmarked cars?
        iii. Were there any other responders there (nurses? Social worker?)
    b. What did the officers do while they were there?
    c. What was the outcome of the encounter?
        i. What were positive outcomes of the encounter?
        ii. What were negative aspects of the encounter?
        iii. What impact did the encounter have on you?
        iv. In what ways do you think police interactions with people with MI are different than calls with people without mental illness?

Perception of Officers and Role
1. Why do you think police should or should not intervene with people with MH issues?
    a. In what circumstances do you think should they become involved?

Perception of Dangerousness
1. Sometimes in the media, we hear violent stories about people with mental illness and police. Why do you think encounters between people with mental illness and police officers have the potential to end in violence?
2. Do you think people with mental illness are more dangerous than people without mental illness? Why/why not?

Future Directions
1. What do you wish the police knew about interacting with you?
2. What do you wish the public knew about police interactions with people with MH issues?

3. How do you think these encounters could be improved?

- Is there anything else you would like to add?
- Is there any advice you would like to give me as I continue this work?

APPENDIX D: INTERVIEW GUIDE PARTICIPANT GROUP 2

Interview Guide
Participant Group 2: Police Officers

Consent

[ ] Consent is reviewed and documented (audio recorded)
[ ] Consent obtained to be audio recorded is documented

Demographical Questions

Age _____Race/Ethnicity _____ Gender_____
Time in service _____ Rank/Position _____
Location (City/town, Province; Rural/urban) _____

Description of Encounters

1. What kind of calls have you been to involving people with MI?
    a. What have been factors involved in calls?
2. What is the composition of the crisis response team?
    a. How many officers are typically involved in calls involving people with mental illness?
    b. Are you a plain-clothed officer?
    c. Do you attend in an unmarked car?
    d. Are there any other professionals that accompany you to calls (for example, a nurse or social worker?)
3. What do you do once you get there?
    a. What are you hoping to accomplish?
    b. How do you respond to the situation?
4. In what ways are calls different when they involve someone with mental illness?
5. What are the outcomes of these encounters?

Perception of Preparedness

1. Do you feel prepared to intervene with people with MI?
    a. In what ways do you feel prepared?
    b. In what ways do you feel unprepared?
2. What training do you have?
    a. In what ways has training been helpful or unhelpful?
3. What do you wish you knew about intervening with people with mental illness?

Perception of Officer Role

1. Why do you think police should or should not intervene with people with MH issues?
    a. In what circumstances do you think should they become involved?

Perception of Dangerousness

1. Sometimes in the media, we hear violent stories about people with mental illness and police. Why do you think encounters between people with mental illness and police officers have the potential to end in violence?
2. Do you think people with mental illness are more dangerous than people without mental illness? Why/why not?

Future Directions

1. What do you wish people with MH issues knew about your role working with people with MI?
2. What do you wish the public knew about your role working with people with MI?
3. How do you think these encounters could be improved?

- Is there anything else you would like to add?
- Is there any advice you would like to give me as I continue this work?

APPENDIX E: RECRUITMENT MATERIALS

Email script sent to community mental health agencies, grassroots and not-for-profit mental health organizations, and police departments:

Hello,

I am a PhD candidate at the University of Windsor exploring interactions between people with mental illness and police officers who have interacted during a mental health crisis. I am currently seeking participants for a 45-60 minute audio-recorded interview regarding their experience. All interviews are confidential. If you are interested in participating and would like more information, or if you know someone who might be interested in participating, please contact me at this email address (crisisresearch@uwindsor.ca) or by telephone at, xxx-xxx-xxxx.

Thank you,

Sarah Faubert, MSW, RSW, PhD (c)
University of Windsor
School of Social Work

Social Media Flyers

APPENDIX F: INTERVIEW SCHEDULE

Name and participant group	**Location**	**Interview Status** Pending Scheduled Complete	**Date/Time** (zone)	**Preferred contact**	**Notes**
Frank (PG1-5)	Windsor, ON	Pending	July 23rd, 2021; 12:00 EST	Cell phone xxx-xxx-xxxx	

APPENDIX G: EXCERPT FROM CODING MANUAL

Participant ID	Original Transcript	Initial Coding	Focussed Coding
PG1-1	I'm not hiding behind. I'm not ashamed of what I went through. Because I want to bring the light into the darkness, that's my job to help bring things to light so people can see what they're going through.	Not hiding Not ashamed Wanting to bring light into the darkness Being a job Helping to bring things to the light so people can see what they're going through	Moving on, helping themselves, and helping others
PG1-1	It's behind me now.	Behind me now	Moving on, helping themselves, and helping others
PG1-4	I have been coaching her along trying to help her	Coaching her along trying to help	Moving on, helping themselves, and helping others
PG1-4	I am starting to see that my purpose for all this is to help others with what they are going through	Helping others with what they are going through	Moving on, helping themselves, and helping others
PG1-9	I work as an ambassador now for CMHA. I have travelled around the country meeting people, talking to people about my experience. I hope my story reaches others- helps someone else when they're in that position	Working as an ambassador Travelling around the country Meeting people Talking to people about their experience Hoping to reach others Helping others when they're in that position	Moving forward, helping themselves, and helping others
PG1-13	I'm doing my masters now, That's what inspired me to do this, It's great to be able to help people. It gives me insight…	Doing her masters Finding inspiration Being able to help people Having insight	Moving on, helping themselves, and others

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