Offloading, Upstreaming, Defunding & Costing: Re-thinking Calls to Police for Absconding Social Work and Mental Health Clients

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Introduction

In Canada, much of the public discourse on "defunding the police" has centred on demands for police to be removed from calls for service involving persons with mental illness (PMI). As we have argued before,[1] what remains unacknowledged is an underexplored aspect of police reform: missing persons and the extent to which mental health is an underlying issue in many single and repeat cases of missing persons. Calls for "defunding the police" and/or creating police non-attendance or diversion policies for mental health calls, as has happened in cities such as San Francisco and New York, occur in a policy space that is completely lacking robust evidence of the current situation and how best to proceed. Missing person cases illustrate how complex the situation is: many missing persons are eloping from hospitals, mental health facilities, and group homes. In other words, they are already plugged into "upstream" institutional resources and networks. When these people go "missing", those same social and healthcare providers "offload" responsibility onto the police to locate and/or return them.

In this chapter, we draw on police data on missing person calls for service from 2019 from a municipal police service to identify the extent to which missing person reports are generated by social and healthcare services, looking at how many of these reports involve individuals with

mental illness. We then introduce a cost analysis to assess how much this one aspect of "offloading" onto police services is being subsumed within police budgets as a "hidden cost". Our focus then shifts into considering what "upstream" solutions currently exist for preventing and thus reducing these calls for service.

1. Offloading

Much has been written on the effects of deinstutionalization on individuals with mental illness and on urban communities that were largely under-funded and thus unprepared to provide the community-based resources required to assist vulnerable individuals, often lacking strong social supports.[2] Many of those individuals, lacking employment opportunities and facing stigma and other structural barriers, were largely warehoused in low-income housing stock -- often single resident occupancy hotels -- in inner-city neighbourhoods with significant drug problems.[3] Not surprisingly, many PMI struggle with substance abuse and homelessness.[4] These factors combine, it has been argued, to create situations that inevitably lead to police interventions, and thus to an increased likelihood of arrest and incarceration for PMI.[5] Despite decades of research that have painted a more complex,[6] if not sometimes contrary,[7] picture of police decision-making with respect to PMI, the "criminalization hypothesis", as this line of thinking has been termed,[8] remains a dominant theme in much public discourse.[9]

In relation to calls to defund the police, there is another problem with invoking the criminalization hypothesis: police arrests only account for a portion of the overall interactions police have with PMI. As one of us has documented elsewhere,[10] other types of interactions can include wellness checks, suicide calls, mental health apprehensions and situations in which an

individual has been the victim of a crime or is a complainant on a disorder call, among others. We are not alone in making this point. Short[11] similarly notes that "it has been argued that policing services have had to pick up the slack, acting as a sort of triage service for psychiatric facilities, apprehending unwell individuals, transporting patients to the hospital, and conducting welfare checks in homes and on the streets." Much of the work generated by such interactions is handled through informal measures typically referred to as "peacekeeping" or "social work", depending on the context.[12] None of these are new observations, either. Egon Bittner's seminal field-based studies of policing in the 1960s documented the challenges police then faced in trying to come up with actions that would resolve situations involving those experiencing mental illness. Where possible, Bittner noted, officers tended to rely on informal actions and sanctions to "keep the peace", reserving law enforcement for more serious offenses or those situations in which jail was a safer option for a vulnerable person than leaving them alone on the street.[13] More recent studies on police decision-making in the grey zone -- that is in those situations in which police have limited choices for responding to situations involving PMI -- has drawn similar conclusions. Police interact with PMI in a variety of different situations, and how they will resolve a call is guided mostly by situational constraints, legal, policy and regulatory guidelines, as well as by individual preference and/or occupational norms.[14]

2. Upstreaming/defunding

There is now a growing body of public health and related research focused on what are termed the "social determinants" of health -- that is, those non-medical factors that can influence health outcomes, such as poverty, racism and family dysfunction. More recently, this literature has grown to include not only health and mental health, but also such behavioural phenomenon as "violence", "crime" and "disorder"[15] Those working within this model advocate for interventions

aimed at addressing the "root causes" of a social ill, rather than relying on the police and the criminal justice system to effect "downstream" or "bandaid" fixes that can worsen health and other outcomes.

