Submission to the Braidwood Inquiry into the use of Tasers

A perspective from the Canadian Mental Health Association BC Division May 10, 2008

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Background

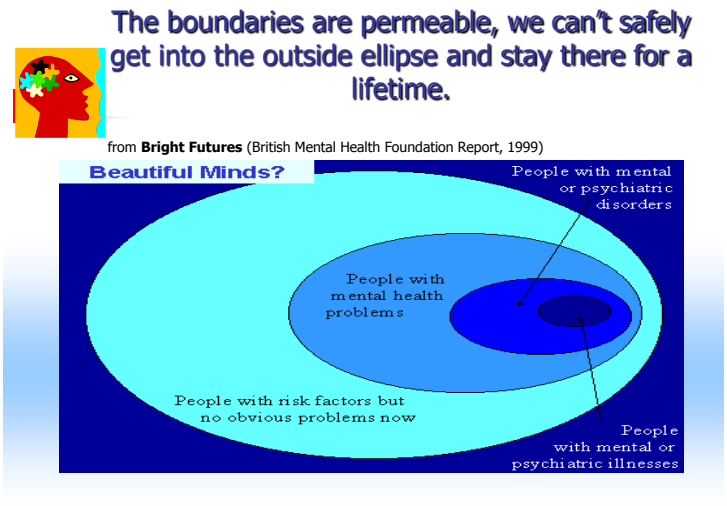
Canadian Mental Health Association, BC Division is a non-profit organization incorporated in 1953. Our mission is to promote the mental health of British Columbians, and support the resilience and recovery of people experiencing mental illness. CMHA accomplishes this mission through advocacy, education, research and services. We have 20 local CMHA branches in communities throughout BC providing information, education, social and other resources for persons with mental illness in these communities.

Mental Illness/Mental Health Problems

This inquiry about the use of taser is in relation to what law enforcement officers and security officers do in response to individuals in a behavioral health crisis. It's helpful to begin with some definitions about whom and what we are talking about when we refer to mental illness or mental health problems.

Mental illness is the term that refers collectively to all diagnosable mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. Alzheimer's disease exemplifies a mental disorder largely marked by alterations in thinking (especially forgetting). Depression exemplifies a mental disorder largely marked by alterations in mood. Attention-deficit/hyperactivity disorder exemplifies a mental disorder largely marked by alterations in behavior (overactivity) and/or thinking (inability to concentrate). Alterations in thinking, mood, or behavior contribute to a host of problems—patient distress, impaired functioning, or heightened risk of death, pain, disability, or loss of freedom (American Psychiatric Association, 1994).

"Mental health problems" refer to symptoms that interfere with daily functioning. The individual may not meet the criteria of signs and symptoms with sufficient intensity or duration to meet the criteria for a mental disorder. Almost everyone has experienced mental health problems in which the distress one feels matches some of the signs and symptoms of mental disorders. The point to make here is that the boundary between what is normal and what is abnormal is very permeable. Someone may have an underlying condition and be but in an environment that triggers a response resembling a mental disorder.



While researchers emphasize there is approximately a one in five life time prevalence of mental illness, at any one point in time there are an estimated 130, 000 individuals in BC with a severe addiction and or a mental illness that is both serious and persistent[1]. There are many more individuals who could be said to be having a mental health problem. We need to get used to the fact that mental illness and mental health problems are common and the distress that accompanies someone in a crisis can be diffused by skilled responders.

The Context regarding People with Mental Illness in BC

There are some important points to make with regards to the management of people with mental disorders in a psychiatric crisis. The context begins with how people come to realize their mental health problem might be a mental illness, how long it takes to get a diagnosis and how they enter the mental

[1] Patterson M, Somers J, McIntosh K, Shiell C & Frankish J (2008) Housing and Supports for Adults with Severe Addictions and/or Mental Illness in British Columbia. CARMHA: unpublished document.
Downloaded on May 6, 2008 at:
http://www.carmha.ca/publications/resources/pub_hsami/Housing_SAMI_BC_FINAL_(pre-desk).pdf

This definition of serious addiction and mental illness (SAMI) includes all of the major Axis I disorders as defined by the Diagnostic and Statistical Manual (DSM-IV-TR), focusing on those individuals whose functional capacity is seriously compromised. This definition includes severe forms of substance use, eating, and anxiety disorders as well as mood and psychotic disorders. Finally, this analysis includes adults between the ages of 19 and 80 years.

health system which is unfortunately for a majority…is in a crisis… one in three of which appear to be responded to by the police.

