

# Toronto Police Response to Emotionally Disturbed Persons 2013



The 2013 Mobile Crisis Team Coordination Steering Committee Report, *MCIT Program Coordination in the City of Toronto* (MCIT Report 2013), acknowledges that:

It is important to recognize that mental illness is not, in and of itself, a police problem. However, a number of issues caused by or associated with people with mental illness often become police issues. ... Law enforcement personnel are routinely the first line of response for situations involving mentally ill people in crisis and as a result, officers may have assumed the role of “street-corner psychiatrists” by default. Neither the mental health system nor the law enforcement system can manage mental health crises in the community effectively without help from the other (p. 8).

In 2011, Toronto police officers were dispatched to over 19,000 calls for service involving emotionally disturbed persons. Of these, officers apprehended over 8600 persons under the *Mental Health Act*. During this time, the Service responded to over 2 million emergency and non-emergency calls for service involving members of the public, and the Service made many more thousands of contacts through such activities as traffic enforcement (665,908), arrests (53,202), vehicle stops (430,520), and recorded community interactions (385,849). It is estimated, therefore, that the Service had over 3.6 million contacts with community members not counting the thousands of undocumented community contacts in 2011.

The number of persons apprehended under the *Mental Health Act*, then, is a significantly low percentage of the total police and community encounters (0.47%). Furthermore, incidents where a serious injury was suffered by the emotionally disturbed person represent an even smaller percentage of encounters. Indeed, for all police and community contacts (over 3 million), whether the police encountered an emotionally disturbed person or not, 64 or 0.0017% resulted in a serious injury (62) or death (2) to the person (Special Investigations Unit 2011 Annual Report). These data demonstrate that in the overwhelming percentage of cases, officers are successful in resolving incidents safely and without resorting to apprehension or force. This fact can be attributed, in part, to community cooperation and input, Board policies, Service procedures, supervision, and officers’ training, judgement, skills, and equipment.

However, this enviable record does not, for a moment, mean that the Service rests on its laurels. On the contrary, there is much the Service continues to learn from the community, especially from consumer-survivors and those who serve them. Their insight is incorporated into the Service’s Priorities, officer training, and Service practices.

*Response by Service Call-Takers, Dispatchers, Police Officers and MCIT*

The Toronto Police Service responds to calls for service involving emotionally disturbed persons or the mentally ill using sound, well-established practices and procedures. These practices and procedures are the result of the latest worldwide research, benchmarking, experience, consultation with subject matter experts, and inquest recommendations.

Overall, the issue and challenges facing the Service and its response to emotionally disturbed people are comparable to those in jurisdictions around the world. For example, our research has shown that police services in the Middle East (Jordan, United Arab Emirates), the Far East (South Korea, China, Singapore, and Japan), and, more predictably Europe (Sweden, the Netherlands, and France), and the United Kingdom, Canada, United States, Australia, and New Zealand report concerns and use police responses that are immediately recognizable to Canadians, particularly as they relate to crisis response. Additionally, the Service's response includes practices that are informed by such research as the Canadian Association of Chiefs of Police Mental Health Guidelines, and work done by the Canadian Mental Health Commission of Canada.

When a call is received, call-takers at Communications Services try to gain as much understanding of the call as possible. They will ask questions to determine, for example, the nature of the incident, its location, the condition of those involved, including whether they are injured or whether there is or has been violence, whether weapons or items that can be harmful are present, and the needs of those involved. The call-takers then relay this information to the dispatchers who, in turn, direct and inform the responding police officers, and arrange for the necessary back-up or additional resources. The call-takers then try to stay on the line with the caller to reassure, reassess and relay new developments to the dispatchers who will, in turn, inform the responding officers.

The call-takers and dispatchers take an initial six weeks of training where response to emotionally disturbed persons is included and emphasized in the curriculum. Those becoming dispatchers receive a further five weeks of training where response to emotionally disturbed persons is again emphasized in the curriculum. In addition, throughout the year, they take in-service training to review any changes or developments in laws and practices. Call-takers and dispatchers are also guided by a unit-specific procedure (C06-04) dealing with emotionally disturbed persons that emphasizes information gathering, empathy and caller reassurance.

The first officers dispatched are Primary Response officers. These are uniform officers generally assigned to radio-dispatched patrol cars. Using their training, judgement and experience, their role is to assess the safety issues and the need for apprehension, arrest, and criminal charges (Procedure 06-04).

