THE EMPOWERMENT COUNCIL

 A Voice for the Clients of the

 Centre for Addiction and Mental Health

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Deputation at the Toronto Police Services Board Town Hall

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***People in Crisis Need a Safe Place to Turn***

The uprising against racially biased use of force by the police has called out for the mental health system to replace the police in crisis calls. But the mental health system is no panacea. The criminal justice system is not the only system in Canada that uses force to control people. The other is the mental health system.[[1]](#endnote-1) Both systems have used excessive force. Both have used it with racial bias.

Mental health professionals and police have successfully de-escalated people, coerced people into compliance, and used force that has resulted in people’s deaths. Mental health professionals don’t shoot. But it is also the case that no mental health service would send workers into situations where anything remotely considered a weapon is involved. In psychiatric facilities, security is routinely called for fairly minor incidents. (The other day a psychiatric hospital called the police because a patient wouldn’t leave a room.) Mental health workers could replace police in some calls. But we can’t assume the outcome would automatically be good without critically examining this path.

We know what the statistics are in policing – in Canada people who are in crisis and people who are Black or indigenous are more likely to die in encounters with police. There is almost no data on the role of race in the use of force in the mental health system. What very little research there is, has found a connection. Being Black makes you more likely to be detained and restrained in the mental health system. Including here in Toronto. This can and has resulted in deaths.

Bias toward people who have mental health issues and bias toward people who are Black have a feature in common – they both exaggerate the dangerousness of that person.[[2]](#endnote-2) People who appear to be in crisis and people who appear to be Black are both subject to attributions of superhuman strength. [[3]](#endnote-3) There is almost no research that looks at the intersection of race, mental state, and use of force. I have testified at inquests and tribunals that it is a reasonable assumption that these biases together create an even stronger, unfounded perception of how much risk a person poses. This intersection of race and crisis has been little studied, but it is not difficult to find evidence that being Black and in crisis is dangerous – to the Black person in crisis. Where IS it safe to be black and in crisis? Changes have to be made to mental health services as well as police services.

The dangers of these two systems – policing and the mental health system – is not that they are full of evil people. The danger lies in their extraordinary powers. This is where the change has to lie. Not in replacing one powerful system with another. What we need in both systems is a new level of transparency, accountability and partnership with the communities that both these systems exist to serve.

*The recommendations that follow include the City and the Province as well as the TPSB – because preventing the loss of lives of people in crisis will not work if addressed solely in silos*.

**Recommendations**

**To Save the Lives of People in Crisis:**

1. **Prioritize the voice of peers, accountable to their community, to evaluate the expansion and development of supports that prevent and respond to crisis**. *Evidence demonstrates that* *meeting the self identified needs of people has the most effective outcomes. This is true both individually and systemically.* *I am bringing together a broad based coalition of peers. The people most effected must have a role in decision making.*
2. **Support the development of a network of noncoercive crisis services rooted in the communities they serve - with phone lines, mobile teams and respite beds that can serve as an alternative to 911**, **with a substantial presence of peers on the staff and Board.**  *Community based, noncoercive crisis services inclusive of peers is the preferred option identified by people who experience crisis, yet there are fewer community based crisis services now than ever (west Toronto has none). This investment will pay off, socially and financially. (Gerstein Centre and Anishawabe are two Toronto examples of good community based crisis services with peer inclusion).*
3. **Support and collaborate with peer run organizations.** *There is an abundance of evidence that peer run organizations can create lasting and substantial benefits, prevent crises, and save millions of dollars in hospital days.[[4]](#endnote-4) (Sound Times, Working for Change and The Empowerment Council are some local examples.)*
4. **As community based services, including crisis services and peer organizations, reduce police calls, resources should be moved from the police budget to support them.**
5. **Mobile Crisis Intervention Teams should have a community based steering committee, which could ultimately become a Board.** *MCITs will work better with community partners.*
6. **Encourage the use of pre charge diversion, when the police refer people for support who could otherwise end up in a bad situation** (e*.g. Sound Times).*
7. **Invest – which means pay for - training by skilled antibias trainers from peer run organizations representing people with lived experience and racialized communities. Training can be both centralized and Divisional.** *Realistically, police are still going to be involved with calls where there is a risk of violence. Inquests keep recommending this training, it is supported by evidence, and police keep agreeing, but it is all meaningless when resources are not provided to enable it. Almost 20 years ago, our organization and its predecessor contracted with the TPS to organize a panel of people from peer organizations that spoke to every patrol officer within 1 year. While there can be no proof of cause and effect, in the following 8 years, deaths of people in crisis by police was reduced to 1 (though everyone would agree that 1 is still too many). Yet this approach was never again supported.*

