POLICE ENCOUNTERS WITH PEOPLE IN CRISIS

An Independent Review Conducted by
The Honourable Frank Iacobucci for Chief of
Police William Blair, Toronto Police Service

July 2014

POLICE ENCOUNTERS WITH PEOPLE IN CRISIS

Table of Contents

Page

ACKNOWLEDGEMENTS 2

EXECUTIVE SUMMARY 4

PART 1 – THE INDEPENDENT REVIEW 35

Chapter 1. Introduction: A Brief Overview 37
Chapter 2. Mandate, Independence, Scope and Methodology 44
Chapter 3. Context 59

PART 2 – DISCUSSION, ANALYSIS AND RECOMMENDATIONS 79

Chapter 4. The Mental Health System and The Toronto Police Service 83
Chapter 5. Police Culture 117
Chapter 6. Selection of Police Officers 129
Chapter 7. Training 143
Chapter 8. Supervision 158
Chapter 9. The Mental Health of Police Personnel 180
Chapter 10. Use of Force 194
Chapter 11. MCIT and Other Models of Crisis Intervention 217
Chapter 12. Equipment 242

PART 3 – THE NEXT STAGE 265

Chapter 13. Implementation 268

PART 4 – APPENDICES 276

Appendix A
List of Individuals Interviewed 278
Appendix B
Selected Bibliography 286
Appendix C
List of Stakeholders that made Submissions 306
Appendix D
Selected Legislative Provisions 309
Appendix E
Selected Toronto Police Service Procedures 349

 | © 2014 Toronto Police Service

ACKNOWLEDGEMENTS

ACKNOWLEDGEMENTS

There are many individuals, organizations and groups that I should like to thank for their participation in the Review and the preparation of this Report. Without that participation, I simply could not have adequately dealt with the issues in my mandate—particularly the recommendations that I have made.

Because of the loss, distress, and grief they have suffered, I start with the members of families of individuals who were killed in a police encounter, and the police officers who were part of lethal outcomes and whose lives were also greatly affected. Their courage and willingness to share their views under difficult circumstances are greatly appreciated.

The Review team and I met with over 100 individuals, who were members of the Toronto Police Service, mental health specialists, academics, representatives of stakeholder groups, counsel for participants at inquests, and experts in specialized fields. They are listed in Appendix A and deserve to be noted for their help and advice.

To the many individuals and groups who made submissions to the Review, I express my gratitude. We gained much knowledge by these submissions and have put the submissions on our website and listed the names of the individuals and groups in Appendix C.

There were a number of institutions that warrant special mention. The Review received much information and cooperation from the instructors and leaders of the Toronto Police College and the Ontario Police College in our visits to those institutions. Their sharing of their training expertise with us was most helpful and I thank them. I would also like to recognize the staff and leaders of the TPS Communications Service for explaining the intricacies of the call-taking and dispatching functions of the Service during our visit to their facility. We also appreciated our visit with a group at Sanctuary Ministries of Toronto, a drop-in centre that attracts many so-called street people who seek help and friendship—and meals. Their commentary and observations provided a valuable perspective, which I greatly appreciated. Another group to acknowledge are the members of the Mobile Crisis Intervention Teams (MCIT) with whom members of my team and I individually accompanied on MCIT ride alongs, to observe their handling of calls involving people in crisis and other people with mental health issues. Again, we were greatly assisted by our time with them and the comments we received.

I should also recognize the various individuals from stakeholder groups who attended a roundtable that brought together knowledgeable and experienced representatives to discuss issues as a group. This provided an opportunity to have different views expressed and discussed. The roundtable participants are listed in Chapter 2.

There are a number of people whom I should thank for providing support during the work of the team and the preparation of this Report. I begin with leadership and staff of Torys LLP for ensuring we had full support and the benefit of services for numerous meetings as well as technical, editing and related services. More specifically, I

wish to thank the support team from Torys LLP who assisted me in the preparation of the Report in various roles: Graham Ross, Rose Lombardi, Brian Unger, Jonathan Lee, Jessica Earle, Tosh Weyman, Jon Silver, Sharon Fitchett, Tina Porfido, Marian Bojovich, Lydia Morrison, Natalie Waddell, and Stefanie Mantzanis. A special thanks goes to Janelle Weed, who worked tirelessly to finalize and produce this Report.

My sincere thanks go to the impressive members of the Advisory Group: Dr. John Bradford, Paul Copeland, and Norman Inkster. Their contribution and sharing of their professional expertise were very helpful in the work of the Review and formulation of this Report.

There were many officers and staff of the Toronto Polices Service who deserve recognition and gratitude. Chief William Blair fully supported the Review and was vigilant to ensure that that Review was independent. He left no doubt that he was interested in improving the efforts of the TPS regarding the issues arising from encounters with people in crisis. Inspector Ian Stratford was the principal liaison of the TPS with my team and me and provided us with great amounts of information, arranged visits and interviews with numerous officials, answered the many queries we put to him, and gave full support to our work. I thank him for all his efforts. I also wish to single out Jerry Wiley, former Senior Counsel to the Office of Chief of Police, whose vast knowledge and experience were of central importance in understanding many of the issues with which we dealt. I also thank him and appreciate all his efforts.

Finally, I should like to thank my team: David Outerbridge, Counsel to the Review, Molly Reynolds, Ryan Lax and Rebecca Wise. It is difficult to imagine having a better team of colleagues who worked assiduously on every aspect of the Review and in the preparation of this Report, and made extraordinary contributions. In this connection, I wish specifically to thank David Outerbridge for his many contributions and his Counsel leadership. I owe all of my team a great debt.

Frank Iacobucci
July 2014

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

A. Introduction

1. On August 28, 2013, Chief of Police William Blair of the Toronto Police Service (TPS) requested that I undertake an independent review of the use of lethal force by the TPS, with a particular focus on encounters between police and what I refer to in this Report as "people in crisis."

2. By a person in crisis I mean a member of the public whose behaviour brings them into contact with police either because of an apparent need for urgent care within the mental health system, or because they are otherwise experiencing a mental or emotional crisis involving behaviour that is sufficiently erratic, threatening or dangerous that the police are called in order to protect the person or those around them. The term "person in crisis" includes those who are mentally ill as well as people who would be described by police as "emotionally disturbed."

B. Mandate

3. My mandate as given to me by Chief Blair was to conduct an independent review of "the policies, practices and procedures of, and the services provided by, the TPS with respect to the use of lethal force or potentially lethal force, in particular in connection with encounters with persons who are or may be emotionally disturbed, mentally disturbed or cognitively impaired."

4. I was instructed by Chief Blair that the hallmark of my Review was intended to be its independence, and that the end result of the Review was to be a report, to be made public, setting out recommendations that will be used as a blueprint for the TPS in dealing with this serious and difficult issue in the future. I elaborate on the issue of independence in Chapter 2.

5. My mandate included reviewing the following topics:

(i) TPS policies, procedures and practices;

(ii) TPS training, and training at the Ontario Police College;

(iii) equipment used by the TPS;

(iv) psychological assessments and other evaluation of TPS police officers and officer candidates;

(v) supervision and oversight;

(vi) the role of the Mobile Crisis Intervention Teams (MCIT) currently employed by the TPS;

(vii) the role of the TPS Emergency Task Force (ETF);

(viii) best practices and precedents from major police forces internationally (in Canada, the United States, the United Kingdom, Australia and other jurisdictions)

(ix) available studies, data and research; and

(x) other related matters falling within the scope of the independent review.

6. As part of the independent Review, I was authorized to engage in, and did conduct, the following activities:

(i) receive submissions and meet with stakeholder groups or individuals;

(ii) examine TPS use of force equipment;

(iii) attend to observe TPS training;

(iv) interview TPS personnel;

(v) consult with experts in the field of mental, emotional and cognitive disorders;

(vi) consult with experts in the use of force, the selection and training of police, crisis intervention and all other matters that are the subject of the review;

(vii) assemble and retain an advisory panel of experts;

(viii) conduct research;

(ix) make recommendations based on the work performed and the information obtained; and

(x) perform such other work as may be reasonably incidental to the independent Review.

C. Preliminary observations

7. Three preliminary comments should be kept in mind.

8. First and above all, I must emphasize the serious and tragic circumstances that are at the heart of the issues canvassed in this Review and discussed in this Report. This Report deals with the loss of life in situations that cry out for attention and raise the fundamental question: How can lethal outcomes be avoided? The impact of the loss of life is enormous, not only on family members and loved ones of the person in crisis who has died, but also on the police officer who applied lethal force, on other colleagues directly involved, and on bystanders who observed the events. All of these matters are explored in this Report.

9. I met with and heard accounts of family members of people in crisis who were killed. Many of their lives have been changed forever by the profound sadness and frustration of thinking about what could or should have been done to have avoided such a disastrous result. Similarly, I met with police officers who witnessed or were otherwise were involved in the shooting of a person, whose lives, and the lives of their family members, have been emotionally scarred as a result, and who seek to deal with the traumatic effects of their involvement.

10. Second, TPS encounters with people in crisis are regrettably part of an international phenomenon that presents a fundamental challenge to modern society. Police services across Canada, the United States, United Kingdom, Australia, and New Zealand—just to mention jurisdictions that we have looked at—face similar challenges in seeking to improve approaches to deal with the difficult situations that arise. It seems that no part of the world is free of these potentially tragic human outcomes.

11. In Toronto, in particular, the TPS is dispatched to approximately 20,000 calls for service annually involving a person in crisis. This is between 2.0% and 2.5% of all occasions on which police are dispatched. Approximately 8,000 of these events involve apprehensions under the *Mental Health Act*. Some of these encounters, sadly, result in the application of lethal force by police. Between 2002 and 2012, the TPS has advised that five people considered to be "emotionally disturbed persons" were fatally shot by police.

12. Third, it is important at the outset to note what this Review and Report are not about and what they are about.

13. The Review and Report are not about laying blame on anyone. In fact, my mandate expressly forbids me from dealing with specific incidents, whether or not they are before the courts in a criminal or civil law context or otherwise. Indeed, I wish to emphasize that anything I express in this Report is not intended to refer to any specific event.

14. The basic purpose of the Review is to consider how, going forward, we as a society can prevent lethal outcomes. Here I would mention that the TPS has done much in this area that is positive, and is a leader in this subject in a number of respects. But I believe improvements can always be made—particularly as knowledge, experience, and examination of the issues increase over time.

D. Chapter topics

15. Generally the chapters in this Report correspond to the headings of the mandate assigned to me.

16. Chapter 1 is an introduction and brief overview of the Review and this Report.

17. The mandate of the Review, as well as its independence, scope and methodology, are described in Chapter 2.

18. Chapter 3 provides a commentary on the important context surrounding the issues that arise in the mandate of my Review.

19. Chapter 4 deals with the mental health system and Toronto Police Service, and underscores the reliance placed on the TPS as a part of that system to deal with the people in crisis and the numerous issues that arise.

20. Chapter 5 deals with a topic about which I heard a great deal from both TPS officers and stakeholders, namely, the centrality of police culture with its positive and negative features.

21. Chapter 6 deals with issues arising from selection of new recruits by the TPS, and from appointments to specialized roles within the TPS, and the relationship of these issues to encounters by the TPS with people in crisis.

22. Chapter 7 deals with the important subject of training, both for recruits and in-service officers, and the role training plays in police encounters with people in crisis.

23. Chapter 8 focuses on supervision, which is critical to ensuring that training is translated into practice.

24. Chapter 9 deals with the role played in police encounters with people in crisis by the mental health of police officers themselves.

25. Police use of force is of critical and controversial importance in the handling of police encounters and is discussed in Chapter 10.

26. Chapter 11 identifies and discusses the MCIT and various other crisis intervention models that police forces have employed to better handle police encounters with people in crisis.

27. Chapter 12 examines the different types of equipment used by the TPS in encounters and the debate over them as well as the procedures to regulate the use of the equipment.

28. Finally, the important subject of the implementation of the 84 major recommendations of the Report is found in Chapter 13.

E. My approach to the Review

29. I assembled a team at Torys LLP to assist me with the Review. The team and I had over 100 interviews or discussions with individuals having different experiences and viewpoints (names of most of the individuals spoken to are in Appendix A), received or obtained well over 1,200 documents consisting of data, policies, procedures, academic literature and commentary, reports and so on (a selected bibliography is found in Appendix B), and received many submissions (listed in Appendix C), all as described in the Report. We also examined Ontario coroners' inquest recommendations and interviewed U.S. and U.K. experts to seek best practices.

30. I invited three distinguished individuals to be my Advisory Group: Dr. John Bradford, an eminent forensic psychiatrist, Paul Copeland, a leading criminal lawyer, and Norman Inkster, a widely respected former Commissioner of the Royal Canadian Mounted Police.

F. Approach of the Report

31. With this background and effort in mind, this Report takes a holistic approach to the mandate given to me. It is clear that police are part of the mental health system—they are the front line mental health workers for many of the most dangerous encounters. Preventing deaths includes preventing the crises in the first place, as well as helping police to deal with crises better. One of the key themes of this Report is the need for inter-disciplinary cooperation, learning and teaching, involving not only police and mental health professionals, but also mental health consumer-survivors. It is their lives and deaths that are at issue and they should not be treated as the problem being discussed. They are our fellow citizens and should work with us to find solutions. I return to this topic below and in many sections of the Report.

32. In preparing this Report, I have tried to be as comprehensive and helpful to the TPS as possible. That does not imply in any way that defects are widespread. Rather, it simply underscores that I have found that, because of the seriousness and complexity of the issues, there is much to be considered.

33. The police have an extraordinarily important role in our society. To serve and protect, they have unique powers and authority and heavy responsibilities and duties. They can, under strict circumstances, use their firearms to take a life and to protect a life. They take their roles seriously and society could not properly function without them. In addition, modern policing has evolved in many ways and the TPS has shown its adaptability over time to make changes that are required.

34. The culture of the TPS has also adapted over time, and it continues to evolve as society itself evolves. By culture, I mean the prevailing attitudes, beliefs, and values of the Service. Ultimately, in one sense the issues addressed in this Report all have to do with police culture, because my recommendations aim to affect behaviour, and meaningful change to behaviour involves assisting in the evolution of the attitudes, beliefs and values that guide behaviour. I address the issue of police culture in more detail in Chapter 5 and more generally throughout the Report.

35. Encounters of the TPS with people in crisis number approximately 20,000 annually. The vast majority of these encounters end peaceably and without incident. But, most unfortunately, there are some lethal outcomes.

36. The premise of the Report is that the target should be zero deaths when police interact with a member of the public—no death of the subject, the police officer involved, or any member of the public. I believe the death of a fellow human being in these encounters is a failure for which blame in many situations cannot be assigned; it is more likely a failure of a system. Policies and procedures should be designed and

exercised with that zero target in mind but, of course, not at the cost of ignoring the safety of the subject, the police, or the public.

37. In that connection, the Report recognizes the extreme difficulty of the situations involving police interaction with people in crisis. Police officers have to act under great pressure in life-and-death situations where tragedy can occur in seconds. Fear is felt by all concerned and often we cannot and should not judge conduct after the fact. At the same time, it is not easy to fairly understand the thoughts and condition of the person in crisis. I explore in Chapter 3 the different perspectives from which one can view such encounters.

38. We therefore cannot resort to absolutes because the context of encounters varies and in each case calls for the application of judgment. Accordingly, a balanced approach must be taken to recommending improvements to existing policies, procedures and practices that will enhance the avoidance of lethal outcomes yet maintain the protection of human life and safety. I have sought to reflect this balance in the Report.

39. There is a huge issue that warrants further elaboration: the mental health system. One cannot properly deal with the subject of police encounters with people in crisis and not consider the availability of access to mental health and other services that can play a role in the tragic outcomes for people in crisis in encounters with the police. Police officers, because of their 24/7 availability and experience in dealing with human conflict and disturbances, are inexorably drawn into mental and emotional fields involving individuals with personal crisis.

40. As I emphasize in the Report, there will not be great improvements in police encounters with people in crisis without the participation of agencies and institutions of municipal, provincial and federal governments because, simply put, they are part of the problem and need to be involved in the solution.

41. In many ways, I have found this reality the most distressing societal aspect of my work on the Review. The effective functioning of the mental health system is essential as a means of preventing people from finding themselves in crisis in the first place. There is not much I can do through my recommendations to remedy the applicable problems in the mental health system, since I can recommend changes only to the TPS. But the basic and glaring fact is that the TPS alone cannot provide a complete answer to lethal outcomes involving people in crisis.

42. As for the recommendations that my mandate permits, several themes emerge. First, the recommendations are comprehensive to cover the topics in my mandate such as recruitment of police officers, their training, supervision and oversight, their wellness, their discipline and positive reinforcements, and the numerous procedures that impact encounters with people in crisis, notably those on the use of force and police equipment available to police officers. Second, the recommendations seek to achieve a balance between using the minimal force required in the circumstances while acknowledging the police officer is exercising judgment in a situation of great pressure and stress. Third, the importance of de-escalation in police encounters cannot be overemphasized nor can the importance of protecting the lives and safety of everyone.

Fourth, the recommendations are many and raise resource issues that may prove to be difficult, but one cannot ignore that what is at stake is human life as well as the treatment of a vulnerable group in our society. Fifth, some recommendations involve further study—for example, regarding possible harmful effects of using conducted energy weapons or the introduction of a pilot project. Sixth, although recommendations are directed at the TPS, other parties or institutions implicitly are urged to be more involved—for example, the Ministry of Health and Long Term Care. Seventh, increased evaluation and monitoring are encouraged to continue the search for improvements. Finally, I have attempted to make recommendations that are practical.

43. As for implementation of recommendations, I strongly recommend the setting up of an Advisory Committee on Implementation that would include representatives of stakeholder groups. The Advisory Committee would provide advice to the Chief of Police for his consideration. The TPS has already been most receptive to stakeholder input so this should not prove controversial. Obviously, senior TPS personnel should also participate in the Advisory Committee. The Committee would in turn make recommendations, including staging of implementation steps to meet resource requirements as is appropriate or necessary, all for the consideration of the Chief. To ensure accountability, after deliberation by the Committee, ultimately the Chief can explain publicly the status of implementation and the reasons for the implementation decisions taken.

44. To conclude this executive summary, I would be remiss if I did not commend the Chief of Police, the TPS and many other stakeholders, including those with lived experience of mental illness, for the efforts they have made to achieve progress in this area. Collectively, they have not assumed that the status quo is as good as it is going to get, and is therefore good enough.

45. It should be noted that Chief Blair and the TPS did not have to call for an independent review. The effect of calling such a review is to take some degree of control away from the TPS over change within the organization. Not only did the TPS do that, but it also agreed in advance that the report and recommendations emanating from the Review were to be made public, without knowing what those results or recommendations would be.

