



POLICY STATEMENT

March 2008

Crisis Intervention Policy for Police Working with People with Mental illness/Concurrent Disorders¹

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.

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 communities involved.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 ECDs 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

¹ Drafts of this policy have been reviewed by and commented on by a number of experts in this area. See *Appendix B*.

² *Study in Blue and Grey*, fact sheets, guide and reports can be found at www.cmha.bc.ca/advocacy/justice.

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. Increased and Improved Crisis Intervention Team (CIT) Training and Models

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.

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) good information and information sharing systems in place; 5) protocols for achieving collaboration with mental health services; 6) development and ongoing support of community crisis response collaboration teams once these professionals are trained; and 7) means of evaluation 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. 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.³

2. Use-of-Force Continuum

A. Emphasize De-escalation

There are two use of force policies relevant to BC: the RCMP Incident Management Intervention Model (IMIM) (which has recently been changed) and the National Use of Force Framework (NUFF).

The main differences between the three versions (IMIM1, IMIM2, and NUFF) are the points on the

³ See, for example, the Mental Health and Justice Consensus Project, *Outcomes of Specialized Police Responses at consensusproject.org/resources/fact-sheets/factsheet_law*.

continuum at which physical control begins, where the use of intermediate devices/weapons begins, and —between IMIM 1 and IMIM2— inclusion of a distinction between passive resistance and active resistance by the person concerned. The new version of IMIM 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. Diagrams of these three models are included as *Appendix A*.

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 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.

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.

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 contain” 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. Use of 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 earliest stage 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 system⁴; 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.⁵ 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 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 single 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.

3. Research and Education

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

⁴ If the device hits a nerve ending when used in Stun mode, it may affect the motor nervous system as well.

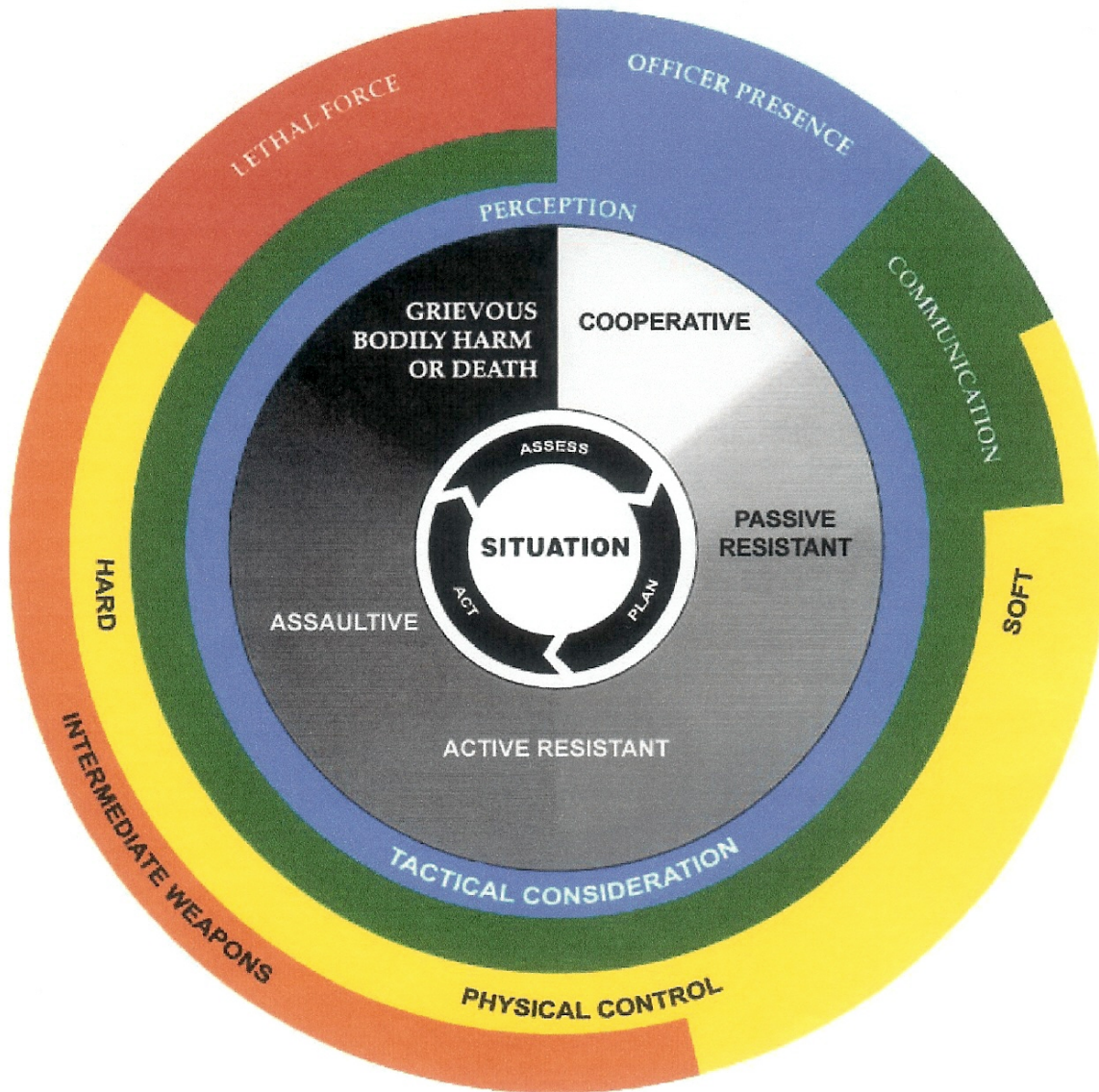
⁵ Pepper spray has been investigated as a possible contributing factor in a small number of in-custody deaths in the United States, where it was found to be a possible contributing factor where the deceased suffered from asthma. See <http://www.ncjrs.gov/pdffiles1/nij/195739.pdf>

