

**BRIEF TO THE SASKATCHEWAN POLICE COMMISSION**  
**Regarding the Use of Conducted Energy Devices by**  
**Municipal Police in Saskatchewan (CEDs)**

by the

**CANADIAN MENTAL HEALTH ASSOCIATION (Saskatchewan Division) Inc.**



August 6, 2009

BRIEF TO THE SASKATCHEWAN POLICE COMMISSION

## I. Background

Our Association welcomes the opportunity to provide a written submission on the above issue.

We fully recognize the important and often increasing role the police and the justice system play in front-line first responder contact with people with mental health and mental illness issues in our community.

(We also believe that) there is an ambivalence among police officers about whether they should in fact be dealing with mental health issues. The police mandate is generally to ensure safety and to provide protection to the public, but some police officers do not consider this mandate to include protecting or providing safety for people with mental illness in crisis – this being the responsibility of the mental health system. This ambivalence is reinforced if there is a lack of comprehensive, ongoing training of police officers in the recognition of mental illness and in mental health crisis intervention, and a lack of contact and support from mental health and emergency services.

The results for persons with mental illness can be serious: long delays in receiving necessary diagnosis and treatment, unnecessary and damaging trauma, criminalization of illness-induced behaviour. The estimates of untreated mental illness in the criminal justice system range from 15 – 40% of the incarcerated population. When police respond to a person in mental health crisis as they are trained to respond to a typical criminal emergency situation – with a show of force and authority – they may in fact escalate the crisis to a point of risking injury or death for police or the public, but most often for the person in mental health crisis.

The impact on police can be traumatic: police officers have been traumatized by the police shooting deaths of persons in mental health crisis, deaths which might well have been prevented if officers had received appropriate training. As well, police suffer frustration at long wait times at emergency departments, refusals to admit persons to hospital, a lack of mental health service alternatives, and a lack of coordinated support.

The general public suffers also. Family and friends of persons with mental illness experience the trauma and frustrations of such interactions, as well as the impact of the criminalization of mental illness. The general public experiences the loss of police response when hours of police time are spent waiting for a person in crisis to be admitted to hospital. The public also receives reinforcement for the false perception that mental illness is a crime rather than an illness, and that persons with mental illness are a public danger – a common and erroneous belief that hurts both persons with mental illness and the public.

**From: Police and Mental Illness: Increased Interactions  
CMHA BC Division, 2005**

## II. The Current Situation

Recent events in the news regarding the RCMP and the use of Conducted Energy Devices (Tasers) have resulted in a great deal of interest in, and an even greater amount of concern regarding interaction between police of all jurisdictions and those with emotional or mental health/illness issues.

While we fully understand that deaths caused by Tasers or firearms are in the small minority of interactions, they occur often enough to raise alarm and reinforce the feeling in the mental health community that there is a serious problem.

As noted in the attached Enclosure: Policing principles of the Final Report “RCMP Use of Conducted Energy Weapon (CEW)” we believe that the following points are very relevant to effective policing:

From the nine principles by Sir Robert Peel:

#4 – The degree of cooperation of the public that can be secured diminishes proportionately to the necessity of the use of physical force.

#6 – Police use physical force to the extent necessary to secure observance of the law or to restore order only when the exercise of persuasion, advice and warning is found to be insufficient.

From the nine principles by Sir Richard Mayne:

#6 – To use physical force only when the exercise of persuasion, advice and warning is found to be insufficient to obtain public cooperation to an extent necessary to secure observance of law or to restore order, and to use only the minimum degree of physical force which is necessary on any particular occasion for achieving a police objective.

All these principles speak to the need for the two key areas we see are lacking in police use of Tasers or firearms when it comes to relating to first responder interaction with those with mental health issues, namely training in diffusing a situation, and the placement of Tasers higher up on the “use of force” models of all police forces.

We believe that the lack of appropriate training for police officers, and the placement of CEWs too low on the use of force continuum have very severely damaged the reputation of the RCMP, and can and will do so for other police forces as incidents of death continue from CEW use unless significant changes to practices are made.

### III. Talk before Tasers is always the best policy

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.

## **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 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.

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 system<sup>4</sup>; 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.<sup>5</sup> 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 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.

**From Crisis Intervention Policy for Police  
working with people with mental illness/concurrent disorders  
CMHA BC Division 2008**

## **IV. Recommendations**

These recommendations, based upon previous work done by our British Columbia Division and the recommendations of the Braidwood Commission Inquiry, are presented by the Canadian Mental Health Association (Saskatchewan Division) Inc.

It is critical, in our view that a combination of effective and appropriate training for police officers in dealing with persons with mental health/illness issues and changes to policy re: the use of CEW's, is essential to preserving the lives of those with mental illnesses, as well as the respect the police officers need and deserve to carry out effective policing in our Province.

1. CMHA recommends that best practices in crisis intervention training be incorporated in police recruit and ongoing training for all officers according to best practice.
2. The Province should require officers that are dealing with emotionally disturbed/mentally ill persons to use de-escalation and/or crisis intervention techniques before deploying a CEW, unless they are satisfied, on reasonable grounds, that such technique will not be effective in eliminating the risk of bodily harm.
3. CMHA recommends that all police agencies develop and implement at the earliest opportunity crisis intervention models based on best practices.
4. CMHA 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 (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.
5. CMHA 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
6. CMHA 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.
7. Work to ensure that all officers equipped with CEDs are trained in the use of, and are equipped with defibrillators.
8. Require all CEDs to undergo regular testing.

**V. Conclusion**

Our Association very much appreciates the opportunity to provide input into the Commission's deliberations on the use of CEDs by municipal police in our Province.

Finding improved ways to have police interact with people with mental health issues through training and CED protocols is critical to saving lives and ensuring effective policing in our communities.

Our Association would be pleased to discuss further with the Commission ways to achieve these important goals.

Respectfully submitted,

CANADIAN MENTAL HEALTH ASSOCIATION  
(Saskatchewan Division) Inc.

**Enclosures:**

["Police and Mental Illness: Models that Work"](#)

CMHA BC Division, March 2005

["Mental Health Crisis: Frequently Asked Questions"](#)

CMHA BC Division, March 2005

["Hallucinations and Delusions: How to Respond"](#)

CMHA BC Division, March 2005

["RCMP Use of the Conducted Energy Weapon \(CEW\)"](#)

Final Report                      June 12, 2008

["Talk before Tasers is always the best policy"](#)

CMHA BC Division, 2009

["Summary of Braidwood Recommendations and Action"](#)

July, 2009

["Best Practice in Mental Health Training for Law Enforcement Personnel"](#)

US Criminal Justice/Mental Health Consensus Project Report, 2002 Chapter VI