The Entanglement of Policing and Mental Health in Mobile Crisis Intervention

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ABSTRACT/RÉSUMÉ

In Canada, most fatal police encounters involve persons with mental illness. This thesis examines the efforts of Ontario's Mobile Crisis Rapid Response Teams (MCRRT)—first-responder units that pair clinicians with crisis-trained police officers—to de-escalate emergency mental health calls and connect persons in crisis to community care. An analysis of provincial mental health legislation reveals a long history of conceptualizing and approaching the problem of mental illness through the policing frameworks of order maintenance and public safety. Combining ethnography and textual analysis, this thesis explores the concepts of visibility, anticipation, and chronicity at work in mobile crisis intervention. MCRRT groups emerge in the context of hypervisible police violence and take up the issue of how best to respond to persons in crisis. This thesis argues that scenes of crisis intervention hold the promise of transformative change while simultaneously reinforcing the paradigm of policing mental health.

Au Canada, la plupart des rencontres mortelles avec la police impliquent les malades mentaux. Cette thèse examine les efforts des équipes mobiles d'intervention rapide en cas de crise (MCRRT) de l'Ontario - des unités de première intervention qui associent des cliniciens à des policiers formés aux situations de crise - pour désamorcer les appels d'urgence en santé mentale et mettre les personnes en crise en contact avec les soins communautaires. Une analyse de la législation provinciale sur la santé mentale révèle une longue histoire de conceptualisation et d'approche du problème de la maladie mentale à travers les cadres de maintien de l'ordre et de sécurité publique. En combinant l'ethnographie et l'analyse textuelle, cette thèse explore les concepts de visibilité, d'anticipation et de chronicité à l'œuvre dans l'intervention mobile de crise. Les groupes MCRRT émergent dans le contexte de violences policières hypervisible. Cette thèse soutient que les scènes d'intervention de crise promettent un changement transformateur tout en renforçant le paradigme de la santé mentale policière.

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LIST OF ABBREVIATIONS

AER	Acutely Elevated Risk
ASIST	Applied Suicide Intervention Skills Training
CAHOOTS	Crisis Assistance Helping Out on the Streets
CBC	Canadian Broadcasting Corporation
CCJA	Canadian Criminal Justice Association
CCTV	Closed-circuit Television
CIT	Crisis Intervention Team
CMHA	Canadian Mental Health Association
COAST	Crisis Outreach and Support Team
CSWB	Community Safety and Wellbeing
DSM	Diagnostic and Statistical Manual of Mental Disorders
MCIT	Mobile Crisis Intervention Team(s)
MCRRT	Mobile Crisis Rapid Response Team(s)
NAMI	National Alliance on Mental Illness
PIC	Person in Crisis
RCMP	Royal Canadian Mounted Police
SIU	Ontario Special Investigations Unit

INTRODUCTION

I began this work with little intention and a tremendous reluctance to study the police. Like many anthropologists, I was "pushed toward a consideration of police in the process of seeking answers to other questions, rather than in an effort to understand the police in and of themselves" (Karpiak and Garriott 2018, 4).

My research interests lie at the intersection of the anthropology of violence and mental health. Compelled by North America's growing housing crisis, I initially set out to examine the mechanisms through which structural violence is embodied in the lives of those experiencing comorbid homelessness and mental illness. As I began conducting background research on this topic, I was struck by how central the police are in current debates over how to deal with this vulnerable population. According to a literature review produced by the Canadian Commission for Complaints against the RCMP, it is well-established that the social ills of homelessness, addiction, and mental illness fall under the purview of the police. So much so that "the issue is less whether the police should be handling these cases and more how best to manage these cases" (CPC 2010, emphasis added). Other researchers have suggested that considering how frequently they interact with persons with mental illness, the police should be allocated additional resources to connect these individuals to housing, healthcare, and social services (Iacobucci 2014; Kouyoumdjian et al. 2019). When it comes to those most marginalized and in need of care, the police are "the institution of last resort, the system that can't say no" (CPC 2010).[1]

Approximately one in every five police encounters in Canada involves an individual with a mental or substance use disorder (Boyce et al. 2015). In contrast to public perceptions associating

[1] This phrase came up throughout my fieldwork, as many of my interlocutors felt their role was a by-product of being the only institution unable to turn people away. I return to this in subsequent chapters.

mental illness with violence (Varshney et al. 2016), most police contacts are unrelated to any crime or involve only minor public order infractions (Wells and Schafer 2006). These encounters may be related to incidents such as threatened or attempted suicide, assessments under the provincial *Mental Health Act*, or being the victim of violence (Kouyoumdjian et al. 2019). Individuals experiencing concurrent homelessness may also come into contact with law enforcement due to the criminalization of daily acts of living—such as sleeping, eating, and panhandling in public spaces—even though policing these behaviours has been shown to deteriorate mental well-being further (Robinson 2019). As a crisis nurse would later tell me, for some people living with mental illness, law enforcement can be "the only thing consistent in a person's life" because they come into contact with the police every day of the year.

In my early research, I was also regularly confronted with news reports of deadly force in wellness checks or emergency mental health calls. Nearly seventy percent of fatal police encounters in Canada from 2000 to 2020 involved individuals with mental health and substance use problems (Singh 2020).[2] Black and Indigenous people are overwhelmingly overrepresented in these cases. In June 2017, Pierre Coriolan, a fifty-eight-year-old Black man, was fatally shot in his apartment after Montreal police received a call that he was in mental distress (MacLellan 2022). Clive Mensah, a Black man living with schizophrenia, died in November 2019 after being tasered several times in his backyard by Peel police officers (Miller 2021a). In May 2020, Regis Korchinski-Paquet, a twenty-nine-year-old Indigenous-Black woman, fell to her death from her balcony during a wellness check with the Toronto police (Cooke 2020). One week later, twenty-six-year-old Chantel Moore, an

[2] No national government database currently tracks police use of force incidents, although calls for such a database are regularly made (Bennell et al. 2022). Research librarians from the Canadian Broadcasting Corporation (CBC) developed a database capturing basic information about 461 fatal police encounters from 2000-2017 (Marcoux and Nicholson 2018). This database was updated to include data through 2020 for a total of 555 cases (Singh 2020). A more expansive project comprised of academics and advocacy groups puts this number at 722 force-involved deaths through 2022 (Tracking (In)Justice 2023).

Indigenous woman from Tla-o-qui-aht First Nation, was fatally shot by Edmundston police as they were carrying out a wellness check at her home (Magee 2020).

The more reports I read, the more I sensed that a complete picture of violence and mental illness in Canada necessitated considering how these issues intersect with police practices and institutions. As Jeffrey Martin writes, "Police culture is a process…through which the ambient or contextual structural violence embedded/emergent in a political field is translated into tangible, overt, 'direct' form. Police culture is where the invisible violence of ordinary life is made visible, where subtextual violence is made explicit" (Martin 2018, 50). What might the overt use of force in police encounters with people experiencing mental illness tell us about the invisible constellations of violence that permeate ordinary life? What might the relationship between the police and the mad or neurodivergent subject reveal about the structural forces that give rise to such moments of acute psychic distress?[3]

Mobile crisis intervention emerged as a rich site to explore these questions and interrogate the entanglement of policing and mental health. In recent years, heightened critical attention to violent police encounters has put pressure on municipal governments across North America to establish alternative services for responding to individuals experiencing mental health or substance use-related crises. One approach involves pairing a mental health clinician with a specially trained police officer to de-escalate crisis situations and avert the use of force in emergency mental health calls. These units, known as Mobile Crisis Intervention Teams (MCIT) or Mobile Crisis Rapid Response Teams (MCRRT) in Ontario, provide assessment, support, and community referrals to

[3] My thinking here is informed by the provocations in "Mad Futures: Affect/Theory/Violence" (2017). On violent police encounters with neurodivergent people of colour, Aho et al. write: "How might we think about not only the specific *acts* of violence inflicted…while also attending to the state-sanctioned and other *structural* forms of violence that preceded and surrounded this event?" (292).

persons in crisis (Ghelani 2022).[4] Because many of these programs emerge as a response to public demands for change in the aftermath of high-profile police shootings, they offer an ideal starting point to examine the synergistic relationship between mental illness, policing, violence, and care.

Police Violence in Canada

There is a tendency among many Canadians to dismiss police violence as something that happens elsewhere, to regard it as a problem localized to the United States, where racial disparities and police brutality have reached a boiling point (Cole 2020; Heath-Rawlings 2020; Pasternak et al. 2022; Simpson 2020). When asked about her thoughts on the Defund the Police movement, one of my interlocutors encapsulated this sentiment, saying: "I feel like a lot of those arguments come from people who are basing their arguments on what happens in the States, which is very different from Canada." By conservative estimates, the rate of police-related deaths in America is at least three times higher than in Canada (Wortley et al. 2021). Yet, the widespread public perception that police violence is not a Canadian problem likely stems less from an appreciation of comparative statistics than Canada's cultivated national image as the land of multiculturalism, tolerance, and equality (Maynard 2017).

There has so far been no major, national-level use of force study in Canada.[5] In 2021, the Canadian Criminal Justice Association (CCJA) commissioned researchers from the University of Toronto to fill some of this gap. Although their analysis was limited by dramatic differences in data collection standards across provinces and an overall lack of transparency from police officials, the authors' findings indicate that the deadly force rate has increased nationwide by twenty-eight percent

[4] Going forward, I will use the MCRRT abbreviation consistently, as this is the most common name for police-clinician teams in Ontario. However, this is not standard across regions within the province or outside of it.

[5] Much of the research on the use of force in Canada has focused on lethal force, relying on publicly sourced databases such as the one compiled by CBC News or Tracking (In)Justice. Since these databases only collect information where persons died due to intentional police force (e.g., shootings, tasers, physical holds) and where this information was publicized, they likely underreport the true prevalence.

over the last twenty years (Wortley et al. 2021). Persons with mental illness are grossly overrepresented in these cases. Despite improved technologies, enhanced de-escalation training, and policy reforms, most Canadian police services reported a longitudinal increase in recorded use of force incidents (17). In contrast, most officers interviewed for the study believed that the use of force had decreased due to these measures (40).

It is telling that, when asked about the impact of race on police use of force, some of the officers in the CCJA study questioned the existence of racial disparities in Canada, citing a lack of data and suggesting that American media skews Canadians' perceptions of the issue. As one officer stated, "Whether it's one hundred percent true or not, those stats I don't have and I'm not sure. A lot of it is coming from the media, and U.S. media specifically, and in Canada I don't think we do a good job telling our story, the Canadian perspective" (46). In truth, available statistics indicate that police use of force is increasing far beyond what can be explained by population growth, with 2022 seeing the highest number of officer-involved deaths on record (Gillis 2023). If we continue to think of deadly force as a uniquely American issue, it is not because concrete data support this view but because police violence, especially racialized violence, doesn't fit into the Canadian *story*.

Comparative framing further services the narrative that systemic racism is just an American problem, obscuring the disproportionate risk and impacts of state-sanctioned violence on marginalized Canadians (Glasbeek et al. 2021; Greene et al. 2022). Despite the research challenges created by the government's neglect to systematically collect or disclose racially disaggregated use of force data, there is a growing body of literature that shows Black and Indigenous Canadians are more likely to be subjected to police violence, particularly lethal force (Andersen et al. 2023; OHRC 2018, 2020; Owusu-Bempah and Gabbidon 2021; Owusu-Bempah and Wortley 2014; Razack 2015; TPS 2022; Wortley et al. 2020). Black and Indigenous people are overrepresented in fatal police shootings, accounting for twenty-seven percent of police-involved shooting deaths in the last two

decades but comprising less than nine percent of Canada's total population (Tracking (In)Justice 2023). From 2013-2017, a Black person in Toronto was nearly twenty times more likely to be shot and killed by the police than a White person (OHRC 2018). More recent statistics, compiled after all police services in Ontario began collecting race-based data in use of force reports in 2020, revealed that racialized groups in Toronto were significantly overrepresented in use of force cases and more likely to experience the highest level of force (i.e., a firearm was pointed). These differences remained even after taking into account what the police were called to investigate, what the primary offence turned out to be, whether the officers perceived any weapons on the scene, and if the call was for a person in crisis (TPS 2022).

The focus of this thesis is not the well-documented racial disparities in Canadian policing.[6] I draw attention to them here because it is impossible to ignore the myriad ways racialized police violence and mental health intersect. Experiencing and witnessing police violence are both deeply traumatic, contributing to an increased risk of lasting mental health symptoms such as stress, hypervigilance, depression, and anxiety (Greene et al. 2022). Black and Indigenous communities experience the collective trauma of repeated exposure to violence and the pervasive fear of police interactions it produces (Waldron 2020). As such, "[t]he mental health impacts of anti-Black police violence extend beyond wellness checks and other interactions between the police and Black people who are already suffering from mental illness at the time of these encounters" (33). Police violence causes enduring psychological harm to the families and communities who experience these incidents vicariously.

[6] For an introduction on how present-day racial profiling and police discrimination fit into the history of settler colonialism, including the origins of formal policing in Canada as a means to control and subjugate Indigenous and racialized populations, see Henry et al. (2014); Gebhard et al. (2022); Maynard (2017); Owusu-Bempah and Gabbidon (2021).

Moreover, I wish to pre-empt the myth that efforts to launch or expand mobile crisis response teams are unconnected to issues of race. In a study examining the racial dimensions of police body-worn cameras, Canadian officers attributed the origin story of these technologies to proactive and forward-thinking police practices, ignoring the fact that public demand for body-worn cameras in Canada was propelled by overtly racialized use of force incidents (Glasbeek et al. 2020). I provide this context to establish unequivocally that the rapid growth of mobile crisis response services in recent years cannot be divorced from highly publicized fatal interactions between police and racialized persons experiencing mental illness. These deadly encounters must be situated within a larger cosmology of violence that includes racial injustice, disproportionate levels of invasive policing in stigmatized and low-income neighbourhoods, and the unfilled need for trauma-informed, robust mental health care.

What emerges as an event is a product of the structures that engender it. The violent police interaction, the escalation of force in a mental health call, and the wellness check that ends in tragedy are not exceptional events so much as evidence of the system expressing itself.

MCRRT Programs in Ontario

The common refrain in the aftermath of violent encounters is that the police are not trained or equipped to respond to persons with mental illness. MCRRT programs dispatch a mental health clinician alongside the police to emergency mental health calls, relying on their skillset to stabilize crises, provide on-site assessments, and connect individuals to community services and supports. Police services in Ontario have been some of the earliest adopters of this approach, with the first

rapid response team established in Hamilton in 2013 (Fahim et al. 2016).[7] In the last five years, there has been a tremendous increase in the formation of MCRRT programs, with over sixty teams across the province (HSJCC 2023). In 2022, the provincial government invested four million dollars to expand MCRRT further (Solicitor General 2022).

Ontario was ideal for my fieldwork because many of the province's older MCRRT programs have established long-term, integrated partnerships between police and health services. Other groups have only emerged in the last couple of years and are still in the pilot project phase. The large number of programs and notable differences in scope and maturity across the province provide a good representation of the diversity in implementation practices of the MCRRT model.

Methods

This thesis is based on a combination of ethnographic and archival work conducted over three months from July to September 2022.[8]

In developing this project, I was confronted with the impossibility of crisis as an ethnographic object. Ethnography is a practice of living with— an effort to attend to and elucidate a particular lifeworld, traditionally through long-term, immersive engagement that emphasizes the ethnographer's physical presence in the spaces where life unfolds (Hammersley 2006). If ethnography is a practice of 'staying with,' how can I hold onto something as transient and liminal as a crisis? How can an anthropologist attend to "what is supposed to be a rupture in the normal order of things" (Fassin and Honneth 2022, 2)? What claim can I make to represent crisis as something

[7] Hamilton first formed a police-mental health partnership in 1997 after a two-year-old boy was stabbed to death by a neighbour with schizophrenia. The police were called about the neighbour's aggressive and erratic behaviour numerous times but failed to apprehend her under the *Mental Health Act*. The Crisis Outreach and Support Team (COAST) program was initially established to educate officers hesitant to bring individuals to the psychiatric emergency department and enhance collaboration between the two sectors. Based on the Car 87 program in Vancouver (est. 1987), it only responds to non-emergent calls (Clairmont 2017).

[8] This study received ethics approval from McGill University's Research Ethics Board (REB File #: 22-05-020).

that exceeds the everyday, that by virtue of its uncertain temporality, resists any attempt to live alongside?

Beyond these epistemological concerns, I am attentive to the ethical considerations of studying a population that is delineated in terms of precarity and the urgency of intervention. In recognition of the limited time frame for a master's thesis, restrictions in accessing spaces of care during the COVID-19 pandemic, and the impracticality and inappropriateness of obtaining participant consent during emergency mental health calls, my thesis is not on an ethnography of persons in crisis. Instead, I focus my attention on the individuals providing crisis services and the discussions that form around the clients who access them, the around-ness. In this sense, my project follows the epistemological concerns of Didier Fassin and Axel Honneth in their construction of a "heuristic of crises" (Fassin and Honneth 2022, 2). I ask what character of knowledge is generated through the assessment of and reaction to mental health crises through the lens of the interventionists tasked with apprehending and responding to them. Although they remain secondary to my project, glimpses of the experience of life marked by chronic and acute mental health crises emerge through this triangulation. These flashes are present in the public-facing materials, oral presentations and descriptions relayed by intervention workers that form the basis of my analysis.