- **For the individual with a mental health problem and or his or her family, coming to terms with the possibility of a mental illness and seeking and accessing care is a challenge.** Research on a cohort of BC individuals, found that from the time of first onset it took three years on average for people with schizophrenia, and schizoaffective disorder to access treatment. From the time of *acute* onset it took on average one year to access care. From the time for first onset it took between seven and eight years for people with mood disorders to access care. From the time of *acute* onset it took six months to access care[2]. This means in terms of crisis response, many individuals experience repeated crises and disturbances before getting to help.
- **A majority of individuals with a mental illness access mental health care via crisis intervention.** In BC research conducted by the Canadian Mental Health Association, 60% of the sample accessed mental health treatment directly from the hospital, through the emergency ward, under emergency or crisis-driven situations. And 30% of the sample was brought to hospital by the police[3].
- **Since the closure of long stay psychiatric institutions there has been an increase in the number of people with mental disorders in contact with the police, in conflict with the law, and in jails.** The increase in the number of mentally ill people in the criminal justice system may be as much a product of the increase in the use of substances by people with mental illnesses as it is due to the deinstitutionalization of mentally ill patients[4]. The point here is that the situation in the community is much more complex than days of old when individuals presented with just a mental illness.
- **The police are increasingly called upon to engage with and manage mentally disordered individuals on a daily basis.** The report Lost in Transition, recently released by the Vancouver Police Department, provides a snapshot of the situation encountered by police departments across North America. The report states that 31% - and in some areas of the city almost 50% of police incidents involved a person believed to be experiencing the effects of a mental illness[5].
- **Current treatment resources are inadequate and frequently result in a revolving door between community and hospital with police and family members mediating access. According to a new analysis from the Canadian Institute for Health Information, 38% of patients discharged with a diagnosis of schizophrenia from a general hospital in Canada had unplanned readmissions (through emergency departments) for a mental illness within one year of their discharge. The analysis also found that 12% of schizophrenia patients (or one in**

[2] Macnaughton E (1999) The BC Early Intervention Study. Canadian Mental Health Association—BC Division.

[3] Ibid

[4] Somers JM, Cartar L & Russo J (2008) Corrections, Health and Human Services**:** Evidence Based Planning and Evaluation. Downloaded on April 23, 2008 from: http://www.carmha.ca/publications/resources/pub_chhr/Corrections_Health_HumanServices_EBPE.pdf

[5] Wilson-Bates, F. (2008) Lost in Transition: *How a Lack of Capacity in the Mental Health System is Failing Vancouver's Mentally Ill and Draining Police Resources* Downloaded on February 4, 2008 from: http://vancouver.ca/police/Whatsnew/transition.htm

eight patients) were readmitted to hospital within 30 days of their initial discharge, in the years 2003 to 2005[6].

There is another contextual factor that influences what the police see in responding to an individual with a mental health problem or diagnosed mental illness. Since the 1950s British Columbia has been in the process of closing the long stay institutions for people with mental illness and developmental disabilities. The premier of British Columbia in speaking to the Union of BC Municipalities has referred deinstitutionalization of mental health care as a "failed experiment" [7]. The situation in the Vancouver Coastal area is particularly acute with Riverview beds having decreased from approximately 1000 in 1998 to 174 in 2008. At this date Vancouver Coastal has only produced 9 of the promised 209 Riverview Replacement beds.[8]

What this means is for people with a severe addiction and or mental illness (SAMI), they are more likely in 2008 to be homeless than ten years ago. A recent report by researchers at Simon Fraser University identifies that approximately 26,250 people in British Columbia (range of 17,500 - 35,500) or 20% are both inadequately housed and inadequately supported[9].

A smaller subset of the SAMI population is absolutely homeless, estimated to be 11,750 (8,000 - 15,500). In BC, there are currently 7,741 housing units with housing-related support available to adults with SAMI. When this housing stock is subtracted from the estimated need, an estimated 18,759 adults with SAMI are at imminent risk of homelessness. Aboriginal people are a greater risk of homelessness and severe addiction and or mental illness. It is estimated that 41% of all Aboriginal peoples in BC are at-risk of homelessness and 23% are absolutely homeless[10].