If the emotionally disturbed person has a history of violence or the use of weapons, the Primary Response officers are instructed to notify the Emergency Task Force (ETF). The ETF are specially trained to bring a broader range of tactics and special equipment to these situations. The ETF can also call on a psychiatrist to come to the scene to help resolve the call. While on patrol, ETF units monitor radio calls that might require their support and if they hear a call, they

will move into that area so they are ready to respond if requested. However, the involvement of the ETF also depends on whether the situation can be contained. If the emotionally disturbed person is mobile and presents an imminent threat of harm, the Primary Response officer may have to intervene and use force before calling the ETF or before the ETF can arrive.

When the situation is stabilized and safe, the Primary Response officers may request the assistance of the Mobile Crisis Intervention Teams (MCIT).

The MCI Teams, consisting of a specially trained mental health nurse from a partner hospital and a police officer, provide a secondary response to calls for service involving individuals experiencing a mental health crisis. If appropriate, the MCIT attends, makes an assessment of the situation and arranges for appropriate medical treatment or community referral. If the person is apprehended under the *Mental Health Act*, the team attends the psychiatric facility where the expertise of the team's mental health nurse helps triage the patient. One of the goals of the MCIT, though, is to divert emotionally disturbed persons from both the criminal justice system and the hospital emergency room and so the teams also make community referrals. In those areas not served by the MCIT or in the event the MCIT is not available, the Primary Response Unit is responsible for resolving the event.

The MCIT is a development of a concept introduced in 1988 in the City of Memphis. The original model partnered the Memphis Police with the Memphis Chapter of the National Alliance on Mental Illness (NAMI), mental health providers, and two local universities. Selected Memphis police officers receive augmented training (40 hours) from a variety of mental health services (including family members) to help officers respond to the needs of the emotionally disturbed. In contrast, all Toronto police officers receive training on responding to emotionally disturbed persons, but the MCIT receive special training. MCIT training is multi-disciplinary - it covers a range of medical and forensic topics and is designed specifically to enhance the effectiveness of the police officer and nurse partnership. It includes consumer-survivor perspectives.

Another distinction is that Memphis police officers are on general patrol until called and, unlike in Toronto, are not partnered with a mental health professional. However, in Memphis, the police resort to an assessment centre staffed by mental health professionals that must accept every case brought to them.

The MCIT Report 2013 noted that:

Although the police-based specialized response has been recognized to contribute to positive client outcomes, it has become increasingly apparent that when persons with mental illness in the community are in crisis, neither the police nor the emergency health system alone can serve them effectively and it is essential for the two systems to work closely together. From the standpoint of the police, officers can benefit from the assistance of mental health professionals when they are called on to deal with difficult or complex situations (p. 14).

Other models include the Hamilton and Peel Regional Police COAST programs, York Regional Police Service's 310-CORE, Durham Regional Police Service's OSCP, Vancouver Police

Service's *Car 87* and, most recently, Ottawa Police Service's *Mental Health Unit*. Like Toronto, each of these models partner a police officer with a mental health professional who is often associated with a psychiatric facility (in Ottawa it can be a psychiatrist for up to three days a week) in a mobile secondary response mode.

The Toronto MCIT model evolved from a partnership with St. Michael's Hospital and addresses the specific circumstances in Toronto. The team's model is the product of the academic and medical research conducted by St. Michael's Hospital and the Service. MCITs were originally funded as part of the Provincial Mental Health and Justice Accord Initiative, prior to the creation of Local Health Integration Networks (LHIN). Today, in Toronto, the LHIN funds the health services on the MCI Team and the Toronto Police Service funds the police officers.

The Service has been working with hospitals to expand the Toronto Police Service Mobile Crisis Intervention Teams (MCITs) across the city. This work has included joining the Toronto East General Hospital (TEGH) in making submissions to the TC-LHIN to fund a team in 54 and 55 Divisions. On September 26, 2012, the TC-LHIN agreed to provide the funding to support the assignment of a psychiatric nurse from the TEGH to a team of police officers from 54 and 55 Divisions. The 54-55 Division team was launched on March 7, 2013. Teams are now available in 12 of 17 police divisions:

- 54 and 55 Division and the Toronto East General Hospital in the Toronto Central-LHIN;
- 51 and 52 Divisions and St. Michael's Hospital in the Toronto Central-LHIN;
- 11 and 14 Divisions St. Joseph's Health Centre in the Toronto Central-LHIN;
- 41, 42 and 43 Divisions and the Scarborough Hospital in the Central East LHIN; and
- 31, 12 and 13 Divisions and Humber River Regional Hospital in the Central and Central West LHINs.