In my initial project proposal, I intended to conduct a comparative study of a nascent mobile psychosocial intervention team in Québec and the more established MCRRT groups in Ontario. However, as I began the early stages of fieldwork, it quickly became apparent that the frameworks, approaches, and goals of these different organizations vary to such an extent that any efforts of comparison across geographies would sacrifice depth of engagement. The degree to which these disparate approaches espouse radically different constructions of the issue and how it should be addressed was further impressed when I attended the 2022 Crisis Intervention Team (CIT) International Conference—a gathering of behavioural healthcare professionals, mental health

advocates, and law enforcement partners from across North America. I sought to situate the specifics of my fieldwork in Ontario within the broader context of crisis response programs, focusing on how speakers and attendees envision the role of police within crisis response and the relationship between law enforcement and mental health professionals. Yet, the presentations and workshops at this event conveyed a heterogenous picture of what is at stake in crisis intervention work, which was often incongruous with my observations in the field.

To understand how first responders assess, react to, and de-escalate crisis situations, I conducted participant observation in the form of ride-alongs during twelve-hour shifts with MCRRT groups from two municipalities in Southern Ontario. Each MCRRT unit consisted of a mental health worker (either a social worker or mental health nurse) and a uniformed police officer with specialized CIT, safeTALK suicide prevention, and Applied Suicide Intervention Skills Training (ASIST). Contrary to my imagination of crisis as something that unfolds openly in public, most of the teams' interventions occurred in private spaces—in houses, group homes, and backyards. Although I was present during these encounters, I did not seek consent from the clients so as not to interrupt their care. Therefore my observations of their behaviour were not recorded nor used for any research capacity.[9] Instead, my observations during these ride-alongs concentrated on the spaces in between interventions, the long periods of waiting in which crisis is "always incipient, on the cusp of continual emergence" (Ingold 2014, 389). I attended to the exchanges between team members in the debriefs immediately following calls, the conversations that took place during prolonged periods of 'driving around,' the shifts in body language when I asked particular questions, and my own affective discomfort at being present in these spaces. I also observed one police department's weekly

[9] On a few occasions, particularly in chapter three, I describe the behaviour of MCRRT responders during intervention calls. I have obscured any details related to the person in crisis. I present these snippets to provide the necessary context for an analysis of my interlocutors' commentary more than a detailed reading of the specific scenes of intervention themselves.

Situation Table—a meeting in which various community organizations, mental health services, and police collaboratively discuss and plan interventions for "difficult cases" with an Acutely Elevated Risk (AER) of harm to self or others.

To understand the circumstances that bring persons with mental illness into contact with the police and the systems of governance that regulate their care, I analyze the Ontario *Mental Health Act* and the shifting policy frameworks from the 19th century to the present day that shape the province's mental health service system. I examine the commitments and visions of reform MCRRT organizations put forward by studying training materials, best practice guides, position papers, and media statements. This project takes shape in the context of ongoing debates over police reform, including the police defunding movement and advocacy groups such as the Toronto-based Doctors for Defunding the Police, which call for resources to be redirected toward community-based mental health and social services. I ground my analysis within this public discourse surrounding police violence and mental health, drawing on different digital media forms to explore the narratives mobilized around persons experiencing mental health crises and to chart the parallel development of mobile crisis intervention programs.

Finally, I conducted six semi-structured interviews with mental health professionals from three crisis intervention organizations. Our conversations focused on their experiences providing crisis support, their perspectives on different intervention approaches, and their visions for the future of mental health care. Although I actively recruited police officers working in the same capacity, none agreed to be interviewed for this study.

On Positionality and Police Ethnography

During one of my ride-alongs, I accompanied a police-clinician unit to a call involving an intoxicated woman who was well-known by MCRRT staff. Two other patrol officers attended the call, making it difficult to maneuver within the cramped living room as the five of us awkwardly crowded around

the woman. At one point, she became agitated and stood up abruptly from her chair. Uneasy on her feet, it appeared for a split second like she was lunging forward in my general direction. The police officer I was with put his forearm out in front of me on instinct. The moment quickly passed as the woman stilled, and I was able to step out of the way, but it registered that his behaviour at that moment was in no way surprising to me. I expected to be protected.

While conducting fieldwork, I never once felt unsafe attending crisis calls or being in the presence of the police. It is not lost on me that my capacity to conduct this kind of participatory research in police-dominated spaces is a product of my privileged class, race, and gender positionality. To illustrate this point: on one occasion, a mental health nurse I was riding along with asked me the familiar question, "What is your background?"[10] Similar to "What are you?" or "Where are you from?" this question signals the operation of the external racial gaze that I am accustomed to as a mixed-race Chinese Canadian. This form of racializing vision is a "dissective process" (Haritaworn 2012, 41) intended to elucidate a narrative that will aid the gaze in "making sense" of the multiracialized body (Paragg 2017, 284). Critically, it differs from other racialized habits of seeing more explicitly rooted in phobia, dehumanization, and annihilation (Fanon [1952] 2008). My ability to feel safe, if uncomfortable, riding in the backseat of a police vehicle for hours on end is driven by the knowledge that my body prompts curiosity or inquisition and not the implicit associations of deviance, aggression or criminality that have sustained anti-Black and anti-Indigenous violence throughout Canada (Waldron 2020). In the simplest possible terms, I write from outside the position of those most impacted by police violence.

[10] I clarified that she was explicitly asking about racial-ethnic identity, not my academic or professional background. In the Canadian multicultural context, "background" is a dominant frame for asking after racialized ethnicities when it is recognized that simply asking "What is your race?" is not politically correct (Paragg 2017, 286).

This last point raises important ethical questions about engaging and representing interlocutors who hold the capacity to enact state-sanctioned violence or, in the case of MCRRT clinicians, work in tandem with those who do. On the one hand, a degree of 'complicity' is necessary to conduct ethnography and garner information, especially in the case of institutions as guarded and secretive as the police, where voicing my disagreement or challenging my interlocutors' views would have precluded me from future discussions (Fassin 2013a). As visual evidence of my 'complicity,' I wore a bulletproof vest. I stood alongside MCRRT staff during crisis calls. I appeared to the people we came into contact with as though I were just another team member. On the other hand, the danger of "studying up" (Nader 1972) is that complicity can bleed into one's writing. When studying institutions of power, it is easy to fall into the trap of "pulling one's punches" in interpreting field notes and writing ethnography to satisfy, or at least not royally piss off, one's informants (Ortner 2010, 226).

I find Beatrice Jauregui's notion of "strategic complicity" particularly helpful in navigating the stormy ethics of police ethnography (Jauregui 2013). Studying the police, Jauregui writes, means being complicit with their violence, no matter how much an ethnographer may try to remain "pure." This is not cause for abandoning one's work. Rather, she writes:

> It means that you must always remain aware of your complicity and put it to work in strategic ways that will allow you to gain some understanding of the complexity of what is happening, and particularly of the multivocality of your various interlocutors, while maintaining your integrity and ethical responsibility by critically questioning what people say they are doing, what people actually are doing, and what people say about why people are doing what they are doing. (147)

In my fieldwork, strategic complicity offered a framework for monitoring my thinking and negotiating the tension between eliciting the voices of my interlocutors and critically engaging with them. I endeavoured to capture this multivocality, attending to the contradictions between my interlocutors' behaviours, their explanations, and my observations to understand the complexities of what is happening in crisis intervention.

The other concern I faced was how to represent MCRRT in writing. Whereas ethnography often presents complex and sympathetic portraits of its subjects, many anthropologists have questioned the ethical and political stakes of trying to "humanize" the police (Karpiak and Garriott 2018). My aim is not to portray the police in a sympathetic light, although when asked if there was anything they wished the public knew about their work, my interlocutors often responded: "that the police are human too." Instead, this thesis asks what the existence and implementation of MCRRT programs reveal about how we understand the relationship between policing and crisis. To the extent that this work can be considered "humanization," it is because anthropology is in the business of "building knowledge about humanity and meaning-making" (Jauregui 2013, 145). And the police, violence, and psychic distress are all profoundly human things.

Overview of Thesis

Each chapter in this thesis addresses a discrete aspect of mobile crisis intervention. In chapter one, I consider the centrality of the police in recognizing and responding to mental illness. Mental health has long been a matter of what Ed Cray has termed "police property," that is, it belongs within the police domain under the frameworks of public safety and order maintenance. This entanglement of policing and mental health has been reinforced throughout the history of mental health policy in Ontario and is present in contemporary approaches to crisis response. I review the different crisis intervention models to provide context for my fieldwork with MCRRT groups in Ontario. Amidst calls for change by activists responding to the surge of police violence in North America, these programs offer solutions despite divergent understandings of the issues they are intended to solve.

Chapter two explores the concept of visibility. I present a reflexive ethnographic account of my experiences trying to gain access to police-clinician spaces to illustrate how these institutions continuously negotiate the tension between transparency and obscurity. Crisis workers operationalize visibility to legitimize and bring their daily labour into public view. At the same time,

forms of mediated visibility, such as bystander videos circulated on social networking platforms, threaten to invalidate this labour and undermine institutional control over the conditions of public seeing. A mental health crisis must become visible for it to be intervened upon; however, this act of making visible brings the person in crisis into the public realm, enfolding them within the discourse of policing and public order.

Chapter three is structured around the events of a single twelve-hour ride-along shift as I explore the ambivalences of anticipation and chronicity in crisis response. MCRRT clinicians navigate myriad uncertainties in their work—not knowing what each day holds, how a situation will unfold, and what happens to a person in crisis after the intervention ends. Yet, the apparatus of crisis response operates along a predictive temporality, presuming that crisis is imminent and that violence always already exists in potential. This contradiction between uncertainty and expectation is most evident in the burnout, fatalism, and sense of inevitability invoked by the chronically ill subject for whom crisis is a scene of continual return. I conclude with some overarching reflections on my relationship as an anthropologist to the themes in this work.

It would perhaps be easier to write this thesis through a single modality—through the lens of policing, publics, mental health systems, or crisis. But how these concerns play out in the everyday is messy and full of contradictions. This thesis attempts to capture that assemblage, to spread out all the messiness of crisis intervention and begin to parse through it.

A Note on Terminology

The terminology used to describe people who come into contact with crisis intervention teams is as varied as it is contested. Tew (2011) asserts that "perhaps more than in any other field of health and social care, language relating to mental health issues is contested and contentious" (4). It is thus unsurprising that my interlocutors adopted an expansive vocabulary, and each held a different set of preferred terms for referring to those receiving crisis services. A non-exhaustive list of the phrases I

heard most often includes: "clients," "service users," "patients," "survivors," "consumers," and "people with lived experience." Nearly all of these are subject to debate within the mental health treatment sector and the literature on mad studies, with contradictory opinions on the utility of choosing specific terms over others and the power relations inherent within (Dickens and Picchioni 2012).

As an anthropologist, I am inclined to frame my analysis in emic terms.[11] In light of the contested terminology, however, I have chosen a compromise between mirroring the language used by my interlocutors and the person-first language advocated for in the psychological literature (Mizock et al. 2022). For example, "persons in crisis" is readily used by MCRRT organizations and shortened in everyday parlance to "PICs."[12] I have chosen not to abbreviate this term to retain the original emphasis on the *person* experiencing distress. As Price (2011) contends, "often the very terms used to name persons with mental disabilities have explicitly foreclosed our status *as* persons" (9). It is for this very reason that terminology is so important: the labels we apply to mental health can cause exclusionary, stigmatic, or discriminatory harm in the service of linguistic expediency (Mizock et al. 2022).

Throughout this thesis, I use the terms "persons with mental illness," "persons experiencing mental illness," "persons in crisis," or similar variants interchangeably.[13] Although carefully considered, I recognize that these terminology choices are decidedly fallible and do little to capture the lived experience of psychic distress.

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[11] See Geertz (1979) on the anthropologist's role in elucidating emic/etic or experience-near/experience-distant concepts.
[12] Pronounced like the short-hand for "pictures."
[13] Some activists and scholars in mad studies reject the term "mental illness" entirely, as it implies "illness, incapacity, or inferiority" (Tew 2011, 5). Other studies have shown that the term may serve as acknowledgment and validation that one is experiencing a great deal of suffering (Mizock et al. 2022). For a longer discussion of language, see Pilling (2022).

CHAPTER ONE: POLICING MENTAL HEALTH

On April 6, 2020, D'Andre Campbell, a twenty-six-year-old man living with schizophrenia, was shot and killed in his home by a Peel Regional Police officer.[14] According to Ontario's Special Investigations Unit (SIU), Campbell called 911 and requested that police be dispatched because his parents were trying to start an argument with him (Martino 2020). Campbell's mother stated that he called 911 because he was in mental distress and "said he wanted to be taken to the hospital" (Kelley and Syed 2020). In the near decade since he was first diagnosed with schizophrenia, Peel police were mobilized more than thirty times in response to Campbell's mental health (Miller 2021b). On a few occasions, he was apprehended under the *Mental Health Act* and taken to a nearby hospital for psychiatric assessment. Other times, he was assessed by a mental health professional dispatched alongside a plainclothes officer as part of the non-emergency Crisis Outreach and Support Team (COAST).

Neither the lower acuity COAST nor the MCRRT unit tasked with responding to emergency mental health situations were dispatched in April 2020. Instead, two patrol officers were called to respond to a "domestic situation" at Campbell's residence and were informed of his mental health history. When they arrived, Campbell was standing in the kitchen holding a knife. Both officers immediately drew their Conducted Energy Weapons and began yelling commands to drop the knife. After Campbell failed to respond, he was tasered and fell to the ground, where he was tasered a second time before regaining his footing and moving to the opposite end of the kitchen island from

[14] In a News Release, the SIU concluded that "D'Andre Campbell *lost his life* after being shot by a Peel Regional Police Officer inside his Brampton home" (2020, emphasis added). This semantic framing displaces Campbell as the object of state violence, suggesting his life can be indirectly lost and further diminishing the possibilities afforded to Black life in a province where Black people are ten times more likely to be shot by police (Wortley 2006, 45). Throughout this thesis, I have chosen to mirror the language of the family and community members living in the sustained aftermath of police killings.

the officers, knife still in hand. Within seconds, both officers drew their firearms, and Campbell was fatally shot twice in front of several family members. Paramedics pronounced him dead on the scene twenty-seven minutes after the officers arrived at the home Campbell shared with his parents and eight siblings. According to the SIU report, "at no point was there any effort made to verbally calm Mr. Campbell" (Martino 2020).

In the weeks that followed, Campbell's family questioned why the officers had taken his life rather than transporting him to the hospital as they had in the past, noting that Peel Regional Police had come to the house on several occasions and should "know the type of person that they're coming to deal with [and] know how to handle the situation when they come to the house" (Kelley and Syed 2020). As Campbell himself told the 911 dispatcher when prompted to provide his home address, "the police had a tracking system on him and knew where he lived" (Martino 2020). Why were the police so heavily involved in Campbell's life and his mental health? What sustained their continued presence in a series of mental health crises, moments that perennially flared up and were ultimately unresolved by repeated police intervention?

The SIU report concluded that the officer who killed D'Andre Campbell had not committed a criminal offence but suggested potential ways his death could have been prevented had the officers discussed how they would approach the situation before entering the home or attempted de-escalation before immediately drawing weapons and yelling orders that a person in crisis would likely have difficulty recognizing. Yet even before the moment of encounter, Deputy Chief Marc Andrews asks whether Campbell's death could have been prevented if the police "hadn't been there in the first place." "[W]hat we really need," he would later say in an interview, "is to lower the frequency of when officers become involved with mental health crises" (Gamrot 2021).

In this chapter, I provide an overview of the literature on mental health crisis response, situating the growth of these programs within the context of the Defund the Police Movement and a

historical review of mental health policy in Ontario. I discuss how the entanglement of policing and mental health has shaped the contemporary landscape of crisis intervention, the various models for responding to emergency mental health calls, and the stated aims of these programs in an effort to trace the outlines of what is at stake in crisis intervention.

The Defund the Police Movement

D'Andre Campbell's death is one of several police-involved killings of Black and racialized Canadians experiencing mental health crises, including the deaths of Regis Korchinski-Paquet, Chantel Moore, and Ejaz Ahmed Choudry in the spring and summer of 2020 alone. Compounded by other images of spectacular violence and police brutality, including the public lynching of George Floyd and the murder of Breonna Taylor in the United States, these events became the focal point of mass protests and heightened scrutiny of police conduct, specifically in their interactions with marginalized, mentally ill, and BIPOC populations.