EMD 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.

Recommendations

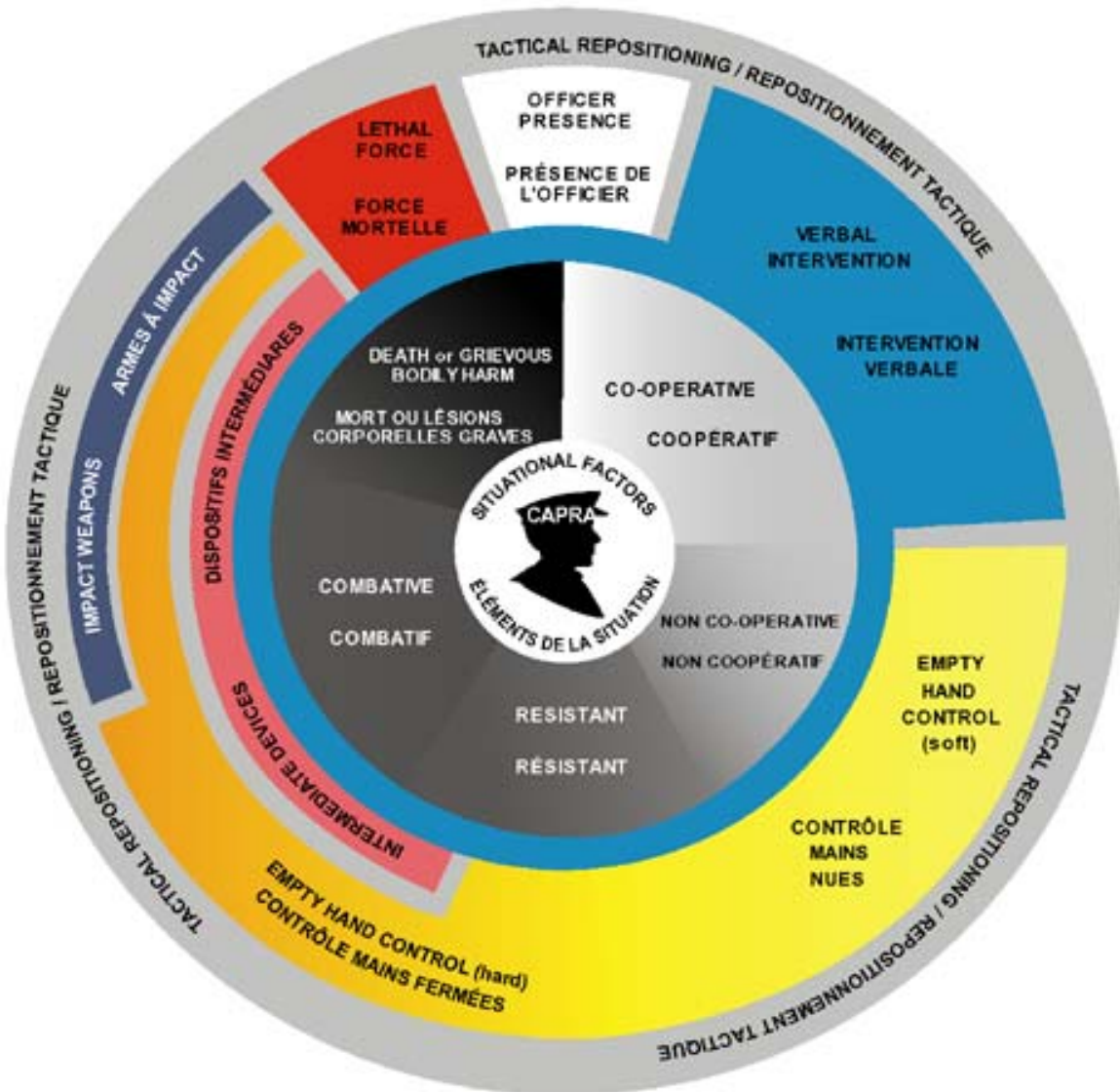
1. CMHA BC recommends that best practices in crisis intervention training be incorporated in police recruit and ongoing training for all officers according to best practice standards set out in the CIT training model
2. CMHA BC recommends that all police agencies develop and implement at the earliest opportunity crisis intervention models based on best practices.
3. CMHA BC recommends that police agencies and governing ministries review and amend use of force policies, particularly in the following areas:
 - a. Development of a use of force policy specific to persons exhibiting symptoms of mental illness and/or concurrent disorders
 - b. Removal of EMD CEDs from the “intermediate device” category. We strongly recommend that these devices be placed on the use of force continuum immediately before and only as an alternative to deadly force, when all other options are exhausted.
 - c. Where CED may be used as an alternative to lethal force, that Emergency Medical assistance (BC Ambulance Service) be called to attend on an emergency basis prior to use of the device.
 - d. Appropriate usage of EMD CED should focus on a single discharge as a means to create a brief opportunity for other forms of containment. Multiple or extended discharges should be strongly discouraged.
4. CMHA BC recommends that a rigorous independent investigation be made into the impact of CEDs on physical and mental health particularly in relation to:
 - a. Factors such as agitation, drug consumption, psychosis and heart problems.
 - b. Persons with mental illness
5. CMHA BC recommends that police agencies institute a system to collect and share comprehensive data on events where CEDs are used, in order to contribute to the study and development of best practices in the use of these devices.