46. For those killed and for their families, nothing can take away their loss. For people in crisis who have had negative experiences with police, self-evaluation by the police and the larger mental health field is meaningful if there is a real change.

47. Recognizing the TPS for taking this initiative is important, but the real work remains to be done, and the true test of the TPS and those organizations with which the TPS interacts will be what changes they make and the approach they take to the task. What they do in this area is fundamentally important to reinforcing public trust and confidence in the Toronto Police Service.

G. Recommendations

48. The 84 Recommendations that I make in the Report are listed here in the order of the chapters in which they appear. I recommend that:

CHAPTER 4: THE MENTAL HEALTH SYSTEM AND THE TORONTO POLICE SERVICE

RECOMMENDATION 1: The TPS create a comprehensive police and mental health oversight body in the form of a standing inter-disciplinary committee that includes membership from the TPS, the 16 designated psychiatric facilities, the three Local Health Integration Networks covering Toronto, Emergency Medical Services, and community mental health organizations to address relevant coordination issues, including:

(a) Sharing Healthcare Information: developing a protocol to allow the TPS access to an individual's mental health information in circumstances that would provide for a more effective response to a person in crisis. This protocol must respect privacy laws and physician-patient confidentiality, and should address:

i. whether, in consultation with the Government of Ontario, the concept of the "circle of care" for information sharing can be expanded to include the police, in circumstances beneficial to an individual's healthcare interests;

ii. how healthcare, treatment and planning information with respect to people with repeated crisis interactions with the police can be shared with the TPS while respecting all relevant privacy and physician-patient confidentiality concerns; and

iii. more specifically, how healthcare information shared with the TPS can be segregated from existing police databases and therefore prevented from subsequently being passed on to other law enforcement, security and border services agencies. Healthcare information should continue to be treated as such, and not as police information;

(b) Voluntary Registry: the creation of a voluntary registry for vulnerable persons, complementing the protocol recommended in (a), which would provide permission to healthcare professionals to share healthcare information with the police, only to be accessed by emergency responders in the event of a crisis situation and subject to due consideration to privacy rights;

(c) Mutual Training and Education: how psychiatric facilities, community mental health organizations, and the TPS can benefit from mutual training and education;

(d) Informing Policymakers: informing policymakers at all levels of government, in the aim of making the mental health system more comprehensive;

(e) Advocacy: advocating more comprehensive and better-funded community supports for people with mental illness. This would be a multi-party initiative led by the mental health sector. It should include, among other things, planning for community treatment supports upon discharge from the hospital, and the creation of more "safe beds" in shelters for people in crisis, to be used when they do not meet the criteria for apprehension under the *Mental Health Act* but need assistance to stabilize their crisis;

(f) Reducing Emergency Department Wait Times: a standardized approach to reducing emergency department wait times for police officers bringing in a person in crisis and transferring care to the hospital. Some relevant measures to be considered include:

i. developing a standard transfer of care protocol that minimizes emergency department wait times, and across Toronto's 16 psychiatric emergency departments. This protocol may build on existing efforts underway;

ii. providing cross-sectoral training for officers and emergency department staff about apprehensions under the *Mental Health Act* and transfer of care;

iii. ensuring adequate communication between officers and emergency departments when en route with a person in crisis to allow the emergency department to make necessary preparations;

iv. arranging a separate waiting area for police-accompanied visitors to the emergency department;

v. having adequate staff to manage mental health crisis situations in the emergency department;

vi. designating a liaison in the emergency department to work with police officers when they arrive with a person in crisis;

vii. developing a protocol between police services and hospitals that sets out specific procedures, expectations, and respect for patient rights;

viii. conducting routine monitoring and evaluation of the protocols put in place, and making any changes warranted;

ix. developing a protocol for how psychiatric facilities' emergency department capacities can be effectively communicated to officers in a timely manner; and

x. developing a protocol to address how people apprehended under the *Mental Health Act* can be equitably distributed among Toronto's 16 psychiatric facilities to ensure the best medical treatment and shortest emergency department wait times; and

(g) Other Matters: any other matters of joint interest.

RECOMMENDATION 2: The TPS more proactively and comprehensively educate officers on available mental health resources, through means that include:

(a) Mental Health Speakers: inviting members of all types of mental health organizations to speak to officers at the divisions;

(b) Technological Access to Mental Healthcare Resources: considering the use of technological means, similar to Vancouver's "Dashboard" system, to efficiently communicate to officers a comprehensive up-to-date list or map of available mental health resources of all types in their area. Such an easily accessible reference tool should aggregate information on all community supports, in addition to major psychiatric facilities; and

(c) Point of Contact: working with mental health organizations to identify key resource people or liaisons, so that every TPS officer has a contact in the mental health system that they feel comfortable contacting for advice and who is able to knowledgeably give that advice.

RECOMMENDATION 3: The TPS amend Procedure 06-04 "Emotionally Disturbed Persons" to provide for the mandatory notification of MCIT units for every call involving a person in crisis.

RECOMMENDATION 4: The TPS, either through the Mental Health Sub-Committee of the Toronto Police Services Board or another body created for this purpose, consider ways to bridge the divide between police officers and people living with mental health issues. This initiative, in furtherance of the formal commitments recommended in Recommendation 5, and building on the mandate for community-oriented policing placed on all police services in Ontario under section 1 of the *Police Services Act*, may include:

(a) Divisional Meetings: inviting members of the community of people who have experienced mental health issues into Divisional meetings to speak with officers;

(b) Community Gathering Places: officers building collaborative relationships with people who have experienced mental health issues at drop-ins, clubhouses, and other gathering places; and

(c) Leadership: the TPS Mental Health Coordinator and Divisional Mental Health Liaison Officers facilitating the initiatives in subsections (a) and (b), as well as other relationship-building and de-stigmatizing programs.

CHAPTER 5: POLICE CULTURE

Statement of TPS commitments relating to people in crisis

RECOMMENDATION 5: The TPS prepare a formal statement setting out the Service's commitments relating to people in crisis and, more broadly, relating to people experiencing mental health issues. The statement should be made public and treated as of equal weight to the Service's Core Values. Among the commitments listed, the Service should consider including the following items:

(a) A commitment to preserving the lives of people in crisis if reasonably possible, and the goal of zero deaths;

(b) A commitment to take all reasonable steps to attempt to de-escalate potentially violent encounters between police and people in crisis;

(c) A commitment by the Service to continuous self-improvement and innovation relating to issues of policing and mental health;

(d) A commitment to eliminating stereotypes and providing education regarding people with mental health issues;

(e) A commitment to involving people with mental health issues directly, where appropriate, in initiatives that affect them, such as police training, and the development of relevant police procedures;

(f) A commitment to working collaboratively with participants in the mental health system (individuals, community organizations, mental health organizations and hospitals);

(g) A commitment to institutional leadership in the area of policing and mental health, and to becoming a pre-eminent police service in this field; and

(h) A commitment to fostering a positive mental health culture within the TPS.

CHAPTER 6: SELECTION OF POLICE OFFICERS

The hiring of new constables

RECOMMENDATION 6: The TPS change mandatory application qualifications for new constables to require the completion of a Mental Health First Aid course, in order to ensure familiarity and some skill with this core aspect of police work.

RECOMMENDATION 7: The TPS give preference or significant weight to applicants who have:

(a) Community Service: engaged in significant community service, to demonstrate community-mindedness and the adoption of a community service mentality. Community service with exposure to people in crisis should be valued;

(b) Mental Health Involvement: past involvement related to the mental health community, be it direct personal experience with a family member, work in a hospital, community service, or other contributions; and

(c) Higher Education: completed a post-secondary university degree or substantially equivalent education.

RECOMMENDATION 8: The TPS amend its application materials and relevant portions of its website to ensure that applicants for new constable positions are directed to demonstrate in their application materials any qualifications relevant to Recommendation 7.

RECOMMENDATION 9: The TPS consider whether to recruit actively from certain specific educational programs that teach skills which enable a compassionate response to people in crisis, such as nursing, social work, and programs relating to mental illness.

RECOMMENDATION 10: The TPS direct its Employment Unit to hire classes of new constables that, on the whole, demonstrate diversity of educational background, specialization, skills, and life experience, in addition to other metrics of diversity.

RECOMMENDATION 11: The TPS instruct psychologists, in carrying out their screening function for new constable selection, to assess for positive traits, in addition to assessing for the absence of mental illness or undesirable personality traits. In this aim, the TPS, in consultation with the psychologists, should identify a specific set of positive traits it wishes to have for new recruits and should instruct the psychologists to screen-in for those traits.

RECOMMENDATION 12: The TPS include the psychologists in the decision-making process for new constable selection, in a manner similar to their involvement in selecting officers for the ETF.

RECOMMENDATION 13: The TPS compile data to allow the Service to evaluate the effectiveness of the psychological screening tests that it has used in selecting recruits. Relevant data may include data that show what test results correlate with officers who have satisfactory and unsatisfactory interactions with people in crisis.

Working group regarding Psychological Services

RECOMMENDATION 14: The TPS strike a working group that includes participation from the TPS Psychological Services unit to comprehensively consider the role of Psychological Services within the TPS, including:

(a) More Information: whether the current process for psychological screening of new constables is effective and whether it could be improved, including whether TPS psychologists should be given more information about candidates to assist them in interpreting their test results;

(b) Involvement of Psychologists in other Promotion Decisions: whether Psychological Services should be authorized to conduct evaluations of, and otherwise be involved in, discussions regarding the selection processes for officer promotions within the Service, and the selection of coach officers;

(c) MCIT: whether the TPS psychologists should be involved in the selection and training of officers and nurses for the MCIT. More broadly, the TPS should consider how to facilitate a close and ongoing relationship between the psychologists and the MCIT in order to enable collaboration and information sharing between the Service's two units with a primary focus on mental illness;

(d) Organizational Structure: whether the TPS should amend its organizational structure so that Psychological Services reports directly or on a dotted-line basis to a Deputy Chief, in order to give greater recognition to the operational role that they play; and

(e) Expanding Psychological Services: how Psychological Services should be expanded to accommodate the officer selection duties and TPS members' wellness needs, as described in this Report.

CHAPTER 7: TRAINING

Recruit training

RECOMMENDATION 15: The TPS place more emphasis in its recruit training curricula on such areas as:

(a) Containment: considering and implementing techniques for containing crisis situations whenever possible in order to slow down the course of events and permit the involvement of specialized teams such as ETF or MCIT as appropriate;

(b) Communication and De-escalation: highlighting communication and de-escalation as the most important and commonly used skills of the police officer, and the need to adjust communication styles when a person does not understand or cannot comply with instructions;

(c) Subject Safety: recognizing the value of the life of a person in crisis and the importance of protecting the subject's safety as well as that of the officer and other members of the public;

(d) Use of Force: making more clear that the Use of Force Model is a code of conduct that carries (i) a goal of not using lethal force and (ii) a philosophy of using as little non-lethal force as possible; and that the Model is not meant to be used as a justification for the use of any force;

(e) Firearm Avoidance: implementing dynamic scenario training in which a recruit does not draw a firearm, as a means of emphasizing the non-lethal means of stabilizing a situation and reducing the potential for over-reliance on lethal force;

(f) Fear: including discussions of officers' fear responses during debriefings of practical scenarios that required de-escalation and communication techniques to defuse a crisis situation;

(g) Stigma: addressing and debunking stereotypes and stigmas concerning mental health. For example, the Toronto Police College (TPC) could build on its use of video presentations involving people with mental health issues by adding interviews with family members of people who have encountered police during crisis situations and police officers who were present during a crisis call that resulted or could have resulted in serious injury or death;

(h) Experience and Feedback: incorporating mental health and crisis situations into a larger number of practical scenarios to provide

recruits with more exposure to, and feedback on, techniques for resolving such situations; and

(i) Culture: laying the foundation for the culture the TPS expects its officers to promote and embody, and preparing recruits to resist the aspects of the existing culture that do not further TPS goals and values with respect to interactions with people in crisis.

RECOMMENDATION 16: The TPS consider whether officers would benefit from additional tools to assist them in responding to crisis calls, such as a quick-reference checklist for dealing with people in crisis that reminds officers to consider: whether the person is demonstrating signs of fear versus intentional aggression; whether medical, background and family contact information is available; whether alternative communication techniques are available when initial attempts at de-escalation are unsuccessful; whether containment of the person and the scene is a viable option; and whether discretion should be used in determining whether to apprehend, arrest, divert or release the person in crisis.

RECOMMENDATION 17: The TPS consider whether the 20-week recruit training period should be extended to allow sufficient time to teach all topics and skills required for the critically important work of a police officer.

In-service training

RECOMMENDATION 18: The TPS consider placing more emphasis, within the existing time allocated to in-service training if necessary, on the areas identified in Recommendation 15.

RECOMMENDATION 19: The TPS consider requiring officers to re-qualify annually or otherwise in the areas of crisis communication and negotiation, de-escalation, and containment measures.

RECOMMENDATION 20: The TPS consider whether to tailor in-service mental health training to the needs and experience levels of different audiences, such as by offering separate curricula for officers assigned to specialty units or divisions with high volumes of crisis calls.

Decentralized training

RECOMMENDATION 21: The TPS consider how decentralized training can be expanded and improved to focus on such issues as:

(a) Platoon training: increasing opportunities for officers to engage in traditional and online mental health programming within their platoons;

(b) Exposure: providing officers with in-service learning exercises that involve direct contact with the mental health system and community mental health resources; and

(c) Peer learning: instituting a model of peer-to-peer education within divisions, such as discussions with officers who have experience with mental health issues in their families, who have worked on an MCIT, who received Crisis Intervention Team (CIT) training, or who have other related experience.

Research and curriculum design

RECOMMENDATION 22: The TPS collaborate with researchers or sponsor research in the field of police education to develop a system for collecting and analyzing standardized data regarding the effectiveness of training at the TPC, OPC and the divisional levels, and to measure the impact that improvements in training have on actual encounters with people in crisis.

RECOMMENDATION 23: The TPS consider whether a broader range of perspectives can be considered in designing and delivering mental health training, for example, by involving TPS psychologists, Police College trainers, additional consumer survivors, mental health nurses and community agencies who work with patients and police.

CHAPTER 8: SUPERVISION

Coach officers and supervisors

RECOMMENDATION 24: The TPS further refine its selection and evaluation process for coach officers and supervisory officers to ensure that the individuals in these roles are best equipped to advise officers on appropriate responses to people in crisis; in particular, that the TPS:

(a) Consider requiring additional mental health training and/or experience for candidates interested in coach officer and sergeant positions, such as CIT training or MCIT experience;

(b) Create an evaluation mechanism through which officers can provide anonymous feedback on their coach officers or supervisors, including feedback on their skills regarding people in crisis; and

(c) Ensure that performance evaluation processes for supervisors include evaluation of both their skills regarding mental health and crisis response, as well as their monitoring of their subordinates' mental health and wellness.

Debriefing

RECOMMENDATION 25: The TPS create a Service-wide procedure for debriefing, including the debriefing of incidents involving people in crisis and incidents involving use of force, which includes consideration of such factors as:

(a) Discretion: the circumstances under which debriefing is mandatory, as opposed to when it is subject to the discretion of the appropriate supervisor;

(b) Participants: which members should participate in the debriefing process, particularly where there is a risk of re-traumatizing an officer suffering from critical incident stress;

(c) Institutional Learning: how the learning points from the debriefing can be shared with other members of the Service;

(d) Process: the appropriate circumstances, methods and selection of appropriate personnel for debriefing incidents that involved people in crisis, whether they were resolved successfully or resulted in unsatisfactory outcomes;

(e) Timing: how to create an expectation that debriefs will be conducted immediately after an incident, where appropriate, to encourage learning through debriefs without the fear of resulting sanctions;

(f) Self-analysis: whether the incident was resolved with the least amount of force possible, as well as whether the officer experienced fear, anxiety and other psychological and emotional effects during the encounter, and techniques for coping with those effects while trying to de-escalate a situation;

(g) Direct Feedback: direct feedback to officers on incidents that could have been resolved with less or no force, including whether the officer considered inappropriate circumstances or failed to consider appropriate factors and any alternative force options that could have been employed;

(h) Critical Incident Response: the importance of conducting debriefs in a manner that respects officers' mental health needs following an incident of serious bodily harm or lethal force, and the role of the Critical Incident Response Team;

(i) Stigma: how to foster discussions regarding stereotypes or misconceptions about people in crisis that may have contributed to the officer's decision-making during the crisis situation; and

(j) Valuing the Role of Debriefs: methods for creating a culture of debriefing and self-assessment within the Service, rather than a systemic perception of debriefing as a routine administrative duty.

RECOMMENDATION 26: The TPS develop a procedure that permits debriefing to occur on a real-time basis despite the existence of a Special Investigations Unit (SIU) investigation. The TPS should work with the SIU and appropriate municipal and provincial agencies to craft a procedure that does not interfere with external investigations, and that maintains the confidentiality of the debriefing process in order to promote candid analysis and continuous education.

Mental health champions

RECOMMENDATION 27: The TPS develop a network of mental health champions within the Service by appointing at least one experienced supervisory officer per division with experience in successfully resolving mental health crisis situations to:

(a) provide formal and informal divisional-level training, mentoring and coaching to other officers;

(b) lead or participate in debriefings of mental health crisis calls when appropriate;

(c) provide feedback to supervisors and senior management on officers who deserve recognition for exemplary conduct when serving people in crisis and those who need additional training or coaching;

(d) meet periodically with other mental health champions at various divisions to discuss best practices, challenges, and recommendations; and

(e) report to the appropriate deputy chief or command officer on the above responsibilities.

Discipline

RECOMMENDATION 28: The TPS establish an appropriate early intervention process for identifying incidents of behaviour by officers that may indicate a significant weakness in responding to mental health calls. Relevant data would include: propensity to draw or deploy firearms unnecessarily; use of excessive force; lack of sensitivity to mental health issues; insufficient efforts to de-escalate incidents; and other behaviours.

RECOMMENDATION 29: The TPS review its discipline procedure with regard to the following factors:

(a) Consistency: whether appropriate consequences are consistently applied to penalize inappropriate behaviour by officers in connection with people in crisis;

(b) Appropriate Penalties: whether officers who demonstrate conduct inconsistent with the role of a police officer are appropriately disciplined, including through suspension without pay or removal from their positions when appropriate;

(c) Supervisory Responsibility: whether there are appropriate disciplinary consequences for supervisors who fail to fulfil their duties to identify and rectify weaknesses in training or performance by officers subject to their oversight;

(d) Use of Force Reports: whether the information recorded in previous Use of Force Reports could be used in determining the appropriate level of discipline in particular incidents involving excessive use of force; and

(e) Legislative Reform: whether the factors listed above require the TPS to work with the provincial government to modify legislative or regulatory provisions.