With increased recognition of the social determinants of both health and crime, over the past decade there have been significant efforts made by Canadian policy-makers, public health officials, police organizations, and community groups, among others, to promote the adoption of "upstream" solutions to a wide variety of downstream issues. It might surprise some to know that police organizations -- in particular both the Canadian and Ontario Associations of Chiefs of Police -- have been actively promoting a "community safety and well-being" model aimed at cross-sector collaboration on addressing root causes of crime, that was also vigorously adopted by the previous Ontario provincial government. To date, such efforts have largely centred on the creation of "Situation Tables", wherein representatives from the police, social services, healthcare and other public sector groups identify "high risk" individuals and attempt to secure them housing, rehabilitative, mental health and other resources to help stabilize their situation.[1] Beyond the promotion of this program, which was also the cornerstone of much police reform work by the Saskatchewan Ministry of Corrections, Policing and Public Safety, most other efforts have been local, frequently underfunded, *ad hoc*, and un-evaluated. This state of affairs has also been true in relation to upstream initiatives in other public sectors, including social work and health-care.[16]

[1] At this time of writing, some ten years after their adoption, Situation Tables and similar other models remain popular among police, but have yet to be subjected to rigorous evaluation, or evaluation that tracks case outcomes.

Arguably, a significant stumbling block to taking a broader social determinants approach to crime, health or any other major social issue is the emphasis advocates have placed on the need to address overarching structural issues -- such as economic inequality -- as *the* primary solution to mental health, homelessness and so on.[17] To date, we have yet to see a strong majority of Canadians demanding income redistribution or housing on demand schemes, likely because of fears of increased public costs and therefore rising taxation. Perhaps in partial recognition of this fact, activist groups began advancing calls for a different form of redistribution: transferring public funds from police budgets to fund increased social and health care services.[18] Presumably, expanding these services would address needs gaps experienced by PMI, thus reducing the number of vulnerable individuals who experience mental health crisis and come into contact with police. What we argue is that there are some simple steps that could be immediately taken to reduce the demand for police services with respect to mental health-related occurrences: health care and social work services could take preventative actions to reduce their reliance on police with respect to PMI who abscond from services -- that is, we could start by 'responsibilizing' those groups who have, to some extent, benefited from the offloading of certain responsibilities to police.[19]

3. Costing

Each year, hundreds of thousands of Canadians are reported missing to police.[20] This is hardly a homogenous group, and previous research has well documented the variety of factors that contribute to this phenomenon.[21] In this section, we focus solely on individuals with serious psychiatric illnesses who have absconded from forensic and/or other healthcare facilities. When such individuals leave or otherwise fail to return to a healthcare setting (such as failing to return after a cigarette break outside the facility), it is a common practice in most, if not all, Canadian

jurisdictions for a police report to be filed. In Canadian provinces such as British Columbia (B.C.), legislation dictates that such a report will be treated as a high priority call ("person at risk" or "high-risk"), necessitating urgent police response.

Information on the prevalence of absconding cases among missing persons reports is not readily available. Fortunately, we can refer to some recent Canadian research, which used closed police files to look at various aspects of missing persons cases. For example, in one recent study, approximately 11.5 percent of those reported missing to a municipal police service were found to have absconded from a hospital or mental health facility.[22] In this study, the strongest predictors of absconding were cognitive impairment, substance dependency, and mental health issues. A follow-up study examined the demographic, health and other risk profiles of those who abscond from hospitals and mental health facilities, finding that individuals with schizophrenia and/or dementia were more likely to abscond from mental health facilities, whereas those diagnosed with depression or bipolar disorders were more frequently reported missing from hospitals.[23] In terms of demographic factors, White males were the most frequent absconders from both settings; however, Indigenous patients were over-represented at 9.7 percent of the total sample. Conversely, Black patients and individuals from other racial or ethnic groups were significantly less likely to abscond from these locations.