In chapter two, I delve more into the circumstances under which mental illness and persons in crisis are made visible to the public. For now, I wish to foreground the role of spectacular violence in rendering black suffering in/visible to white audiences. Historically, the widespread circulation of images of brutality, torture, and lynching was "intended to shock and to disrupt the comfortable remove of the reader/spectator," bringing slavery "close" to cultivate antislavery sentiment in white witnesses (Hartman 1997, 17-18). Hartman argues that this emphasis on the spectacular rather than the structural violence and idioms of power that permeate the everyday ultimately reinforces the illegibility of black suffering because only the most spectacular events are registered (22). In contemporary life, the horrors of police brutality captured on video and circulated through social media operate similarly, bringing violence close for a white audience unaccustomed to encountering it in the everyday. These images make the spectacle of deadly force visible while

obscuring the fact that, as the essayist Hannah Giorgis writes, "To be black in America is to exist in haunting, mundane proximity to death at all moments" (2016).

It is telling that these instances of hypervisible police violence are often described as events that 'spark' protests or conversations about police reform (Altman 2020; Gamrot 2020c; Maynard 2020; Stelkia 2020).[15] In this sense, the spectacle of police violence represents what Barthes calls a *punctum*. In photography, a punctum is the "element which rises from the scene, shoots out of it like an arrow, and pierces [the viewer]" (Barthes 1981, 26). Similarly, the fatal police encounter is the event in an unwieldy present that punctures the surface and makes contact, bruises the observer. Like a punctum, this "lightning-like" event carries the "power of expansion" (Barthes 1981, 45)—the potential to fill the whole picture, to swell into mass demonstrations or a "global reckoning" with racism and police brutality (Silverstein 2021).

These headlines also call to mind Kathleen Stewart's description of the erupting event as "a snapped live wire sparking" (Stewart 2007, 9) in which what "throws itself together in a moment is already there as potential" (30). Drawing on Wallace Stevens' description of the poetics of an incipient universe,[16] Kathleen Stewart theorizes an eruption as:

> [T]he moment when a list of incommensurate yet mapped elements throws itself together into something. Again. One time among many. An event erupting out of a series of connections…through a fast sensory relay. Disparate things come together differently in each instance, and yet the repetition itself leaves a residue like a track or a habit […] (ibid)

[15] In Black cultural studies, the term "hypervisible" describes the overproduction and exposure of certain images of black bodies coinciding with the continued invisibility of Black people as ethical and political subjects (Fleetwood 2010, 16). I use it here to refer to this simultaneity and to denote the excessiveness of this violence.

[16] From Wallace Stevens, "July Mountain" (1955):

> We live in a constellation
> Of patches and pitches,
> Not in a single world…
> In an always incipient cosmos

We might think of fatal police encounters as 'sparking' events, but they are "already a question and a something waiting to happen" (ibid). They exist in the potential mapping and sheer repetition of anti-black logics; the intensifying scope of law enforcement powers; the criminalization of race and poverty; the precarious lives of persons with severe mental illness, and yet also the systematic disinvestment in mental health care, affordable housing, and social services. These interconnected forces converge into one hypervisible event of police violence, with each successive event a palimpsest of all that came before. Fatal encounters between the police and persons experiencing mental health crises are eruptions that catch the public's attention but ultimately arise out of a matrix of the ordinary—out of constellations not yet visible.

In their latest book (2022), Didier Fassin and Axel Honneth identify the two effects of crisis. The first is the flashpoint, the spark, the surging revelation of constellations of violence that had been previously illegible. The second is what catches: what questions emerge about the structures and conditions that give rise to crisis, and what political demands for transformative change emerge from this flash of recognition.[17] Fassin and Honneth emphasize that "in the contexts of domination, often this revelation is not for those affected, but instead for the rest of society, which had hitherto been blind to these circumstances" (2). It is important to note that Black families, community members, and activists have been mobilizing and staging demonstrations for over a century. The contemporary eruption is unique insofar as it emerges at the intersection of multiple crises, including the global coronavirus pandemic, that lay bare a polyphony of health and social inequalities even as the resulting political contestations mirror past generations of struggle (Maynard 2020).

[17] I am reminded of the words of Franny Choi in her series of poems, "Upon Learning that Some Korean War Refugees Used Partially Detonated Napalm Canisters as Cooking Fuel." She writes, "Every day, an extinction misfires, and I put it to work" (2022, 62). What flashes up in the aftermath of fatal police violence is an extinction put to work.

The dual crises of police violence and mental health have resulted in a movement to Defund the Police that questions the efficacy of prior and ongoing attempts at police reform, as well as the expanding scope of police into the social sector and community well-being. Activists and scholars have critically examined the efficacy of racial bias training when, as African-American Studies scholar Keeanga-Yamahtta Taylor writes, "All the training in the world cannot change the deployment of police in some neighbourhoods versus others [or] the cultural assumptions about who commits crime" (Taylor 2020). In Ontario, the SIU has been criticized for its lack of diversity and role in police oversight. The SIU is an independent civilian law enforcement agency that investigates police incidents resulting in death, serious injury, sexual assault allegations, or shootings. As of December 2021, just eight of the fifty-two SIU investigators are persons of colour; half of the lead investigators have prior policing experience; seventeen of the twenty-seven as-required investigators and all nine forensic investigators have police backgrounds. According to one former director, the unit is so homogenous that investigators often come into work wearing police rings and ties (Ballingall 2016). According to the family of Ejaz Choudry, a sixty-two-year-old Pakistani immigrant living with schizophrenia who was killed by Peel police in his home after a family member called a non-emergency line to request medical help (Miller 2021c), the SIU has "historically failed victims of police violence and brutality" (Gamrot 2020c).[18]

Calls to defund or abolish the police have been shaped by these critiques and follow a black radical tradition that is not only about contesting and dismantling state-sanctioned violence but is also an act of world-building that seeks to establish the structural conditions that cultivate and sustain life (Maynard 2020). Defund the Police demands resources be divested from prisons and police institutions and reinvested to address the upstream causes of harm, including funding life-

[18] The SIU was formed in 1990 through the work of activists with the Black Action Defence Committee, who called for an independent civilian oversight body to investigate police misconduct following a series of high-profile murders of Black men (Morgan 2020).

affirming initiatives such as supportive housing, safe supply, and mental health services. Doctors for Defunding the Police, a Toronto-based group of physicians and medical students, identifies the role of police in responding to mental health crises as a focal point for this change, noting that too often, police interactions with individuals experiencing psychic distress turn fatal. According to one of the co-organizers, Dr. Saadia Sediqzadah, many racialized patients with mental health disorders have paranoias associated with being disproportionately contacted by police (Glauser 2020). The group argues that police shouldn't be responding to mental health calls. Instead, funding should be reallocated toward creating new community emergency mental health services to support racialized and vulnerable populations (Shoush et al. 2020).

What is striking is the extent to which police representatives purport to agree with these statements, at times even claiming original authorship over them, while simultaneously resisting the fiscal and political project as the heart of defunding. In an interview retrospective of his first year as Peel Police Chief, Nishan Duraiappah described the public sentiment that police should not be the ones responding to mental health calls as "an awakening of a narrative we've been saying, that police are overused. For matters that we're not the most appropriately [sic] ones to respond to" (Yawar and Amin 2020). On another occasion, he addressed the defund the police movement directly:

> [T]he spirit of what [defund the police organizers] are saying is *exactly what the police have been saying for a long time*. We are not the professionals, whether it be mental health or addictions, older adult isolation, youth-based problems, to be able to resolve them. (Wittnebel 2021, emphasis added)

This sentiment was reflected by the officers I accompanied during my fieldwork. In an informal conversation at the 2022 Crisis Intervention Team (CIT) International Conference, a Canadian police sergeant told me animatedly: "All these calls for 'defund the police, defund the police,' I agree with you. This should not be my job. But then everyone backs off," he said, raising his hands and taking several performative steps backwards. He explained that social organizations are often unwilling "to do the hard work" of supporting persons with severe mental illness and compete with

each other for funding instead of working together, causing police to take on roles that should not be theirs. "All these people on Tik Tok and Instagram don't know what they're talking about when they call for defunding the police. The police are the only ones who want to do this work," he said.

Although officers affirm that mental health "isn't our job," the Ontario Police Services Act requires municipalities to adopt a Community Safety and Wellbeing (CSWB) Plan for police to address mental health, homelessness, and social isolation issues in collaboration with social service providers. For example, the Peel Regional Police Service is mandated to: "work in partnership with community mental health agencies in an effort to reduce the stigma and impact of mental illness in society and to share responsibility for improving the quality of life for the mentally ill and developmentally challenged." In a statement following the release of the D'Andre Campbell SIU report, Police Chief Duraiappah pointed to its COAST and MCRRT teams as programs intended to fulfill this mandate and prevent tragedies such as Campbell's in the future.[19]

Co-responder programs that pair mental health professionals with uniformed or plainclothes officers to respond to mental health calls are often identified in media reports and scholarly articles as effective, or at least promising efforts to improve crisis response for individuals in psychic distress, citing lower rates of arrests and involuntary hospitalizations (Semple et al. 2021) or officer-level outcomes such as enhanced attitudes about individuals living with mental illness (Compton et al. 2014). Beyond the efficacy of these programs—and the limitations and assumptions of the outcome variables used as proxies for determining efficaciousness—I would like to discuss how these iterative reforms reinforce the centrality of police in recognizing and responding to the problem of mental illness. In discussing the future of crisis response, a volume on the gold standards of law enforcement issued by the University of Toronto Mississauga Forensic Science Program

[19] Each of these programs pairs a mental health professional with a police officer. MCRRT (est. February 2020) was in effect but unavailable at the time of Campbell's death. COAST (est. 2007) was also in effect but only responds to non-emergent calls.

states: "There is an inherent need for an alliance between police officers and mental health professionals" (Aghasi and Beaudoin 2021, 159). What is inherent in this relationship? What sustains the entanglement of policing and mental health?

In what follows, I adopt a historical lens to examine the circumstances that bring persons in crisis into contact with the police, unravelling how the figure of contact has been aided through each iteration of Ontario's mental health policy reform.

How Mental Health Becomes Police Property

Maintaining Order

Research studies on co-response programs often attribute frequent police interactions with persons with mental illness to processes of deinstitutionalization and a corresponding lack of community resources to fill this gap in mental health care (Cotton and Coleman 2010; Ghelani 2022; Lamanna et al. 2018; Semple et al. 2021). As community mental health systems lag behind ongoing reductions to inpatient psychiatric beds, police become default first responders for individuals unable to access long-term care (Glauser 2020). Consequently, police have been characterized as "society's de facto 24/7 mental health workers" (Thompson 2010, 9), "front-line mental health workers" (Shore and Lavoie 2019, 157), and "streetcorner psychiatrists" (Teplin and Pruett 1992, 139). While deinstitutionalization has had a profound impact on the criminalization of mental illness and the ability of persons with mental illness to access care, this cause-and-effect simplification masks how mental health has always been a matter of "police property," a site where the dual police mandates

of law enforcement and order maintenance coalesce in the body of the mentally disordered patient as a locus for social control.[20]

For over a century and a half, the prevailing response to madness was to segregate mad persons from the larger society in mental hospitals. Before the 1830s, in Upper Canada, the primary responsibility for the care and housing of persons with mental illness rested with families. Those deemed "wholly destitute" or who were "too violent to be controlled by such means as can be used in private families" were committed to local jails (Brown 1984, 27).

There are a number of competing explanations for what motivated the dramatic shift from family homes and jails as spaces of care to the extraordinary power of the asylum. Humanitarian arguments attribute this change to a general tending toward reform and growing public sympathy for the poor insane. This sympathetic concern coupled with the burgeoning idea that the most humane and therapeutic approach to madness was to isolate individuals in total institutions where life and care could be formally administered (Scull 2021, 70-71). Yet, the body of historical literature on institutionalization suggests that if these humanitarian aims were present, they were secondary concerns to more salient fears that persons with mental illness were a "dangerous moral contagion" threatening the social and political order (Brown 1984, 36). In fact, there is evidence to suggest that the "lunacy reform" movement in Upper Canada originated in part from petitions of prisoners aggrieved at sharing space in jails with dangerous and otherwise "revolting" mad persons (37). As Foucault observes in his analysis of similar petitions in France, the confinement of persons with mental illness to jails was viewed as an injustice, not for the mad, "but *for others*" (Foucault [1965] 1988, 228). Thus the creation of a specialized institution for the mad following the passage of the

[20] The term "police property" was initially coined by Ed Cray in *The Enemy in the Streets* (1972) and later refined by Canadian sociologist John A. Lee (1981) to refer to the social abandonment of marginalized groups deemed problematic and left to the police to control through coercive power. The use of 'property' signifies that the problem of mental health not only *belongs* to the police but that they *possess* persons with mental illness.

asylum act of 1839 cannot be attributed primarily to shifting standards of care but rather to broader concerns over the increasing costs associated with housing the mad in local jails and the ongoing threat posed by the presence of deviants in the public space.

Simmons criticizes the social control theory that the main purpose of mental health policy in this period was to label and contain deviants. According to Simmons, this theory implies that "mental illness is not an illness as such" (Simmons 1985, 98) but a label ascribed to specific subsets of people who pose a threat to the social order and need to be contained. He points to the fact that, by the 1930s, the majority of mental hospital patients were suffering from illnesses with discernable physical causes (e.g., syphilis, epilepsy) and thus were institutionalized "not because they were poor, unemployed, or a threat to the political or social order, but because they were ill and had no other place to go" (100-101).

In addition to assuming patient demographics were the same in the 1930s as they were during the onset of the asylum a century prior, this analysis is predicated on a narrow definition of deviance, one in which individuals whose mental illness is not readily linked to physical causes are the only ones whose "bizarre or aberrant behaviour" poses a threat to the ideals of bourgeois society (99). Adopting a broader view of deviance as any departure from accepted norms removes this requirement that social control can only be exercised on those whose psychosis is not tied to organic causes. The fact that many of the individuals remanded to mental hospitals required a high level of long-term care and would, "because of the nature of their illness, have been institutionalized under any political or economic system" (Simmons 1990, 6) does not account for the shape these mental hospitals took on as total institutions nor the emphasis they placed on "moral therapy" and cure through productive rehabilitation (Kritsotaki et al. 2016). As Erving Goffman writes in *Asylums,* mental hospitals and prisons shared profound similarities. Both exercised total authority over regulating all aspects of life, a fact that was "symbolized by the barrier to social intercourse with the

outside and to departure that is often built right into the physical plant, such as locked doors, high walls, barbed wire, cliffs, water, forests, or moors" (Goffman [1961] 2017, 4). Both mental asylums and prisons were contained spaces for systematically changing and rehabilitating the self (12). They sought to "reset[] the inmate's self-regulatory mechanisms so that after he leaves he will maintain the standards of the establishment of his own accord" (71), removing the individual's sense of autonomy and self-determination in the process.

Acknowledging that mental hospital patients were ill and in need of care does not negate that the structure of that care was centred around control, segregation, and moralism. From the early 19th to late 20th century, the systems and structures governing care for persons with mental illness were modelled on the same social control and detainment practices applied to prison inmates. The modern police mandate to maintain order and protect public safety echoes the function of asylums in sequestering persons with mental illness under the framework of safety and the perceived danger of madness.

Deinstitutionalization and its Effects

The mid-twentieth century saw a steady reduction in inpatient psychiatric beds, culminating in the eventual closure and reformation of mental hospitals. This process, termed deinstitutionalization, is often defined as the movement of psychiatric patients from residential hospitals to community-based alternatives (Lamb and Bachrach 2001). The second part of this definition—the idea that deinstitutionalization was meant to involve establishing high-quality community care and comprehensive social services deemed more preventative, humane, or effective than asylum care—has often been ascribed retroactively. In Ontario, there was never a clear-cut policy to discharge psychiatric patients from provincial mental hospitals to a network of community support services. Instead, deinstitutionalization began as the trend of discharging patients more quickly when the total patient population exceeded capacity and mental hospitals became increasingly overcrowded

(Simmons 1990). This process of discharging chronic, long-term care patients to make room for new admissions was made more palatable by the neuroleptic drug revolution in the 1950s, which promised to alleviate the symptoms of psychosis but proved insufficient in the absence of formal treatment (Scull 1977). The policy of deinstitutionalization was therefore "largely borne of fiscal and legal necessity and not of logically analyzed mental health considerations" (Sealy and Whitehead 2004, 249). Or as Simmons puts it, the policy was crafted to reduce the long-stay population in mental hospitals "regardless of what happened to the patients afterward" (Simmons 1990, 160).

Without any strategy or commitment to developing an infrastructure of community care,[21] deinstitutionalization amounted to little more than rapid dehospitalization and transinstitutionalization—the transfer of patients to alternative institutions such as nursing homes, general hospitals, and penitentiaries. Patients discharged from hospitals without access to counselling services, recreation, vocational support or a sense of belonging to the community were especially vulnerable to homelessness and incarceration.