With the partnership of TEGH, teams now cover the south central part of Toronto from the Etobicoke border to the Durham Region.

While MCI teams are not currently operating in 22, 23, 32, 33 and 53 Divisions, the Service is discussing with the designated hospitals and the LHINs the feasibility of establishing them. In the meantime, however, those areas are not un-resourced. All primary response officers are trained and equipped to respond to emotionally disturbed persons and the local divisions are supported by a variety of neighbourhood and city wide organizations including, for example, the Gerstein and St. Elizabeth centres both of which have community mobile crisis teams.

The teams operate seven days a week on a ten hour shift. Generally, the teams work either from 12:00 – 22:00 hours or 13:00 - 23:00 hours. The two teams serving 12, 13 and 31 Divisions work 10:00 – 20:00 hrs. The teams' hours of operation are based on a needs analysis and reflect the circumstances of their neighbourhoods.

The introduction of the newest team also offered an opportunity for greater harmonization across teams. Common client assessment and reference tools are being developed and specific team training, emphasizing de-escalation and client support, started in February 2013. It includes consumer-survivor perspectives and both police and nurses attend this training.

More recently, the TC-LHIN has been examining ways to help the Service further enhance and expand the Police MCITs in Toronto. In October 2012, the Toronto Central-LHIN established the *City of Toronto Mobile Crisis Intervention Team Coordination Steering Committee* to examine the current state of MCIT and design a program that provides coordinated coverage in all areas of the City that meet the needs of the population using crisis services. The Steering Committee was co-chaired by Deputy Chief Michael Federico, and Rob Devitt, CEO of Toronto East General Hospital. The purpose of the committee was to lead the development of a cross City of Toronto model for MCITs that included integration with the continuum of crisis and other local mental health services.

The Steering Committee included the following stakeholders: Toronto Police Service, current Mobile Crisis Intervention Team services, participating GTA-LHIN representatives, Mental Health and Addictions Services Access, Emergency Medical Services, Acute Care Alliance, mental health and addictions crisis services, and the City of Toronto Mental Health Promotion Program. The Steering Committee was co-chaired by Toronto East General Hospital and Toronto Police Service.

The Steering Committee was accountable to the Toronto Central-LHIN and engaged the community (i.e. providers and the public) consistent with the LHIN's community engagement guidelines. In this way, the Steering Committee obtained consumer-survivor input. Canvassed were *The Empowerment Council*, an independent organization consisting of people who have received mental health or addictions services; the *Toronto Police Services Board Mental Health Sub-Committee*, a standing committee of the Board comprising mental health organization representatives and consumer-survivors dedicated to examining issues related to the mentally ill and policing; and the *Toronto East General Withdrawal Management Services* consisting of consumers of withdrawal management services and their families.

The Steering Committee met monthly until March 2013. The final report, the *MCIT Program Coordination in the City of Toronto*, was delivered to the TC-LHIN in April 2013.

According to the MCIT Report 2013, Mobile Crisis Intervention Teams are part of the solution and there is evidence of their effectiveness at de-escalating a mental health crisis (p. 8). It was found that:

...psychiatric emergency teams consisting of police officers and mental health professionals are able to deal with psychiatric emergencies in the field, even with a population characterized by acute and chronic severe mental illness, a high potential for violence, a high incidence of serious substance abuse, and long histories with both the criminal justice and the mental health systems (Lamb, H., L. Weinberger, and W. DeCuir 2002, "The Police and Mental Health" *Psychiatric Services* 53(10):1266–127).

However, while the Report recommends, in part, further expansion of the teams into the areas of Toronto not currently served, it cautions that the MCIT is only one part of a larger community response. It recognizes that providing proper support for people with mental illness requires multiple strategies and organizations working together at the community level.

Consequently, police action at the scene may include referral to community services, apprehension under the *Mental Health Act* and transportation to the nearest psychiatric facility, or arrest and charges if warranted. Even if the emotionally disturbed person is arrested, however, pre-charge diversion can be considered to, for example, short-term residential beds (Safebeds). After charges are laid, pre-trial diversion options are still available. For example, the person might be referred to Mental Health Court, or the Mental Health and Justice Prevention Program. However, the success of community referral depends on the capacity of the community to respond so the Service supports efforts to build a greater community capacity.