In a previous study using the same dataset, researchers identified adults and youth with histories of repeatedly being reported missing.[24] Armed with this information, they then looked at the locations from which "repeat missing people" are most likely to abscond. They found that for adults, the top five locations included three health facilities and two homeless shelters/mission

centres, thus indicating that individuals under MHAs not only abscond, but some do so repeatedly.[25] In terms of the rate at which such individuals are reported missing, we have little to go on. An earlier study found that within a one-year span 230 individuals under MHAs were reported missing to police from two Vancouver area hospitals.[26]

PMI abscond from hospitals, psychiatric and social service facilities for various reasons. Previous research shows that such reasons include seeking freedom, accessing drugs or alcohol, negative treatment experiences, negative experiences with other service users and/or feelings of boredom, insecurity or a lack of safety, among others.[27] When this happens, protocol at most, if not all, facilities, is to report the individual missing to police as soon as their absence is noticed.[28] In one case we previously documented, an individual was reported missing despite the fact it was known she was on a bus with two security guards from the hospital from which she had absconded.[29] It wasn't that she was actually missing, it is that the security guards were unable to convince her to return. In this and similar other instances in which someone has absconded, a report is taken, a call is dispatched, responding officers typically file a 'risk assessment' form to determine the level of response and then, depending on the assessed risk, one, several or all units on patrol may be requested to look for this person. If the individual has absconded from a psychiatric facility, police have to have the appropriate committal forms to take the person into custody and transport them back.

Where that is not the case, a wellness check occurs, the complainant is notified the person will or will not return voluntarily, and the case documented and closed. In a small proportion of cases, fortunately very few, a formal search must be conducted, drawing on not only uniformed patrol

but also a search manager and members of the service's search and rescue team. Each of the steps described is a use of police resources that produces hidden costs typically "absorbed by police services".[30] To date, published Canadian studies that have looked at costs for mental health-related police calls have focused near-exclusively on mental health apprehensions and police wait times in hospitals.[31] Significantly less is known about other types of MH-related activities -- including missing persons inquiries involving absconders -- with the exception of two U.K.-based studies[32] and one Canadian study that estimated costs of PMI involvement in different types of offenses as a portion of a police budget.[33]

Scholars are frequently known to cite a "gap in the literature" as a rationale for conducting a study. In the instant case, we are attempting to begin the process of addressing a critical gap in knowledge on an important public policy issue. How we intend to do this is by demonstrating the existence of service issues that are both easily identified through analysis and remedied through practical strategies aimed at reducing service demands. Rather than taking a "whole apple" approach to shrinking the size of the policing footprint, we are showing how "small bites" can work to achieve this objective while realizing service efficiencies and cost benefits. To do this, we have chosen to analyze missing person calls for service as a starting point in a much larger project.

4. Data and methods

Materials

As previously stated, to explore this matter, we used data obtained from a crime analyst at a Canadian municipal police service who extracted all police calls for service over 2019 from their services record management system (RMS). These data contain particulars on each police report,

such as the dispatcher comments, event synopses, occurrence details, type of report initially determined by the dispatcher, the final type of report concluded after a police investigation, final Uniform Crime Report (UCR) categorization, times and locations, and other additional information acquired by police (for example, event address, time cleared, and so on.). Data were then anonymized by this crime analyst, who then extracted all calls for service and generated an *Excel* spreadsheet documenting these occurrences split by crime-related calls and social-related calls. This provided a total of 42,996 files (12,910 crime-related call records and 30,086 social-related) over this one year. From this, any files related to missing persons in both crime- and social-related records were extracted into a separate dataset. This is the data from which we draw upon for this study. Therefore, our final sample includes 2,033 missing person calls for service over 2019 from one Canadian police agency.

Coding and Variables

The covariate "Location Type" existed as a pre-existing category within the missing person calls for service *Excel* dataset. These were generated by the police service RMS (were not research-determined) and result from the dispatcher taking information on the location from which the call originates. However, as police data quality is a known issue, we also read each missing person file in full to extract addresses and locations, verify the coding, or adjust the coding if necessary. At this time, we intended to exclude any files in which we could not confirm the location type or if this information were missing completely -- a process known as listwise deletion. However, we were able to verify all files, and, as such, no missing person records were removed from our final sample.

The RMS-generated categories under the "Location Type" covariate included the following: "group home", "hospital", "mental health facility", "private dwelling", "school", "retirement home", "mission centre and homeless shelter", "mall", "park", "streets/roads/highways", "parking garage", "other non-commercial/corporate places", and "other public, commercial dwelling unit". The classifications of "group home", "hospital", "mental health facility, "private dwelling", "retirement home", and "mission centre and homeless shelter" were coded just as they were assigned in the police RMS and, as previously stated, were verified through our coding process. The categories of "public park", "mall", and "other public, commercial dwelling unit" were collapsed into one. This category was labelled "public". At this time, the remaining uncoded categories of "streets/roads/highways", "parking garage", and "other non-commercial/corporate places" were collapsed into an added group named "other". The "other" category was created as these location types and/or addresses could not be determined as either public or private, and so were thought appropriately placed within an "other" grouping.