Deinstitutionalization is a continuous process with social ramifications that extend beyond a mere shift in the locus of care (Lamb and Bachrach 2001). Persons with untreated mental illness may be inappropriately arrested for bizarre and disruptive behaviour that is hard to recognize as symptomatic. Law-enforcement officers may arrest a person with mental illness for a minor violation and take them to jail if they think that there are no other viable options for obtaining shelter and psychiatric treatment, an action known as "mercy booking" (Lamb et al. 2002; Morabito et al. 2014). The criminal justice system has thus assumed the place of mental hospitals in "becoming the system

[21] Until the 1980s, "community care" referred to psychiatric units in general hospitals and homes for the special care of elderly patients (Simmons 1990). Only in the 21st century has the term "community mental health" come to stand for something more closely resembling care—as in holistic services, social support, and emotional labour or "care work" (See Murphy 2015 on the politics of care). The extent to which these ideals are fully realized is a separate discussion.

that can't say 'no" (Lamb and Bachrach 2001, 1042), with the police facilitating the oscillation of the most severely ill patients between hospitals and prisons.

The current system is a decentralized conglomerate of underfunded, under-resourced and oversubscribed services that fail at upstream intervention, leading individuals with severe mental illness to be "rehospitalized in what has been termed the 'revolving door' of acute hospital admissions" (Yohanna 2013, 888). Because the Ontario *Mental Health Act* provides police with the sole authority to apprehend a person in crisis, the revolving door of acute hospital admissions is also the revolving door of police contact. As one of the social workers I interviewed stated, "The entire system is set up to rely on [the police] to engage in these mental health calls."

Ontario Mental Health Act

Decades before deinstitutionalization took hold, Ontario mental health law prescribed a role for police in facilitating the apprehension, examination and committal of persons with mental illness. In 1937, under Section 25 of the *Mental Hospitals Act*, anyone could bring information to a justice of the peace concerning a person "suspected or believed" to be "mentally ill or mentally defective." The justice of the peace could then issue a warrant for police to forcibly "apprehend" the person for examination by two medical practitioners. If the person was determined to be experiencing mental illness, they would be certified and committed to a provincial mental hospital. If found *not* unwell, the person could still be remanded to an institution for up to sixty days. Moreover, any person who appeared to be "conducting himself in a manner which in a normal person would be disorderly" could be apprehended by police at any time without a warrant.

The language used in the *Mental Hospitals Act* evinces the assumed relationship between mental illness and criminality. A person with mental illness was "detained," "imprisoned," or "confined" to a psychiatric institution. A patient could be "released on probation" to the "custody" of friends and family. A "warrant" was issued to apprehend people suspected of having a mental

illness or bring back patients released on probation and later deemed "defective." Patients who "escaped" institutions would be re-apprehended by police without a warrant. Anyone who "abetted" a patient to escape was charged a fine or imprisoned for thirty days if the penalty could not be paid.

Beginning in the 1960s, reforms to mental health law focused on extending patients' rights, raising the threshold for involuntary hospitalization, and introducing checks and balances for psychiatrists (Simmons 1990). However, the current *Mental Health Act* maintains much of the original language and procedures surrounding police "apprehension." Under Section 16, anyone can still bring information under oath before a justice of the peace regarding a person "apparently suffering from mental disorder." If a serious harm test is satisfied or the person is someone with a recurrent mental disorder who has responded to treatment in the past and poses a risk of harm when untreated, then the justice of the peace can issue a Form 2 order. Police are then required to take the person into "custody forthwith to an appropriate place where he or she may be detained for examination by a physician." Under Section 17, a police officer can apprehend a person directly and transport them to a psychiatric facility for assessment if the person is acting or is believed to have acted in a "disorderly manner" and there is "reasonable cause" to believe there is a threat of harm.[22]

The language of the contemporary *Mental Health Act* remains analogous to that of criminal law. For example, the criteria for involuntary admission is if a patient has a mental disorder that is likely to result in serious physical impairment of the person, serious bodily harm to the person, or serious bodily harm to others. Nowhere does the *Mental Health Act* define "serious bodily harm." Without a clear set of criteria, the operational definition used by many administrative review boards is the definition of bodily harm from the *Criminal Code of Canada* or the one laid out by the Supreme Court of Canada in the context of criminal law (Byrick and Walker-Renshaw 2016). In a province where wait times for mental health counselling and community psychiatry can extend from six

[22] *Mental Health Act,* RSO 1990, c. M.7. https://www.ontario.ca/laws/statute/90m07

months to one year (Moroz et al. 2020), police apprehension is the most expedient way to be seen by a psychiatrist. As such, appearing before a justice of the peace or calling the police during a mental health crisis is often the first step in requesting care.

Current mental health legislation adopts a police framework to conceptualize and respond to persons in crisis. Terms like 'disorderly behaviour' and 'bodily harm' resonate as much with the language of policing as with the psychiatric vocabulary found in the Diagnostic and Statistical Manual of Mental Disorders (DSM). Given the lengthy history of policing mental health, the fact that law enforcement officers serve as first responders for persons in crisis is not an accident of circumstances related to deinstitutionalization. Rather, mental illness is 'police property' by design, and the police "are expected to deal with this 'property' through means accessible to them" (Huey et al. 2022, 2), including through apprehension, detention or the use of force.

In the next section, I review the relevant literature on select models of crisis response. Each of these programs articulates a different vision of the role law enforcement should play in addressing the problem of mental illness.

Approaches to Crisis Response

The landscape of crisis intervention is a patchy, heterogeneous terrain. In North America, several alternative models for responding to persons in crisis have emerged, with significant variations in terminology, reach, and implementation. For this overview, I will focus only on *first intercept* emergency responses,[23] which can be grouped into three overarching, albeit somewhat arbitrary categories: the police-based CIT model; co-responder police-mental health clinician teams; and non-police affiliated mobile crisis units. It is common for these programs to emerge either directly or indirectly in the aftermath of spectacular police violence.

[23] Other approaches can include prevention and early intervention efforts (*intercept zero*) or later intercepts (detention, re-entry post-incarceration or institutionalization etc.) and case management services.

Police-based CIT Programs

The CIT model originated in Memphis, Tennessee, after a fatal police shooting involving twenty-seven-year-old Joseph Dewayne Robinson, a Black man with a history of mental illness and substance abuse (Rogers et al. 2019). Four White police officers responded to a 911 call from Robinson's mother, who was concerned that her son was using cocaine and cutting himself. After Robinson lunged toward the officers, he was fatally shot at least ten times, sparking protests from community members critical of the police mishandling of individuals with mental illness in acute crises (Sweeney 1999).[24]

In response, city officials used a seed grant from the local chapter of the National Alliance on Mental Illness (NAMI) to organize a community task force consisting of representatives from the Universities of Memphis and Tennessee, mental health and addictions professionals, mental health advocates, and law enforcement. The task force established the Memphis Police Department Crisis Intervention Team to reduce instances of injury and lethal force in police encounters with people with mental health and substance use disorders. When appropriate, the program would also divert individuals from the criminal justice system and into the mental health treatment system, serving as a "potent agent for overcoming the negative stereotypes and stigma associated with mental illness" (University of Memphis 2014). In the years prior, an average of seven people with mental illness were fatally shot by Memphis police annually. From 1987 to 1999, this figure dropped to just two people in total (Sweeney 1999). Press reports picked up on these results and the program's self-proclaimed track record of safe intervention, suggesting the Memphis model could be implemented in other municipalities to address local concerns over fatal police encounters with persons with

[24] The University of Memphis CIT website characterizes the community's reaction as an "angry protest against the officers with cries of racism and police brutality." In contrast, the subsequent response by city officials is described as such: "Calmer voices prevailed calling for the community to develop a better way to intervene with individuals in mental health crisis" (University of Memphis 2014).

mental illness (ibid). CIT has since become recognized as a "Best Practice" model and has grown to over 3,000 programs across the United States, Canada, the United Kingdom and Australia.

The Memphis program articulates a series of CIT core elements. The first component is a 40-hour CIT training for self-selected, volunteer officers that covers mental health topics such as signs and symptoms of mental illness, de-escalation skills, site visits with persons with mental illness in the community, and presentations given by families and advocates on community resources (Usher et al. 2019). Some agencies have opted to make CIT training mandatory for all patrol officers. However, a key component of the original design is that the training is only volunteer-based. The rationale is that volunteer officers are already predisposed to having an interest in handling mental health calls; not all officers possess a suitable disposition for crisis work. The second component involves training dispatchers to recognize mental disturbance calls and preferentially assign CIT-trained officers to respond. The third component is to identify a central designated psychiatric emergency drop-off with a no-refusal policy to minimize police officer transfer time and ensure officers can quickly return to patrol after encountering persons experiencing mental illness (Watson and Fulambarker 2012). CIT International emphasizes that this approach to crisis response is a relationship-driven collaboration between law enforcement, behavioural health professionals, persons with lived experience, family members, and advocates of individuals with mental illness.

Although CIT has been rapidly adopted by police departments across North America and touted as a best-practice model, there is not enough research to establish that it is an evidence-based approach (Compton et al. 2008; Taheri 2016; Watson and Fulambarker 2012). To date, there have been no randomized controlled trials of CIT.[25] Quasi-experimental designs frequently rely on self-

[25] Conducting a randomized control trial would involve significant obstacles around blinding, consenting participants, and maintaining model fidelity (Puntis et al. 2018). Prospective studies are not the only way to measure the effectiveness of an intervention, but their absence speaks to the relative dearth of evidence overall.

reported, officer-level outcomes to assess the effects of CIT on its stated aims. One of the most promising findings indicates that CIT-trained officers are less likely to arrest persons in crisis and instead refer them to community services or transport them to psychiatric treatment facilities (Compton et al. 2014). However, this self-reported reduction in arrests of persons with mental illness is inconsistent with official arrest statistics, which show no difference in arrest frequency between CIT and non-CIT officers (Rogers et al. 2019). Similarly, CIT-trained officers report improved attitudes toward persons with mental illness and greater confidence in handling mental health crises than non-CIT officers; however, this may be attributed to CIT's self-selecting, voluntary nature (Compton et al. 2008). Meta-analyses indicate that CIT has no impact on use-of-force outcomes and has not significantly decreased the number of individuals killed or injured in mental health calls (Rogers et al. 2019; Taheri 2016). Furthermore, the 40-hour CIT training has become a checkbox for police departments facing pressure to address systemic issues but unwilling to commit to substantive changes (Westervelt 2020).[26]

Despite conflicting assessments of its efficacy, the CIT model continues to flourish. In a scathing critique, Geller describes this phenomenon as the prioritization of fashionable social policy change over evaluated treatment interventions, with the result being that CIT "might just as well stand for Consecutive Interventions without Treatment" (Geller 2008, 58).

Co-responder Police-Mental Health Teams

Of the different approaches to crisis intervention, I have chosen to focus on co-response teams as spaces where the relationship between mental health and policing is made most explicit. The co-response model pairs a mental health clinician (typically a psychiatric nurse or a social worker) with a

[26] CIT has been identified as the gold standard in police mental health training. Only nine of the forty hours are dedicated to learning and practicing de-escalation skills.

police officer trained in crisis intervention.[27] While the earliest examples developed along a similar timeline as the Memphis model,[28] co-response is being increasingly identified as an improvement to the shortcomings of the police-only CIT model, particularly the limited impact of de-escalation training in changing the decision to use deadly or injurious force (Rogers et al. 2019). Co-response expands on the theory that increased collaboration between the police, mental health providers, and psychiatric emergency services will improve interactions with persons with mental illness. In a joint response, police bring their experience handling violent and potentially injurious situations, while clinicians provide mental health consultations to officers and care to persons in crisis (Shapiro et al. 2015, 607). Co-responding officers typically receive standard CIT training, which may be supplemented with an additional eight hours of Advanced CIT, ASIST suicide prevention and Safe Talk training. According to my interlocutors, the officer's role within the MCRRT pair is "to keep people safe, but also to help."[29]

Like CIT, co-response programs are highly variable in their mandates, operations, and availability. They go by a variety of names corresponding to an array of discrete acronyms. In one variation, crisis triage workers answer calls from a non-emergency crisis line, performing intake and risk assessments. When possible, triage staff attempt to de-escalate calls directly over the phone. For non-emergency calls that require in-person intervention, phone staff dispatch a COAST unit consisting of a mental health worker and a plainclothes officer in an unmarked vehicle. COAST will conduct an on-site mental health assessment, help the person in crisis develop a safety plan, and

[27] There is some discrepancy over which model "co-responder" refers to. In the academic literature "police co-response" or "co-response crisis teams" refer to this combined police-clinician ride-along format. This is at odds with the understanding of the individuals actually involved in these teams and in other police-based approaches, for whom "co-responder" refers to two mental health clinicians responding without police involvement. I have chosen to use the former consistently throughout to avoid conflicting with the academic literature.

[28] The first co-response program in Canada, Vancouver's single-unit Car 87, was established in 1978 and formalized in 1987.

[29] I wonder if these are incompatible in some way.

refer them to other community programs or agencies. In some cases, COAST will also conduct follow-up visits to a person's residence following an initial crisis response.

Other co-response teams offer rapid or emergency response services. In Ontario, these programs are typically called MCIT or MCRRT. MCRRT units are dispatched by police services in response to 911 calls and cannot be formally requested by the public. In some programs, these teams act as first responders and are dispatched directly to crises. In other instances, such as the Toronto Police Service, MCIT is strictly a secondary response only sent when the regular patrol unit has already responded and assessed the situation as safe (Lamanna et al. 2015). In Ontario, MCRRT officers are typically employed by the local police service and supervised by a Staff Sergeant. The co-responding nurses and social workers are embedded within the police service but employed by a partnering hospital or the local branch of the Canadian Mental Health Association (CMHA) and supervised by a mental health team manager.

Tremendous variation across programs has made it difficult for researchers to assess the outcomes and underlying mechanisms of disparate co-response teams. Some studies indicate that persons in crisis have more positive experiences with MCRRT than regular patrol officers. Where persons in crisis expressed fears of police based on previous traumatic interactions and times when they felt treated like criminals, MCRRT units were comparatively able to de-escalate situations calmly and compassionately (Kirst et al. 2015; Lamanna et al. 2015). While there is mixed evidence that co-response models reduce overall hospitalizations, research indicates that co-response teams are more likely to transport persons in crisis to the hospital voluntarily over involuntary apprehension (Shapiro et al. 2015; Puntis et al. 2018). It is unclear whether this is because MCRRT units are dispatched to less severe situations or because they can better support persons in crisis in reaching a voluntary decision. Increased voluntary transfers may also account for the shorter average time co-response teams spend waiting in the emergency department, as police are only required to

wait until a person in crisis is admitted to the hospital in the case of involuntary transfers (Lamanna et al. 2015).

One of the major limitations of MCRRT is its availability. In 2020, the Peel MCRRT only responded to about 35% of the mental health calls police received (Miller 2021b). In Toronto, the co-response program only attends 11% of mental disturbance calls (Iacobucci 2014).[30] Even though co-response teams heavily emphasize their role in linking persons in crisis with community mental health services, both clients of these services and MCRRT staff lament that there are no effective pathways to receive the treatment and care needed to prevent future crises (Lamanna et al. 2015; Puntis et al. 2018). One clinician explained that there are insufficient psychiatric in-patient beds, forcing individuals to leave the hospital before they are ready and leading to subsequent crises. If they "weren't pushed out the door so quickly, we wouldn't have these people coming back to our attention. There are discharges where somebody gets seen by us within twenty-four to forty-eight hours after they were discharged. That should never happen."

Overall, there is little research to determine whether MCRRT averts the escalation of force and injuries, improves officer perceptions of persons with mental illness or is cost-effective. Like the CIT model, "there is a striking lack of evidence for the effectiveness of co-response models of triage despite the substantial investment these services have received" (Puntis et al. 2018, 9). The heterogeneity of co-response programs "creates a problem of circularity, whereby service providers cannot follow good practice guidelines because there are none," and good practice can't be established because the idiosyncrasies of each program make them difficult to compare (8).

[30] News articles that champion the co-response model frequently present misleading statistics. For example, the Toronto Star reported that in its first month, the Peel MCRRT program diverted 70% of mental health calls from the hospital (Gamrot 2020a). However, MCRRT only responds to 35% of the roughly 6,500 mental health calls Peel Regional Police receive each year. It would be more accurate to report that 70% of the calls MCRRT responded to did not result in apprehensions, which is not equivalent to "diversion," as it is not clear how many of these would have ended up in the hospital without the MCRRT program.

Non-police Mobile Crisis Units

Groups like Doctors for Defunding the Police call for emergency mental health services to move away from the police entirely. The most frequently cited example of this model is the Crisis Assistance Helping Out on the Streets (CAHOOTS) program in Eugene, Oregon, which was formed as a collaborative initiative between the White Bird Clinic and the Eugene Police Department in 1989. The White Bird Clinic, initially established in 1969 as a counterculture collective, operates a medical clinic, drug-alcohol treatment program, and counselling services in addition to its crisis response team. The program's name is a nod to the fact that the grassroots community agency is now in 'cahoots' with the police.