This means that the situation for police and others responding to crisis in the community is very complex. Not only are there people with severe addictions and mental health issues often caught up in a revolving door but there is a significant number of individuals in BC who are living in precarious situations leading to public disorder and likely to draw attention of the police.

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[6] Canadian Institute for Health Information (2008) Hospital Length of Stay and Readmission for Individuals Diagnosed With Schizophrenia: Are They Related?

[7] Premier's Speech to 2006 BC Union of Municipalities AGM
http://www.news1130.com/news/local/article.jsp?content=20061027_201016_2156

[8] Lorna Howes. Presentation to Beyond Beds Conference April 29, 2008 Victoria BC

[9] Patterson M, Somers J, McIntosh K, Shiell C & Frankish J (2008) Housing and Supports for Adults with Severe Addictions and/or Mental Illness in British Columbia. CARMHA: unpublished document.
Downloaded on May 6, 2008 at:
http://www.carmha.ca/publications/resources/pub_hsami/Housing_SAMI_BC_FINAL_(pre-desk).pdf

[10] Ibid

Introduction to CMHA – BC's Policy Position

Our work with Police and People with Mental Illness

Over the past eight years, police and justice issues related to mental health has developed into one of CMHA BC's policy priorities, beginning with intervenor status at the 1999 Coroner's inquest into the police shooting death of Donald Meyer. CMHA BC followed up with a research report (*A Study in Blue and Grey, 2003*) outlining best practices in police Interventions with persons with mental illness. This report has become a primary source of guidance in many communities for the development of comprehensive programs for police response to persons with mental illness.

In 2005, we initiated the Mental Health and Police Project in six communities where local stakeholder groups mapped first response to persons with mental illness, determined the gaps and issues in that response, and developed action plans to address them. This successful project was expanded to another three communities in 2006. Other outcomes from this project include a series of eight fact sheets, a guide to developing collaborative response in the community, a clearinghouse of resources, and a series of enhancement projects for a number of the participating communities.[2]

CMHA BC recognizes that the police in British Columbia are increasingly first responders to mental health crises, and there is no doubt that police have become front line mental health workers in recent years. A recent review estimates that between 7 to 40% of police contacts are with people with mental illness. A CMHA BC study found that over 30% of people came into contact with police during their first experience trying to access mental health care in BC. This is a trend seen across North America and beyond, earning police the nickname "psychiatrists in blue."

At the same time we are seeing changes in the composition of our police forces, with a large number of retirements and an influx of new and younger officers. As of 2005, the police strength in BC (i.e. number of police officers including independent municipal forces, municipal RCMP forces, RCMP provincial forces, and aboriginal officers) was 7,201 members; no doubt the number is now higher. Currently the Translink police force has 121 sworn members, and has 20 deployed Conducted Energy Devices as of July 2007.

Aside from police officers, the Canadian Border Services Agency currently has 1,160 uniformed designated peace officers. We also have an extensive private force in the form of licensed security personnel of which there are currently approximately 11,000 in BC—8,000 of which are security guards. These latter figures are relevant in terms of potential legislative changes enhancing the powers and capacities of private security personnel to carry and use restraining devices and other means of control.

CMHA BC has been active for a number of years in working collaboratively with police and other community stakeholders to improve first response to persons with mental illness. We continue to be involved in a number of initiatives in the area of justice, and promote best practices in the development of police education and policy in this area.

We see this as a time of tremendous opportunity to instill in the official police forces and the private security sector a greater knowledge and appreciation of persons with mental illness and the most successful way to interact with them, especially in times of crisis. We strongly recommend that police agencies and the ministries that govern them review their policies and amend them so as to conform to

evidence of best practice in responding to persons with mental illness, most specifically in the following three areas:

1. Standardized Crisis Intervention Training Embedded in Policy
2. Placement of Tasers on Use-of-Force Continuums
3. Increased Research into and Monitoring of the Use of Tasers

Standardized and Improved Crisis Intervention Training

The first level of intervention is and always should be verbal crisis intervention. The effectiveness of such intervention depends, however, on an officer's level and quality of training, his/her natural and enhanced abilities, and the commitment to priority use of such intervention. This commitment has to be demonstrably supported not only by the individual officer but throughout the organization.