For coding whether or not mental health-related issues were implicated in the police missing person call for service, we generated a binary dummy variable created to represent whether each report had mental health considerations documented throughout or not (0 = mental health not implicated, 1 = mental health implicated). To create this covariate, we coded all of the files manually within the *Excel* document. This was performed through the following steps. First, we conducted an initial manual review of any available qualitative or free text information in the police report (for example, event synopses, dispatcher comments, and event occurrence detail). This occurred to reveal any words within the records representing mental health components. Through this, we were able to collate a broad list of keywords for using to search through all the

reports to extract whether mental health was implicated or not. These keywords include, for example, “ADHD”, “OCD”, “Bipolar”, “Depressed/Depression”, “Suicidal/Suicidal Ideation”, and “Anxiety/Anxious”, and others. Then, we manually searched for these keywords throughout all of the missing person records (i.e., ‘CTRL + F’ within the *Excel* dataset).

After locating files through keyword search, we finally read each file individually in full before coding to ensure mental health is implicated within the record, instead of only relying upon the keyword search to code. This process occurred as some files had one or several keywords in the qualitative information but did not explicitly state or show that mental health was implicated in the call for service. Put another way, it was necessary to manually read each file before coding to ensure coding accuracy and that codes were not formed based on assumptions about the meaning of the comments. Once it could be verified that the file did include mental health considerations, the record was subsequently coded as “1” to indicate this implication.

Analytical Approaches

For the analytical approaches undertaken, descriptive and statistical analyses were employed first to identify the extent to which missing person calls for service are generated by social and health services. Frequency and crosstabulation analysis were used to examine the location types and show how often mental health is and is not implicated across all police calls for service categories based on the “Mental Health” variable. Then, logistic regression was used to predict the extent to which mental health is implicated in police missing person calls for service and the different call types. This model was selected as, given that the dependent variable in the analysis is binary (mental health implicated; 0 = no and 1 = yes) and involves bounded categories, the

application of a linear probability model violates the standard Ordinary Least Squares (OLS) assumptions. For predicting location types generating police missing person service calls, we employed multinomial logistic regression. This occurred as “Location Type” is a categorical variable that has unordered groupings of location types.

After this, a cost analysis is introduced across the cases identified as from social and health services and those involving mental health implications to assess the hidden cost of this offloading of responsibilities by other services for the police. For conducting this analysis, we utilized the first logged time in which the dispatcher received the call for service and calculated the number of minutes passed until the service call was marked as “cleared”. This information was extracted from the data columns titled “Date Received” and “Date Cleared”. Then, we captured the descriptive details and generated an average time to clearance across the various location types and split these further by the level of urgency assigned to each case. The latter process occurred as it is known that different case urgency levels reflect different police responses and, therefore, will incur different policing costs. In sum, we employ a mixture of analyses to understand the implications of defunding the police on missing person police service calls. The results of these analyses are presented below, with the respective analytical approaches outlined in each section.

5. Results

Where do police missing person service calls come from?

Table 1 presents a descriptive overview by way of frequency analysis of the different location types in which police missing persons calls for service originated. When comparing call figures across the different place types, the leading location from which missing person service calls are

derived is private dwellings (n = 546; 26.9 percent). That being said, concerning the whole sample, most service calls are from locations that are not private (n = 1487). Specifically, 73.1 percent of missing person calls for service stem from social and health services or other public places -- in essence, mission centres/shelters, group homes, mental health facilities, and hospitals. To expand on this, second to private dwellings is mission centers and homeless shelters, of which initiated 23.5 percent or 478 missing person service calls for police.

Group homes emerged as third in the ranking of police missing person calls for service. This location type generated 451 calls for service throughout 2019, or 22.2 percent of all missing person police reports. Group homes exist to support special populations that need a supervised living environment, including, but not limited to, children and youth in care, individuals with developmental or physical disabilities, and/or victims of domestic abuse. The purpose of group homes is essential to contextualize as conversations surrounding defunding the police are centered on police not being involved in service calls involving such groups of people, yet, as it appears, these facilities are the callers seeking assistance with persons under their care and safeguarding yet who are going missing.