In the CAHOOTS model, a medic and a crisis worker are dispatched through 911 communications to stabilize urgent medical needs or psychological crises while providing assessment, referrals and transportation to further treatment services. In calls where crime, violence or a life-threatening emergency is reported, CAHOOTS will call the police for backup or is dispatched as a joint response. Of the over 18,000 calls CAHOOTS responded to in 2021, police were called for backup an average of 2% of the time (EPD 2022). The program estimates that it diverts 3-8% of calls from the police, saving the city $8.5 million in public safety spending (White Bird Clinic 2020). The group now offers training and guidance to municipalities who want to start similar programs.

In the last two years, CAHOOTS has been identified as a promising alternative to police response for non-violent mental health crises in hundreds of American and international media reports, including a docuseries created by Oprah Winfrey and Prince Harry (Kapadia and Porter 2021). This praise was not, however, echoed among the officers or mental health clinicians I interacted with. Presenters at the CIT International Conference appeared to begrudge any mention of CAHOOTS, with one speaker even opening his presentation by declaring, "We don't say the C-

word here." The main critique of the non-police mobile crisis model is that it risks clinician safety by placing them in unpredictable and potentially dangerous situations. One of the crisis nurses I interviewed noted that "some of [her] most violent, threatening calls have come in as something that sounded like nothing." During a ride-along, another clinician shared how, on her first MCRRT shift, she tried to kneel to talk to a person in crisis at eye level and failed to notice that the ground was covered in feces and used needles. The officer she was partnered with, trained to assess a scene for potential hazards, noticed the needles and pulled her back.[31] She believes that having a partner who is "always thinking about liability and safety" creates a space for her to perform an intervention without having to think about those things.

Resistance to this model also stems from exasperation with the public claiming to know the best approach to crisis response, a grievance that came up frequently throughout my fieldwork. In the words of one of the clinicians I spoke to: "Something I've found is that people who do this job would rather have a cop with them. People who don't do this job think that the police have no business in mental health."

Even still, many cities across North America have begun to pilot similar projects. After several months of protests throughout 2020, Portland, Oregon, piloted the Portland Street Response, a non-police crisis team consisting of two community health workers, a mental health therapist and a paramedic. In September 2022, Peel launched a pilot clinician crisis response team through conversations with CMHA, Roots Community Services, and Punjabi Health Services. However, the program has struggled to hire enough mental health workers to complete the model (currently, there are only three crisis workers on staff), in part because funding for the program

[31] It is dubious that a nurse would not notice these obvious hazards given that the first step of first aid is always to survey the scene and consider your personal safety before intervening. However, my interlocutors provided other example scenarios to support the need for a police joint response (e.g., the presence of hidden weapons).

comes from separate government grants and is not taken directly out of the police budget (Dickson et al. 2022).

What is at stake?

What cuts through in all of this is the urgency of a solution. Throughout my fieldwork, the most common response I have gotten when explaining my project—to friends, guest speakers, and interviewers—is that the research I am doing is "really important" and "something must be done."

What's harder to grasp is any consensus about what that *something* is. Compiling a list of the stated aims of different crisis intervention programs, even those with similar operations from within the same crisis response model, produces a refracted picture. Many of these disparate objectives exceed therapeutic aims. They include: de-escalating crisis situations; reducing the risk of injury or death to the persons with mental illness and/or the responding officer (Rogers et al. 2019); diverting persons in crisis from the criminal justice system (Bailey et al. 2018); diverting persons in crisis from the emergency department (McKenna et al. 2015); referring individuals experiencing psychic distress to community resources (Blais et al. 2020); reducing the unnecessary engagement of law enforcement in non-criminal or non-medical matters (Chapman et al. 2020); relieving the pressure on front-line officers and emergency rooms (Semple et al. 2021); de-stigmatizing mental illness amongst the general public; improving cost-effectiveness (Shapiro et al. 2015); and raising awareness and educating officers on the complexity of mental illness and appropriate responses (Compton et al. 2014).

After going on ride-alongs and conducting interviews throughout the summer, I felt I had a hold on the subject, however equivocal. But when I attended the CIT International Conference in Pittsburgh, what I found was unrecognizable. A set of wildly different actors across multiple geographies shoehorned into a singular vision of crisis intervention, yet each espousing a contradictory approach. In one session on oversight in CIT programming, a presenter explained the

importance of re-training officers whose actions conflicted with the principles of mental health de-escalation, not because it could help improve client outcomes but because "you might just be able to save an *officer's career*."

If these alternative crisis response models are solutions, is there even a shared understanding of what the problem is?

CHAPTER TWO: VISIBILITY AT WORK

> The exercise of power is always an exercise in activating selective in/visibilities.
> –Andrea Brighenti (2007, 339)

This chapter is a meditation on the concept of visibility and the heterogenous ways it operates in crisis response. Drawing on my fieldwork and interview data, I outline how co-response organizations negotiate the tension between transparency and obscurity in their work. I trace the contours of the complex politics of seeing that dictate which elements of crisis intervention are rendered visible and what is conversely left unseen. Finally, I examine the impact of new forms of mediated visibility on persons in crisis. The "publicness" or visibility of a crisis is what sustains law enforcement contact and enshrines mental health within the frameworks of policing, public safety, and order maintenance.

Fieldwork: Riding Along

Several months before beginning my fieldwork, I contacted the hospital manager of an MCRRT team in Southern Ontario to discuss the possibility of doing participant observation and recruiting their staff members for interviews. After meeting with me twice, forwarding my research materials and ethics certificate to the hospital director for approval, and briefly introducing my study during a staff meeting, the manager agreed to distribute my interview recruitment notice to the team and connect me with the partnering police precinct to arrange ride-along shifts.[32] The manager was generous with their time, following up with me on multiple occasions to ask how my research was progressing, whether I had any difficulties attaining the necessary police clearances and if there was

[32] As noted in chapter one, most co-response teams operate out of the local police station. Although mental health workers and police officers are dispatched jointly and work together, they have different employers and report to different supervisors. I had received the "green light" from the hospital to recruit interview participants but needed to apply to the police department separately to obtain ride-along permissions.

anything else they could do to support my work. Their willingness to advocate on my behalf in securing these clearances reflected an expressed desire to expand the body of research on crisis intervention, which remains limited, but also that I might personally benefit from seeing the MCRRT program in action. In their words: "I hope it is a great learning experience." Despite the hospital manager's support, scheduling with this police precinct remained challenging. My request was passed up the chain from the Sergeant in charge of supervising the crisis response branch to the Staff Sergeant for special approval, which seemed to surprise the hospital manager as ride-alongs with these teams are a relatively common occurrence.[33] Over a dozen emails and two months later, I finally had a confirmed date for a ride-along.

When I arrived at the precinct on the agreed-upon date, there was a problem. A new mental health hire was being trained that day, and there were not enough seats in police vehicles for both of us. Since mental health trainings are scheduled independently by the hospital, the Sergeant was unaware of this when he suggested the best times for me to observe and only learned of it when he came into work that morning. Apologetic, he called the staff member in charge of hospital scheduling to "get this sorted out," only to discover that not only was she not aware I was coming in today, but she had never even heard of me or my study. This surprised me, as the hospital manager had sent an email introducing me directly to this staff member.[34] By this point, I had been actively conducting interviews for a few months. I had already participated in two ride-alongs with mental health workers employed by the same hospital but embedded in a different police precinct. Still, I had caught her off guard. My attempts to clarify my identity by referring to my various

[33] This MCRRT group has mentored other organizations looking to establish similar crisis intervention programs. According to one nurse, they have had ride-alongs with officers and officials from British Columbia, Nova Scotia, Australia, and the United States.
[34] She did not reply to this introduction or my two follow-up emails. The hospital manager took personal leave a week before the scheduled ride-along, significantly contributing to the confusion.

correspondences with the hospital manager and police department did not seem to alleviate the tension and suspicion surrounding my presence.

After two and a half hours of back-and-forth, it was decided that I could accompany one of the MCRRT units for the day. However, owing to the vehicle situation, we would be placed in a regular, non-police minivan with no dispatch monitor, effectively preventing the unit from responding to calls. The hospital administrator apologized for the mix-up and proposed I send her a selection of alternative dates to coordinate a replacement shift for me to observe, saying, "We want to make sure there is no one being trained next time, and you have a good experience." Another month of calls and emails passed before I realized I had been shut out.

The problem of access, while a common feature in anthropological fieldwork, poses a particular set of obstacles in arranging police ethnography. This is perhaps best exemplified by Didier Fassin's efforts to undertake participant observation 'inside' law enforcement spaces, as chronicled in *Enforcing Order* (2013). Although Fassin conducted fieldwork accompanying an anticrime squad in the banlieues of Paris from 2005 to 2007, his subsequent attempts to replicate the study in other police districts were frustrated by bureaucratic authorizations extending well beyond the local police hierarchy. Fassin writes about his multiple attempts to gain re-entry into the world of the police, including his decision not to publish or present his findings to avoid any public-facing materials interfering with his bids to secure the necessary permissions. Despite his extensive academic credentials and support from authorities such as the minister of higher education backing his research request, Fassin's efforts to gain access were circumvented for six months.[35] The request was transferred from one department to another, each time accompanied by instructions to wait for approval from increasingly senior officials and assertions that such research was certainly welcome

[35] At the time of his initial police study, Fassin was already a double doctorate, professor at the University of Paris North, and Director of Studies at L'École des Hautes Études en Sciences Sociales.

pending the appropriate sign-off, only for communications to end in a circuitous and fruitless loop. After receiving a final letter of refusal from the cabinet of the minister of the interior, Fassin concludes that the sort of in-depth ethnographic study of policing he had conducted a few years earlier had now become "impossible" (Fassin 2013a, 14).

While Fassin attributes much of this to the particular politics of France, namely the tremendous powers of censorship exercised by the Ministry of the Interior in restricting all varieties of police research and penalizing individual officers for breach of secrecy, his recounted tribulations are valuable in signifying the distinct institutional resistance of law enforcement to external scrutiny and, more specifically, ethnography as a form of inquiry predicated on bearing witness. On ethnography as fieldwork, Fassin writes: "Because it allows witnessing where those in power do not want evidence of what is ongoing to be seen, [ethnography] can be an object of avoidance, suspicion or prohibition—much more than is the case for questionnaires or interviews, which only give access to discourses and are carried out with no difficulty (Fassin 2013b, 630)."

Putting aside the question of whether interviews can be rightfully considered ethnographic (Hammersley 2006; Hockey and Forsey 2012), I wish to challenge the assertion that they are always carried out with no difficulty. If, as Fassin says, "secrecy and opacity are the rule, disclosure and transparency the exception" (2013a, 14) in law enforcement, then the presumption of people's ready willingness to grant access even to plain discourse is a fallacy. Indeed, police chiefs regularly sit for interviews with journalists, especially when responding to public inquiries about the use of force. However, this controlled engagement in public discourse is restricted to the upper echelons of the police hierarchy. It is motivated by a pragmatic interest in good publicity rather than any particular affinity for the production of knowledge. Despite his dismissal of interviews as discrete from ethnographic fieldwork, what Fassin makes clear is the extent to which access problems when investigating sensitive topics like law enforcement stem from the threat of transparency. To the

degree that ethnography is exceptional in arousing anxiety or suspicion, it is because the anthropologist's physical presence in occluded spaces serves as a continuous visual reminder that the researcher's findings might, as one hospital administrator I encountered put it, "come back to bite us."

My own difficulties retaining access to police-clinician units over the course of my fieldwork were quite similar. Considering traditional ethnography takes place over a long period, at least a year if not several years (Hammersley 2006), and my timeframe as a master's student would be condensed to a couple of months, the primary driver for selecting my topic of study was project feasibility. My initial research queries were all met positively, and I was buoyed by the perceived eagerness of my crisis intervention contacts to engage with this work. I approached one group in Québec through their public contact information. I received a response from a City official offering to facilitate interview access and "any information that you might need concerning the project." I sent follow-up letters, noting I had obtained ethics committee approval and a major grant from the Social Sciences and Humanities Research Council, to no reply. No matter how interested or excited my contacts seemed at first, my efforts to gain access from either the clinician or police side inevitably met the same dead-end.

Whereas transparency is a central component of the community policing model (IACP 2018), the operations of specialized Crisis Intervention Teams remain obscured in many ways. In my fieldwork, the tension between transparency and obscurity was manifest in the contradiction between my contacts' initial eagerness to invite me 'inside' police-clinician spaces and their resolute control of knowledge when I found the doors of entry unexpectedly closed. Attending to these pressure points when access is conditionally given or taken away provides insight into what the interlinked policing and healthcare institutions "seek to show or, on the contrary, hide" (Fassin

2013a, 21). In the next section, I take up this first point and reflect on the kinds of labour co-response teams seek to make visible.

Unseen Labour

"I want to explain myself a little here before we get going so that you don't think I'm standoffish," MCRRT Officer Jason said when we finally left the precinct in a minivan on the afternoon of the largely unrealized ride-along. I had spent the preceding hours answering question after question posed by the hospital staff, mental health nurse, and police Sergeant to corroborate my identity and pinpoint where the miscommunication had originated. Throughout these exchanges, Jason spoke very little. He appeared visibly annoyed, silently fuming. Now, in the car, he voiced his exasperation:

> I'm frustrated. I'm upset because I knew about this [ride-along] a month ago. I have been cc'd on emails about this for at least a month, yet now we find ourselves not in the proper police car. I don't have access to the dispatch system. I'm normally excited to take people along, to show people what we do, because I don't know what your biases are. I don't know if you think Police are just thugs. I want to be able to show you that we are doing good work, and I'm not going to be able to do that today.

Later on, he reiterated how he had taken psychiatrists, public officials, mental health workers and other police officers on ride-alongs in the past. He saw them as a valuable way for people to learn about and better understand crisis response, welcoming the opportunity to show the public that MCRRT does good work.

I want to call attention to the relational quality of what Jason terms "good work," the fact that the success of co-response programs is intimately connected to the visibility and public recognition that what they are doing is good. As I established in chapter one, crisis response teams often emerge as a result of heightened scrutiny of policing and demands for change in how the police interact with persons experiencing mental ill-health. However, from Jason's perspective, "people within the community itself don't always know about the work that we are doing," making it difficult to demonstrate how the police are responding to public calls for action. The project of co-

response teams is therefore not only to do good work by performing interventions, de-escalating crises, and providing referrals; equally critical is the task of drawing public attention to this labour and selectively "bringing the invisible back to visibility" (Brighenti 2007, 327).

The mental health workers I interviewed uniformly agreed that the work of police officers, both in the co-response model and on regular patrol, is frequently misunderstood by the public because of the asymmetry between what actions get narrativized or captured in the media and what disappears from public view. Whereas stories of fatal use of force are visually salient and can become the subject of extensive news coverage, the more mundane police work and everyday practices are rarely reported. As Julia, a mental health nurse who values the close partnership she shares with MCRRT officers stated:

> We hear all about the shitty stuff and the bad stuff that happens, but for every bad incident, there are a thousand good ones where officers are responding to a delusional old lady and making her a cup of tea and tucking her in bed. And there's cops helping people change their tires and helping new moms in crisis. None of that stuff gets talked about, and that stuff is meaningful and like glue in the community.

For Julia, the daily labour of "what actual community policing looks like" is obscured by the exceptional reports of fatal encounters between officers and individuals with mental illness.

Other clinicians echoed this sentiment that for every bad incident, countless mental health crises are successfully resolved without the use of force (Clifford 2021). According to Robert, an MCRRT nurse, "If people knew the amount of calls we go to, and the amount of good outcomes and the near misses, the almost tragedies—if they understood the percentage about how well things are done, how many times we actually pull a rabbit out of a hat when circumstances look so dire, they would be amazed." Leia, an MCRRT social worker, acknowledged that the public perception of the police reflects real problems in systemic racism and the mistreatment of minority communities. However, she also believes the public lacks awareness of the sheer volume of calls that patrol officers receive, most of which are successfully de-escalated, because "you only hear about the ones

where they didn't de-escalate and something went wrong." Leia recollected a recent call she attended in which an officer calmly approached a man threatening his girlfriend and himself with a knife. The officer verbally de-escalated the situation and got everyone out of the house safely without using force. From the purview of a citizen accompanying police on these calls, Leia is a regular witness to situations like this, where the potential for violence is forestalled through police action. While she is able to recognize these instances as examples of "the good that does happen" in everyday police work, this labour remains invisible to the general public: "We don't hear those stories because nobody got it on media because it happens all the time."