Currently, the 6 month police recruit training at the Justice Institute (which is the main recruit training centre for municipal forces in BC) provides a very limited crisis intervention/mental health component. There is a three hour classroom component specific to mental health, with mental health related issues otherwise sprinkled throughout the training. This is extremely limited, considering the percentage of police contacts involving mental health issues is relatively high[11], and considering that this type of training is significantly different from the majority of police recruit training which is historically based on "command and control" approach; the significance of any crisis intervention training techniques is likely to be lost in the mix of "command and control", weapons, and physical control training.

The use of proven effective crisis intervention team models is neither widespread nor uniform in BC. CMHA BC's publication *Study in Blue and Grey: Police Interventions with People with Mental Illness* (2003) provides a comprehensive review of the issues, challenges, and solutions in this area. Evidence based best practices suggest that key components for effective crisis response include:

1) Developing a core of carefully selected "first call" crisis response officers available 24 hours a day 7 days a week;
2) Specialized system of dispatch;
3) Comprehensive 40 hour integrated training for designated officers, dispatch, psychiatric liaison nurses, and other first responders (e.g. ambulance paramedics) with ongoing annual training;
4) Having an accessible point of entry to mental health services (reception centre) available 24 hours/day and 7 days/week with a no refusal policy;
5) Good information and information sharing systems in place;
6) Protocols for achieving collaboration with mental health services;
7) Development and ongoing support of community crisis response collaboration teams once these professionals are trained; and
8) Means of evaluating and measuring outcomes.

At a systemic level, high level inter-ministerial and interagency policy support of effective crisis response models is a necessity, as is the leadership and financial support required to implement the model successfully.

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[11] The Vancouver Police Department report *Lost in Transition* indicates between 30 and 49% of police calls received during the research period involved a mental health issue. While the methodology of data collection was compromised in this study, these numbers reflect what we have heard anecdotally from police.

Research data confirms the benefits of using crisis response models, particularly Crisis Intervention Team models, to reduce injury and death to police officers and persons with mental illness and to increase more appropriate outcomes to interventions.[12]

Placement of Tasers on the Use-of-Force Continuum

Training for CED varies from province to province and police agency to police agency, generally by the use-of-force training officers and in relation to the use-of-force continuum. As CEDs are relatively new devices, there is some disagreement on where they should be placed on the use-of-force continuum, but in most continuums, they are included in the "intermediate weapons" category which also includes capsicum spray and impact weapons (batons, beanbag shotguns, rubber bullet rifles).

There are several use-of-force policies relevant to BC: the RCMP Incident Management Intervention Model (IMIM) (which has recently been changed, and is currently undergoing further revision) and the National Use of Force Framework (NUFF). The four versions are quite similar. The main differences between the three versions (IMIM1, IMIM2, and NUFF) are the points on the continuum at which physical control begins, where the use of intermediate weapons begins, and —between IMIM 1 and IMIM2— inclusion of a distinction between passive resistance and active resistance by the person concerned. The IMIM2 now includes physical control as a tactic from the virtual outset of the interaction and recommends the use of intermediate devices starting specifically with active resistance.

The newest (and yet to be approved) IMIM makes two changes: the use of physical control is moved to a midpoint of the "communication" response (showing a concurrent communication and soft physical control option) and the use of intermediate weapons is moved to a slightly later stage in active resistance (still at the front end of active resistance).

Diagrams of the three models (as well as the as-yet-to-be-approved new model of IMIM) are included at *Appendix A*.

A. Emphasize De-escalation

The challenge with use of force policies is that they do not acknowledge the distinction between interventions with persons who do not exhibit mental illness and/or mental illness with substance misuse problems (known as concurrent disorders) and with those who do. A use of force policy appropriate for police response to normal resistance or aggression is not the most appropriate model for interactions with persons experiencing and exhibiting the symptoms of mental illness and/or concurrent disorders and can potentially cause more harm than good. For example a person experiencing hallucinations and/or delusions may well exhibit active resistance or signs of aggression in response to police commands or physical control out of very real fear; applying usual police command and control tactics can escalate the fear and the crisis reaction. Some standard police commands (such as to kneel or lie down), and/or attempts at physical control may instigate a strong negative response due to previous trauma experiences or paranoid delusions. These issues are not taken into account in a generic framework.