Rewards

RECOMMENDATION 30: The TPS create incentives for officers to put mental health training into practice in situations involving people in crisis, and to reward officers who effectively de-escalate such crisis situations. In this regard, the TPS should consider inviting community organizations or other agencies to participate in determining division-level and Service-wide awards for exceptional communications and de-escalation skills.

Performance reviews and promotion

RECOMMENDATION 31: The TPS consider revising the process for performance reviews and promotions to:

(a) establish an explicit criterion that experience with people in crisis will be considered in making promotion decisions within the Service;

(b) place a greater emphasis on crisis de-escalation skills such as communication, empathy, proper use of force, patience and use of mental health resources; and

(c) determine the appropriate use of information contained in Use of Force Reports in assessing an officer's performance and suitability for promotion or particular job assignments.

De-escalation requirements

RECOMMENDATION 32: The TPS enforce, in the same way as other TPS procedures, those procedures that require an officer to attempt to de-escalate, such as Procedure 06-04 "Emotionally Disturbed Persons". In particular:

(a) Professional Standards investigations under Section 11 of Regulation 267/10 under the *Police Services Act* should investigate whether applicable de-escalation requirements were complied with and, if not, a finding of contravention of Service Governance and/or misconduct should be made;

(b) in appropriate cases, officers who do not comply with applicable de-escalation requirements should be subject to disciplinary proceedings; and

(c) supervisory officers should be formally directed to (i) monitor whether officers comply with applicable de-escalation requirements, and (ii) take appropriate remedial steps, such as providing mentoring and advice, arranging additional training, making notations in the officer's personnel file, or escalating the matter for disciplinary action.

CHAPTER 9: THE MENTAL HEALTH OF POLICE PERSONNEL

RECOMMENDATION 33: The TPS create a formal statement on psychological wellness for TPS members. This statement should:

(a) acknowledge the stresses and mental health risks that members face in the course of the performance of their duties;

(b) confirm the Service's commitment to providing support for members' psychological wellness;

(c) emphasize the importance of members attending to their mental health needs;

(d) emphasize the importance of members monitoring the mental health of their colleagues, and assisting colleagues to address mental health concerns;

(e) emphasize the role of supervisory officers in monitoring the mental health of those under their command, and in intervening to assist where appropriate;

(f) set out the psychological wellness resources available to members of the Service; and

(g) be accessible online and used in training at all levels of the Service.

RECOMMENDATION 34: The TPS consider whether to establish a comprehensive psychological health and safety management system for the Service.

RECOMMENDATION 35: The TPS provide a mandatory annual wellness visit with a TPS psychologist for all officers within their first two years of service.

RECOMMENDATION 36: The TPS consider providing less frequent periodic mandatory wellness visits with a TPS psychologist or other counsellor for all police officers, or, if it is not immediately possible to provide wellness visits to all officers, for any officer who works as a first responder, coach officer, or supervisory officer. The TPS should also encourage all officers to seek counselling voluntarily.

RECOMMENDATION 37: The TPS promote a greater understanding of the role and availability of the TPS psychologists, the EFAP and peer support groups as confidential resources that officers are encouraged to make use of to help them stay mentally healthy.

RECOMMENDATION 38: The TPS consider whether it would be helpful to establish an Internal Support Network for people who have experienced a shooting or other traumatic incident, or more generally to help officers with work-related psychological stresses.

RECOMMENDATION 39: The TPS consider creating a new procedure, substantially modelled after Procedure 08-05 "Substance Abuse," to address members' mental health, and specifically to require officers in supervisory roles to monitor for mental health concerns of TPS members under their command, in order to identify means of providing help for mental health issues before a fitness for duty issue arises.

RECOMMENDATION 40: The TPS provide officers in supervisory roles with training specific to monitoring other officers' psychological wellness and guiding preventive intervention where it is warranted.

CHAPTER 10: USE OF FORCE

Improving the Use of Force Procedure to reflect best practices

RECOMMENDATION 41: The TPS revise its Use of Force Procedure to supplement the Ontario Use of Force Model and guidelines with best practices from external bodies such as the International Association of Chiefs of Police, the United Nations and other police services in order to:

(a) incorporate approaches to minimizing the use of lethal force wherever possible;

(b) increase the emphasis placed on the seriousness of the decision to use lethal force in response to a person in crisis;

(c) further emphasize lethal force as a last resort to be used in crisis situations only where alternative approaches are ineffective or unavailable;

(d) articulate the importance of preserving the lives of subjects as well as officers wherever possible;

(e) recognize indicators of mental health crises as symptoms rather than threats to officer safety;

(f) acknowledge that many mental health calls result from crisis symptoms rather than criminal behavior;

(g) emphasize that police responding to people in crisis are usually required to play a helping role, not an enforcement role; and

(h) articulate that communication with a person in crisis should be a default technique in all stages of assessing and controlling the situation and planning a response.

Updating the Use of Force Procedure

RECOMMENDATION 42: The TPS regularly update its Use of Force Procedure to reflect best practices and the results of further research into the most effective means of communicating with people in crisis. In this regard, the TPS should seek alternative approaches for officers when a person in crisis does not appear to comprehend or have the ability to comply with the Police Challenge; and consider consulting with provincial agencies, the Ontario Police College, mental health experts, consumer survivors, and others with specialized experience to ensure that the Use of Force Procedure reflects best practices.

CHAPTER 11: MCIT AND OTHER MODELS OF CRISIS INTERVENTION

Crisis Intervention Teams

RECOMMENDATION 43: The TPS develop a pilot Crisis Intervention Team (CIT) program, intended to complement the MCIT program, along the lines of the Memphis/Hamilton model, in the aim of being able to provide a specialized, trained response to people in crisis 24 hours per day.

RECOMMENDATION 44: The TPS fully implement the 10 core elements of the Memphis/Hamilton CIT model comprehensively discussed in this Report.

RECOMMENDATION 45: The TPS should study the effectiveness of CIT officers who participate in its pilot program by analyzing, among other things:

(a) whether a greater proportion of calls involving a person in crisis are addressed by a specialized response;

(b) whether CIT officers use various forms of force less frequently than non-CIT officers;

(c) whether CIT officers feel more capable and confident in interacting with people in crisis than non-CIT officers;

(d) whether the relevant community notes a difference in the way they are treated by CIT officers versus non-CIT officers;

(e) whether the proportion of persons entering the criminal justice system who suffer from mental illness declines; and

(f) any other metrics deemed relevant.

RECOMMENDATION 46: The TPS should amend its procedures and training to enable, where appropriate, a CIT officer to take charge of a call when a person in crisis may be involved, regardless of whether they are the first officer to arrive.

The Mobile Crisis Intervention Team

RECOMMENDATION 47: The TPS establish a six-month probation period for MCIT officers, which culminates in a review, to ensure that the best-suited people are in these roles. Those who successfully complete probation should be subject to a minimum commitment of two years as part of the MCIT.

RECOMMENDATION 48: The TPS expand the availability of MCIT to provide at least one MCIT unit per operational division. The following matters related to expanding MCIT should be addressed, in cooperation with applicable Local Health Integration Networks and partner hospitals:

(a) Hours: Whether MCIT service should be provided 24 hours per day;

(b) First Response: Whether MCIT can act as a first response in certain circumstances; and

(c) Alcohol and Drugs: Whether MCIT can respond to calls involving alcohol or drug abuse.

RECOMMENDATION 49: The TPS require all coach officers and supervisory officers to attend the training course designed for MCIT officers so that they gain greater awareness of mental health issues and the role of specialized crisis response.

RECOMMENDATION 50: The TPS establish a system of awards and recognition within TPS for exemplary MCIT service as part of the overall system of recognition and awards identified in Recommendation 30.

RECOMMENDATION 51: The TPS encourage supervisory officers, coach officers, and others with leadership roles to promote awareness of the role of the MCIT program within the TPS so that all front line officers know the resources at their disposal in helping a person in crisis.

RECOMMENDATION 52: The TPS, as part of training at the platoon level, include sessions in which MCIT units educate other officers on the role of the MCIT unit and best practices for interacting with people in crisis.

RECOMMENDATION 53: The TPS consider whether to amend Procedure 06-04 "Emotionally Disturbed Persons" to identify exceptions to TPS requirements such as handcuffing, the use of in-car cameras, and other measures, in recognition that the apprehension of a person in crisis under the *Mental Health Act* differs from other types of police apprehensions.

RECOMMENDATION 54: The TPS solicit the input of MCIT members to learn from their first-hand experience, with respect to any proposed changes to the MCIT program.

CHAPTER 12: EQUIPMENT

Conducted Energy Weapons

RECOMMENDATION 55: The TPS advocate an interprovincial study of the medical effects of conducted energy weapon (CEW) use on various groups of people (including vulnerable groups such as people in crisis), as suggested by the Goudge Report.

RECOMMENDATION 56: The TPS collaborate with other municipal, provincial, and federal police services to establish a central database of standardized information concerning matters related to the use of force, and CEW use specifically, such as:

(a) the location of contact by CEW probes on a subject's body;

(b) the length of deployment and the number of CEW uses;

(c) any medical problems observed by the officers;

(d) any medical problems assessed by Emergency Medical Services (EMS) or hospital staff;

(e) the time period between the use of a CEW and the manifestation of medical effects;

(f) the subject's prior mental and physical health condition;

(g) the use of CEWs per ratio of population;

(h) the use of CEWs per ratio of officers equipped with the devices; and

(i) the use of CEWs in comparison to other force options.

RECOMMENDATION 57: The TPS review, and if necessary amend, the Use of Force and CEW Report forms to ensure that officers are prompted to include all standardized information required for the database proposed in Recommendation 56.

RECOMMENDATION 58: The TPS collaborate with Local Health Integration Networks, hospitals, EMS, and other appropriate medical professionals to standardize reporting of data concerning the medical effects of CEWs.

RECOMMENDATION 59: The TPS consider conducting a pilot project to assess the potential for expanding CEW access within the Service, with parameters such as:

(a) Supervision: at an appropriate time to be determined by the TPS, CEWs should be issued to a selection of front line officers in a limited number of divisions for a limited period of time with the use and results to be closely monitored;

(b) Cameras: all front line officers who are issued CEWs should be equipped either with body-worn cameras or audio/visual attachments for the devices;

(c) Reporting: the pilot project require standardized reporting on issues such as:

i. frequency and circumstances associated with use of a CEW, including whether it was used in place of lethal force;

ii. frequency and nature of misuse of CEWs by officers;

iii. medical effects of CEW use; and

iv. the physical and mental state of the subject;

(d) Analysis: data from the pilot project be analyzed in consideration of such factors as:

i. whether CEWs are used more frequently by primary response units, as compared to baseline information on current use of CEWs by supervisors;

ii. whether CEWs are misused more frequently by primary response units, as compared to baseline information on current use of CEWs by supervisors;

iii. the disciplinary and training responses to misuses of CEWs by officers and supervisors;

iv. whether use of force overall increased with expanded availability of CEWs in the pilot project;

v. whether use of lethal force decreased with expanded availability of CEWs in the pilot project; and

vi. whether TPS procedures, training or disciplinary processes need to be adjusted to emphasize the objective of reducing deaths without increasing the overall use of force or infringing on civil liberties; and

(e) Transparency: the TPS report the results of the pilot project to the Toronto Police Services Board (TPSB), and make the results publicly available.

RECOMMENDATION 60: The TPS ensure that all CEWs issued to members (including those CEWs already in service) are accompanied by body-worn cameras, CEW audio/visual recording devices, or other effective monitoring technology.

RECOMMENDATION 61: The TPS ensure that CEW Reports are reviewed regularly, and that inappropriate or excessive uses are investigated.

RECOMMENDATION 62: The TPS discipline, as appropriate, officers who over-rely on or misuse CEWs, especially in situations involving non-violent people in crisis.

RECOMMENDATION 63: The TPS provide additional training, as appropriate, to officers who misuse CEWs in the course of good faith efforts to contain situations without using lethal force.

RECOMMENDATION 64: The TPS require officers to indicate on CEW Reports whether, and what, de-escalation measures were attempted prior to deploying the CEW.

RECOMMENDATION 65: The TPS carefully monitor the data downloaded from CEWs on a periodic basis, investigate uses that are not reported by Service members and discipline officers who fail to report all uses appropriately.

RECOMMENDATION 66: The TPS periodically conduct a comprehensive review of data downloaded from CEWs and audio/visual attachments or body cameras, to identify trends in training and supervision needs relating to CEWs as well as the adequacy of disciplinary measures following misuse.

RECOMMENDATION 67: The TPS revise its CEW procedure to emphasize that the purpose of equipping certain officers with CEWs is to provide opportunities to reduce fatalities and serious injuries, not to increase the overall use of force by police.

RECOMMENDATION 68: The TPS review best practices on safety of CEWs in different modes, both from TPS personnel that are already using CEWs and from other jurisdictions that have implemented policies on permitted methods of discharging CEWs.

RECOMMENDATION 69: The TPS consider the appropriate threshold for permissible use of CEWs, and in particular whether use should be limited to circumstances in which the subject is causing bodily harm or poses an immediate risk of bodily harm to the officer or another person, and no lesser force option, de-escalation or other crisis intervention technique is available or is effective.

RECOMMENDATION 70: The TPS require that all officers equipped with CEWs have completed Mental Health First Aid or equivalent training in mental health issues and de-escalation techniques.

RECOMMENDATION 71: The TPS ensure that training on potential health effects of CEWs, including any heightened risks for people in crisis or individuals with mental illnesses, is updated regularly as the state of knowledge on the topic advances.

Body cameras

RECOMMENDATION 72: The TPS issue body-worn cameras to all officers who may encounter people in crisis to ensure greater accountability and transparency for all concerned.

RECOMMENDATION 73: The TPS develop a protocol for protecting the privacy of information recorded by body-worn cameras. The protocol should address the following matters:

(a) Use and Retention: The privacy protocol should address the appropriate methods of storage and length of retention of body camera recordings, limits to accessing and sharing this information, and mechanisms through which individuals recorded can request access to, and the deletion of, information stored by the TPS;

(b) Discretion: The TPS should establish the scope of discretion for officers to disable recording, reporting measures to be taken when a camera is deactivated, and consequences of misusing that discretion. Examples include requiring officers to notify Communications Services of the reason for disabling a body camera and the duration of the deactivation, or requiring officers to file

reports detailing any circumstances in which their body cameras were deactivated;

(c) Discipline: The TPS should establish and enforce clear disciplinary measures for members of the Service who do not comply with the privacy protocol and the discretionary/use protocol to be developed concerning body cameras;

(d) Balancing Interests: The TPS should investigate appropriate options for balancing an individual's right to privacy, an officer's discretion, and the need for accountability in public policing; and

(e) Collaboration: The TPS should work closely with civil liberties groups, legal advisors, consumer survivors, provincial government agencies, privacy commissioners and other appropriate stakeholders in developing the protocol.

Alternative equipment options

RECOMMENDATION 74: The TPS conduct a review of alternative equipment options and tactical approaches, including examples from other jurisdictions, to assist in further reducing the number of deaths arising from police encounters with people in crisis.

CHAPTER 13: IMPLEMENTATION

Advisory committee on implementation

RECOMMENDATION 75: The Chief of Police strike an advisory committee, to advise the Chief of Police on how best to implement the recommendations contained in this Report. In this regard, I recommend:

(a) Stakeholder Membership: The advisory committee should include leading members of key stakeholder groups, including hospitals, community mental health organizations, the police and those with lived experience of mental illness;

(b) Limited Membership: The advisory committee should be of manageable size—large enough to provide adequate representation of stakeholder groups, but small enough to be efficient;

(c) Advisory Role: The advisory committee should play only an advisory role and should not have decision-making authority, unless the Chief of Police determines otherwise;

(d) Defined Role: The role of advisory committee members should be defined in clear terms at the time of the creation of the advisory

committee, so that there is no misunderstanding as to their function and authority;

(e) In Camera Meetings: The discussions of the advisory committee should be held in camera in order to promote candour and collegiality, unless otherwise directed by the Chief of Police. Advisory committee members should agree as a condition of membership that they will not disclose the committee's discussions;

(f) Communications with the Public: The advisory committee and its individual members should not advocate publicly or use the media as a vehicle for seeking to persuade the Chief of Police (or the TPS more broadly) to make specific decisions, or to criticize the TPS. The advisory committee should not be a political body but rather a true advisory body, with the effectiveness of its advice deriving from the quality of its membership;

(g) Staffing: The advisory committee should be provided with reasonable assistance by staff as needed, whether using existing TPS personnel or otherwise; and

(h) Annual Reports: The advisory committee should prepare annual reports for the Chief of Police, summarizing the state of progress in implementation, any significant divergences between the advice of the committee and the decisions taken by the TPS in the past year, and major recommendations going forward relating to implementation, prioritization, scheduling, planning, resource allocation, public reporting and related topics.

Transparency and accountability

RECOMMENDATION 76: In order to ensure transparency and accountability during the implementation stage, the TPS issue a public report at least annually after the date of release of this Report, with the following contents:

(a) a list of recommendations implemented in whole or in part to the date of the report, with an explanation of what was done and when;

(b) a list of those recommendations still to be implemented, with an indication of the anticipated timing of implementation;

(c) if applicable, a description of resource constraints that affect the ability of the TPS to implement any recommendations, or the timing of implementation;

(d) if applicable, a description of any other limitations on the ability of the TPS to implement any recommendations (such as lack of

cooperation from other organizations, change in circumstances, etc.);

(e) if applicable, a list of recommendations that the TPS decided not to implement at all, and an explanation of the reasons for decision;

(f) if applicable, a list of recommendations that the TPS decided to implement in modified form (different from what was recommended in this Report), and an explanation of the reasons for decision; and

(g) a discussion of any significant divergences between the advice of the advisory committee and decisions made by the TPS.

Leadership

RECOMMENDATION 77: The Chief of Police and the Executive Management Team of the TPS play a significant leadership role in requiring implementation of the recommendations in this Report, and in encouraging (through leadership by example and otherwise) voluntary compliance.

RECOMMENDATION 78: The TPS appoint a senior officer to assume overall operational responsibility and executive accountability for the implementation of the recommendations in this Report, subject to the direction of the Chief of Police or the chief's designate.

RECOMMENDATION 79: The TPS create an implementation team, led by the senior officer identified above and composed of those TPS members charged with responsibility to implement recommendations within specified areas of the Service (e.g., within the MCIT program, within Psychological Services, within the Toronto Police College, etc.).

RECOMMENDATION 80: The Chief of Police or his delegate appoint, within each TPS division and unit, at least one TPS member formally charged with responsibility for ensuring effective implementation of the recommendations in this Report at the division or unit level.