Ride-alongs are therefore an important pedagogical tool for MCRRT groups engaging in what Rob Mawby (2002) calls "image work," defined as the activities through which police forces shape the police image to communicate and preserve organizational legitimacy. These activities include overt public relations enterprises, such as the RCMP rebranding "use of force" incidents as "police interventions" and reinscribing weapons tactics as "intervention options" (RCMP 2022). They also include the symbolic and mundane actions that produce social meanings of policing, such as MCRRT units visiting group homes on slow days to establish themselves as non-threatening and reassure residents of their benevolence in the event of future crisis calls. Image work is an exercise in the strategic re/direction of attention, the operation of police power by enhancing the visibility of certain activities and symbols rather than others. Changes to the MCRRT uniform, including removing the traditional red stripe on the side of the officer's pants and adding a patch that reads "Crisis Team" to the front of their vests, are intended to minimize visible markers of the police and instead direct attention to their shared role with mental health crisis workers. Similarly, ride-alongs counteract public perceptions of excessive use of force by showing participants that violence is absent in the average MCRRT shift, heightening the visibility of aspects of the job like call volume,

successful de-escalation scenarios, and community work that are not captured in the media but 'happen all the time.'

The co-response model is itself a form of image work that cultivates the police's reputation as guardians of safety and members of the helping professions. The clinicians I spoke to asserted that, except for "a few bad apples," most police officers enter the job to help people. As Robert explained, "the anti-police culture in North America" is not at all justified because "the majority of people who become police officers are people who want to help people. And their motivation and their character is [such that] there's very little difference between them and a firefighter, or them and an EMT, or them and a doctor, or them and a nurse." Robert glosses over the crucial distinction separating the police from all other first responders, namely their unique capacity for state-sanctioned violence and lethal force. Rather, he positions law enforcement as on equal moral footing with healthcare practitioners. By design, MCRRT programs bolster the claim that the police are indistinguishable from the caring professions by concretizing this association in visual form. Driving around in a police vehicle, responding to calls in tandem, and adopting the matching aesthetic of Crisis Team bulletproof vests, the police are seen and represented as equal partners with mental health workers. One mental health worker summarized the political function of this shared visibility, saying: "I've heard comments from [police officers] in this job like: 'Well, we've been doing 911 calls, mental health calls for our whole careers, so this partnership is just for public perception'…There's a level of the police trying to prove that they're good by using us [mental health workers] to do that." Though the police-clinician partnership may be geared toward meeting the needs of persons in crisis, it also plays a critical role in advancing the police image.

In consideration of Jason's keenness to demonstrate the good work MCRRT is doing and mental health workers' objections to the poor public understanding of what the police do on a daily basis, I got the sense that my interlocutors "may have thought that, through what I saw and heard, I

would become a sort of witness to their moral probity" (Fassin 2013a, 29).[36] I also came to realize that, despite the legitimation afforded by bringing MCRRT's activities into public view, there is a point at which uncontrolled visibility becomes threatening. For all the authority conferred by being seen to be doing good, there is always the possibility that widening the field of visibility will expose hidden harms or that what is seen will be interpreted in unfavourable ways. In my case, my capacity for witnessing good work was tempered by the fact that my gaze during crisis intervention scenes could not be easily managed, and my observations were in the service of research, not publicity or program reproduction. In a standard intervention, the MCRRT unit is the one who looks, while the person in crisis is the one who is looked at.[37] Being co-present during these calls, I became enfolded in this economy of looking—a bodily extension of the visual field. Even as a small-fry graduate student, my role as a researcher was met with a level of institutional apprehension that it appears other ride-along participants were not subjected to, suggesting that the politics of transparency are not so clear-cut.

Mediated Visibility

Co-response teams have a strategic interest in not only which actions are brought into public view but also "in *how* their personnel and activities become visible to others" (Goldsmith 2010, 915). The officers and clinicians I spoke to expressed concerns over the upsurge in bystander video recording as a form of 'making visible' that interferes with getting persons in crisis the help they need or deliberately misrepresents MCRRT's conduct in civilian encounters. Prior studies on police attitudes toward bystander video have found that officers are bothered by the physical use of cameras and the

[36] During scheduling, Sergeants wanted to ensure I was riding along with their most experienced officers and clinicians, not the backfill from regular patrol who fill in during holidays and absences. I interpreted this as both a safety consideration (experienced MCRRT units have accommodated ride-alongs in the past) and a matter of perception (a desire for me to see only the best MCRRT offers).
[37] See Brighenti's discussion of gendered asymmetries in seeing (2007, 330-331).

spatial proximity of bystanders getting in the way of their work (Newell 2021; Sandhu and Haggerty 2017). These issues present an additional concern for MCRRT, as mental health interventions are intended to be confidential. Officer Jason pointed to instances when homeless individuals called 911 to request MCRRT, only for activists protesting the police from within encampments to film these encounters and thereby prevent police-clinician teams from providing crisis services. Jason said, "If it weren't for all the protestors, we would have a lot more success strengthening our relationship with the individuals in these encampments."

In addition to concerns about bystander interference, my interlocutors expressed anxieties over the loss of context in video clips and the capacity for civilians to intentionally manipulate recordings to portray co-response teams in a negative light. Deborah, an MCRRT social worker, described an encounter from a few years ago when she and her partner were dispatched to respond to a man standing in the street and behaving erratically. "He's one of those guys who is preaching about his religion, and I went to talk to him, and yeah, he's a little bizarre," Deborah explained. Although the man was not experiencing a mental health crisis, this was his seventh interaction with the police in one week of sidewalk evangelism. Every single day, a different member of the public reported him. MCRRT frequently receives calls in more affluent areas about panhandlers or people acting "bizarre" in public spaces, but this particular call lingers with Deborah because it was caught on camera:

> I always remember that encounter because somebody recorded us. It was when the whole 'we hate police' thing was going on. Somebody was recording us for fear for his safety. And I couldn't believe that I just gave this guy money and listened to him for like ten minutes tell me about his religion, took his pamphlets, treated him with so much respect. And you were worried that—like you are going to cut this video, so it just looks like we are harassing him.

Deborah's indignation at being filmed during an otherwise innocuous civilian interaction speaks to the "crisis of visibility" (Haggerty and Sandhu 2014) brought on by new technologies of witnessing. As Andrew Goldsmith writes, visibility plays a critical role in retaining police legitimacy and shaping

public perception because it "invites assessments of the propriety (or rectitude) of their behaviour" (Goldsmith 2010, 914). This visibility was traditionally limited to only those directly involved in police-civilian encounters, making it much easier for police organizations to control the conditions of public seeing and communicate their lawful authority through image work. However, new forms of mediated visibility (e.g., CCTV footage, bystander videos, social networking platforms) allow police behaviour to be witnessed by audiences far removed from the original spatial-temporal locale, opening officers up to heightened scrutiny, accusations of misconduct, and public rebuke (ibid). In the literature on this new visibility (Thompson 2005), one of the most common reasons officers give for being apprehensive about bystander video is that "the ten-second clip taken out of context" does not capture the sequence of events leading up to an officer's decisions, particularly regarding the escalation of force (Newell 2021, 86). Deborah echoed a similar sentiment that videos recorded by members of a vigilant public often lack the situational context necessary to interpret an officer or co-responder's conduct accurately. "People just see these little clips [online] and then miss the whole of everything else going on," she said.

What is distinctive about how the anxieties and tensions around mediated visibility manifest in crisis response compared to regular patrol is the perception that bystander footage decontextualizes not only an officer's conduct but also the complexities of mental illness and the circumstances leading a person to experience a mental health crisis. Deborah narrated a case in which an MCRRT officer might use force to subdue a person in crisis:

> A situation looks really bad, but we have done everything we can, and nothing has worked to that point. [Let's say] your son was tased. However, you're afraid he's going to murder you, and he's been a barricaded person for four hours now. We've been trying to negotiate, and we can't. And he started swinging at officers, so unfortunately, he was tased. We try to do everything as least intrusive as possible. So when people see that brief clip of 'look at those horrible officers,' you missed hours, if not months, of build-up. People can become very, very unwell. People can hide it.

The 'loss of context' Deborah invokes in this imagined example is two-fold. First, a video recording offers limited coverage of the encounter because it is cut down to a brief snippet that does not show all the work that goes into an intervention, the ways co-responders attempt to negotiate or de-escalate a high-intensity situation, or the actions the person in crisis takes that cause police to respond with force. More notably, it fails to capture the cumulative, festering quality of mental illness. The potentially months-long decline that went unnoticed, the years of chronicity that precipitated this particular crisis. What the public does not see is just how "very, very unwell" a person can become.

Deborah's statements signal the enduring illegibility of mental illness and the narrow circumstances under which a person's deteriorating mental health becomes actionable. The clinicians I interviewed identified psychiatric disorders, untreated trauma and suicidal ideation as some of the most pervasive issues they encounter daily. As one clinician put it, these forms of psychic distress are "happening all around [us]…all day, every day." Yet, they remain invisible to others because they do not manifest in immediately obvious physical ways (Masana 2011).[38] People may further attempt to hide their symptoms to avoid stigma, guard against shame, present the social ideal of health, or because they lack self-recognition of their illness. As a result, the severity of a person's mental illness may not be known until it escalates and reveals itself as a crisis. According to one MCRRT nurse, unless a crisis registers externally as such and first responders are called early enough, "no one would have had any clue that it was happening in front of them."

[38] Even when symptoms involve a noticeable change in physiognomy (e.g., psychotic disorders, substance use disorders), persons experiencing mental illness remain invisible to the social gaze in so far as they are 'seen' but not recognized, accepted or legitimized (Masana 2011, 139). For example, persons experiencing psychosis are "seen as an identifiable figure, for the most part because of their visibly 'strange' behaviour (Cross 2004, 212). The experience of being unwell is recognized only as visual *wrongness*, as "visible differences of appearance and behaviour that demarcate a symbolic boundary between 'us' and 'them" (199).

If crisis is what brings a person's declining mental health to the attention of MCRRT for it to be intervened upon, then violence in these encounters is what makes persons in crisis visible to the public. For many people without lived experience of mental illness, either personally or as a caregiver, knowledge of what crisis looks like, who the mad are, and what it means to be unwell is derived from public representations and iconographies of mental illness. In cinema and visual art, images associated with madness—unkempt hair; straitjackets and other restraints; wasting bodies; uncontrolled physical movements; audible dialogues with oneself—produce and reproduce the cultural category of mental illness. Although incomplete and sometimes inaccurate representations, they "enable the intended audience to recognize that it is madness that is being portrayed" (Cross 2004, 19). With the rise of new forms of mediated visibility, images of fatal mental health interventions circulated on social media and the news have superseded traditional visual forms and become a predominant source of information about mental illness (Clifford 2021, 159). The consequence of this new visibility is that persons in crisis "become known publicly through the images capturing their contact with the police" (16), that is, through videos like the ones Deborah described that depict police officers using physical force. Increasingly, images of violence are how viewers recognize that what they are witnessing is a person in crisis.

In drawing attention to the spectacle of police violence, bystander videos obscure the structural and everyday forms of violence that make individuals vulnerable to crises in the first place. Although these images draw attention to the problem of untreated mental illness, they ultimately perpetuate the illegibility of psychic suffering because only hypervisible events are registered. Crisis becomes recognizable only through the framework of violence.

Public Crisis

In addition to fielding calls in line with their express mandate to perform mental health interventions, MCRRT responds to many inappropriate requests for police assistance. Julia and her

coworkers coined the term "Botox Karens" to refer to the contingent of wealthy, suburban elites who call 911 to remove panhandlers from public spaces under the veil of mental health concerns. In a recent incident, Julia and her officer partner were dispatched in response to a report about a homeless individual near a children's playground. According to the report, the suspected person with mental illness was "being disruptive, acting erratic, and acting crazy," preventing people from enjoying the park. "When we arrived, it was just a homeless person living their life," Julia said. After performing a risk assessment and determining that this individual exhibited no signs of mental distress, she realized:

> What [the caller] meant was that they were preventing people from enjoying the park by just existing…The caller justifies their actions by saying things like, 'I'm just trying to keep [the city] clean.' They want to keep people who look like they fit. Anyone who is scraggly, has the wrong skin colour, is homeless or different, or, god forbid, has a mental illness does not belong.

Although it is not strictly part of their original mandate, MCRRT is tasked by "Botox Karens" with preserving or creating a certain sanitized public order. Julia noted that this cleansing impulse is a deeply racialized and class-stratified attempt to eliminate any visible markers of difference and eject disordered bodies from open spaces such as parks or urban seating areas. The assumption is that acting 'strangely' in public is a visible sign of unaddressed mental illness and that these subjects, by virtue of their aesthetic or social disruption, belong "outside the community of ordinary human beings" (Barham and Hayward 1990, 75).

Police interactions with persons with mental illness are not merely the product of mentally disordered behaviour but, critically, the public's adverse reaction to that behaviour (CPC 2010). In her examination of discretionary decision-making in law enforcement officers' handling of mental health cases, Teplin (1984) determined that the outcome of a mental health call was "related only peripherally to the degree of psychiatric symptomatology" (163). Rather, underlying situational factors played a significant role in the officers' approach, and encounters with a higher degree of

"publicness" or visibility were more likely to result in formal hospitalization or arrest. Conversely, individuals whose mental illness manifested in quiet, unobtrusive ways were more likely to be handled informally because their behaviour did not offend the sensibilities of "decent" people (169). Therefore, the public nature of disorderly behaviours (e.g., panhandling, using substances, acting "bizarre," causing a disturbance) is a major determinant of police contact and intervention outcomes. High rates of police-mental health encounters are partly a consequence of the public's low tolerance for aberrant behaviour and the "hypervigilant responses of community residents" (CPC 2010) who call the police for assistance in expelling the disordered other from public space.

This brings me to my final point: crisis is a visibility problem. Being seen to be acting 'wrongly' in public is what leads to disproportionate levels of law enforcement contact and, ultimately, police use of violent or fatal force. Consider the case of a bystander video Deborah witnessed online. A man had locked himself in a public washroom and began exhibiting what she hypothesized to be symptoms of psychosis. "Police ended up having to go hands-on and pull this guy out of the bathroom, put him on the stretcher, and then paramedics look like they sedated him. I know exactly what is happening on that call because I've been on one similar. He's having a psychotic break in the bathroom. You have to get them out to safety. You're going hands-on," she explained.[39] In this case, law enforcement officers were called to respond because the man's crisis unfolded in a public space, making it an issue of public safety rather than intrapsychic experience. It is not the crisis that triggered police response or the decision to go hands-on, but the publicness of that crisis. According to Brighenti, "One of the main distinctions in modern western sociopolitical culture is the dichotomy between the public space, associated with visibility, and the private space, associated with invisibility" (2007, 331-332). Public crises thwart this distinction, rendering visible what would ordinarily be a private mental illness. When people call 911 to report someone "acting

[39] "Hands-on" is a euphemism in police circles for sub-lethal physical force.

crazy," MCRRT is mobilized to restore this natural order and shield the public from persons in crisis by removing them from sight.

Crisis is a visibility problem even in ostensibly private spaces. There is no shortage of stories of persons experiencing mental health crises being killed by police officers in their own homes. Pierre Coriolan was alone in his apartment when police were dispatched in response to a neighbour's 911 call about a man in distress with mental health problems, audibly yelling and breaking things in his apartment (Ross 2022). He was sitting on his couch holding a screwdriver and a small steak knife when the Montreal police arrived. When he stood up and began walking towards the officers, he was tased, then shot with rubber bullets, then shot three times with live ammunition—at which point he fell to the ground and, still moving, was beaten with a baton (Shingler 2020). Clive Mensah was found "acting erratically and swinging his arms" by Peel police officers dispatched to a series of noise complaints in the area (Miller 2021a). He was tasered, restrained, and pepper sprayed several times in the backyard of his own group home residence despite following the officers' orders to lie down. In each of these incidents, neighbours called the police to attend to disruptive behaviour that had exceeded the private and entered the public sphere.

On the shifting boundaries between public and private life, Thompson (2011) writes, "what we might think of as 'the public sphere' today has become a complex space of information flows where 'being public' means 'being visible' in this space, being capable of being seen and heard by others" (63). A person in crisis enters the public realm when their private experience of mental illness becomes visible, when others can see and hear their distress. In contrast to the persistent invisibility of mental illness, which can go unrecognized or be hidden from view, the externalized nature of crisis is what enables MCRRT to form an intervention. Yet, this public character is also what enfolds persons in crisis within the discourse of policing, within concerns over public safety and the maintenance good public order.

CHAPTER THREE: ANTICIPATION AND CHRONICITY

1:20 p.m. I am sitting in the back of an unmarked police SUV, the bulletproof vest I've been given tightening around my shoulders. The backseat is hardened plastic with iron bars on the windows and a clear plexiglass cage separating my seat from the other. "That's where the prisoner sits," Officer Harris tells me. As we pull out of the precinct, Harris fills his partner Julia in on the calls from earlier in the week. "I saw Clarice last night. She was waving a knife," he says. Julia shakes her head. "She's going to kill someone someday."