Making up 10.1 percent of all police missing person service calls, or 205 reports, are mental health facilities for longer-term stays. Hospital facilities, including emergency mental health units and general hospital care facilities, comprised 6.0 percent or 122 calls for service. These are highlighted here as standard rhetoric regarding demands to defund the police is that police should also not be handling service calls involving persons in crisis and/or persons experiencing mental illness. Yet, other facilities existing to provide servicing and protection for these individuals appear to be locations that call the police to handle missing persons from their facility in this dataset. Lastly, public arenas (n = 106; 5.2 percent), retirement homes (n = 65; 3.2

percent), and other areas (n = 60; 3.0 percent) are also calling police to respond to persons who have gone missing, albeit they are the least location types in the mix of places that generate service calls.

Table 1. Descriptive Overview of the Location Types Reporting Persons Missing to the Police

Location Type	Total	%	Cumulative %
Private	546	26.9	26.9
Mission Center/Shelter	478	23.5	50.4
Group Home	451	22.2	72.6
Mental Health Facility	205	10.1	82.7
Hospital Facility	122	6.0	88.7
Public	106	5.2	93.9
Retirement Home	65	3.2	97.1
Other	60	3.0	100.1
Total	**2033**	**100.0**	**100.1***

*Discrepancy in total percentage is likely due to the rounding procedure.

In examining the general descriptive picture of the location types generating police missing person calls for service, we can understand that health and social services are primary callers for police services for missing persons in this dataset. Additionally, with mission centers and homeless shelters being the second key contributor to police calls for service, the third being group homes, and the fourth being mental health facilities, it also becomes apparent that vulnerable populations in contact with institutional facilities and networks are frequently the focal population in police missing persons call for service. Put another way, these individuals are already plugged into "upstream" institutional resources and networks. Yet, from our data, it appears as though these social and healthcare providers are, in fact, "offloading" responsibility onto the police as a means to locate missing people.

To what extent is mental health implicated in police missing persons calls for service?

Next, inquired about how many of these calls for service implicate mental health-related issues in their reports. Table 2 presents the results of the crosstabulation analysis. We can see that

mental health is involved in 36.0 percent or 731 police missing person calls for service. This means that most missing person service calls do not disclose mental health-related issues within the dispatcher's comments. To further assess this matter, we also conducted logistic regression. As documented in Table 2, we can see that mental health-related issues being involved in police missing person calls for service did not emerge as statistically significant (OR = 0.921, $p > .05$). Therefore, missing persons call for service: (1) often do not implicate mental health-related matters, but (2) are not significantly more or less likely to involve mental health.

Table 2. Descriptive Overview and Logistic Regression Examining the Extent to Which Mental Health is Implicated in Police Missing Person Service Calls

Mental Health?	Total	Percent	OR*
No	1302	74.0	-
Yes	731	36.0	0.921 (0.017)
Total	**2033**	**100.0**	

*Odds ratio from logistic regression predicting mental health being implicated in missing person calls for service.
Standard error is in paratheses below OR.
'No' is the base category.
Weighted estimate by 95% confidence interval.

To what extent is mental health implicated in police missing persons calls for service across the location types?

With the above in mind and our knowledge of the existing literature discussing the pervasiveness of mental health in police calls for service, we sought to conduct additional analyses to understand the extent of mental health being implicated in police missing persons calls for service across the location types reporting persons missing. Table 3 presents the results of this analysis. Unsurprisingly, across the calls that did implicate mental health-related issues, mental health facilities emerged as the highest group implicating such issues in their services calls related to missing persons (n = 205; 28.0 percent). Closely following mental health facilities are group homes (n = 170; 23.3 percent), mission centres and homeless shelters (n = 158; 21.6

percent), and private dwellings (n = 138; 18.9 percent). However, regarding the latter location type, private dwellings also comprise the group in which the highest number of service calls did not implicate mental health (n = 408, 31.3 percent). The main takeaway here is that this is a clear illustration of how complex missing persons can be, with a substantial number of missing persons eloping from facilities that they are plugged into while having mental health-related concerns as an underlying issue.