Topic-specific reviews

RECOMMENDATION 81: In connection with those recommendations above that call for further study, examination and analysis of specific issues:

(a) Stakeholder Input: Where appropriate, the TPS seek to involve representatives of affected stakeholders meaningfully in the work;

(b) Deliverables: The TPS identify specific deliverables sought from those tasked with the work, and a timeframe for delivery; and

(c) Reporting Requirement: There be a regular reporting requirement for any work taking place over an extended period, whereby the senior TPS officer in charge of implementation is kept informed regarding the progress of the work.

Third-party cooperation and relationships

RECOMMENDATION 82: In connection with those recommendations above that call for the TPS to work with outside organizations such as government ministries, hospitals and others, the TPS take a leadership role in forging and fostering the necessary relationships.

RECOMMENDATION 83: The TPS collaborate with academic researchers, hospitals and others to evaluate the effectiveness of TPS initiatives undertaken as a result of this Review, including, where applicable, both quantitative and qualitative evaluations.

Ongoing review

RECOMMENDATION 84: A follow-up review be conducted—whether by TPS personnel, by an independent review body or by committee of interested stakeholders—in five years' time to assess the degree of success achieved in minimizing the use of lethal force in encounters between the TPS and people in crisis, and to make further recommendations for improvement. I recommend that the results of that review be made public, and that the reviewers be similarly tasked with developing recommendations for implementation.

PART 1

The Independent Review

CHAPTER 1

Introduction: A Brief Overview

Chapter 1. Introduction: A Brief Overview

1. On July 27, 2013, Sammy Yatim was fatally shot by an officer of the Toronto Police Service (TPS).

2. On August 28, 2013, Chief of Police William Blair requested that I undertake an independent review of the use of lethal force by the TPS, which was to focus on encounters between police and what I refer to in this Report as "people in crisis." By a person in crisis I mean a member of the public whose behaviour brings them into contact with police either because of an apparent need for urgent care within the mental health system, or because they are otherwise experiencing a mental or emotional crisis involving behaviour that is sufficiently erratic, threatening or dangerous that the police are called in order to protect the person or those around them.

3. Specifically, I was asked by Chief Blair to conduct an independent review of "the policies, practices, and procedures of, and the services provided by, the TPS with respect to the use of lethal force or potentially lethal force, in particular in encounters with persons who are [people in crisis]."

4. My Review was emphatically intended to be, and was, independent. The end product was to be a report, to be made public, setting out recommendations for the TPS for future consideration and action.

5. I begin with three preliminary comments.

6. First and above all, I must emphasize the serious and tragic circumstances that are at the heart of the issues canvassed in this Review and discussed in this Report. This Report deals with the loss of life in situations that cry out for attention and raise the fundamental question: How can lethal outcomes be avoided? The impact of the loss of life is enormous, not only on family members and loved ones of the person in crisis who has died, but also on the police officer who applied lethal force, on other colleagues directly involved, and on bystanders who observed the events.

7. I met with and heard accounts of family members of people in crisis who were killed. Many of their lives have been changed forever by the profound sadness and frustration of thinking about what could or should have been done to have avoided such a disastrous result. Similarly, I met with police officers who witnessed or were otherwise involved in the shooting of a person, whose lives, and the lives of family members, have been emotionally scarred as a result, and who seek to deal with the traumatic effects of their involvement.

8. Second, TPS encounters with people in crisis are regrettably part of an international phenomenon that presents a fundamental challenge to modern society. Police services across Canada, the United States, United Kingdom, Australia, and New Zealand—just to mention jurisdictions that we have looked at—face similar challenges in seeking to improve approaches to deal with the difficult situations that arise. It seems that no part of the world is free of these potentially tragic human outcomes.

9. Third, it is important at the outset to note what this Review is not about and what it is about.

10. It is not about laying blame on anyone. In fact, my mandate (which I discuss more fully in Chapter 2) expressly forbids me from dealing with specific incidents, whether or not they are before the courts in a criminal or civil law context or otherwise. Indeed, I wish to emphasize that anything I express in this Report is not intended to refer to any specific event.

11. The basic purpose of the Review is to consider how, going forward, we can prevent lethal outcomes. Here I would mention that the TPS has done much in this area that is positive, and is a leader in this subject in a number of respects. But I believe improvements can always be made, particularly as knowledge, experience, and examination of the issues increase over time.

12. The mandate of the Review, as well as its independence, scope and methodology, are described in the next chapter. Upon being asked to conduct the Review, I immediately had to assemble a team which I did by selecting individuals from Torys LLP to work with me and by creating an Advisory Group of distinguished professionals who provided insights and comments from different perspectives that were most helpful.

13. The team and I received or obtained a mass of data, policies, procedures, academic literature and commentary, reports and so on. We reviewed well over 1,200 documents, had numerous interviews with individuals having different experiences and viewpoints, and received many submissions, all as described in the next chapter. We also examined Ontario coroners' inquest recommendations and interviewed U.S. and U.K. experts to seek best practices.

14. With this background and effort in mind, this Report takes a holistic approach to the mandate given to me. It is clear that police are part of the mental health system—they are the front line mental health workers for many of the most dangerous encounters. Preventing deaths includes preventing the crises in the first place, as well as helping police to deal with crises better. One of the key themes of this Report is the need for inter-disciplinary cooperation, learning and teaching, involving not only police and mental health professionals, but also mental health consumer-survivors. It is their lives and deaths that are at issue and they should not be treated as the problem being discussed. They are our fellow citizens and should work with us to find solutions. I return to this topic below and in many sections of the Report.

15. In preparing this Report, I have tried to be as comprehensive and helpful to the TPS as possible. That does not imply in any way that defects are widespread. Rather, it simply underscores that I have found that, because of the seriousness and complexity of the issues, there is much to be considered.

16. The police have an extraordinarily important role in our society. To serve and protect, they have unique powers and authority and heavy responsibilities and duties. They can, under strict circumstances, use their firearms to take a life and to protect a

life. They take their roles seriously and society could not properly function without them. In addition, modern policing has evolved in many ways and the TPS has shown its adaptability over time to make changes that are required.

17. The culture of the TPS has also adapted over time, and it continues to evolve as society itself evolves. By culture, I mean the prevailing attitudes, beliefs, and values of the Service. Ultimately, in one sense the issues addressed in this Report all have to do with police culture, because my recommendations aim to affect behaviour, and meaningful change to behaviour involves assisting in the evolution of the attitudes, beliefs and values that guide behaviour. I address the issue of police culture in more detail in Chapter 5 and more generally throughout the Report.

18. Encounters of the TPS with people in crisis number approximately 20,000 annually. The vast majority of these encounters end peaceably and without incident. But, most unfortunately, there are some lethal outcomes.

19. The premise of the Report is that the target should be zero deaths when police interact with a member of the public—no death of the subject, the police officer involved, or any member of the public. I believe the death of a fellow human being in these encounters is a failure for which blame in many situations cannot be assigned; it is more likely a failure of a system. Policies and procedures should be designed and exercised with that zero target in mind but, of course, not at the cost of ignoring the safety of the subject, the police or the public.

20. In that connection, the Report recognizes the extreme difficulty of the situations involving police interaction with people in crisis. Police officers have to act under great pressure in life-and-death situations where tragedy can occur in seconds. Fear is felt by all concerned and often we cannot and should not judge conduct after the fact. At the same time, it is not easy to fairly understand the thoughts and condition of the person in crisis. I explore in Chapter 3 the different perspectives from which one can view such encounters.

21. We therefore cannot resort to absolutes because the context of encounters varies and in each case calls for the application of judgment. Accordingly, a balanced approach must be taken to recommending improvements to existing policies, procedures and practices that will enhance the avoidance of lethal outcomes yet maintain the protection of human life and safety. I have sought to reflect this balance in the Report.

22. So far, to a great extent, I have been discussing only the police and people in crisis but there is a huge issue to which I have alluded that warrants further elaboration: the mental health system. One cannot properly deal with the subject of police encounters with people in crisis and not consider the availability of access to mental health and other services that can play a role in the tragic outcomes for people in crisis in encounters with the police. Police officers, because of their 24/7 availability and experience in dealing with human conflict and disturbances, are inexorably drawn into mental and emotional fields involving individuals with personal crisis.

23. As I emphasize in the Report, there will not be great improvements in police encounters with people in crisis without the participation of agencies and institutions of municipal, provincial and federal governments because, simply put, they are part of the problem and need to be involved in the solution.

24. In many ways, I have found this reality the most distressing societal aspect of my work on the Review. The effective functioning of the mental health system is essential as a means of preventing people from finding themselves in crisis in the first place. There is not much I can do through my recommendations to remedy the applicable problems in the mental health system, since I can recommend changes only to the TPS. But the basic and glaring fact is that the TPS alone cannot provide a complete answer to lethal outcomes involving people in crisis.

25. As for the recommendations that my mandate permits, several themes emerge. First, the recommendations are comprehensive to cover the topics in my mandate such as recruitment of police officers, their training, supervision and oversight, their wellness, their discipline and positive reinforcements, and the numerous procedures that impact encounters with people in crisis, notably those on the use of force and police equipment available to police officers. Separate chapters in the Report deal with these topics. Second, the recommendations seek to achieve a balance between using the minimal force required in the circumstances while acknowledging the police officer is exercising judgment in a situation of great pressure and stress. Third, the importance of de-escalation in police encounters cannot be overemphasized, nor can the importance of protecting the lives and safety of everyone. Fourth, the recommendations are many and raise resource issues that may prove to be difficult, but one cannot ignore that what is at stake is human life as well as the treatment of a vulnerable group in our society. Fifth, some recommendations involve further study—for example, regarding possible harmful effects of using conducted energy weapons or the introduction of a pilot project. Sixth, although recommendations are directed at the TPS, other parties or institutions implicitly are urged to be more involved—for example, the Ministry of Health and Long Term Care. Seventh, increased evaluation and monitoring are encouraged to continue the search for improvements. Finally, I have attempted to make recommendations that are practical.

26. As for implementation of recommendations, I strongly recommend the setting up of an Advisory Committee on Implementation that would include representatives of stakeholder groups. The Advisory Committee would provide advice to the Chief of Police for his consideration. The TPS has already been most receptive to stakeholder input so this should not prove controversial. Obviously, senior TPS personnel should also participate in the Advisory Committee. The Committee would in turn make recommendations, including staging of implementation steps to meet resource requirements as is appropriate or necessary, all for the consideration of the Chief. To ensure accountability, after deliberation by the Committee, ultimately the Chief can explain publicly the status of implementation and the reasons for the implementation decisions taken.

27. To conclude this introductory overview, I would be remiss if I did not commend the Chief of Police, the TPS and many other stakeholders, including those with lived

experience of mental illness, for the efforts they have made to achieve progress in this area. Collectively, they have not assumed that the status quo is as good as it is going to get, and is therefore good enough.

28. It should be noted that Chief Blair and the TPS did not have to call for an independent review. The effect of calling such a review is to take some degree of control away from the TPS over change within the organization. Not only did the TPS do that, but it also agreed in advance that the report and recommendations emanating from the Review were to be made public, without knowing what those results or recommendations would be.

29. For those killed and for their families, nothing can take away their loss. For people in crisis who have had negative experiences with police, self-evaluation by the police and the larger mental health field is meaningful if there is a real change.

30. Recognizing the TPS for taking this initiative is important, but the real work remains to be done, and the true test of the TPS and those organizations with which the TPS interacts will be what changes they make and the approach they take to the task. What they do in this area is fundamentally important to reinforcing public trust and confidence in the Toronto Police Service.

CHAPTER 2

Mandate, Independence, Scope and Methodology

CHAPTER 2. MANDATE, INDEPENDENCE, SCOPE AND METHODOLOGY

Table of Contents

Page

A. MANDATE 44

B. INDEPENDENCE 46

C. SCOPE OF THE REVIEW 46

(1) The Review is forward looking 46
(2) Lethal force 47
(3) Persons who are or may be "emotionally disturbed, mentally disturbed or cognitively impaired" 47
(4) Terminology 48

D. METHODOLOGY 50

(1) Interviews 50
(2) Literature review 51
(3) Police College site visits 53
(4) Communications Services site visit 53
(5) MCIT ride along 53
(6) Mental health site visits 53
(7) Consultation with the Advisory Panel 54
(8) Roundtable discussion 54
(9) CACP/MHCC conference 55
(10) Stakeholder input 55

Chapter 2. Mandate, Independence, Scope and Methodology

A. Mandate

1. On August 28, 2013, I was asked by Chief of Police William Blair to undertake an independent review of the use of lethal force by the Toronto Police Service (TPS). The focus of the Review is on encounters between police and individuals identified in this Report as "people in crisis."

2. In light of the fatal shooting of Sammy Yatim on July 27, 2013, Chief Blair concluded that he had a responsibility to cause a review to be conducted as required by section 11 of Regulation 267/10 under the Ontario *Police Services Act*.

3. Section 11 of O. Reg. 267/10 provides that a chief of police shall cause an investigation to be conducted forthwith into any incident involving a police force with respect to which the Special Investigations Unit (SIU) has been notified, subject to the SIU's lead role in investigating the incident. The SIU is required to be notified when there is an incident involving serious injury or death that may have resulted from criminal offences committed by police officers.

4. The purpose of the investigation by the Chief of Police is to review the policies of, or services provided by, the police force in question, and to review the conduct of its police officers. All members of the police force are required to cooperate fully with the Chief of Police's investigation.

5. Chief Blair divided the review into two parts.

6. One part of the review was conducted by officers within the Professional Standards unit of the TPS, who examined the conduct of the police officers involved on the night that Mr. Yatim was killed. I was not involved in this part of the review.

7. This Report addresses the second part of the review.

8. My mandate was to conduct an independent review of "the policies, practices and procedures of, and the services provided by, the TPS with respect to the use of lethal force or potentially lethal force, in particular in connection with encounters with persons who are or may be emotionally disturbed, mentally disturbed or cognitively impaired."

9. I was instructed by Chief Blair that the hallmark of my Review was intended to be its independence, and that the end result of the Review was to be a report, to be made public, setting out recommendations that will be used as a blueprint for the TPS in dealing with this serious and difficult issue in the future.

10. My mandate has included reviewing the following topics:

    (i) TPS policies, procedures and practices;

(ii) TPS training, and training at the Ontario Police College;

(iii) equipment used by the TPS;

(iv) psychological assessments and other evaluation of TPS police officers and officer candidates

(v) supervision and oversight;

(vi) the role of the Mobile Crisis Intervention Teams currently employed by the TPS;

(vii) the role of the TPS Emergency Task Force;

(viii) best practices and precedents from major police forces internationally (in Canada, the United States, the United Kingdom, Australia and other jurisdictions)

(ix) available studies, data and research; and

(x) other related matters falling within the scope of the independent review.

11. As part of the independent Review, I was authorized to engage in (and did conduct, as explained below under "Methodology") the following activities:

(i) receive submissions and meet with stakeholder groups or individuals;

(ii) examine TPS use of force equipment;

(iii) attend to observe TPS training;

(iv) interview TPS personnel;

(v) consult with experts in the field of mental, emotional and cognitive disorders;

(vi) consult with experts in the use of force, the selection and training of police, crisis intervention and all other matters that are the subject of the review;

(vii) assemble and retain an advisory panel of experts;

(viii) conduct research;

(ix) make recommendations based on the work performed and the information obtained; and

(x) perform such other work as may be reasonably incidental to the independent review.

B. Independence

12. This Review was conducted on an independent basis, at arm's length from the Toronto Police Service.

13. The Review team that I assembled consisted exclusively of lawyers and other personnel at Torys LLP, none of whom is affiliated with the TPS. No one from the TPS was on the Review team, and the Review was conducted exclusively by the Review team.

14. The TPS appointed two individuals to act as a liaison between the TPS and the Review team: Inspector Ian Stratford and Mr. Jerry Wiley. Inspector Stratford is a member of the Prosecution Services group within the TPS Professional Standards unit. Mr. Wiley was formerly (until he retired) Counsel to the Office of the Chief of Police at the TPS. Inspector Stratford and Mr. Wiley collected some of the background documents and information that were considered by the Review team, arranged the logistics for some of the interviews, arranged and attended some site visits, and otherwise served as administrative liaisons. Neither individual was involved in the substantive analysis that I conducted with my Review team, in the development of my recommendations, or in the drafting of this Report.

15. During the course of the Review, the Review team interviewed numerous individuals, including members of the TPS, as well as many other individuals. With the exception of our meetings with a small subset of TPS members, which were attended by the liaison officers, all of the interviews were conducted on a confidential basis between the individuals and the Review team. The persons interviewed were informed that the information they provided to the Review would not be attributed to them in this Report, and would not otherwise be shared in a way that could identify the individual. The goal was to encourage candour in discussing these difficult issues.

16. I arrived at all of the recommendations in this Report independently.

C. Scope of the Review

1. *The Review is forward looking*

17. This Review is by its nature forward looking, designed to lead to improvements in the policies, procedures and practices that guide TPS officers, the training that provides them with the skills and competencies to respond effectively, and the equipment TPS officers employ.

18. The ultimate purpose of the Review is to help prevent future deaths.

19. As a professional organization tasked with serving the public, the TPS must engage in periodic self-examination and self-assessment, to ensure that the Service and its members conduct themselves in accordance with the highest professional standards and in a manner consistent with best practices. A key purpose of this Review is to help the TPS meet this requirement with respect to those matters that fall within the Review's scope.

20. The act of engaging in professional improvement does not, by itself, imply that the organization is deficient or that the status quo reflects a failure. The purpose of this Review is to review the current policies, procedures and practices within the TPS in order to assess, from a policy perspective, whether improvements can be recommended. My mandate does not include making judgments about the legal adequacy of these policies, procedures and practices, or about whether the TPS meets any particular legal standard. I have not made such judgments in this Report. Overall, as a result of this Review, my assessment is that the Toronto Police Service is a progressive police force with a genuine commitment to public service. Like all organizations, it is capable of further improvement. The TPS is to be commended for seeking to do so.

21. To elaborate further, this Review is not concerned with the conduct of specific police officers, nor is it concerned with specific incidents in which the TPS has used lethal force. The Review makes no factual findings and reaches no conclusions about any issue of criminal, civil or disciplinary liability; in fact, this is expressly prohibited by the terms of my mandate. Although this Review arose following the shooting of Mr. Yatim, I want to be very clear that the recommendations made in this Review are not a specific response to that shooting or to any other individual incident. Nothing in this Report should influence or is intended to influence the outcome of any court process or other adjudicative proceedings.

2. *Lethal force*

22. The Review is focused on the use of lethal force. The Review is therefore restricted to examining, seeking to prevent, and seeking to help manage those circumstances in which a more serious use of force may be deployed or considered—usually circumstances involving a weapon such as a gun or a conducted energy weapon (CEW). It is important to be clear that this Review is not a comprehensive review of all situations in which the TPS may use force. Rather, this is a focused review that is concerned specifically with minimizing the use of deadly force in police encounters with people in crisis.