### *Training*

The Toronto Police Service provides training to all its police officers on interactions with emotionally disturbed persons that helps officers develop appropriate responses. This training emphasizes communication and de-escalation skills. The content of the training reflects the latest knowledge and practices in the field of mental health, crisis resolution, and police use-of-force. The use of scenario-based training that echoes real events (often the subject of inquests) has been included in the annual use-of-force requalification program for all front-line officers and is delivered to new police officers as part of the recruit training program.

The specific de-escalation techniques that are taught include developing a rapport with individuals. While communicating with someone in crisis, officers are instructed to:

- Continuously assess the threat, both the person and the context
- Be professional
- Model composure
- Be aware and cognizant of body language
- Provide physical space as appropriate
- Use names and engage
- Use calm and clear language
- Validate the emotionally disturbed person's feelings/situations
- Encourage relaxation
- Provide realistic reassurances
- Be clear about limits/authority
- Remain patient

As part of the training, officers are told to avoid the following:

- Heightening panic
- Challenging delusions
- Joking, whispering, or laughing
- Judging or preaching
- Monopolizing the conversation
- Invalidating the individual/situation
- Confusing the individual with rapid fire questions
- Giving multiple choices

- Using psycho-babble or legalese
- Threatening or deceiving
- Touching (if possible)

These specific de-escalation techniques are incorporated into the dynamic scenario training where each officer participates in up to six scenarios during the session. The scenarios have been designed so that 80 percent of them require de-escalation as the anticipated and suggested response.

One particular component of the 2013 program is a lecture focusing on communication and mental disorders. This is a 90 minute class that explores effective communication, good judgement and decision-making. Self-control techniques are taught with professional conduct being promoted at all times. This lecture also addresses the justification for the use-of-force while stressing that de-escalation and disengagement are viable options. Thirty minutes is devoted to specific strategies for de-escalation and conflict prevention. A feature of this lecture stresses that the safety of the individual, the public, and the officer is paramount.

To assist in the development of training, and to incorporate the experiences of consumer/survivors into police training to help de-stigmatize the disease and those who suffer from it, the Service has consulted extensively with advocacy groups, mental health professionals, and consumer-survivors.

On January 31, 2012 the Board's Mental Health Sub-Committee participated in a workshop at the Toronto Police College reviewing and developing scenario-based training. The Members agreed that the following should be considered key points in all police training related to interaction with individuals experiencing mental illness:

1. Respectful approach
2. Utilize available resources
3. Create and use time and space to help de-escalate
4. Critical reflection
5. Don't make assumptions
6. Be flexible and open to different options
7. Give the person more control
8. Prepare yourself for each call
9. The goal is to reduce the likelihood of using force
10. Focus on what is happening right now

As a result, the Service translated these concepts and principles into the Service's police training. These ten elements, dealing with knowledge, insight, and judgment that challenge assumptions and de-stigmatize mental illness, are included in the 2013 In-Service Training Program which is mandatory annual training for every Toronto police officer.

In addition, the Service has been involved in a number of other training initiatives:

- The Service has been conducting research into the training with other police services, for example, Durham, Peel, Hamilton, and York.
- In 2012, the MCIT Coordinator attended the Crisis Intervention Team International Conference to look at what other police services are doing across the United States, Australia, the United Kingdom and Sweden.
- In February 2013, training for the MCITs commenced. This training is multi-disciplinary, covers a range of medical and forensic topics and is designed specifically to enhance the effectiveness of the police officer and nurse partnership. It includes consumer-survivor perspectives, emphasizes de-escalation and client support, and both police and nurses attend this training.
- During 2012, the Schizophrenia Society of Ontario (SSO) conducted presentations to primary response officers on platoon training days. Five divisions (13, 42, 51, 55 and Traffic Services) were reached. The SSO provided information about its services and offered insights to help police officers serve people dealing with mental illness including schizophrenia. In addition, the sessions featured a survivor of schizophrenia who shared personal experiences as a way to help de-stigmatize the disease and those who suffer from it.