National Use of Force Framework

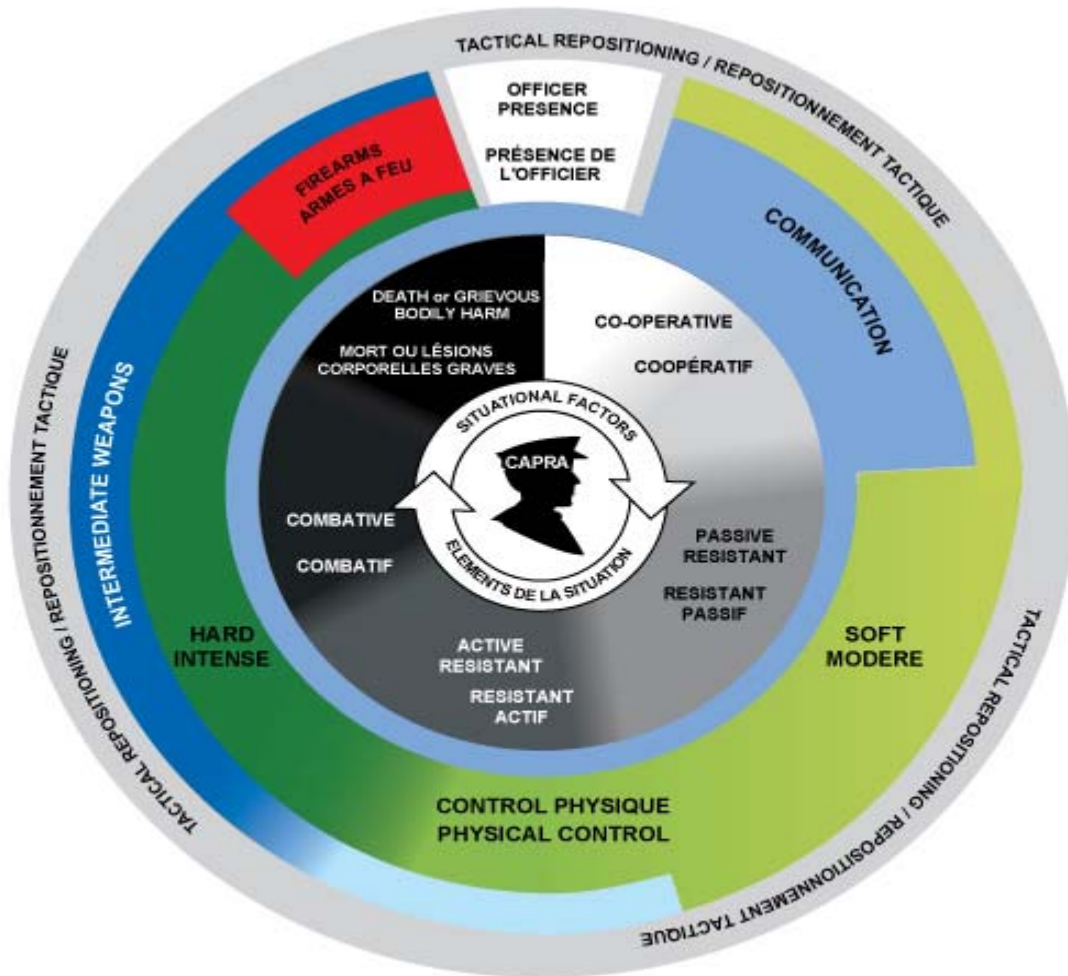


The officer continuously assesses the situation and acts in a reasonable manner to ensure officer and public safety.

RCMP Incident Management Intervention Model (old)



RCMP Incident Management Intervention Model (new)



Research

- RCMP Incident Management/Intervention models and instruction materials
- National Use of Force Framework
- Office of the Police Complaints Commissioner
 - Taser Technology Review and Interim Recommendations (2004)
 - Taser Technology Review – Final Report (2005)
- Commission for Public Complaints against the RCMP
 - Report into a complaint concerning RCMP treatment of a person experiencing a mental health crisis (Heafey Report) (2004)
- Canadian Police Research Centre
 - Technical Report: Review of Conducted Energy Devices (2005)
- Frontline Reports
 - Munetz et al., Police Use of the Taser with People with Mental Illness in Crisis, *Psychiatric Services* (2006)
- PoliceOne.com News - Chris Lawrence
 - What other medical emergencies can look like excited delirium? (2006)
 - Excited delirium and its medical status, part 2 (2006)
 - The Thomas Theorem: Frontline response to excited delirium (2007)
- Amnesty International
 - Canada: Excessive and lethal force? AI's concerns about deaths and ill-treatment involving police use of tasers (2004)
 - Canada: Inappropriate and excessive use of tasers (2007)
- Coroner's jury verdict
 - inquest regarding Otto Vass (2006)
- American Civil Liberties Union
 - recommendations regarding taser use (2004)
- Minneapolis Civilian Police Review Authority
 - Taser Policy and Training Recommendations (2006)