23. A related limitation is that I concluded the Review should consider only direct interactions between police and a member of the public, whether in the context of a confrontation or incident to arrest. Although death or serious injury can also occur while an individual is in custody, the Review did not examine the unique issues relating specifically to in-custody deaths.

3. *Persons who are or may be "emotionally disturbed, mentally disturbed or cognitively impaired"*

24. The mandate of the Review is to focus, in particular, on encounters by TPS officers with persons who are or may be "emotionally disturbed, mentally disturbed or cognitively impaired."

25. Regulation 3/99 under the Ontario *Police Services Act* (Adequacy and Effectiveness of Police Services) requires the Chief of Police to establish procedures and processes in respect of "police response to persons who are emotionally disturbed or

have a mental illness or a developmental disability." My understanding is that the identification of these three categories of person within the mandate of the Review derives from this legislative requirement.

26. It was identified during the early stages of the Review that separate considerations may apply to persons who are cognitively impaired (whether as a result of dementia, developmental disability or other causes) as distinct from persons suffering from mental illness or emotional crisis. While much of what is addressed in this Report will apply to police encounters with those who are cognitively impaired, a discrete treatment of the issues raised uniquely by cognitive impairment is beyond the scope of the Review.

27. Based on the information I have considered as part of the Review, it has become clear that, at the moment that a police officer encounters a member of the public who is exhibiting erratic, threatening or assaultive behaviour, the reason for the behaviour is not always immediately apparent. The police officer cannot always tell whether the person is experiencing a mental or emotional disturbance, or a cognitive impairment. It may be only after the incident that it is determined that the person was mentally ill, or impaired by drugs or experiencing an emotional crisis. Thus, while the focus of this Review is on individuals who fall into the three categories described in the mandate, that is not the exclusive focus. Much of what follows in this Report is relevant to any encounter by police with a person where lethal force may be considered.

4. *Terminology*

28. As is discussed throughout this Report, there are many different stakeholder groups with an interest in the inter-relationship between policing and mental health. There are likewise as many perspectives on the appropriate terminology to use when describing members of the public whose mental or emotional crisis brings them into contact with police.

29. In police vocabulary, the most commonly used term is "emotionally disturbed person" or EDP. The term "emotionally disturbed person" derives from legislation (section 13 of O. Reg. 3/99 under the *Police Services Act* as noted above) and is entrenched in the TPS lexicon. In TPS Procedure 06-04 ("Emotionally Disturbed Persons"), an emotionally disturbed person is defined as including "any person who appears to be in a state of crisis or any person who is mentally disordered."

30. However, the term "emotionally disturbed person" is viewed by some stakeholders within the mental health community as being somewhat pejorative. Others feel that the term focuses attention unduly on the behaviour of the person ("disturbed") rather than on the person himself or herself, and the person's entitlement to be treated with dignity regardless of mental or emotional condition. Other stakeholders within the mental health community (including those who fall within the scope of the term) have confirmed to the Review team that they find the terminology acceptable and neutral.

31. Another terminological concern relates to the terms "mental illness," "mentally disturbed" and "mentally disabled." Not all people who are experiencing an emotional or

mental crisis and whose behaviour elicits a call to the police suffer from a mental illness or mental disturbance. The terms are, in that sense, under-inclusive. The concept of a mental disability connotes a permanent condition, which may not be accurate. Moreover, some stakeholders within the mental health community prefer not to use terms like "mental illness" because the terms are viewed as incorporating an inherent assumption that there is a biological or medical basis for human behaviour that may be caused by other factors.

32. Similar concerns have been expressed about terms like "consumer survivor". A consumer survivor is generally understood as a person who has consumed the services or resources of the mental health system, and who has survived their own mental condition, or the mental health system itself (or both). Again, the term is under-inclusive because not all persons who are experiencing a mental or emotional crisis have had prior contact with the mental health system. The term is also not universally accepted.

33. Our goal in this Review is to use terminology that is at the same time accurate, descriptive and neutral. The terminology should evoke the least stigma and stereotyping, and should be viewed as properly reflective of the dignity and humanity of the persons being described. They are, after all, our brothers and sisters, our mothers and fathers, our husbands and wives, our daughters and sons. They are not apart from us. They are us.

34. I have elected to use the term "person in crisis" in this Report, to refer to those whose behaviour brings them into contact with police either because of an apparent need for urgent care within the mental health system, or because they are otherwise experiencing a mental or emotional crisis involving behaviour that is sufficiently erratic, threatening or dangerous that the police are called in order to protect the person or those around them. The term "person in crisis" is not restricted to people with mental illness. The term gives primacy to the person, and focuses on their experience ("crisis") in the specific moment that the police are involved, without drawing conclusions or making assumptions about the specific reasons for that experience, or about their mental or emotional condition before or after the incident.

35. The term "person in crisis" is one of the terms used by the TPS and by other police agencies. The existence of a state of crisis is referenced in the definition of "emotionally disturbed person" in the TPS procedure noted above, and is recognized in the name "Mobile Crisis Intervention Team." The TPS generally describes the role of the MCIT program as being to assist people experiencing a mental health crisis. Similar terminology is found in international policing standards documents such as the Model Policy on Responding to Persons Affected by Mental Illness or in Crisis, prepared in 2014 by the International Association of Chiefs of Police.[1] While I recognize that the term "person in crisis" may be viewed as somewhat broad and inexact, it is no more so than the term "emotionally disturbed person," while at the same time in my view being

[1] International Association of Chiefs of Police National Law Enforcement Policy Centre, Responding to Persons Affected by Mental Illness or in Crisis: Concepts and Issues Paper (Alexandria, VG: International Association of Chiefs of Police National Law Enforcement Policy Centre, January 2014).

preferable for the reasons noted. When used in this Report, the term "person in crisis" includes any person suffering from mental illness or otherwise falling within the TPS definition of "emotionally disturbed person," who comes into contact with police as described in the previous paragraph.

D. Methodology

36. The work of the Review was undertaken over the course of 10 months, from early September 2013 to early July 2014. The work involved the following principal components.

1. *Interviews*

37. The Review team interviewed or otherwise met with more than 100 people. Interviews took place in person at the Review team's offices, by teleconference, and at various locations that the Review team visited during the course of the Review as described below.

38. The Review team sought to speak with representatives of all affected stakeholder groups, including:

(a) persons with lived experience of mental illness;

(b) representatives of consumer survivor organizations (e.g., the Empowerment Council);

(c) family members of persons killed by police;

(d) doctors, nurses and administrators within the hospital system (Toronto East General Hospital, Mount Sinai Hospital, Centre for Addition and Mental Health);

(e) administrators, staff and clients of mental health community resources (the Gerstein Centre; Sanctuary Ministries of Toronto drop-in centre);

(f) representatives of mental health organizations (Mental Health Commission of Canada, Canadian Mental Health Association);

(g) lawyers representing families of persons killed by police;

(h) lawyers representing the police;

(i) representatives of civil liberties organizations (e.g., Canadian Civil Liberties Association);

(j) academics specializing in criminology, policing, training, equipment, and other fields;

(k) a representative of the SIU;

(l) a former judge of the Mental Health Court;

(m) psychologists and psychiatrists specialized in policing;

(n) mental health nurses and administrators of the Mobile Crisis Intervention Team (MCIT);

(o) members and staff of the Toronto Police Services Board;

(p) members of the Mental Health Sub-Committee of the Toronto Police Services Board;

(q) representatives of other police services (e.g., London Metropolitan Police);

(r) educators at the Ontario Police College; and

(s) members at all levels of the Toronto Police Service, including:

- officers involved directly in encounters in which a person in crisis died;
- senior management (Chief Blair, Deputy Chief Federico, Deputy Chief Peter Sloly);
- officers responsible for discipline and performance evaluation;
- police psychologists;
- administrators of 911 call intake and police dispatch;
- officers responsible for training at the Toronto Police College;
- officers assigned to the MCIT;
- officers responsible for the administration of the MCIT program; and
- the officer in charge of the Emergency Task Force.

39. A listing of the individuals with whom the Review team spoke is set out in Appendix A of this Report. The names of certain individuals have been omitted at their request.

2. *Literature review*

40. The Review team conducted an extensive literature review, canvassing a very large volume of research, statistics, historical information, recommendations and best practices literature relating to the subject matter of the Review. In total, more than 1,200 documents were reviewed. The material included documents collected by the TPS

as well as documents obtained independently by the Review team and documents submitted to the Review by stakeholders. A selected bibliography listing many of the documents reviewed can be found in Appendix B of this Report.

41. The materials reviewed included:

(a) applicable legislation;

(b) TPS policies and procedures;

(c) TPS reports;

(d) policies and procedures of other police services;

(e) academic literature on a variety of topics germane to the Review;

(f) inquest submissions and recommendations;

(g) training materials;

(h) reports and background documents relating to a variety of mental health issues;

(i) reports from police services in other jurisdictions;

(j) reports regarding the health effects of CEWs;

(k) media articles;

(l) documentaries and other videos regarding policing and mental health; and

(m) videos showing incidents involving the use of lethal force by the TPS.

42. The TPS did not refuse to provide any documents requested by the Review team. At the conclusion of the Review process, I requested and received from the TPS a certificate confirming the completeness of information provided. The certificate states that the TPS has provided or caused to be provided to the Review team all documents and information in its possession or control of material relevance to the mandate and terms of reference issued to me by Chief Blair in respect of my Review. The certificate also states that all factual information provided by the TPS to the Review is complete and accurate to the best of the Service's knowledge, information and belief.

43. As noted, the Review received information from other sources as well. Where practicable, members of the Review team took steps to verify the factual accuracy of information.

3. *Police College site visits*

44. The Review team conducted one-day site visits to both the Toronto Police College in Etobicoke, Ontario and the Ontario Police College in Aylmer, Ontario.

45. At the Toronto Police College, the Review team was given a series of briefings regarding the training provided to police recruits, and regarding the in-service training provided annually to members of the TPS. The team viewed training videos dealing with police use of force and de-escalation in encounters with people in crisis, and viewed several real-life simulations of encounters with people in crisis and the debriefing exercises that followed. In addition, the Review team viewed the firearm requalification exercises required of TPS officers as part of their annual in-service training.

46. At the Ontario Police College, the Review team was given a series of briefings regarding the training provided to all new police recruits in the Province of Ontario on topics such as firearms, defensive tactics, communication and debriefing. The team also viewed videos showing filmed examples of the live simulation training that new recruits experience at the College as part of their initial training to become a police officer.

4. *Communications Services site visit*

47. The Review team visited the TPS Communications Services centre, where the Service's 911 call takers and police dispatchers are located. The topics addressed during this site visit included the manner in which 911 calls involving people in crisis are triaged, the types of information provided to officers responding to a call involving a person in crisis, the resources and techniques available to a 911 call taker who is contacted by a person in crisis, the psychological effect of the job on 911 call takers and the mental health resources provided by the TPS, and the communication constraints that arise when there is a crisis that elicits multiple 911 calls, multiple officers dispatched to a scene, and significant radio traffic.

5. *MCIT ride along*

48. Four Review team members accompanied four different MCIT units during their daily shift on four separate occasions. As explained in Chapter 11 (MCIT and Other Models of Crisis Resolution), each MCIT unit consists of a uniformed police officer from the TPS and a mental health nurse from a local hospital. The two-person team travels in a marked TPS police car, and responds to police calls involving persons who are, or are believed to be, in crisis or suffering from a mental illness. On the occasions that a Review team member accompanied an MCIT unit, the Review team member was able to observe the daily routine of the MCIT in its interactions with members of the public who are the subject of MCIT calls, and discuss issues regarding the MCIT in real time with the MCIT members.

6. *Mental health site visits*

49. The Review team undertook two site visits to organizations that provide care and support for persons experiencing mental health issues.

50. The first visit was to the psychiatric emergency department at the Centre for Addiction and Mental Health (CAMH) on College Street in Toronto. Dr. David Goldbloom, Senior Medical Advisor at CAMH (and the Chair of the Mental Health Commission of Canada), explained the functioning of the emergency department and described CAMH's generally very positive experiences with TPS officers who attend at the emergency department with persons apprehended under the Ontario *Mental Health Act*.

51. The second visit was to Sanctuary, a centre that helps some of the City's most vulnerable persons, including the homeless, addicts, prostitutes and others—many of whom experience mental health issues. At Sanctuary, the Review team met with a group of staff and clients at the centre, who had a discussion with the Review team about their first-hand experiences with the TPS.

7. *Consultation with the Advisory Panel*

52. At the outset of the Review I assembled a three-person multi-disciplinary Advisory Panel to assist the Review team. The distinguished members of the Advisory Panel were forensic psychiatrist Dr. John Bradford, criminal lawyer Paul Copeland, and Norman Inkster, former Commissioner of the Royal Canadian Mounted Police.

53. The Advisory Panel advised the Review team on a confidential basis regarding the scope and subject matter of the Review, participated in meetings and conference calls with the Review team, attended the roundtable discussion described below, and reviewed and commented on portions of the draft Report.

8. *Roundtable discussion*

54. The Review team held a half-day roundtable discussion on April 3, 2014 with representatives of various stakeholder groups, including persons with lived experience of mental illness, mental health professionals, civil liberties advocates, and members of the TPS. Advisory Panel members were also in attendance.

55. The purpose of the roundtable discussion was to allow the different stakeholders to engage with one another about the issues addressed by the Review, and to challenge one another's ideas in a constructive manner designed to assist the Review team in assessing and reconciling some of the conflicting perspectives on these challenging issues.

56. The full list of invited participants at the roundtable discussion is as follows:

Dr. John Bradford	Advisory Panel member and forensic psychiatrist
Pat Capponi	Lead Facilitator, Voices from the Street
Paul Copeland	Advisory Panel member and lawyer
Dr. Dorothy Cotton	Professor of Psychology, Queen's University

Mike Creek	Director of Strategic Initiatives, Working for Change
Bethan Dinning	Articling student (seconded), Canadian Civil Liberties Association
Julian Falconer	Lawyer, Falconers LLP
Constable Diana Korn-Hassani	MCIT and Mental Health Coordinator, Divisional Policing Support Unit, Toronto Police Service
Kristina Niedra	Project Manager, Baby-Friendly Strategy and MCIT, Toronto East General Hospital
Dr. Catherine Martin-Doto	Corporate Psychologist, Psychological Services, Toronto Police Service
Sukanya Pillay	General Counsel and Executive Director, Canadian Civil Liberties Association
John Sewell	Coordinator, Toronto Police Accountability Coalition
Roslyn Shields	Senior Policy Analyst, Centre for Addiction and Mental Health
Junaid Subhan	Lawyer, Falconers LLP
Linda Young	Director, Maternal, Newborn & Child, Mental Health, Interprofessional Practice and Organization Leader, Toronto East General Hospital

9. *CACP/MHCC conference*

57. On March 25-26, 2014, Review team members attended a national conference on policing and mental health co-sponsored by the Canadian Association of Chiefs of Police (CACP) and the Mental Health Commission of Canada (MHCC). Criminal justice and mental health leaders, researchers, and people with lived experience of mental illness discussed innovative ways to make interactions safer for people in crisis, police officers, and the communities in which they live. Some of the initiatives discussed at the conference are addressed in this Report.

10. *Stakeholder input*

58. It was critical to the Review process to ensure that all affected stakeholder groups were given an opportunity to make submissions to the Review.

59. A website was created (www.tpsreview.ca), identifying the mandate of the Review and explaining the manner in which stakeholders could make submissions to the Review.

60. The Review team also assembled a comprehensive list of stakeholder organizations, including police organizations, mental health organizations, government organizations, persons with lived experience of mental illness, family members of persons killed, lawyers, civil liberties organizations, community mental health organizations and others. A mailing was sent to all of these organizations, soliciting their input and inviting them to make submissions to the Review.

61. Stakeholders were invited to provide the Review with: (a) proposed recommendations and an explanation of the basis for the recommendations; (b) evidence or other material supporting the recommendations; (c) discussion and analysis of the issues; (d) suggestions for further research, investigation or inquiry by the Review team; (e) documents recommended for consideration by the Review team; and (f) the names of individuals that it was recommended should be interviewed by the Review team.

62. A large number of stakeholders made submissions. In total, the Review team heard from over 40 individuals and organizations, and received many thoughtful, comprehensive and helpful submissions, some of which included extensive supporting materials. All of the submissions were read and considered by the Review team, and many of the ideas and recommendations in those submissions find expression in this Report. The submissions can be found on the Review website.

63. A separate letter was sent to the families of 20 individuals who died between 2002 and 2012 as a result of an interaction with the TPS, where the TPS determined that the individual's mental health may have been a factor in the encounter. To protect the privacy of the family members, and with my agreement, the TPS did not provide the Review with the contact information for the family members. Rather, the TPS sent my letter to the family members directly. Twenty-four letters were sent to family members relating to these 20 deaths. I was contacted by members of two families in response to the letter.

64. I was also contacted, separately, by family members of two individuals killed in encounters with other police services, outside of Toronto.

65. A list of the individuals and organizations that provided written submissions to the Review is set out in Appendix C of this Report. In the interests of protecting their privacy, I have not listed the names of individuals who made submissions to the Review and asked that their names not be disclosed.

CHAPTER 3

Context

CHAPTER 3. CONTEXT

Table of Contents

Page

A. INTRODUCTION 59

B. THE IMPORTANCE OF PERSPECTIVE 59

(1) The perspective of the front line police officer 60
(2) The perspective of the person in crisis 62
(3) The perspective of those directly affected by a death 63

C. THE TORONTO POLICE SERVICE 64

(1) Geographic scope 64
(2) Size and demographics 65
(3) Corporate structure 65
(4) The Special Investigations Unit 68
(5) TPS initiatives relating to police and mental health 69

D. DEATHS OF PEOPLE IN CRISIS DURING ENCOUNTERS WITH THE TPS 71

E. THE SOCIAL CONTEXT RELATING TO MENTAL HEALTH AND POLICING 74

F. THE LEGAL CONTEXT 76

(1) Mental Health Act and regulation 76
(2) Police Services Act and regulation 76
(3) Criminal Code 78
(4) Common law 78
(5) Human Rights Code 78

Chapter 3. Context

A. Introduction

1. The purpose of this chapter is to describe some key features of the context within which the issues addressed in this Review arise. The chapter has five sections.

2. The first section deals with the issue of perspective, by which I mean the importance of viewing the issues addressed in this Review from the perspective of those who experience those issues first hand. Two of those perspectives are those of the front line police officer and of the person in crisis. One cannot meaningfully seek to improve encounters between police and people in crisis without understanding what it is like for them to be in such an encounter. I also address a third perspective, the importance of which is profound—the perspective of those who live on after a death, and are forever affected by it.

3. The second section describes some pertinent background facts relating to the Toronto Police Service, including its size, structure, and composition, as well as its recent history of efforts to improve the manner in which police interact with people in crisis.