Table 3. Crosstabulation of Location Type and Mental Health (MH) Implications in Police Missing Persons Calls for Service

Location Type	MH – Yes (%)*	MH – No (%)*	Total (%)
Private	138 (18.9)	408 (31.3)	546 (26.9)
Mission Center/Shelter	158 (21.6)	320 (24.6)	478 (23.5)
Group Home	170 (23.3)	281 (21.6)	451 (22.2)
Mental Health Facility	205 (28.0)	0 (0.0)	205 (10.1)
Hospital Facility	12 (1.6)	110 (8.5)	122 (6.0)
Public	38 (5.2)	68 (5.2)	106 (5.2)
Retirement Home	9 (1.2)	56 (4.3)	65 (3.2)
Other	1 (0.1)	59 (4.5)	60 (3.0)
Total	**731 (36.0)**	**1302 (74.0)**	**2033 (100.0)**

** Column percentages are in relation to the column totals. Row percentages are in relation to the final sample.*

Are certain location types significant drivers of police missing person service calls?

So far, our analyses have revealed that (1) social and health services make up the most substantial number of police service calls for missing persons across the location types; (2) mental health-related issues emerged as somewhat underlying across missing person service calls; and (3) yet missing person service calls across certain location types implicate mental health substantially. To this end, we now present the results of two multinomial logistic regression models to predict service calls across the location types and predict mental health implications. Model 1 predicts which location types are the main drivers of police missing person service calls in comparison to private dwellings. Then Model 2 introduces mental health-related implications across the location types. These two models exist first to predict the extent to

which each location type may contribute to missing person service calls and then extend this understanding by predicting mental-health implications across each location type. In order words, to see if location type and mental health calls compound such that they can significantly impact police missing person calls for service.

First, to discuss Model 1, several location types emerged as significantly more likely to generate police missing person calls for service compared to private dwellings. Specifically, retirement homes and hospital facilities emerged as over two times (2.505 times and 2.016 times, respectively) significantly more likely to generate police missing person service calls when compared to private dwellings. Mental health facilities emerged as 1.636 times significantly more likely to generate police missing persons calls for service, group homes as 1.441 times significantly more likely, and mission centers and homeless shelters as 1.474 times significantly more likely. This means that all of these location types are predicted to generate police missing person service calls more than private dwellings. In contrast, public areas, such as parks or malls, emerged as 0.153 times less likely to generate police missing person service calls than private dwellings. Other places did not emerge as statistically significant.

Turning to Model 2, we can see some changes across the statistically significant covariates. Most notably, when implicating mental health in a service call, the effect size of mission centres and homeless shelters, group homes, and hospital facilities increased. To expand on this, mission centres and homeless shelters emerged as 1.589 times more likely to generate a missing person service call that implicates mental health in Model 2, compared to 1.475 times more likely without mental health implications in Model 1. Group homes emerged as 1.789 times more likely

in Model 2, whereas these locations emerged as 1.441 times more likely in Model 1. The effect size of hospital facilities increased more substantially, with Model 2 reporting that these locations are 2.817 times significantly more likely to generate a service call when mental health-related issues are involved, in comparison to Model 1 recording 2.016 times more likely. Lastly, and expectedly, the mental health facilities' covariate effect size increased when interacting with mental health implications in police service calls. It increased to 2.011 times significantly more likely in Model 2 compared to 1.636 more likely in Model 1. The effect size of retirement homes decreased, although these locations still emerged as 1.523 more likely to generate a police missing person call for service than private dwellings when including mental health implications. What do these findings mean? Ultimately, that when a missing person service call involves mental health implications, mission centres and homeless shelters, group homes, and hospital facilities are around two times significantly more likely to generate such calls involving mental health-related issues in comparison to private dwellings. Therefore, in our dataset, health and social services offloading responsibilities to police compound as a matter when recognizing that mental health-related issues can underlie missingness and exacerbate police missing person service calls.

Table 4. Multinomial Logistic Regression Predicting Calls For Service Across Location Types

	Location Type	**Location Type x Mental Health**
Private (Base)		
Mission Center/Shelter	1.475*	1.589***
	(0.027)	(0.097)
Group Home	1.441**	1.789**
	(0.028)	(0.033)
Mental Health Facility	1.636***	2.011***
	(0.088)	(0.194)
Hospital Facility	2.016***	2.817**
	(0.103)	(0.398)
Public	0.153*	0.355***
	(0.015)	(0.112)

Retirement Home	2.505***	1.523*
	(0.129)	(0.193)
Other	0.082	0.589
	(0.011)	(0.097)
Number of Observations	2033	2033

Standard errors are in parentheses below parameter estimates.
Model 1 = Location only, Model 2 = Location interacting with mental health implications.
Displayed in this table are the relative risk ratios from the multinomial logistic regression models.
**p <.05; **p <.01; *** p <.001.*
Weighted estimates by 95% CIs.