Clarice is a woman with borderline personality disorder who is chronically suicidal. The MCRRT team receives calls about or from Clarice almost daily, seeing her every week for the past year. Julia explains that when they respond, the goal is often just to keep Clarice safe for the night. They listen to her, validate her, and get her to take her medication. When these measures fail, the team is forced to apprehend her and bring her to the emergency room, where Julia says she is well-known by hospital staff: "They hate her because they see her as wasting resources. They don't treat her well. They're so unkind to her. And I get where they're coming from because they're also just incredibly busy. The last thing they want to see is systemic burnout, but they also know we can't do anything."

Under the Mental Health Act, MCRRT apprehends Clarice to the hospital whenever her suicidal ideation poses a risk of serious bodily harm to herself or others. What constitutes grounds for apprehension becomes more challenging to assess when Clarice's life is delimited by her sustained proximity to *risk*.[40] With each unresolved episode, each recursive return to crisis,

[40] The language of "risk" is woven throughout mental health legislation and the field of crisis intervention (e.g., persons at risk of harm, risk of substantial physical and mental deterioration, risk management in healthcare settings, etc.). Risk is not a neutral category. What or who is considered 'a risk' or 'at risk' is a "reflection of a complex interplay of competing knowledge claims, interests, politics, ideologies, technologies, emotions and moralities" (Stanford 2012, 21).

interventionists feel drained of their time, goodwill, capital and human resources. According to Julia, Clarice is "desperate for help," but her level of psychic distress is so consistently elevated that "there's only so much a psychiatrist can do, short of medicating her into a coma."

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I wrote in the introduction that the fatal police encounter is an incipient moment in a larger constellation of structural and interpersonal violence—a rupture in the hegemonic order of things in which the exceptional event abruptly exceeds the structures that engender it. When I began this work, I was interested in thinking through these eruptions. I wished to consider police violence and mental health crises as reciprocal intensities—mirror images that, by virtue of their sudden discharge, might carry the surging potential to make visible the ordinary negations and refusals of life that saturate the everyday.[41] In the same way that violence is often the punctum that sparks transformative political change, I expected the eruption of a mental health crisis, and the subsequent intervention by crisis workers, to signify the opportunity for transformative care in a system that is otherwise devoid of meaningful mental health infrastructure. Attending to these moments of crisis would provide insight into the structural and affective forces driving them and the kinds of labour that might give rise to imaginaries of repair.

What I found in my fieldwork was typically much flatter; the revolutionary temporality I had imagined didn't match up with the long durée of chronic mental illness. While my interlocutors relayed the challenges of rapidly responding to high-stress situations, including the vertiginous feeling of needing to "go from zero to one hundred" at a moment's notice, our ride-alongs were characterized mainly by long hours spent driving around waiting for mental health calls that didn't always materialize. The calls that did come through were primarily "regulars" like Clarice, who is just

[41] Here, I paraphrase Kathleen Stewart: "the intensity of erupting events draws attention to the more ordinary disturbances of everyday life" (2007, 74).

"always like this." These calls unfolded according to their own distinct rhythm, at once habitual and vibrating with immediacy, both played out and uncertain.

This chapter combines ethnography and affect theory to explore the strange temporalities involved in crisis response. I approach the scene of crisis intervention as a suspended present, in which interventionists improvise exchanges with persons in crisis and strive to cultivate hope for an alternative future. In turn, I consider how their efforts to interrupt the moment of crisis and suspend the foreclosing of possibility are exhausted by the chronically ill subject for whom crisis is ongoing. Drawing on the work of Lauren Berlant, I argue that dependency on crisis services is a cruelly optimistic attachment that facilitates continual return to the scene of the police-clinician encounter—to the promise of a cure that is not working.

Interrupting and Making Sense of Chaos

Crisis narratives have often been framed in terms of acceleration, disorientation, and chaos.[42] In her seminal memoir *An Unquiet Mind*, Kay Redfield Jamison describes her experience of madness as the gradual awareness that her "life and mind were going at an ever faster and faster clip until finally…they both had spun wildly and absolutely out of control" (1997, 68). In narrating her escalating manic episodes, Jamison invokes both a phenomenological and temporal loss of control. As her thoughts travel at increasing speeds, accelerating to the point of destabilizing incoherence, her body becomes "uninhabitable," full of "destruction and wild energy gone amok" (115).

The first step in performing crisis intervention is to provoke an interruption in that wild, spiralling incoherence. As Julia explained, "Seeing the words 'crisis team' on the [bulletproof] vest gives the person in crisis a bit of a pause. They see it and think, what am I doing? And that creates

[42] For a more comprehensive list of metaphors and tropes used in mental illness narratives, see Janis Jenkins's ethnography of antipsychotic medications and their effects on subjective illness experience (2015), Erick Fabris's work in the field of mad studies (2011), and Daniel Knight's reflections on vertigo (2021).

enough of a pause to form an opening for the intervention to proceed." Many of my interlocutors made this same connection between halting time and creating or identifying "openings." According to one police Sergeant, having the experience of clinicians available during crisis calls is invaluable to persons in crisis because it "gives people a moment," during which the overly swift reaction and response pattern of mental disorder and police intervention is paused long enough for successful de-escalation to occur. If the experience of crisis is an overwhelming sensation of "being wildly out of control" (Jamison 1995, 115), then the effect of police symbols (the uniform, bulletproof vest, weapons etc.) is to interrupt that spiral and hold time in place. Julia described this approach: "People will see the uniform, and they'll stop what they're doing because they're like, 'Oh, I'm not in control anymore,'…And then I can swoop in and say, 'Hey, I'm not a cop. I'm a nurse. Let's chat." The interruption triggered by police presence forms an opening for therapeutic intervention. MCRRT's job is to open this space long enough and wide enough for the intervention to unfold.

These scenes of crisis response are necessarily improvisational when uncertainty is such a prominent feature of the work. Deborah, a social worker, identified the "unknown" as the most challenging aspect of her job:

> You don't ever know what you're getting. You don't know if you're going to come to work and sit in a car for twelve hours and do nothing. Or you don't know if you're going to have seven calls…you just never know what your day is going to look like. You never know when a call is going to be. Even the fact you could be on your way to a call fully planned and not be required or be pre-empted off and sent to another thing. There's just so much unknown.

When a call comes through dispatch identifying a person in crisis by name, MCRRT teams will try to mitigate these uncertainties by accessing the person's medical records or police file while en route toward the scene. They can read any physician, nurse or social worker assessments that may have been completed over the years and read through all the catalogued notes from any previous police interactions, including non-criminal calls that never lead to an arrest. As one nurse put it, MCCRT has access to "a lot of information about a lot of people." All this background information can help

responders understand what they might be heading into (particularly when it includes notes about potential escalating triggers). Still, this archived data fails to assuage uncertainty or account for the slipperiness of real-life crises. The information provided to 911 by the caller may differ significantly from the actual situation. Even when a person in crisis has an extensive medical or police history, it is impossible to know what happened in the days and weeks leading up to the event. Deborah explained how not-knowing impacts her approach: "Some people like to hypothesize what it probably is [and] make a game plan ahead of time. And I used to be like that, but I stopped it because, too often, we don't know what we're getting. So I try to be really focused on what information we actually have."

Focusing on the information at hand only as it becomes immediately available is a mode of adapting to uncertainty by attuning to an emergent present. Josh, a social worker, described how he deals with the anxiety of not knowing whether a crisis call will suddenly escalate: "Whenever we're going to a call, I just focus in on what we know rather than on the possibilities of what might happen…the temptation is to think about all the possibilities in the way like if he does *x,* I'm going to do *y* and overanalyze. And I think the much better thing is to really be present with people." Rather than attending to anticipated outcomes, Josh adapts his behaviour moment-by-moment. He modifies the tone of his voice in response to shifts in the person's affect and is able to pivot when a crisis is suddenly not what he thought it was. Erin Manning writes that this kind of improvisational technique "subvert[s] the linear time of if-then" (2012, 37). According to Manning, improvisation prolongs the space of potential by "making 'if' an open question, a time-loop, a folding proposition for the moving" (ibid). By redirecting his attention from the temptation of *if x, then y* and simply being present with the person in crisis, Josh can better perform his role amid so many unknowns.

This improvisational quality is most readily apparent when crisis interventionists purposefully escalate clients to assess their risk. "Sometimes we escalate clients on purpose to figure

out where they're at," one social worker explained. "I want them to start screaming because I need to see what their trigger is. I need to see where they're at. And I need to understand what's going on with them." My interlocutors defined their role as "making sense of chaos." Escalation brings affects shooting to the surface. In this regard, it is one way for interventionists to gain purchase over an uncertain situation and begin the challenging work of teasing apart the chaos.

Cultivating Hope

"We dance together," Robert said of his relationship with his police partner Gina. Several co-response teams explained the unfolding scene of crisis intervention as an improvised choreography, a "delicate dance." The police and the clinician read each other's body language: when one person steps forward, the other steps back. This dance played out during a 911 call the MCRRT unit received from a relative concerned that their loved one was suicidal. On scene, the person in crisis was visibly distressed but denied suicidal intent. As the intervention unfolded, Robert entered into a full-fledged argument with the person, pushing back against their repeated assertions that the mental health system has and will continue to fail them. When Robert felt he was not getting anywhere, Gina stepped in. They parried back and forth, back and forth, until finally, something broke. Or else everyone was just too exhausted to continue. After two hours of counselling, Gina and Robert left the scene, having established a safety plan and provided referrals to various social service agencies. The moment the car door shut, we all sighed in unison. Gina and Robert immediately launched into a discussion of what just happened.

"It was like pulling teeth in there!" Gina exclaimed. Robert agreed this was a tough call because the person's stress level was discordant with their willingness to seek further help. "I was trying to push [them] to see if [they are] at risk. I was trying to break through those walls." Robert continued, "Once the raw emotions, tears, anger come out—now that we've got the emotions out there, that's when we're able to create an opening where we can actually get somewhere…But

[they're] so set in [their] thinking!" Gina nodded in agreement. "[They] think [they have] a crystal ball. There's no room for what-ifs."

In the scene above, Robert and Gina work to interrupt and gain control over the moment of crisis. Their improvised dance is staged to hold open space for "what-ifs" and convince the person in crisis that this time the mental health system will provide the support it hasn't in the past. For crisis workers, cultivating this sense of hope is an integral part of what constitutes a successful intervention. Josh explained, "You're meeting and working with people who, for lack of a better word, just are or feel hopeless because they've tried quote-unquote everything, and nothing works." According to Josh, what's most important in an intervention is first building trust and rapport with the person in crisis and then "trying to create some sense of hope or meaning or help them to identify some sense of meaning that things can actually change because that's a very big challenge."

The ability to improvise in crisis calls and stage moments when change feels possible is tempered by the structurally prescribed outcomes inherent in MCRRT's mandate. Every call must end in either an apprehension, arrest or some sort of referral. As a system, crisis response resists ambiguity. Co-response teams are tasked with establishing whether a person is genuinely in crisis or not, at risk or not, apprehendable or not when the reality is usually something in between. This mandate holds firm even when the nature of risk is inherently fluid or is directly challenged by the recurring crises of "regulars" like Clarice. One officer explained, "In these cases, MCRRT has to stretch the verbiage of 'risk to self and others.' If not, then just going down [certain streets], we would need to apprehend every other person."

Most threatening to the apparatus of mobile crisis intervention are the "regulars" who defy the intentions behind these programs and how they should ideally operate, which Josh summarized as: "We respond to the situation; we stabilize the situation; we move on to the next one." The chronically ill subject refuses this ideal type. How can interventionists create an opening when the

crisis is extended and ongoing? How to make sense of chaos when encounters are no longer improvised but rehearsed—when each episode fails to add up to something different?

Fatalism and Inevitability

3:00 p.m. No crisis yet. We drive to one of the community hospitals so I can walk through the Emergency Department and get a sense of the process around mental health apprehensions while we wait for an MCRRT call to come through dispatch. As we back into one of the parking stalls behind the ambulance bay, another unmarked police SUV pulls into the spot next to ours. It's the non-emergency COAST unit, only there's no mental health worker today, just a plainclothes officer with a bulletproof vest, gun and taser. I am told it is fairly common for the police-clinician COAST team to be missing its clinician, which surprises me, given how many media reports champion this model. In this region, only MCRRT's mental health professionals must be certified clinicians trained in social work, nursing, or occupational therapy. Because the lower-acuity COAST workers don't need to be similarly certified, they are paid significantly less, making it difficult to find people to fill these positions and leading to high staff turnover rates. Sometimes the COAST team is just a police officer, but never the other way around. On days like this, the officer only responds as additional backup on MCRRT or other police calls because he cannot do outreach alone. He's a floater.

Four other uniformed patrol officers are present at the hospital: two waiting with a handcuffed patient in the Emergency Room and two in the parking lot outside. We stop to talk to the officers outside, and the conversation loops back to Clarice. Last night, the MCRRT team apprehended Clarice, fearing for her and others' safety. They brought her to the hospital and left around 11:00 p.m. The psychiatric emergency unit discharged her shortly after, unbeknownst to Harris. Around 2:00 a.m., she was re-apprehended by the patrol officers we're talking to now, under the same risk criteria, in an apparent round of crisis musical chairs. Because the psychiatric emergency closes overnight, the officers have been waiting with her since morning and are just

leaving the hospital now. Clarice has been admitted this time, which Julia hopes will buy them a few days before she calls again.

"The system is a disaster," Julia says. "There are so many risks in releasing people who are suicidal, but there's no accountability." *Accountability for whom or to whom?* I wonder. She explains how this lack of accountability stems from apathy and high staff turnover. When emergency rooms are short-staffed and operating in "survival mode," providers inevitably end up "exhausted by these frequent flyer-type patients who are experiencing these sublethal things." Instead of assessing Clarice's risk of suicide at this particular moment, the psychiatric emergency staff register her as someone who is always at risk but less than dead. Her position in an ongoing cycle of admission and discharge remains unchanged. Julia, however, questions the assumption that every case will turn out the same:

> We're bringing people to the hospital, and then if the doctor doesn't see them for six hours…that can be really dangerous, especially if they're in chronic pain. Their risk then increases as they're discharged. Having that experience in the hospital leaves people feeling devalued, as though no one cares about them.

There's so much fatalism in Julia's voice as she describes how the hospital treats Clarice. How hard she has to work to convince the staff that "she's not faking it; this person is actually *living* this." Still, all that fatigue and frustration leads to the expectation that the outcome will always be the same. Even Julia confidently asserts, "So, we'll see her again."

*

The sense of inevitability my interlocutors invoked when discussing the chronically ill brings to mind Eve Sedgwick's notion of paranoia. As an affect theory and epistemological practice, paranoia is anticipatory and mimetic. In seeking to predict all the bad things that will happen before we encounter them, paranoid knowing forecloses the possibility of anything being different from the way it already is. As Sedgwick writes, paranoia tends to "grow like a crystal in a hypersaturated

solution" (2003, 131), clouding over any alternative ways of experiencing and making sense of the world (130).

Engrained in the structure of the co-response model is a paranoid imperative to anticipate all contingencies before they happen. The involvement of police officers in mental health calls is often rendered a matter of maintaining safety in the event of unexpected violence and in light of high-risk situations.[43] Yet, in presupposing the potential for future violence, police presence in these mental health calls reifies its anticipated inevitability. As Leia affirmed, "People in crisis [are] not going to be violent a lot of the time, but you have to be prepared for them to become violent." This future-oriented vigilance is confirmed each time a seemingly benign call turns threatening. Co-response teams drive around in anxious anticipation of imminent crisis. Guarding themselves against unanticipated risk, they enact a predictive futurity in the unfolding present.

The structural dominance of this type of paranoid knowing is reinforced by the repetitive encounters MCRRT has with "regulars" like Clarice.[44] Crisis workers gave a wide range of estimates for the percentage of total calls from people they have interacted with before. In an interview, one mental health worker placed this value at five percent, only to give a figure of twenty to forty percent during a ride-along a few weeks later. This variation suggests that regardless of the actual statistic, the prevalence of chronic cases feels more ubiquitous in the moment of actually having to respond to them, a form of myopia that is bolstered by the fact that rapid response teams do not

[43] Examples of "high-risk" situations given by mental health workers include meth-induced psychosis and associated aggression (risk to MCRRT), as well as suicide-related calls requiring police infrastructure such as cell phone triangulation and the use of lights and sirens to reach a scene more quickly (risk to the person in crisis). "Safety" is most often used to refer to safeguarding the mental health worker, but it can also refer to the safety of the person in crisis or other community members.

[44] Persons in chronic crisis were alternately described as: "well-known," "frequent fliers," "regular users," "repeat offenders," "repeat customers," and "consumers of services," among others.

conduct follow-up visits and therefore do not get to witness their clients' forward progress. Josh expressed the burnout and frustration engendered by this arrangement:

> [T]he other hard part of crisis is I primarily see people when they're at their worst. I don't get to see them a year down the road where they're doing well…[T]he burnout is twofold. One is when you're seeing the same people day in and day out; you're not seeing a consistent change. That can be very draining. And then two is not knowing whether you're doing good work because, again, you don't get to follow up on that person…it is kind of troubling.