4. The third section provides some statistical information regarding the extent of interaction between the TPS and people in crisis, including the number of incidents per year in which people identified by the TPS as having mental health issues are killed by a member of the Service.

5. The last two sections describe at a high level some relevant aspects of the social context and the legal context for policing and mental health in Toronto.

B. The importance of perspective

6. There is a danger, in a review of this type, of being unrealistic.

7. Encounters in which police use lethal force against a person in crisis often take place in the space of seconds, in a rush of emotion, adrenaline, and fear. Those who review such encounters after the fact, on the other hand, have the benefit of time, information, detachment, and hindsight.

8. It is critically important not to ignore this fundamental difference in perspective. I have therefore sought, as best as I can, to understand what it is like to be the police officer, or to be the person in crisis, in the highly charged moment of a potentially violent encounter. Without that perspective, one cannot fully appreciate what causes fatal encounters, or be well situated to try to prevent them.

9. Deaths of people in crisis in encounters with police usually (although not always) involve front line police officers who act as primary responders to incidents and calls for

service by the public.[1] The front line police officer and the person in crisis are, in that sense, the central focus of this Review.

10. I have tried to learn the perspective of a front line police officer, and to feel what it is like to walk in an officer's shoes, by speaking with a wide array of TPS members of all ranks from many different parts of the Service, including officers who have had direct personal experience with fatal and potentially fatal encounters. I have equally tried to learn the perspective of the person in crisis, and to feel what it is like to walk in the shoes of a person with mental health issues or a person experiencing emotional crisis by meeting with people with lived experience of mental illness, meeting with family members of deceased persons, meeting with many mental health service providers, participating in an MCIT ride along, and reviewing extensive material on the topic.

11. Although necessarily imperfect, the following paragraphs set out my understanding of the relevant aspects of these two perspectives.

1. *The perspective of the front line police officer*

12. I strongly believe based on my personal observations and abundant secondary evidence that most front line police officers within the TPS have a genuine desire to fulfill their mandate of serving and protecting the community, and a genuine desire to avoid causing harm. They have a strong sense of duty. Certainly no officer begins his or her daily shift wanting to cause serious injury or death, or wanting to be involved in a dangerous encounter. If they can avoid causing harm, police officers would like to do so. It is, in fact, the existence of this pervasive desire of TPS personnel to do good that inspires in me the confidence that this Review will produce positive results.

13. Front line police officers have one of the most challenging jobs that society has to offer. They are demanded to perform difficult and unpleasant tasks that most citizens are unwilling or unable to carry out themselves. These tasks often involve risking their lives in order to control and apprehend people who are violent or otherwise dangerous—including not only violent criminals, but also people in various forms of crisis who are not criminals but who may, knowingly or not, be a threat to themselves or others. The job of the front line officer is one of considerable risk. Officers regularly have to balance their duty to confront danger (with often very limited information about the nature of the danger) against the personal risks to themselves—a very challenging task that few others in society are required to undertake in the same way or to the same extent.

14. The dangerousness of police work highlights two key points that are relevant in the ongoing effort to reduce the incidence of lethal encounters between police and people in crisis: (1) the utility of ensuring police are provided with the best available information about people in crisis and their likely reactions to police behaviour; and (2) the importance of training police on how best to control people in crisis without the need for force—that is, training (both at the police colleges and on an ongoing basis at

[1] Certain specialized TPS units have also experienced deaths of civilians in connection with police contact in recent years, including the Emergency Task Force, the Toronto Drug Squad, and the Guns and Gangs Unit.

the Divisions) on how to assess the relative risk posed by a person in crisis, and on how to transform potentially violent encounters into peaceful resolutions.

15. Police operate within an organization that places a high value on personal toughness and self-reliance. Yet front line police are exposed to scenes of despair, pain, tragedy, and horror as a regular part of their job. It is virtually inevitable that such exposure affects their own mental health—causing at the very least some degree of emotional detachment from the subjects with whom they deal, and not infrequently more serious mental health issues. The importance of the mental health of the police themselves should not be underestimated in analyzing how to ensure better outcomes of encounters with people in crisis.

16. Another feature of the TPS, which is similar to other police organizations, is the Service's para-military command structure and its pervasive focus on legal compliance. Front line officers become accustomed to dealing with certain types of dangerous situations through a system of command, physical confrontation (if necessary), enforced compliance, and negative sanctions for non-compliance. While this compliance-based approach can be very beneficial in many contexts, it can be counterproductive when dealing with a person in crisis, who may not understand or be able to respond to commands. This is not to say that all police interactions with members of the public are premised on a compliance-based approach—far from it. Many, if not most, encounters between the police and the public are cooperative and respectful. But in dangerous situations, there is a tendency and, in some contexts, a real or perceived requirement for police to use a compliance-based approach. This can be problematic when a more conciliatory approach, focused on de-escalation, delay, and containment, is preferable to confrontation.

17. Another key element of the front line officer's perspective, which must be acknowledged as being both inevitable and acceptable, is fear. Police are entrusted with the weighty responsibility to use lethal force if necessary, and they are under tremendous pressure to carry out that responsibility with honour and integrity, without error. At the same time, front line officers are confronted regularly with threats and potential threats to their personal safety that inevitably cause them to be afraid, and therefore, to experience a very strong and natural urge to protect themselves. The perception of being in potential danger is ever-present for the front line officer—far more so than for the average member of the public. It is understandable that officers may feel impelled to try to control dangerous situations quickly. Fear, particularly if combined with less-than-ideal mental health of the officer, makes empathy and patience more difficult.

18. Finally, front line police officers operate in a society that sends seemingly contradictory messages about police encounters with people in crisis. A police officer who dies at the hands of a person with mental illness is hailed as a hero. Yet when a police officer kills a person in crisis (usually to avert being killed himself or herself), the officer may be vilified. This is not to say that officers do not sometimes make errors in these encounters—clearly they do. Errors are part of the human condition. The point is that, even when officers do not make errors and are fully justified in having used force against a person in crisis, they tend to be subject to a level of criticism that few others in

society must bear. One result is, I believe, a level of skepticism among police when people outside the organization suggest that there is room for the police to improve.

2. *The perspective of the person in crisis*

19. The person in crisis has a very different perspective on an encounter with the police. The person in crisis does not come from a position of power, and does not enter the encounter with the imperative of achieving control and resolution. By definition, the person in crisis is not immediately capable of even self-control, let alone control over the situation.

20. Above all, the person in crisis needs help. Whether it is by reason of mental illness, or a more transient mental or emotional crisis (possibly induced or exacerbated by drugs or alcohol), the person is in anguish. The person's crisis may manifest itself in belligerent behaviour, making it more challenging to receive help. The person may also be experiencing delusions that make it difficult or impossible to understand what is real. The person's need for help makes an encounter with the police in one sense desirable, because the police have the mandate to serve and protect those in need.

21. Problems arise between a person in crisis and the police when one of two things happens.

22. In some encounters, the problem arises because the person in crisis poses such an imminent and serious danger that it is essential that the police either immediately contain the person or immediately use force to subdue the person. When analyzing how to prevent deaths in such encounters, one must focus on how to prevent either the crisis itself or the encounter with police from occurring in the first place (which involves improving the mental health system, among other things). One must also look at methods and means of containing or subduing the person without lethal force (which involves looking at tactics and equipment).

23. In other encounters, the person in crisis does not pose the same type of imminent and serious danger, but problems arise because the police do not de-escalate the situation successfully. A failure to de-escalate can arise from a number of causes, including lack of understanding by police regarding the level of risk posed by the person in crisis, or a lack of knowledge or ability on how to de-escalate effectively. While it is clear that the TPS devotes considerable effort to educate its members on proper risk assessment and to train them on effective de-escalation techniques, it is also clear that the education and training are not 100% effective. There have been encounters between the TPS and people in crisis in which there has been a failure to de-escalate.

24. In this second category of failed encounter, what the person in crisis needs is empathy, patience, guidance, and help. I was informed by several people with lived experience of mental illness that people in crisis are often afraid, whether because of delusions or simply because the crisis itself is alarming. The arrival of police and the perceived possibility of force being applied also cause fear in these crisis situations. Some people in crisis carry weapons, not necessarily because they wish to be aggressive, but because they feel a need to protect themselves from real or perceived threats. When

police arrive, what many people in crisis most need is reassurance. Many people in crisis would like the police to help them make the crisis diminish, and to make them safe.

25. The person in crisis also views the treatment they receive by police as an issue of fairness. Many people in crisis suffer from mental illness, which makes them different from others in ways that they cannot necessarily control. Their difference deserves accommodation, within reasonable limits. When police do not have the necessary characteristics~~i.~~e., ability, attitude, information, training, equipment, etc.~~or~~ resources to accommodate appropriately, there is a perception of unfair treatment. The person in crisis does not want to be treated as an object, but as a fellow human being.

26. I do not mean to minimize the reality that some people in crisis are aggressive and, in order to protect them and others from serious bodily harm, cannot be helped by police at the moment of crisis through any means other than physical restraint. Part of the tremendous challenge for police is to distinguish such cases from cases where a slower, more empathetic approach is called for. But from the perspective of the person in crisis, the approach taken by police can make the difference between living and dying.

3. *The perspective of those directly affected by a death*

27. There is a third perspective that must also be considered. It is a perspective that has had a profound effect on my appreciation of the issues in this Review. It is the perspective of those directly affected by a lethal encounter, who live on after the death and are permanently scarred by it. This group of people includes not only the family of the person killed, but also the officer who caused the death, and the officer's family.

28. When a person in crisis is killed by police, it has a terrible effect on the deceased person's family. In addition to the heartbreak of the loss itself, family members often experience a tremendous sense of guilt—guilt that they could not protect their parent, sibling, spouse, or child from death, and guilt that they were unable to provide the person with access to necessary treatment. Guilt is often accompanied by blame, which may be directed outward, at the police and mental health system, or inward, at other family members. Families can be destroyed, as can their faith in some of the central institutions of our society.

29. What is often not appreciated is the effect of police killings on the officers themselves. Causing the death of a person who needs help is a police officer's nightmare. Regardless of how justifiable the killing may have been (in terms of being necessary in order to protect the life of the officer or others), the officer experiences self-doubt and guilt, which is exacerbated to a very high degree by the ensuing Special Investigations Unit (SIU) investigation, media scrutiny, and inquest, as well as any legal proceedings that may follow. The mental health of the officer is placed in significant jeopardy, both in the immediate and longer terms. The officer's family suffers alongside, watching with a feeling of helplessness as the officer goes through all of the painful stages of trying to heal.

30. The families of people who are killed by police often do not know or understand the perspective of the officer or the officer's family, especially when there is real or

perceived uncertainty as to whether the killing could have been avoided. Everyone suffers, including to some degree, the public perception of the police. It is all part of a terrible tragedy.

31. When the issues are looked at from these perspectives, the importance of seeking to prevent lethal encounters between police and people in crisis becomes crystal clear. If reasonable steps can be taken to prevent even one unnecessary death, then those steps must be taken.

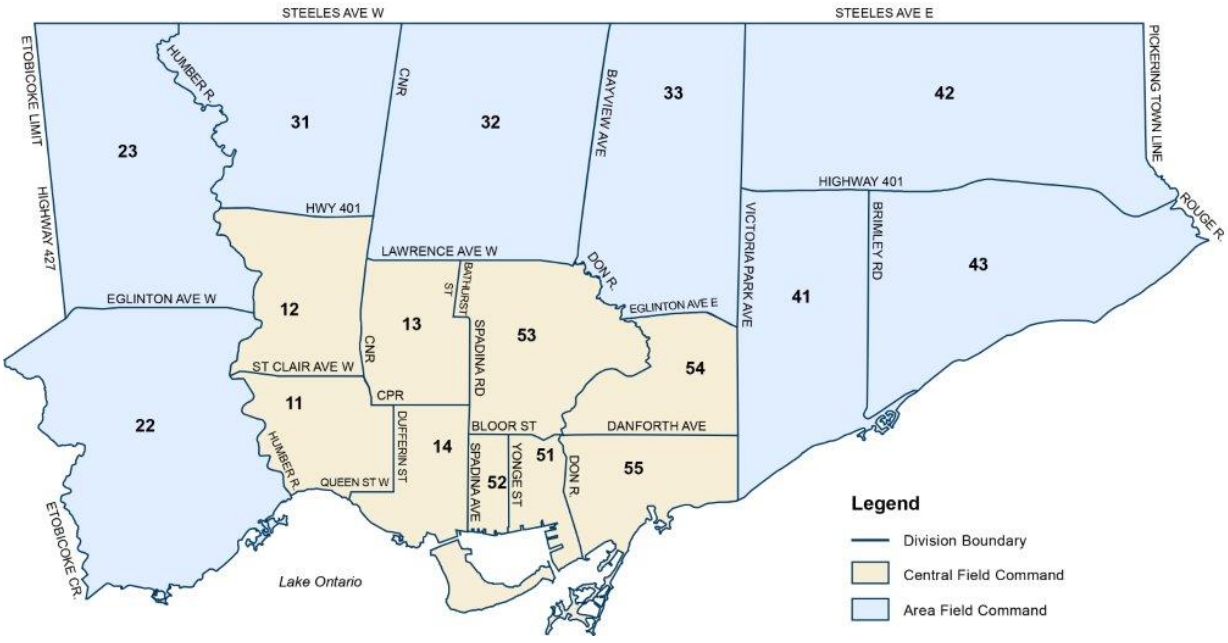
32. I turn now to discuss some relevant background facts regarding the Toronto Police Service.

C. The Toronto Police Service

1. *Geographic scope*

33. Established in its current form in 1998 with the amalgamation of the City of Toronto, the Toronto Police Service has existed in various forms since the early part of the 19th century.

Figure 1. Divisional map of the Toronto Police Service



34. The TPS provides police services for the entire City of Toronto, from Lake Ontario in the south to Steeles Avenue in the north, and from Highway 427 in the west to Pickering Town Line in the east.

35. For policing purposes, the City is divided into 17 Divisions, each with its own police station. A map of the 17 Divisions is set out in Figure 1.

2. *Size and demographics*

36. The TPS is the third-largest police service in Canada after the Royal Canadian Mounted Police and the Ontario Provincial Police. It is the largest municipal police service in Canada, and one of the largest in North America. The TPS's size and professional experience position it well to play a leadership role at the provincial, national and international levels.

37. According to statistics provided to me by the TPS in connection with this Review, as of March 2014, the TPS employed over 7,900 people, including 5,388 full-time police officers and cadets, as well as 2,339 full-time and 244 part-time civilian members. In this Report, when I refer to an officer, this refers to a sworn police officer rather than a civilian member of the TPS. When I refer to a member of the TPS, or to TPS personnel, this may refer to either an officer or a civilian member.

38. Among the 5,388 police officers, approximately 19% are women and approximately 23% are from a racial minority.

39. The officer ranks can be divided into four groups by level of seniority: cadets in training, police constables, supervisory officers (sergeants and staff sergeants, detectives and detective sergeants) and senior ranks (from the rank of inspector to Chief of Police).

40. Police constables make up by far the largest group, consisting of 4,060 officers as of March 2014. The supervisory officers (sergeants and staff sergeants, detectives and detective sergeants) numbered 1,185 as of the same date and there were 84 in the senior management ranks, as well as 59 cadets.

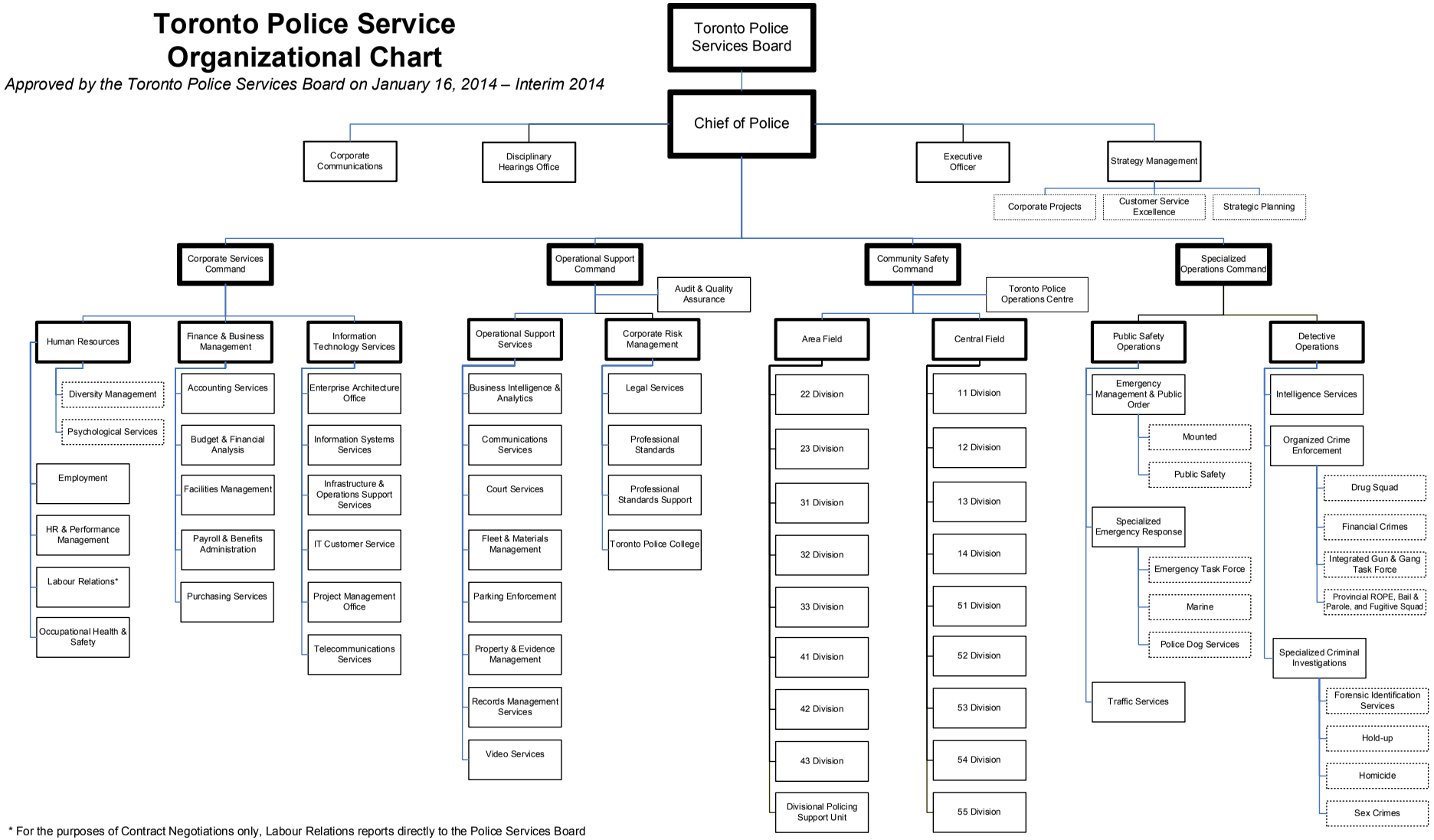
41. The average age of a TPS police officer is currently 41.8 years. In the case of officers who serve as front line officers and as members of a primary response unit (PRU), the average age is 40 years. Less than 7% of TPS officers are younger than 30. Among front line officers who are members of PRUs, the proportion that is younger than 30 is 11.6%. The average age of new recruits to the TPS is currently approximately 28 years. I address the effect of the age of police officers in the context of the discussion of supervision in Chapter 8.