[12] Dupont, R., Cochran, S.: Police response to mental health emergencies: barriers to change. J Am Acad Psychiatry Law 28:338-44, 2000 [Medline]

We emphasize that when dealing with persons with mental illness in crisis, the most appropriate and effective response is use of de-escalation techniques. Once mental health issues are suspected or identified, much greater emphasis needs to be placed on the use of de-escalation techniques through communication rather than physical control and use of any type of weapon. De-escalation techniques (a cornerstone of Crisis Intervention training) include a non-threatening approach with positive problem-solving communication and require an understanding of the nature, symptoms and experience of mental illness and some empathy for what the individual is experiencing.

These de-escalation techniques must be clearly understood and practiced as they are very different from the communication techniques generally used in police interventions. There must be a recognition and acceptance that these techniques take time and patience, and require listening skills and ways of interacting that may be out of synch with police practices of "command and control" applicable in other police interventions. These are, however, the methods most likely to effectively resolve an incident involving a person with mental illness safely and with the best outcome for all involved.

Ancillary to this, verbal communication will only be effective if it is understood, therefore all efforts must be made to ensure that potential cultural and language issues are considered and addressed from the outset, through information gathering at the initial call, and through the dispatch of officers with appropriate language and cultural knowledge or that persons with the language, cultural and crisis communication skills are called in to assist with effective communication.

B. Conducted Energy Devices

Recent events have highlighted concerns respecting police use of Conducted Energy Devices (CED), more commonly known as Tasers®. When police in British Columbia first began using the CEDs in 1999, CMHA endorsed their use as a less lethal alternative to deadly force. With continued use of CEDs, we must acknowledge concerns, however, about the number of deaths related to their use and the lack of independent and consistent research data related to potential physical, mental and emotional harm, particularly for people with mental illness. Since 2001, at least 22 people have died in Canada after CED applications—including four in BC over a single 15 month period. We have no current data on the number of cases where police have used CEDs in situations specifically involving people with mental health issues, or the impacts of these incidents.

While we continue to endorse the use of CEDs as a preferred alternative to lethal force options, we are concerned about their placement on the use-of-force continuum used by police agencies as an "intermediate device" that is recommended for use at the early stages of active resistance. We strongly recommend that these devices be used only as an alternative to deadly force, when all other options are exhausted.

Special consideration must also be given to the manner in which CEDs are applied. Although CEDs may be used in two ways, no distinction is made in the use of force framework. When used in stun mode, the device is pressed against the body and generally only affects the sensory nervous system[4]; in Electro-Muscular disruption (EMD) mode, probes are shot into the body which then conduct electricity from the device via wires attached to the probes. In EMD mode, the electrical charge overrides the central nervous system.

The CED in Electro-Muscular Disruption mode (as opposed to Stun mode) is the only one of the intermediate devices consistently associated with a higher incidence of death as either a sole or contributing factor. At this stage of development and evaluation of the CED, there is no consistent and

independent evidence that EMD CED applications do not cause or contribute to death in some circumstances. CEDs in EMD mode should not be considered for use on an individual who is not an imminent threat to cause death or grievous bodily harm. Factors indicating the potential presence of psychosis, drug use or withdrawal, "excited delirium," or heart problems—which may increase the potential for death in conjunction with CED application—should also be recognized as a heightened risk in the application of CED. As such, EMD CED application should be considered as a very last option before lethal force particularly where these factors are suspected to be present, and policies should require that medical personnel be called on an emergency basis before or as soon as possible after CED use in these circumstances.

One other factor which has been linked to deaths following application of EMD CEDs is multiple and/or prolonged discharges. As the initial CED discharge will effectively incapacitate an individual for only a brief period of time, officers should be prepared to immediately use other means of containment prior to application of a first discharge. Only if all other means of containment or control are ineffective and the individual continues to be an imminent threat to cause death or grievous bodily harm after the first discharge should any additional shocks be given.