*We do not recommend entirely shifting police training to an academic institution, as this will professionalize training such that meaningful control of content and delivery by the community will be excluded. And mental health professionals can also treat people who have mental health issues with bias, as well as with racial bias, and excessive force. There is considerable evidence that mental health professionals hold more negative views of people with mental health issues than does the general population.[[5]](#endnote-5) They also need antibias training. We need a new hybrid approach, and suggest working with the peer coalition and MHAAP to develop one.*

1. **Abandon body worn cameras**. *I have supported body worn cameras at inquests as a means of accountability, primarily to assess whether training in de-escalation is being used in the field. However, this pandemic has brought us to a different economic time. Money spent on cameras could be more effectively spent on resources that would prevent many crises from developing.*
2. **Encourage collaborative relationships with police and community services**. Support community - based policing. Insist all partners have anti bias training.
3. **Work with communities and the Toronto Police Service to encourage effective relationships between the TPSB, TPS, and the Advisory Panels.**
4. **Work with police in the UK to more fully explore the use of shields and helmets**. *People in crisis in Toronto who have died when shot by police in the last 23 years have not had guns, they have had impact or edged “weapons” (scissors in the case of Michael Eligon). They have died in minutes of police appearing on calls. De-escalation takes time, and every method that does no harm and can safely achieve the opportunity to de-escalate should be emphasized. The shields that TPS chose to explore this option previously were unusable.*
5. **Add intersectionality, such as being in crisis AND racialized, to the analysis of use of force data**, **including “show force” when CEWs are demonstrated but not used**. *Train that “show force” is not de-escalation and must not substitute for de-escalation.*
6. To the province: For the whole crisis system to operate without racially biased use of force, all mental health facilities must be required to keep data on the demographics (such as race) of who they restrain – which includes all forms of restraint. Then they need to address the results. *CAMH is doing so because they support an independent voice for their service users – the Empowerment Council – who made the request. There is every reason to believe it is an issue at every facility. People in crisis need to be safe at every part of their journey.*

*Some research materials are provided below in end notes.*

*More can be provided on request in support of each recommendation.*

1. This paper addresses systems that can apply to anyone in the country, but another important system empowered to use force is immigration/border services. [↑](#endnote-ref-1)
2. Ruiz, J. and C. Miller (2004). An exploratory study of Pennsylvania police officers' perceptions of dangerousness and their ability to manage persons with mental illness. Police Quarterly, 7: 359-371.

Spector, Rachel. (2009). Is there racial bias in clinicians' perceptions of the dangerousness of psychiatric patients? A review of the literature. Journal of Mental Health. 10. 5-15. 10.1080/09638230020023570. [↑](#endnote-ref-2)
3. Waytz,‎ Adam. K. Hoffman, S. Trawalter. A Superhumanization Bias in Whites' perceptions of Blacks, Social Psychological and Personality Science, Vol 6, 352-359, 2014 [↑](#endnote-ref-3)
4. Bevin Croft, and Nilüfer \_ Isvan, Impact of the 2nd Story Peer Respite Program on Use of Inpatient and Emergency Services

Psychiatric Services in Advance, March 2, 2015; doi: 10.1176/appi.ps. 201400266

Ochocka J. et al, A longitudinal study of mental health consumer/survivor initiatives: Part 3—A qualitative study of impacts of participation on new members , Journal of Community Psychology, 30 March, 2006 [**https://doi.org/10.1002/jcop.20099**](https://doi.org/10.1002/jcop.20099)

Trainor, J., Shepherd, M., Boydell, K.M., Leff, A., & Crawford, E. (1997). Beyond the service paradigm: The impact and implications of consumer/survivor initiatives. Psychiatric Rehabilitation Journal, 21, 132–140. [↑](#endnote-ref-4)
5. de Tribolet-Hardy, E., Kesic, D. & Thomas, S.D.M. (2015). Police management of mental health crisis situations in the community: status quo, current gaps and future directions. *Policing and Society*, *25*: 294–307. <http://dx.doi.org/10.1080/10439463.2013.865737>

Henderson, C., Noblett, J., Parke, H., Clement, S., Caffrey, A., Gale-Grant, O., Schulze, B., Druss, D. & Thornicroft, G. (2014). Mental health–related stigma in health care and mental health-care settings. *Lancet Psychiatry,* *1*: 467–482.

Horsfall, J., Cleary, M. & Hunt, G.E. (2010). Stigma in mental health: clients and professionals*. Issues in Mental Health Nursing*,*31*: 450–455. DOI:10.3109/01612840903537167 [↑](#endnote-ref-5)