Though they have access to a healthcare records database, MCCRT mental health workers cannot look at a person's medical chart outside the context of directly performing an intervention since this would violate the Personal Health Information Protection Act. As a result, they never know whether a person's mental health has improved after an intervention; they only see the chronically ill individuals who remain unchanged. Josh described this inability to assess whether or not he is doing "good work" in terms of burnout, drained affect, and mental unrest. Other crisis workers employed similar metaphors of bodily fatigue in describing the toll of not witnessing clients change over time. Deborah stated, "I am tired…the job takes little bits of you. You become numb or slightly jaded." This drained vitality manifests in the interactions and affective exchanges between co-response teams and "regulars" during scenes of crisis intervention.

If most interventions play out like a well-improvised dance, scenes with the chronically ill more closely resemble a circular conversation that goes nowhere. Robert begins each intervention by asking the person in crisis, "What can we do for you *today*?" emphasizing the concrete actions that can be done in the present moment. He keeps looping back to this question, which goes unanswered as the chronically ill describe their past suicide attempts, ongoing symptoms, paranoias, and medical issues. Unlike the interventions that result in apprehension, the creation of a safety plan or the phone number of a referral service, there's no real resolution here. The intervention ends when the police-clinician team just slowly leaves, having established the absence of risk and determined that nothing else can be done.

"He will call back," Robert said after we left the residence of a man with chronic pain and multiple mental health diagnoses. By the time Robert and Gina had typed up their notes from the intervention, the man had called the crisis line with threats of suicide two more times. In contrast to other calls where Robert and Gina try to cultivate hope and create openings for new possibilities, encounters with their most "well-known" clients seem to solidify the paranoid knowledge that future crises are not only inevitable but already in process.

A Cruelly Optimistic Attachment to Crisis Response

8:45 p.m. I can feel the fatigue setting in. It's nearly eight hours into a twelve-hour shift, and we've attended two calls: one that resulted in mental health apprehension and the other a non-mental health domestic violence call that Harris was requested to attend as a translator for regular patrol. Julia enjoys days like today because they offer relief from the more emotionally intense crises. For his part, Harris prefers when there are lots of calls because otherwise, "it makes for long days." Parked at the far end of a vacant Cineplex lot while Harris types up his mandatory notes from the domestic violence call, I get what he means about the long days. All that waiting can weigh on you.

Clarice's name crops up again when Julia tells me about the Situation Table. Once a week, the Police Department meets with social workers and community agencies to discuss the (anonymized) individuals who call emergency services most frequently. People like Clarice call the non-emergency crisis line at least three or four times daily. "We sometimes focus on the negative, but [the Situation Table] is a very positive thing," Julia says. It's an opportunity for the different agencies (shelters, case management services, recreation programs, etc.) to come together and try to support people who are at such 'acutely elevated risk' that crisis is imminent. A few weeks later, when I observe a Situation Table meeting, the anonymized cases all sound eerily similar. Despite all the support services at the meeting and the numerous people and organizations mobilizing around

these individuals, I have the haunting feeling that all of this has already happened. This is not the first time each person has been presented as a case at this table.

The impulse to predict the future is infectious. When my thoughts dwell on Clarice, I try to resist the instinct to write an imagined trajectory, to lapse into the kind of future-tense thinking that presumes I can predict what will happen to her or any of the chronically ill clients that MCRRT sees regularly. But it's hard to hold open space for what-ifs when the expected is continually reproduced. In my notes, I write, 'She *is never going to get help*.' And I wonder.

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The Ontario *Mental Health Act* provides police with the unique authority to apprehend a person "apparently suffering from mental disorder" for transport to a healthcare facility, where they are legally required to receive a physician's examination and subsequent psychiatric assessment. By my interlocutors' estimates, wait times to see a psychiatrist outside this framework can range from nine months to one and a half years. For minors, the wait for mental health treatment can extend to two and a half years, with an estimated 28,000 children and youth on treatment waiting lists (CMHO 2020). In an underfunded and fragmented mental health system, calling the police is a care-seeking behaviour for marginalized groups experiencing mental health crises who cannot access help otherwise. This was particularly true at the onset of the pandemic when many mental health and addiction sector organizations suspended programs or switched to virtual services that remained inaccessible to low-income and homeless populations (CMHA 2020). "Nobody was offering outreach and support during the pandemic," one MCRRT police officer explained. "In the context of a lack of supports, where there's no structure, and you don't have the skills to manage the everyday, having an emotional eruption is what gets you that support."

Yet this practice of care-seeking persists even amongst those already well-connected to health and social services. Laura, a woman who lives in supportive housing and struggles with

chronic suicidality, will frequently call emergency services and crisis hotlines even when on-site staff are readily available. For the crisis workers dispatched in response, Laura's propensity to call 911 reflects her unwillingness to participate in the moral labour of advancing her own care. "They have to be wanting actually to change and engage in services, and oftentimes are not in the place to do that," Deborah said of individuals like Laura who request care outside their assigned service agencies. Teresa, a mental health nurse, echoed that a person who calls MCRRT frequently "doesn't want to engage in help and is constantly stuck." Although crisis workers identify overreliance on emergency services as a direct impediment to personal and social change, Laura continues to call the police in a constant cycle of crisis, intervention, apprehension, and discharge. In Theresa's words, "When a person MCCRT has seen more frequently increases their calls for service, there are complex problems that person is trying to navigate…what we're doing now is not working."

Lauren Berlant's "cruel optimism" concept reveals our propensity to form attachments to objects that ultimately threaten our well-being. According to Berlant, all attachments are optimistic in that they form around the cluster of promises an object puts forth—whether this is the promise of love, self-transformation, or the *good life.* An optimistic attachment becomes cruel when we turn and return to the same scenes of desire despite their failure to realize these promises. Berlant writes, "A relation of cruel optimism exists when something you desire is actually an obstacle to your flourishing" (2011, 1). Cruel Optimism's double-bind is that the object's presence is intimately tied to a subject's sense of living on and looking forward to being in the world, such that the object comes to feel like "the only thing that makes living worthwhile" even as it poses "a threat to existence itself" (44).

I consider dependency on co-responding crisis intervention teams as a relation of cruel optimism precisely because life for the chronically ill subject is so organized around these scenes of encounter that "the loss of what's not working is more unbearable than the having of it" (27). For

Laura, an emotional eruption is the only thing that demarcates the otherwise homogenous experience of "dead time" (Kroijer 2014), a sense of waiting and powerlessness that emerges when the problems of the present world hold little promise of change. The affective register of dead time is a bodily sense of exhaustion and the feeling of being stuck in slow continuous time without meaning (76). In this regard, the emerging episode of crisis stands in actionable relief to the slower, suffused violence of prolonged (yet sublethal) psychic suffering, loneliness, inertia, and inescapable boredom that characterize Laura's everyday life.[45] Berlant further describes relations of cruel optimism as "vehicle[s] for attaining a kind of passivity, as evidence of the desire to find forms in relation to which we can sustain a coasting sentience, in response to being *too* alive" (2011, 43). When the affective intensity of being alive in the world is *too much* to bear, Laura turns toward the predictability of crisis response as a stabilizing form that helps guard against self-dissolution.[46] Even though each successive intervention fails to prevent the next crisis, Laura reproduces the habit of calling 911 because the loss of this familiar scene threatens temporal collapse into unmediated dead time. For Laura, the experience of crisis is both recursive and inextricable from the act of mobilizing others around her care.

The cruel optimism of crisis response is that the chronically ill return to the scene of the police-clinician encounter as holding the promise of meaningful change, even when this imagined future never materializes, and even as this dependency on crisis services deepens the intractability of their mental illness. Berlant writes, "The affective structure of an optimistic attachment involves a sustaining inclination to return to the scene of a fantasy that enables you to expect that this time,

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[45] Most crisis workers attributed the motivations for repeated 911 calls to issues of "boredom" and "loneliness," which perhaps speaks less to the validity of these calls for service than the forms of care that are absent in a psychiatric or reactive approach to addressing the problems of psychic life. Alison Fixsen takes up this question in her autoethnography of psychosis in an inpatient environment (2021).

[46] See Massumi (2002) for more on "intensities."

nearness to this thing will help you or a world to become different in just the right way" (2). According to Leia, what drives individuals like Laura to call crisis services is precisely this desire to believe that this intervention will differ from the last. "I think that people who use 911 [continually]…they end up developing a dependency because of either a positive interaction or a negative interaction they want to reinvent," she said. When co-response teams interact with a person in crisis, they work to hold open the present moment and cultivate hope that change is possible. Persons in crisis return to these encounters, seeking to relive them regardless of whether or not the interaction had a positive or negative outcome because it is within the suspended potential of these scenes that there may be hope for a better life or, at the very least, "a sense of well-being that spreads out for a moment" (117).

For their part, clinicians also hold onto the promise that *this* time, *this* intervention will make the world and the chronically ill different in just the right way. As Leia explained:

> We deal with so many people that are really, really chronically ill. But if we deal with that same person in an episode maybe ten times, but we deal with them appropriately and kindly and with our integrity intact, maybe that one time that person can change a little bit of their life from our interaction. Maybe that's the one; maybe ours is the one interaction that helps them get admitted into the hospital and stay there to stabilize, or maybe ours is the one interaction that helps them stay out of the hospital and actually thrive in the community.

Leia's comments reflect the tension between fatalism and optimism mental health workers have when responding to the chronically ill. The cruel optimism of crisis intervention is that it "stage[s] moments when life could become otherwise, in a good sense" (48)—both for the person in crisis and for the co-response team dealing with widespread burnout and fatigue—even when the province's financial and epistemological commitment to crisis response precludes other forms of mental health care.

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No crisis *yet*. This 'yet' is built into every aspect of mobile crisis intervention. Into the hours spent driving around and waiting for a call to come in, for a crisis to be revealed, for something to go

wrong. Into officers safeguarding against the violence that exists already in potential. The paranoid sense of already knowing what will happen. Crisis and its eternal return.

MCRRT, like other approaches to crisis intervention, is occasionally described as a "diversion program." Media reports emphasize the success of co-response teams by citing the number of calls "diverted" from emergency rooms or jails (Gamrot 2020a). Even this framing inscribes its own 'yet,' suggesting the premeditated outcome of all police mental health calls is either apprehension or arrest. This anticipatory structure leaves no room to imagine how life or crisis might be otherwise, or what care might look like outside the framework of managing dis/order. It does not hold open the possibility for *what-ifs*. And yet, tomorrow's shift is full of unknowns.

CONCLUSION

> They haven't thought it through. They haven't really understood what the true nature of the problem is. And therefore, how can they make a suggestion when they don't understand the problem? Trying to give a solution before we understand the problem is foolishness.
>
> –Robert, on public calls to move away from a police-based system of mental health response.

Throughout my fieldwork and writing, I have continuously returned to this question: what problem are mobile crisis intervention teams trying to solve?

My interlocutors' persistent feelings of frustration and burnout denote urgent problems in how the mental health system operates. According to Julia, gaps in service delivery undermine what MCRRT units are able to accomplish by meeting persons in crisis where they are at. In her words, "I don't feel like we can apprehend someone who really needs help, whether it be because they're seriously suicidal or having a psychotic episode, and confidently feel like me taking them to the hospital is going to be the answer." Pervasive stigma amongst healthcare providers, overfull emergency rooms, and an under-resourced hospital infrastructure have created a climate where individuals at risk of harm who are apprehended under the *Mental Health Act* may still not receive adequate care or support. For Julia, the benefits of MCRRT become eroded in a context where follow-up support is negligible, where what happens after the intervention ends fails to prevent future crises. She remarked, "I used to say a crisis team was only as good as its follow-up. Now, it's not as black and white because I see the good we are able to do regardless. But it's still hard to see when people are discharged after being apprehended and then overdose. It makes me think, 'What are we even doing?"

All the clinicians I spoke to identified a need for enhanced long-term care options and increased continuity of care. However, they each held differing opinions on what should be prioritized. A non-exhaustive list of their suggestions includes: more in-patient hospital beds and

increased length of stay for those who need it; intensive case management "for those really difficult clients"; more centralized care plans and inter-agency co-operation; timely and appropriate addiction support; walk-in crisis counselling; shorter wait times for accessing services; and trauma-specific programs. Amidst this heterogeneity was the collective agreement that public calls for change are premised on a lack of understanding of the core issues plaguing the mental health system. From their perspective, a vigilant public that presses for defunding the police or moving away from police-based crisis response lacks awareness of the true nature of community policing, the good work MCRRT programs do, or the needs and challenges of persons with mental illness.

In dismissing members of the public as presenting solutions without understanding the issues at hand, my interlocutors overlooked their own gaps in knowledge and lack of insight into what marginalized community members articulate the problems to be. In an interview, Robert asserted that the reason some people are afraid of the police is that they are immigrants from countries where "there are heinous things being committed by police." This outlook neglects the long-standing fear of police contact and trauma-related symptomology accompanying those who experience or witness police violence in Canada (Greene et al. 2022). Later on, Robert attributed the criticism of police presence in mental health calls to a vocal minority of "very angry people" whom he believes are "trying to find ways to vent their anger and people to focus their anger on what they have not truly understood." When I asked if he felt any of that anger was justified, Robert stated that some vocal critics have had bad experiences with the police that skewed their view of police institutions, singling out parking tickets as the primary driver of many individuals' poor perception of the police. "A lot of people formulate their opinion of police by their interactions with traffic officers," he said. "Traffic officers are not the nicest people in the world. But that is the face of all police to a lot of people...you're now basing that one interaction as being indicative of the whole." The suggestion that much of the public opposition towards policing is based on individual

encounters with traffic officers flies in the face of many minority communities' experiences of systemic over-policing, including Indigenous communities whose interactions with the police have been characterized by a concrete and painful history of residential schools, child scoops, over-incarceration, and physical violence (Glasbeek et al. 2020).

Deborah also contended that, as first responders, MCRRT staff hold a unique authority over knowledge of mental health. In contrast, the public is ignorant of the gritty realities of mental illness and is shielded from the truth of "what the world really is like." She stated:

> We know the darkness of the world. We know the underbelly of the world. We see all this where other people have this sense of ignorance to what actually happens…People are super, super unwell and people, others, don't really understand how unwell somebody can get…So I think a lot of these people online who are defund the police and all this, they really do have the best intentions. They want to be helpful. They want to save people. But they're ignorant to what is actually going on in the world. And I think that's a lovely privilege that we don't have.

The absence of "privilege" Deborah invokes underscores the myopia of her perspective, her privilege as a white woman safeguarded by direct and institutional police protection to ignore the systemic subjugation of Black and Indigenous life that is central to the Defund the Police Movement. Her statements, like others I heard, suggest that "the power the police hold in society is sometimes invisible even to themselves" (Newell 2021, 6).

While writing this thesis, I have periodically noticed myself arguing with my invisible interlocutor, trying to convince them that police violence or systemic racism exist, even though this has never been my aim as a researcher.[47] Ortner warns of the pitfalls of "pulling one's punches" when interpreting and writing ethnography (2010, 226). If indignation is a common motivation for many anthropologists concerned with power (Nader 1972), then the reverse challenge of "studying up" is avoiding the impulse to turn one's work into a treatise refuting the claims of one's interlocutors. At times during fieldwork, I felt compelled to take on a pedagogical stance, to

[47] I take police violence as a starting point.

expound the valid reasons people have for not trusting the police, which have everything to do with being shot and killed in their homes and nothing to do with parking tickets. This would have represented a considerable departure from my role as an ethnographer and likely made it impossible to complete this work. Sitting with my own affective discomfort has allowed me to trace the disconnects between contradictory understandings of the problem MCRRT is positioned to solve.

Throughout this thesis, I have explored the entanglement of policing and mental health as evidenced by the application of policing frameworks like order maintenance and public safety to persons in crisis. MCRRT programs blur these boundaries through the explicit partnership of law enforcement officers and clinicians. Even though these pairs respond to situations in tandem, at the end of the day, the officers still hold the ultimate authority over how an intervention will proceed. Under the *Mental Health Act*, the power to apprehend a person experiencing severe mental illness can only be exercised by the police. This unequal dynamic influences how clinicians navigate their relationships with their partners on a day-to-day basis. According to Leia, "As a healthcare worker working with the police…you have to be very strong in who you are as a clinician because you're going to be pushed to just be a police officer, even though you're not. That is the mindset they want to take on. They want you to, yes, be in partnership, but at the end of the day, the police still hold the power." Josh was even more explicit, describing how he tries to "build political capital" with MCRRT officers to spend it in certain situations where he and his partner disagree over whether a person in crisis should be apprehended.

The problem may not be transparent. What is clear is that MCRRT programs are not a panacea for shifting the mental health burden away from the police. If anything, they reinforce law enforcement's centrality in a reactive model of crisis response where police have the legislative authority, institutional resources, and integration within the emergency response system to reach

people where they are at. If anything, mobile crisis intervention teams deepen the inextricable knot of policing and mental health.

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