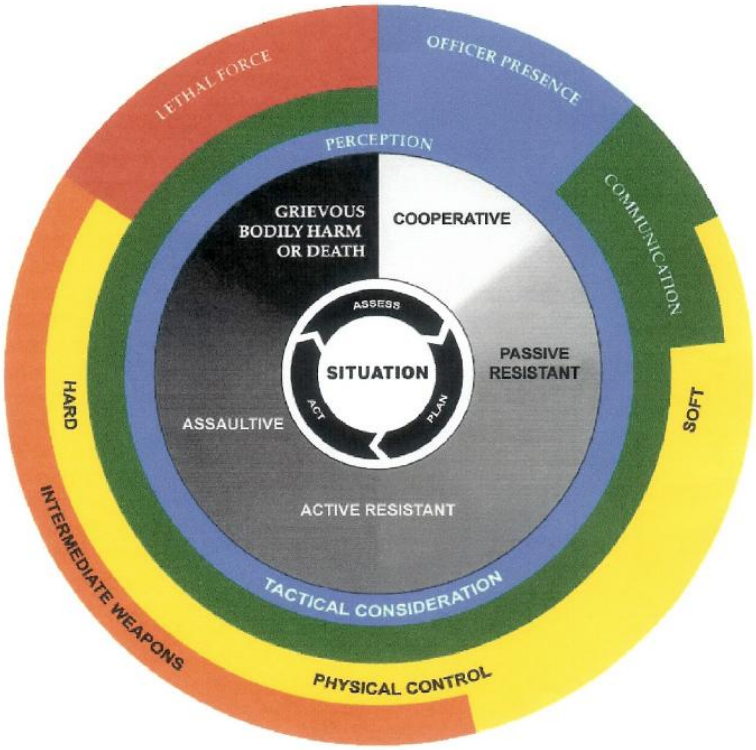
Increased Research and Education into the Use of Tasers and their Impact

While there have been a number of studies conducted on deaths following the application of EMD CEDs, there is no consistent and independent peer-reviewed literature indicating that these CEDs are not potentially lethal.

Rigorous independent research is required on the impact of EMD/ Stun CED application in cases where the individual survives as well as where the individual dies especially where factors such as agitation, drug consumption, psychosis and/or heart problems are present. Due to a consistent correlation in the deaths after the application of EMD CED of persons apparently experiencing "excited delirium," further studies should be undertaken on the nature and resolution of this state in other contexts without the application of CED, and other alternative responses to this cluster of symptoms. Research is also needed on the potential impact of CED application on mental and emotional health, particularly among persons with mental illness.

Appendix A

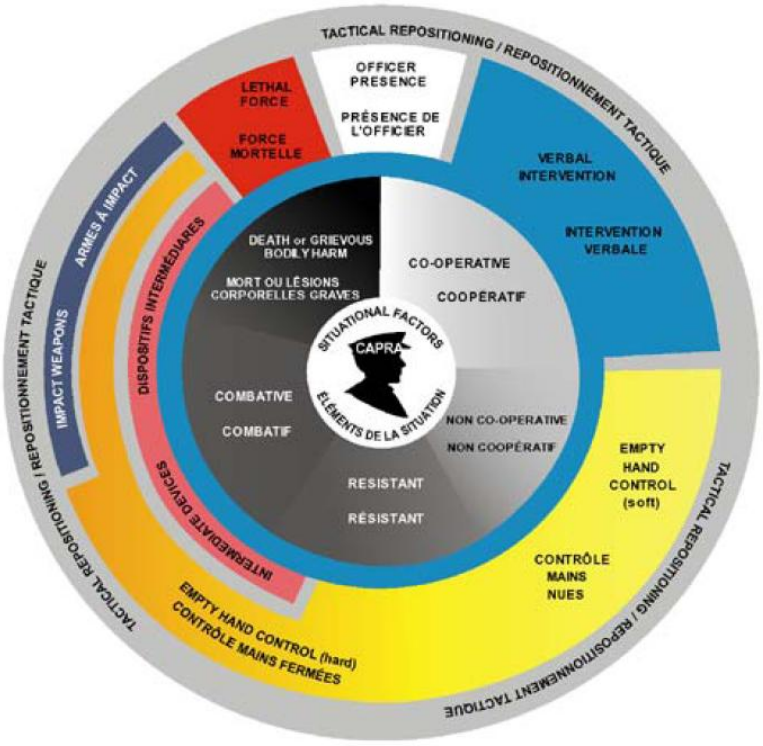
National Use of Force Framework



The officer continuously assesses the situation and acts in a reasonable manner to ensure officer and public safety.