#### *Consumer-survivor input into training*

For some time consumer survivors have been looking for a way to incorporate their lived experience into police training to sensitize officers to the specific challenges consumer-survivors face and to help de-stigmatize mental illness. In response, the Toronto Police College collaborated with Ms. Pat Capponi, Co-Chair of the Board's Mental Health Sub-Committee and Director of *Voices from the Street*, a speakers bureau of individuals who have had direct experience with homelessness, poverty, and mental health issues, and Ms. Jennifer Chambers, Executive Director of the *Empowerment Council*, to develop a training module. It was decided that a training video showcasing consumer-survivors and their experiences would be produced.

While this initiative started out as a short ten minute video, it expanded into a full 30 minute training session after the producers realized just how powerful the message of consumer survivors was. A further 11 minute video was developed for platoon and distance training. When this presentation was shared with the Mental Health Sub-Committee at its April 10, 2013 meeting, members were equally impressed.

With the addition of this 30 minute module, the total time dedicated specifically to de-escalation, sensitivity and de-stigmatization training in the annual In-Service Training increases to 150 minutes. In the mandatory 16 hour In Service Training Program (ISTP) that all front line officers are required to take each year, more than six (6) hours of training is devoted to some aspect of dealing with the emotionally disturbed or the mentally ill.



### *Addition of 2013 Service Priority Dealing with Mental Illness*

To underscore the importance of safe and effective police interactions with people experiencing mental illness, the Board, at its meeting of November 14 2012 approved the following recommendations:

- (1) That a priority entitled “*Focusing on Police Interaction with Individuals Experiencing Mental Illness*” be included in the list of priorities in the current Business Plan (the extended 2009-2011 Business Plan); and
- (2) That the Board’s Mental Health Sub-Committee meet with the Toronto Police Service’s Corporate Planning Unit to provide input in developing the goals, performance objectives and indicators arising from this priority. (Min. No. P282/12 refers).

As a result, the 2013 Service Priorities and Business Plan, approved by the Board at its meeting of December 14, 2012, includes the specific priority entitled *Focusing on Police Interaction with Individuals Experiencing Mental Illness* (Min. No. P313/12 refers). This is a major achievement as it represents the first time that a priority specifically dealing with this distinct issue has been included. The priority represents significant work on the part of the Board’s Mental Health Sub-Committee and the Service and consists of detailed goals, performance objectives and indicators.

### *Police Mental Health Records*

The issue of police reference checks as they relate to consumer-survivors has been raised with the Service and the Board. The concerns focus on the impact of the program on individuals’ privacy and employment rights, and the stigma of mental illness.

The Service has established practices pursuant to the Toronto Police Services Board’s Policy that governs police reference checks (Min. No. P292/10 refers). The Service’s current practices were developed three years ago after an extensive 14 month process which included close collaboration with the Information and Privacy Commissioner of Ontario, the Ontario Human Rights Commission, and broad consultation with appropriate stakeholders. At that time, the Board and the Service took a leadership role and received many deputations on the matter as the policy was being developed.

Under the Service’s practices, applicants may request that their non-criminal contact with police (mental health contacts) be suppressed for the purpose of employment or volunteering with vulnerable sector employers or agencies. The Service retains non-criminal, non-conviction records for operational and investigative purposes only, and only discloses them for the purpose of vulnerable sector checks under the Police Reference Check Program. Non-criminal, non-conviction dispositions are not released for regular employment reference checks. Furthermore, the Service discloses the information only to the applicant and not to the employer. The program complies with the Ontario Human Rights Code and the Canadian Charter of Rights and Freedoms.

The Police Reference Check Program requires that all employers or volunteer agencies in the vulnerable sector in Toronto that require applicants to obtain background checks from the

Service enter into a Memorandum of Understanding with the Service. This agreement stipulates that they will adhere to the Ontario Human Rights Code as it relates to employment and that they will take regular training (provided by the TPS) to remain current with Human Rights employment related legislation. There are presently 2,793 agencies registered with the Service. Information about the Toronto Police Service Reference Check Program is posted on the Service's Internet site. Finally, the Service publicly reports to the Board on matters related to the Police Reference Check Program and since 1995 has submitted 29 reports related to policy and practices.

The Ontario Association of Chiefs of Police (OACP) has released guidelines for police services to address police record checks process in Ontario and ensure an equal level of service under the province's related legislation, policies, procedures, and directives. These guidelines are not binding on police services; it is still up to local authorities to establish service specific practices. The Toronto Police policy and practice is comparable if not superior since much of the OACP document relied on the Toronto experience. However, while the Board's policy and the Service's practices are now used as the basis for policy development by police services across Canada, the Board and the Service frequently review them to ensure they remain appropriate.