3. *Corporate structure*

42. The governance structure of the TPS is dictated in large part by the Ontario *Police Services Act*.[2] An organizational chart for the Toronto Police Service is set out in Figure 2.

[2] R.S.O. 1990, c. P.15.

Figure 2. Toronto Police Service organizational chart



* For the purposes of Contract Negotiations only, Labour Relations reports directly to the Police Services Board

43. To reflect the important principle of civilian oversight over police, the Toronto Police Services Board (TPSB) is at the top of the governance structure. Under section 31 of the *Police Services Act*, the TPSB appoints the Chief of Police, and all deputy chiefs of police. The Board has the power to direct the Chief of Police, but that power is limited, in that the Board is not permitted to direct the Chief of Police with respect to specific operational decisions or with respect to the day-to-day operation of the police force. The Board is empowered to generally determine, after consultation with the Chief of Police, objectives and priorities with respect to police services in Toronto, and to establish policies for the effective management of the police force. Under section 39 of the *Police Services Act*, the Board is required to submit a budget estimate for the TPS to Toronto City Council.

44. I pause to note that the oversight role played by the TPSB is beyond the scope of this Review. During the course of the Review, I received several recommendations from stakeholders regarding the importance of effective Board governance and oversight, and the topic was also raised in some interviews. It is clear that the Board and the Chief of Police need to work well together as partners, and that the Board itself needs to function efficiently and effectively in order to provide necessary civilian oversight. However, as the topic is outside of my mandate, I make no specific recommendations in this Report about the Board.

45. The Chief of Police has ultimate operational authority over the TPS. Under section 41 of the *Police Services Act*, the Chief of Police is responsible for administering the TPS and overseeing its operation in accordance with the objectives, priorities, and policies established by the Board. The Chief is also required to ensure that members of the TPS carry out their duties in accordance with the Act and its regulations in a manner that reflects the needs of the community, and to ensure that discipline is maintained in the TPS. The Chief must also ensure that the TPS provides community-oriented police services. The Chief of Police reports to the Board and must obey its lawful orders and directions.

46. Below the Chief of Police, the TPS functions using a hierarchy-based command-and-control system.

47. The Chief's operational authority is delegated downward through a chain of command. The "Senior Command" is a group of five individuals comprised of the chief, three deputy chiefs and the chief administrative officer (the CAO, who is a civilian but equivalent in rank to a deputy chief). Senior Command meets on an *ad hoc* basis as the Executive Management Team.

48. Each of the three deputy chiefs and the CAO is responsible for one of four Commands, as set out in the organizational chart at Figure 2.

49. The CAO is responsible for the Corporate Services Command, which deals with the internal administration of the TPS, including human resources, finance, and IT.

50. The deputy chief responsible for the Operational Support Command is in charge of units that support police operations but are not directly involved in policing. This

Command includes Communications (i.e., 911 call-takers and dispatchers), the Toronto Police College (which trains new recruits and provides annual in-service training to all officers), and the Professional Standards unit (which reviews the conduct of officers alleged to have breached applicable standards and prosecutes disciplinary proceedings).

51. The Community Safety Command consists of the 17 police divisions, the Central Field and Area Field Commands, as well as the Toronto Police Operations Centre and the Divisional Policing Support Unit. All front line police officers and their supervisors report up the chain of command to the Deputy Chief responsible for the Community Safety Command.

52. The Deputy Chief of the Specialized Operations Command oversees various specialized police units in the areas of Public Safety (including emergency management, public order, the Emergency Task Force, and the marine and canine units) and Detective Operations.

53. There are also certain offices that report directly to the Chief of Police rather than through a deputy chief or the CAO, including the Corporate Communications office, the Disciplinary Hearings Office, the Executive Officer, and the Strategy Management office.

54. All members of the TPS are required to comply with commands from the Chief of Police. The vast majority of commands are set out in writing in Standards of Conduct, Operational Procedures, and Routine Orders. These are standing directions to the members of the Service. A number of these standing directions are relevant to the mandate and subject matter of this Review, and I discuss them in more detail below in various chapters of the Report.

4. The Special Investigations Unit

55. The TPS is subject to independent oversight by several different bodies with varying functions as set out in the *Police Services Act* and its regulations. It is beyond the scope of this Review to examine the independent oversight functions that these bodies perform, but it is worthwhile to identify the role of the Special Investigations Unit (SIU) specifically, since that body figures prominently whenever the police use lethal force.

56. Under section 113 of the *Police Services Act*, the SIU is created as a unit within the Ontario Ministry of the Solicitor General. The SIU is responsible for investigating the circumstances of serious injuries or deaths that may have resulted from criminal offences committed by police officers. Whenever police use lethal force, the SIU investigates whether the officer who caused the death committed a criminal offence. If there are reasonable grounds to do so, the SIU director is required to cause an information to be laid against a police officer in connection with the matters investigated, and to refer the information to the Crown Attorney for prosecution.

57. The SIU's role is limited. The SIU does not examine whether a police officer's conduct complied with internal Service governance requirements as set out in Standards of Conduct, Operational Procedures, and Standing Orders. The latter type of

examination is undertaken internally by the TPS Professional Standards unit. I address the role of the Professional Standards unit in more detail in Chapter 8 (Supervision).

5. *TPS initiatives relating to police and mental health*

58. This Review is not the first time that the Toronto Police Service has sought to look at whether there are ways in which it can improve itself in order to avoid lethal outcomes resulting from encounters between police and people in crisis. The following is a summary of selected TPS initiatives since 1996 to address issues of policing and mental health. The summary is both encouraging and sobering—encouraging because it shows the TPS's commitment to addressing these difficult issues, and sobering because, like many other police services, the TPS struggles to find a solution.

59. Mental Health Coordinator: In 1996, the TPS created the position of Mental Health Coordinator. The Coordinator was responsible for addressing policing and community issues relating to mental health, including educating front line officers on legislative changes, representing the TPS to government and community agencies in relation to mental health issues, identifying and correcting problems within the Service relating to police and mental health, and developing and updating TPS policies, procedures, and training.

60. The position of Mental Health Coordinator still exists today, and is discussed further in Chapter 4 (The Mental Health System and the Toronto Police Service).

61. Use of Force Committee Final Report: In 1997, then Chief of Police David Boothby established a Use of Force Committee to review all aspects of police use of force to examine if there were ways to reduce the necessity for the application of deadly force without compromising officer safety. The establishment of the Committee came after the TPS had used lethal force four times within the first four months of that year.

62. The Use of Force Committee was not concerned exclusively with encounters with people in crisis, but one of the key areas of focus was "Dealing with Emotionally Disturbed Persons." The Committee made three recommendations in this area: (1) the establishment of a standing committee to identify, develop, and coordinate suitable responses and resources to help the Service effectively intervene when dealing with the emotionally disturbed; (2) the establishment of partnerships between the TPS and mental health care agencies; and (3) the completion of a handbook dealing with officer response to mental illness.

63. More generally, the Committee made recommendations dealing with rules and directives, supervision, training, less lethal force options, the Emergency Task Force, and the creation of a standing committee on use of force.[3]

64. Crisis Resolution Course: One of the recommendations of the *Use of Force Committee Final Report* was the introduction of a Crisis Resolution course delivered at the Toronto Police College. This recommendation was implemented in 1999.

[3] See Toronto Police Service Use of Force Committee, *Use of Force Committee: Final Report* (Toronto, ON: Toronto Police Service, 1998), online: Toronto Police Service <http://www.torontopolice.on.ca/publications/files/reports/1998useofforce.pdf>.

65. The objective of the course was to provide training to ensure that a police officer's goal, when faced with any potentially violent confrontation, is to control and de-escalate that situation using tactical communications, crisis resolution, basic officer safety tactics, and the minimum force required. A further objective was to reinforce the principle that disengagement is always an option, in order to secure police and public safety, containment and the utilization of other resources.

66. In an attempt to affect not only the skills and abilities of the officers, but also their attitude, a philosophy statement was developed for the course that was used in debriefings. The philosophy statement was: "A police officer's success in any situation will be measured by the degree to which the situation is safely de-escalated."[4]

67. The Crisis Resolution course has been modified over time. About 1,800 officers received the intensive 50-hour course before the decision was made (for logistical and financial reasons) to integrate the course with other in-service training courses that are taught at the time of annual firearm requalification at the Toronto Police College.[5] As discussed in more detail in Chapter 7 (Training), all TPS officers now receive crisis resolution training every year as part of their annual in-service training.

68. Saving Lives Conference: In June 2000, the Urban Alliance on Race Relations and the Queen Street Patients' Council held a conference titled "Saving Lives: Alternatives to the Use of Lethal Force by Police."

69. The Conference Mission Statement, which was signed by then Chief of Police Julian Fantino and then Toronto Police Services Board Chair Norm Gardner, expressed the Service's commitment to work in good faith at the Conference to discuss the use of lethal force by police, particularly as it related to less lethal technology, issues of mental health, issues of race, issues of police accountability, issues of community responsibility, and potential solutions to avoid deaths. The goal of the conference was to bring about dialogue and progress on developing alternatives to the use of lethal force by police.[6]

70. Mobile Crisis Intervention Teams (MCIT): The first MCIT unit became operational in 2000, providing coverage for one police division in conjunction with St. Michael's Hospital. As explained below in Chapter 11 (MCIT and Other Models of Crisis Resolution), MCIT teams consist of a front line police officer and a mental health nurse from a partner hospital who act as secondary responders to calls for service involving mental health issues. The goal of the MCIT program was (and remains) to assist front line officers in interacting with people with mental health issues, to help those with mental health issues to get access to treatment and community referrals, and to divert people with mental health issues from the criminal justice system to the mental health system where appropriate.

---

[4] Sergeant Scott Weidmark, Toronto Police Service, "Status of the Initiatives of the Toronto Police Service that deal with Mentally Ill, Emotionally Disturbed Persons" (Toronto, ON: Toronto Police Service, December 2005). The annual requalification training is discussed in further detail in Chapter 7 (Training).

[5] *Ibid*.

[6] See Urban Alliance on Race Relations & Queen Street Patients Council, *Saving Lives: Alternatives to the Use of Lethal Force by Police – Report of a Conference Held in Toronto, June 23-24, 2000* (Toronto, ON: Urban Alliance on Race Relations, 2002), online: Urban Alliance on Race Relations <http://urbanalliance.files.wordpress.com/2012/05/savinglivesreport.pdf>.

71. The MCIT program has expanded several times since 2000, as explained in Chapter 11, and now provides coverage to all police divisions in conjunction with six partner hospitals.

72. Mental Health Sub-Committee: In September 2009, the Toronto Police Services Board approved the establishment of a Mental Health Sub-Committee to examine issues related to mental health. The Sub-Committee's mandate is to facilitate ongoing communication with the community and other stakeholders, to enable the Board to deal with mental health issues in an informed, systematic, and effective manner.[7]

73. The Mental Health Sub-Committee is composed of members of the Board, members of the TPS, and members of the community. The Sub-Committee is currently co-chaired by Board Chair Alok Mukherjee and Ms. Pat Capponi, a community member with lived experience of mental illness.

74. The terms of reference of the Mental Health Sub-Committee provide for it to: consider, among other things, enhancements to existing TPS mental health initiatives; facilitate information sharing on mental health issues; facilitate enhanced dialogue between the Board, the TPS and members of the mental health community; and advise the Board on current and proposed mental health initiatives involving the TPS and the community.

75. To date, the work of the Sub-Committee has focused in particular on improvements to police training at the Toronto Police College, and limiting the use of conducted energy weapons such as Tasers. These two topics are addressed in more detail in Chapter 7 (Training) and Chapter 12 (Equipment).

76. Service priority dealing with mental illness: In November 2012, to underscore the importance of safe and effective police interactions with people experiencing mental illness, the Toronto Police Services Board approved a new priority, entitled "Focusing on Police Interactions with Individuals Experiencing Mental Illness" in the TPS business plan. It was recommended that the Board's Mental Health Sub-Committee meet with the TPS to provide input in developing the goals, performance objectives, and indicators arising from this priority. As a result, the 2013 Service Priorities and Business Plan, approved by the Board in December 2012, includes the new priority.[8]

D. Deaths of people in crisis during encounters with the TPS

77. It is helpful in addressing the issues in this Review to have an understanding of the frequency with which people in crisis are killed during encounters with the Toronto Police Service. I therefore requested that the TPS provide me with data on this point, which I set out below.

[7] See Toronto Police Service Board, Min. No. P265/09.

[8] Toronto Police Service, *Toronto Police Service: 2013 Business Plan* (Toronto, ON: Toronto Police Service, 2013), online: Toronto Police Service <http://www.torontopolice.on.ca/publications/files/brochures/2013business_plan.pdf>.

78. Some may consider a statistical analysis of the number of such deaths to be offensive or impersonal, and perhaps symptomatic of the problem of treating people with mental health issues as objects rather than human beings. That is certainly not my intention.

79. Ultimately, the goal for the Service in any given year should be zero deaths of people in crisis—and indeed, zero deaths of any police officer or member of the public. In working toward that goal, it is relevant for the TPS to assess whether it is succeeding in reducing its use of lethal force in encounters with people in crisis from year to year. In order to perform this assessment, the TPS needs to and does keep track of data showing facts such as the population of the City of Toronto, the number of TPS calls for service in the year, the number of calls for service involving mental health issues, the number of encounters with people in crisis in which a weapon or violence is used by the person, and the number of deaths, among other things. It is for this reason that I set out the following statistical data.

80. According to data collected by the TPS and provided to the Review, the TPS had 1,914,653 calls for service in 2013, including both emergency and non-emergency calls. This is roughly consistent with the number of calls for service in 2012 and 2011. These calls for service do not represent the entire universe of police contacts with members of the public. The TPS has more than 1.5 million additional contacts per year in the form of traffic enforcement stops, arrests, vehicle stops, and recorded community interactions. The total number of contacts with community members per year in recent years has thus been in the range of 3.5 million contacts. The population of the City of Toronto, according to the most recent Statistics Canada data (from 2011) is 2,615,060.[9]

81. Out of the 1,914,653 calls for service in 2013, 29,611 (or 1.5%) were identified as involving what the TPS refers to as an "emotionally disturbed person" or EDP.

82. A single event may elicit multiple calls for service. In 2013, out of the 1,914,653 calls for service, police were dispatched to the scene 838,483 times. Out of the 29,611 "EDP calls," police were dispatched 20,550 times. This means that EDP calls made up approximately 2.5% of all occasions on which police were dispatched in 2013. The number of police dispatches in response to EDP calls in 2012 was lower at 18,839, and the percentage of EDP-related dispatches was also lower in 2012 at 2.0% (18,839 dispatches out of 921,722).

83. Out of the 20,550 dispatches in response to EDP calls in 2013, the TPS apprehended a person under the *Mental Health Act* on 8,384 occasions.[10] This represents 8,384 apprehensions rather than 8,384 separate individuals, as some individuals were apprehended under the *Mental Health Act* on more than one occasion in the year. The number of such apprehensions in 2012 was 8,543 and in 2011 was

[9] Statistics Canada, "Focus on Geography Series, 2011 Census: Census metropolitan area of Toronto, Ontario" (2014), online: Statistics Canada <http://www12.statcan.gc.ca/census-recensement/2011/as-sa/fogs-spg/Facts-cma- eng.cfm?LANG=Eng&GK=CMA&GC=535>. The census metropolitan area of Toronto includes the area within which the TPS operates and does not include other parts of the Greater Toronto Area (such as Mississauga, Brampton, Markham, Vaughan, Oakville, etc.).

[10] R.S.O. 1990, c. M.7.

8,688. In 2010 and 2009 the number of apprehensions was lower, at 7,800 and 7,627 respectively.

84. In order to identify how many deaths per year involved what the TPS considered to be an "emotionally disturbed person," I requested that the TPS review its existing data relating to cases between 2002 and 2012 in which the SIU invoked its mandate because a person died during an encounter with the Toronto Police Service. Determining whether a person qualifies as an EDP is not an exact science. The TPS selected individuals for inclusion based on the following three criteria:

(a) There was information in a report to the Toronto Police Services Board that identified a mental health issue in connection with the encounter (such as suicidal behaviour, self-harm, hearing voices, the existence of a psychiatric condition, an apprehension under the *Mental Health Act*, etc.);

(b) There was information in a report to the Board that, in connection with the death, the TPS procedure titled "Emotionally Disturbed Persons" was examined; or

(c) An inquest was held and, in the Coroner's verdict or in the recommendations, it was identified that the individual had experienced mental health issues.

85. Notably, these TPS criteria for selection are focused primarily on symptoms and other evidence of mental illness, and may not capture certain other types of crisis that an individual may experience, such as an emotional crisis or a crisis induced by drugs or alcohol. It should be noted, too, that in some of the more recent cases involving a death during an encounter with the TPS, a report to the Board may not yet have been delivered, or an inquest may not yet have been held. The numbers that follow must be viewed with these limitations in mind.

86. Based on the criteria it used, the TPS has advised that the total number of people it identified as an emotionally disturbed person who died between 2002 and 2012 as a result of being shot by a TPS officer is five—one in each of the years 2004, 2008, 2010, 2011, and 2012.

87. The total number of people fatally shot by the TPS during the 2002-2012 time period (including these five EDP deaths as well as other deaths) was 25, with the number of deaths in any year ranging from one to five. Out of the 25, four were killed by members of the Emergency Task Force (ETF), 20 were killed by front line police officers, and one was killed by an officer from a specialized police unit other than the ETF. In addition, during the 2002-2012 time period, 34 people were injured by police firearms, two of which involved the ETF, 31 of which involved front line officers, and one of which involved an officer from a specialized unit other than the ETF.

88. There were other EDP deaths in encounters with the TPS during the 2002-2012 time period—a total of 22 other deaths by the Service's calculation, for a total of 27 deaths of people meeting the above TPS "emotionally disturbed person" criteria during

that period. These other deaths were the result of suicide (13 deaths), as well as restraint asphyxia, acute drug intoxication, cardiac arrest, and unknown causes.