RCMP Incident Management Intervention Model

(old)



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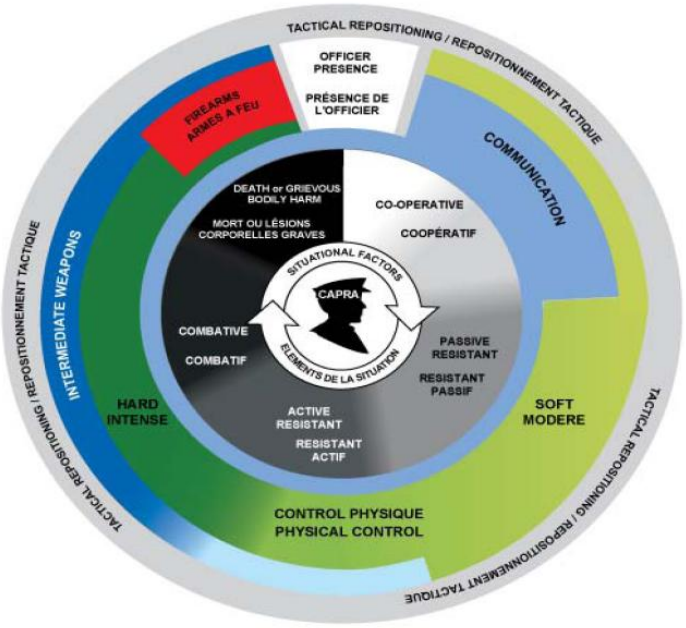
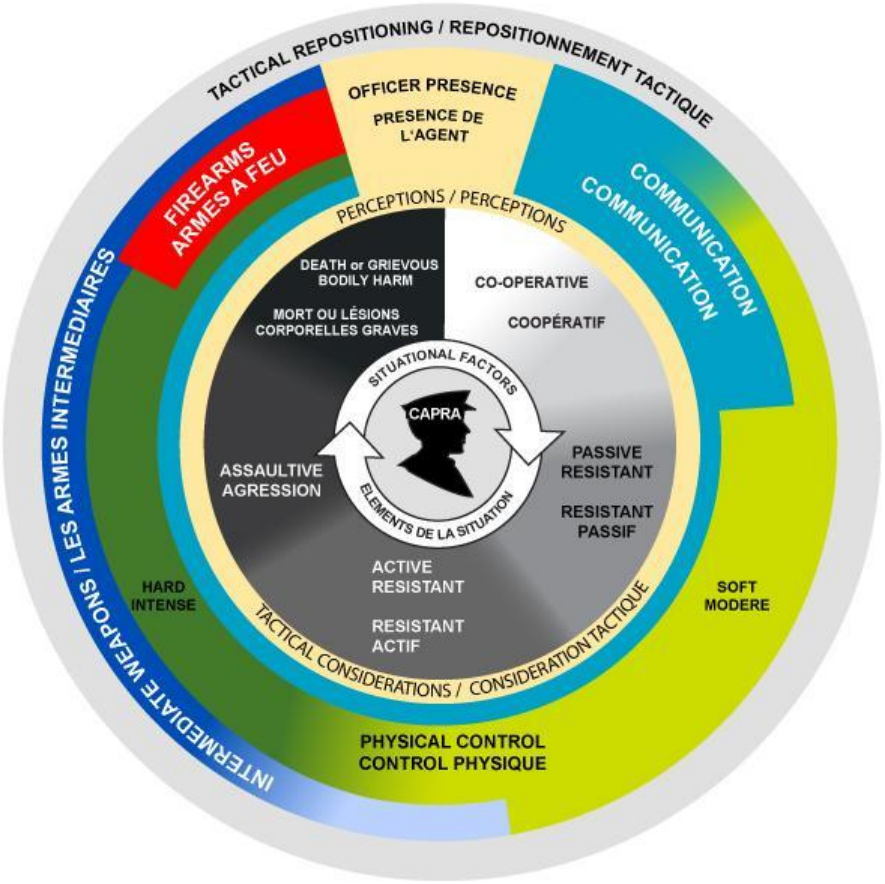
RCMP Incident Management Intervention Model

(new)



Incident Management Intervention Model
Modèle d'intervention pour la gestion d'incidents



The officer continuously assesses risk and applies the necessary intervention to ensure public and policy safety.

L'officier évalue continuellement les risques et applique la forme d'intervention convenable afin d'assurer la sécurité du public et des services policiers.

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