#### *Hospital Protocol - Emergency Room Guidelines*

When the police apprehend an emotionally disturbed person under the *Mental Health Act*, the officers are required to take the person to the nearest psychiatric facility (in the case of MCIT it will be the partner hospital). Once there, the officers must wait with the person for the hospital to accept custody. This often takes some time. If brought in by Primary Response Officers, it is two officers who wait. Consequently, while waiting, the officers are not available for calls for service in the community.

The issue of police wait-times at hospitals, therefore, has been under review for some time. In 2012, the Service helped draft a hospital protocol to reduce police wait-times. It is currently being reviewed by hospitals and the Service. The protocol allows hospitals to accept custody of patients apprehended under the *Mental Health Act* and who are not charged with a criminal offense without requiring a hospital psychiatrist to attend if the patient is secure and the hospital's authorized representative is satisfied that the officers have left sufficient information for an appropriate assessment. As a result, the apprehending officers may leave the patient at the hospital and return to primary duties sooner than before.

The Service is also watching with interest a development between the Hamilton Police Service and St. Joseph's Health Centre where they are following a similar protocol but one that allows officers to leave patients at the hospital who are, in the opinion of the officers and the appropriate hospital staff, stable and a very low risk of harm or flight. While it is too early to have sufficient data for a reliable evaluation, the Service is not aware of any difficulties to date.

#### *Police and Community Partnerships*

The Service and the Board are committed to establishing effective, lasting partnerships with the community. For example, through the Board's Mental Health Sub-Committee a regular forum

has been established for community stakeholders to consult and collaborate with the Board and the Service in the development of effective police responses to persons who are emotionally disturbed or suffering from a mental disorder.

Also, Divisional Policing Support Unit researches and develops community-based programs that help respond to the needs of vulnerable groups, including the emotionally disturbed. It establishes and maintains liaisons with the agencies that support and service many vulnerable groups. Some of the agencies include:

- the Centre for Addiction and Mental Health,
- the Canadian Mental Health Association,
- Empowerment Council
- Voices from the Street
- the Canadian Coalition for Seniors' Mental Health,
- Community Resource Connection Toronto,
- Connex Ontario,
- The Consent and Capacity Board,
- Health Canada,
- the Community Partners Housing Directory,
- the Ministry of Health and Long Term Care,
- Mood Disorders Canada,
- Anishnawbe Health Mental Health Crisis Line
- the Office of the Public Guardian, and
- The Ontario Review Board.

Finally, to reflect the importance that the Service assigns to the issue of police response to the emotionally disturbed, it has assigned the portfolio to a deputy chief, the second highest ranking member of the Service. Deputy Chief Federico has assembled a dedicated team that consists of an Inspector in charge of MCIT support, two Staff Sergeants: one in charge of overseeing the Service's response to the vulnerable sector, including the emotionally disturbed, and a second who oversees government partnerships; and two constables: one who is the program coordinator for the MCIT, and the other who supports the elderly. Moreover, Deputy Federico is the Service representative on the Board's Mental Health Sub Committee, and personally participates in community outreach and consultation to build strong relationships with the consumer-survivor community and those who support them.

#### Conclusion:

The Toronto Police Service responds to calls for service involving emotionally disturbed persons or the mentally ill using sound, well-established practices and procedures. These practices and procedures are the result of the latest worldwide research, benchmarking, experience, consultation with subject matter experts, and inquest recommendations. Additionally, the Service's response includes practices that are informed by such research as the Canadian Association of Chiefs of Police Mental Health Guidelines, and work done by the Canadian Mental Health Commission of Canada. Evidence shows that in the overwhelming percentage of cases, officers are successful in resolving incidents involving emotionally disturbed persons

safely and without resorting to apprehension or force. This fact can be attributed, in part, to community cooperation and input, Board policies, Service procedures, supervision, and officers' training, judgement, skills, and equipment. However, this enviable record does not, for a moment, mean that the Service rests on its laurels. On the contrary, there is much the Service continues to learn from the community, especially from consumer-survivors and those who serve them. Their insight is incorporated into the Service's Priorities, practices, and officer training. While the Service is confident that it has achieved the right balance between crisis response and the need to protect the vulnerable of society it continues to monitor its practices to ensure this balance is maintained.