What is the 'Hidden Cost' for Policing Related to Health and Social Services "Offloading"?

Our results so far have shown that mental-health related service calls from social and health services are not only primary drivers of police reports but also are significantly more likely to occur in missing person reports compared to private dwellings. To this end, our final analysis involves introducing a cost analysis based on the variable "time to clearance" involving only those health and social service locations. As can be seen, the average time to clearance -- which involves from the moment dispatch receives the service call until the call is cleared -- is 456 minutes or 7.6 hours. The range of clearance times is the minimum amount of time a call involved was 11.6 minutes, and the maximum amount of time taken up by a service call from these location types is 2,839.7 minutes or 47.3 hours.

Table 5. Descriptive Statistics of 'Time to Clearance' Variable

Variable	N	Mean	Std. Dev.	Min (mins)	Max (mins)
Time To Clearance	731	456.0	395.0	11.6	2839.7

The average cost for a first-class constable in the police service from which these data are derived is $48.85 per hour. We have estimated that the typical call consumes about 7.6 hours of police time for an average cost of approximately $371.28. There are certain caveats with this figure. First, clearance times do not tell us how the time was actually spent. It may be the case

that an officer only spent two hours actually responding to the call, which would reduce the figure. It also does not tell us how many officers were involved in the call. We have estimated based on one officer, but it may be the case that for specific calls, as we noted above, multiple units may be involved, including a patrol Sergeant. Multiple officers would increase the call costs. With these caveats in mind, our call costs for the 731 cases identified as originating from an institution or other facility are $35,709 per annum.

6. Discussion

In the preceding pages, we presented an analysis of police RMS data on missing person files from a municipal police service for the year 2019 to demonstrate the extent to which demands for police services related to absconding are generated by healthcare and social work facilities. Our point in offering this analysis is to highlight one aspect of police-civilian encounters with PMI that, to date, has received far too little attention. Whereas much of media and public attention has focused on police wellness checks,[34] or calls involving individuals in extreme emotional or psychological crisis,[35] the more mundane but routine patterns of police interactions have escaped attention. What has also escaped attention is how many of the same institutional groups that are being held up as solutions to real or perceived crises in police encounters with PMI are, in fact, contributors to police workload in this area. The demands they generate arise through deliberate offloading of responsibilities for patients or clients who leave their premises. We have looked at this process here in the context of absconding, but it also occurs in relation to other call types.[36]

Recent calls to reimagine policing have employed economic arguments to shape policy and practice -- namely, through reducing police budgets and reallocating funds to social and health

care-based solutions ("defunding the police"). We believe that a similar argument could be made for reversing the trend of healthcare and social work institutions towards "dumping" aspects of their caseload responsibilities onto policing. One way to do this is to show the hidden costs associated with this offloading that are presently subsumed within police budgets. Based on our estimates, we believe that the one municipal police service is absorbing approximately $35,000 per year in taking on this one task. Multiplying this cost for this one call type[2] over 200 or so police agencies across Canada helps us start to understand the extent to which social and healthcare offloading is generating some of the costs associated with policing.

Our goal in highlighting both the problem of "offloading" and its costs is not to simply critique the present system, but rather to point out that shifts in policy and practice "upstream" -- that is, by health care and social work organizations -- could reduce police workload. Further, a more obvious solution -- in terms of preventing the potential harm that critics of the police worry about, reducing the footprint of public policing and, from a purely economic standpoint, reducing costs of absconding -- would be to focus on prevention efforts at the source.[37] However, many would-be reformers shy away from such efforts fearing the possibility of passive or active coercion being employed against institutionalized youth or adult mental health patients.[38] We believe that prevention is the key; however, we must begin to develop non-coercive strategies. If we don't, any long-term reform in this area will be stymied.

Notes

[2] It is worth noting, for example, that police are also responsible for returning individuals to psychiatric facilities on involuntary admissions. Future research might consider looking at this role and associated costs.

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[11] Short, "Policing and the Mentally Ill," 176-191.

[12] Egon Bittner, "The police on skid-row: A study of peacekeeping," American Sociological Review 32, no.5 (October, 1967): 699-715.

[13] Ibid.

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