E. The social context relating to mental health and policing

89. Mental health is given a relatively low priority in Canada. According to the World Health Organization, mental illness accounts for 13% of the world's disease burden, yet Canada invests only 7.2% of its health spending in its mental health services, and the percentage is declining. While countries like Australia, New Zealand, and the United Kingdom all have had mental health plans, service targets, and targeted investments since the late 1990s, Canada did not have a national mental health plan until 2012.[11]

90. Health care is a provincial responsibility in Canada. Ontario has developed a mental health plan setting out policy direction, and does invest in mental health initiatives, but the overall percentage of health spending dedicated to mental health in Ontario has substantially declined over the past 35 years, from 11.3% in 1979 to 8.2% in 1992 to less than the national average of 7.2% in 2011.[12]

91. Mental health has simply not been as high a priority for the Ontario government as other health issues.

92. The relative shortage of funding for mental health care in Ontario affects police, because the police are called upon to respond when a person with a mental health issue poses a danger to self or others, commits a crime, causes a disturbance, or otherwise is in crisis. More mental health spending would lead to more treatment resources both in hospitals and in the community, and more social supports. It is reasonable to expect that these resources and supports would reduce the incidence of police contact with people in crisis by reducing the incidence of crises, and by creating alternative ways of helping to resolve them.

93. The relative reduction in mental health spending over time has coincided with the de-institutionalization process of recent decades. Through this process, people with mental health issues are more often treated in the community rather than in psychiatric institutions, and are not detained against their will except in a relatively narrow range of circumstances involving primarily danger to self or others. The overall effect has been an increased number of people with mental health issues living in the community, while decreasing the resources available to serve them.

94. Within the City of Toronto, the effect has been an increase in the number of calls to the TPS involving people in crisis. By way of example, as noted in the data set out above, the number of *Mental Health Act* apprehensions by the TPS was 7,627 in 2009, while in 2013 it was 8,384. Many of the individuals from the TPS with whom we spoke commented on this trend—an ever-increasing involvement by front line police officers with people in crisis. One front line officer referred to sometimes having 3 or 4 calls with

[11] Steve Lurie, "Why Can't Canada Spend More on Mental Health?" (2014) 6 Health 684 at 684-686, online: Scientific Research: Open Access <http://file.scirp.org/Html/6-8202813_44016.htm>.

[12] *Id*. at 686.

a mental health aspect per day currently, and in the range of 300 to 400 such calls per year.

95. The TPS have become *de facto* front line mental health workers. Responding to mental health calls is now a regular and central part of the front line officer's job, as illustrated by the increased demand for the MCIT program, which is discussed in more detail in Chapter 11 (MCIT and Other Models of Crisis Intervention), and the increased training in the area of mental health over recent years, as described in Chapter 7, (Training). The role of the TPS within the mental health system is the subject of its own discussion in Chapter 4 (The Mental Health System and the Toronto Police Service).

96. One of the main concerns for police, in their expanded mental health role, is the degree of risk posed to the front line officers who are required to respond to calls involving a person in crisis. One sees this concern manifested, for example, in the requirement that two armed police officers be dispatched in response to any EDP call.[13]

97. The question of whether people with mental health issues pose a greater risk of violence is a controversial one. Several stakeholders from the mental health community expressed the view that people with mental illness are no more likely to be violent than other members of the community, while at the same time, they are at increased risk of being a victim of violence. There is a concern that people with mental illness are subject to unfair stereotyping as having a propensity to violence, and that police may use more force than necessary in apprehending people under the *Mental Health Act* as a consequence.[14]

98. At the same time, the Review was provided with research showing that there are statistical correlations between violence and specific types of mental illness, and that the correlations often increase when the individual also has a substance abuse disorder. There is also research showing that certain types of violent behaviour are more often committed by people who are mentally ill.[15]

99. The relevance of the debate over violence and mental illness is not that it can be resolved as part of this Review. Rather, this debate highlights the importance of educating police about these issues and about the symptoms of various mental illnesses in order to help front line officers accurately assess the risk posed by a specific person in crisis. With mental health calls to the TPS increasing, it is more important now than ever that police be well informed about the issues.

---

[13] Toronto Police Service, "Communications Services Directives regarding/involved EDP's" [*sic*] (Toronto, ON: Toronto Police Service, undated) at C.5.5.4, C.6.1.6.

[14] See e.g. Canadian Mental Health Association Ontario, "Violence and Mental Health: Unpacking a Complex Issue" (30 September 2011), online: Canadian Mental Health Association Ontario <http://ontario.cmha.ca/public_policy/violence-and-mental-health-unpacking-a-complex-issue/>.

[15] See e.g. Katrina Witt, Richard van Dorn & Seena Fazel, "Risk Factors for Violence in Psychosis: Systematic Review and Meta-Regression Analysis of 110 Studies" (2013) 8:2 PLOS ONE e55942; S. Fazel *et al.*, "Schizophrenia, substance abuse, and violent crime." (2009) 301:19 JAMA 2016; Jeffrey W. Swanson *et al.*, "Violence and Psychiatric Disorder in the Community: Evidence From the Epidemiologic Catchment Area Surveys" (1990) 41:7 Hosp Community Psychiatry 761.

F. The legal context

100. Before proceeding to Part 2 of the Report, which contains a detailed discussion and analysis of the issues forming part of the Review mandate, it is helpful to provide a summary of the legal context in which the issues arise.

101. In one sense, the legal context is not directly relevant, because this Review is concerned with best practices, not with the minimum requirements for legal compliance. One of the main messages of this Report is that members of the TPS should strive for the optimal outcome, not just a lawful one. But the legal context is relevant for a different reason, because it helps to explain the powers of the police, the rights of the person in crisis, as well as the constraints within which both must operate.

1. *Mental Health Act and regulation*

102. The Ontario *Mental Health Act* is central in outlining both police powers and the rights of a person experiencing mental health issues. The statute is premised on the central principle that people, even if they are believed to be in need of observation, care, and treatment in a psychiatric facility, cannot be compelled to receive care and treatment except in a narrow range of circumstances. The liberty of the individual is given primacy in most cases.

103. The major exception is where the person is reasonably believed to pose a danger of serious bodily harm or serious physical impairment to himself or herself, or a danger of serious bodily harm to another person. In such cases, under section 17 of the *Mental Health Act*, a police officer may apprehend the person, take the person into custody by force if necessary, and take the person to be examined by a physician. The police may also be involved in apprehending a person to be examined where a justice of the peace has issued an order for this purpose under section 16 of the *Mental Health Act*, and in certain other circumstances set out in the Act.

104. Under section 33 of the *Mental Health Act*, a police officer who takes a person in custody to a psychiatric facility is required to remain at the facility and retain custody of the person until the facility takes custody of the person. Under section 7.2 of Regulation 741 under the Act,[16] the officer in charge of the psychiatric facility or his or her delegate is required to ensure that a decision is made as soon as is reasonably possible as to whether or not the facility will take custody of the person. As explained below in Chapter 4 (The Police and the Mental Health System in Toronto), the requirement for police to remain at the psychiatric facility is a controversial one, because hospital wait times for police can last for hours depending on the hospital, thus preventing police from returning to their police duties.

2. *Police Services Act and regulations*

105. I address the role of the *Police Services Act* and its regulations at various places throughout this Report. The key features of the legislation, for purposes of this Review, are the following:

[16] R.R.O. 1990, Reg. 741.

(a) Section 1 of the Act sets out the principles in accordance with which police services are to be provided in Ontario, which include the need to ensure the safety and security of all persons, and the importance of safeguarding the fundamental rights guaranteed by the Ontario *Human Rights Code*.[17]

(b) The powers and responsibilities of the Toronto Police Services Board are set out in Part III of the Act.

(c) The independent oversight roles of the SIU (Part VII of the Act and O. Reg. 267/10), the Independent Police Review Director (Parts II.1 and V of the Act) and the Ontario Civilian Police Commission (Part II of the Act) are set out.

(d) The obligation of the Chief of Police to cause an investigation to be conducted into any incident with respect to which the SIU has been notified is set out in section 11 of O. Reg. 267/10.

(e) Section 41 of the Act sets out the principal duties of the Chief of Police, and section 42 sets out the principal duties of a police officer.

(f) The requirements relating to Adequacy and Effectiveness of Police Services are set out in O. Reg. 3/99. Section 13(1)(g) requires the Chief of Police to establish procedures in respect of police response to persons who are emotionally disturbed or have a mental illness or a developmental disability. Section 29 requires the Toronto Police Services Board to establish policies in respect of the same issue.

(g) Requirements relating to equipment and use of force are set out in Regulation 926.[18]

(h) The minimum hiring criteria for police officers are set out in section 43 of the Act, and the requirement of a one-year probationary period for new officers is in section 44. The minimum requirements for the training of new recruits at the Ontario Police College are set out in O. Reg. 36/02.

(i) There is a Code of Conduct for police officers set out in O. Reg. 268/10. Breach of the Code of Conduct constitutes misconduct that can be prosecuted under the disciplinary process set out in Part V of the Act. The Code of Conduct identifies what constitutes discreditable conduct, insubordination, neglect of duty, deceit, breach of confidence, corrupt practice, unlawful or unnecessary exercise of authority, damage to clothing or equipment, and consuming drugs or alcohol in a manner prejudicial to duty.

[17] R.S.O. 1990, c. H.19.

[18] R.R.O. 1990, Reg. 926.

(j) The internal disciplinary process and the definition of police misconduct are set out in Part V of the Act.

3. *Criminal Code*

106. The *Criminal Code*[19] contains provisions dealing with the use of force by police officers. Section 25 provides protection where force is used in the administration or enforcement of the law. A police officer is, if he or she acts on reasonable grounds, justified in using as much force as is necessary for that purpose. In the case of force that causes death, the force will be considered justified if the officer believed on reasonable grounds that it was necessary for the self-preservation of the officer or the preservation of anyone under the officer's protection from death or grievous bodily harm.

107. In the case of a police officer who is lawfully arresting a person, if the person takes flight, the police officer is justified in using force that is intended or likely to cause death if the police officer believes on reasonable grounds that: the force is necessary to protect the police officer, anyone lawfully assisting the police officer, or any other person, from imminent or future death or grievous bodily harm; and that the flight cannot be prevented by reasonable means in a less violent manner.[20]

108. Section 26 of the *Criminal Code* clarifies that anyone who is authorized by law to use force is nonetheless criminally responsible for any excess thereof.

109. I discuss the role of these *Criminal Code* provisions, and of the related case law interpreting them, in Chapter 10 (Use of Force).

4. *Common law*

110. Police officers who use lethal force, as well as the Toronto Police Services Board, may be subject to civil claims for recovery of damages in connection with a use of lethal force. A civil claim may be available, for example, for the tort of negligence or for an intentional tort such as assault or battery. The potential for civil liability (and criminal liability) in connection with the use of force is discussed in Chapter 10 (Use of Force), and is relevant to the issue of debriefing, which I discuss in Chapter 8 (Supervision).

5. *Human Rights Code*

111. Section 1 of the Ontario *Human Rights Code* forbids discrimination in the provision of a service to any person on the basis of disability. A disability includes, under section 10(1) of the *Human Rights Code*, a mental disorder, a condition of mental impairment, or a developmental disability.

[19] R.S.C., 1985, c. C-46.

[20] *Id.*, s. 25(4).

PART 2

Discussion, Analysis and Recommendations

CHAPTER 4

The Mental Health System and the Toronto Police Service

CHAPTER 4. THE MENTAL HEALTH SYSTEM AND THE TORONTO POLICE SERVICE

Table of Contents

Page

I. THE CURRENT SITUATION 84

A. Mental healthcare resources in Toronto 84
(1) The mental health system as a revolving door 84
(2) Types of mental health services in Toronto 85
(a) In-patient and out-patient counselling and treatment facilities 85
(b) Mental health crisis intervention 86
(c) Short-term crisis support beds 86
(d) Mental health case management 86
(e) Assertive Community Treatment Teams 87
(f) Peer-support and self-help 87
(g) Vocational and employment supports 88
(h) Abuse services 88
(i) Housing support and special care 88
(3) Accessibility of information regarding mental health services 89
(4) Government involvement 90
(a) Ontario Ministry of Community Safety and Correctional Services 90
(b) Ontario Ministry of Health and Long-Term Care 91
(c) Other arms of government 92

B. The role of the TPS in serving people in crisis 93
(1) Serving people in crisis is a core part of policing in Toronto 93
(2) Mental health and the TPS business plan 94
(3) TPS framework for responding to people in crisis 95
(a) Procedures governing response to emergencies 95
(b) Communications Services 96
(c) Front line officers 97
(d) Supervisory officers 98
(e) Emergency Task Force 98
(f) Mobile Crisis Intervention Teams 99

C. Points of intersection between the mental health system and the TPS 100
(1) Apprehensions under the Mental Health Act 100
(2) Emergency room transfer of care procedures 101
(3) Mobile Crisis Intervention Teams and their oversight 104
(4) Officers in charge of mental health coordination 104
(5) Human Services and Justice Coordinating Committee 105
(6) The Mental Health Sub-Committee and the involvement of the mental health community 105

Table of Contents
(continued)

Page

(7) Information sharing, privacy, and physician-patient confidentiality 106

II. OVERVIEW OF ISSUES HIGHLIGHTED BY STAKEHOLDERS 108

A. The mental health system 108
B. The Toronto Police Service 109
C. Points of intersection between the mental health system and the TPS 109

III. RECOMMENDATIONS 111

Chapter 4. The Mental Health System and The Toronto Police Service

1. A universal theme, frequently conveyed to this Review by police, mental healthcare workers, and the community of people who have experienced mental illness, is that Ontario does not have a mental health system.

2. That is, Ontario does not have a coordinated, comprehensive approach to treating mental health issues. Instead, there is a patchwork collection of hospitals, community treatment organizations, housing programs, and mental health practitioners, only some of which receive public funding—funding that is, in any event, often inadequate to meet the needs of the community. This patchwork of resources is tasked with addressing the significant and complex challenge of proactively treating mental illness.

3. At the same time as the system is weak, the modern trend toward the deinstitutionalization of people with mental illness, and the modern principle that patients should have the freedom to decline mental healthcare except in extreme cases, mean that a substantial number of people in crisis find themselves in encounters with the police. The police, in turn, because of the relatively disorganized state of mental health resources, may lack sufficient awareness of the resources that do exist, as this information is not comprehensively organized and accessible.

4. As a result of these problems, and in spite of both there being many resources available and the efforts of the many dedicated individuals who work tirelessly to provide mental healthcare, the reality is that the mental health "system" in Toronto is one in which people often get lost.

5. It needs to be said that Toronto would benefit from a systematically organized, coordinated, comprehensive, and better-funded mental health system. This suggestion is not intended as a comment about, or a reflection on, the individuals working in mental health in Ontario, many of whom are leaders in their fields. It is a comment on the overall funding and coordination of mental healthcare in the province, which does not function as a comprehensive system for care.

6. Though the mental health system is not the subject of this Review, it is impossible to address the topic of policing people in crisis without reference to it. The degree to which the system provides adequate care to people in crisis directly shapes the demands placed on the Service, which provides front line emergency response to mental health crises. As a result of both the weak mental health system from an organizational and resource standpoint, and the high volume of police interactions with people in crisis, the TPS has, in effect, become part of the mental healthcare system. This chapter discusses this reality, and suggests ways of seeking to improve it from the perspective of the Service.

7. Helping people in crisis is a challenge that must be addressed by both the mental health system and the police, in cooperation. This chapter discusses coordination between the mental health system and the Toronto Police Service. Topics include the mental healthcare resources available in Toronto, the role of the TPS in serving people in crisis, and points of intersection between the mental health system and the TPS.

I. The Current Situation

A. Mental healthcare resources in Toronto

8. There are significant issues with both the availability of mental health resources in Toronto, and the effective use of existing resources. In this section, I discuss: (a) the types of mental healthcare resources that are available in Toronto; (b) the accessibility of information regarding mental health services; (c) the involvement of different branches of government in this area; and (d) key gaps in mental health services available in Toronto that have implications for policing.

1. *The mental health system as a revolving door*

9. In the course of this Review, it was repeatedly mentioned that Ontario's public system for mental health treatment functions more as a crisis management system than as a proactive and preventive treatment system that aims to solve problems over the long term.[1] Many people characterize the mental health system as a revolving door.

10. For example, a member of my Review team witnessed one incident in which a person in crisis was brought back to a hospital by the Mobile Crisis Intervention Team (MCIT), only days after she had been discharged from two weeks of hospital treatment. The MCIT officer and nurse commented that returning recently discharged patients to hospital is a very common part of their job. Psychiatric treatment facilities do not have enough beds to meet demand, and as a result, doctors are under pressure to discharge patients. This issue is exacerbated by the overall *Mental Health Act* policy that forbids psychiatric facilities from holding people against their will unless a strict set of requirements are met. Thus, hospitals become a revolving door for mental health treatment: they respond to crises, but often do not effectively treat patients for long-term improvement.

11. Police often apprehend a person in crisis under the *Mental Health Act* and bring that person to an emergency department.[2] However, the physician sometimes makes a determination that the person does not meet the criteria for an involuntary admission to the hospital under the *Mental Health Act*, and therefore, the person must be released if he or she does not wish to stay voluntarily for treatment.[3] Before an individual's release, hospitals may not make a sufficient effort to connect the individual with appropriate community mental health resources, or the person may refuse this help. As a result,

---

[1] The Review was advised that the forensic mental health treatment system—the mental health treatment system connected to the judicial system, which addresses the needs of people who cannot be considered responsible for the commission of a crime owing to their mental illness—is more coordinated and comprehensive than the more general mental health treatment resources. We have also been told that there are strong pressures to divert patients away from the forensic mental health system because it is more costly. For more information on the forensic mental health system, see Centre for Addiction and Mental Health, "The Forensic Mental Health System in Ontario: An Information Guide" (2012), online: Centre for Addiction and Mental Health <http://www.camh.ca/en/hospital/health_information/the_forensic_mental_health_system_in_ontario/Pages/the_forensic_mental_health_system_in_ontario.aspx>.

[2] For apprehension provisions, see *Mental Health Act*, R.S.O. 1990, c. M.7, s. 17 [*MHA*].

[3] For criteria for involuntary admission, see *id*., s. 20.1(1)(5).

police may reencounter the person in the community after a few days—or even after only a few hours, once again in need of help.[4]

12. The inadequacy of resources for mental health treatment in Ontario, as in many jurisdictions across Canada and internationally, stems in part from the de-institutionalization of mental health treatment over the last six decades. Sixty years ago, people with mental illness were "warehoused in asylums, with no voice to express their own thoughts and feelings. No safe space."[5] A landmark in the deinstitutionalization process in Canada was the Canadian Mental Health Association's 1963 policy, "More for the Mind," which advocated de-institutionalized, community-based treatment of mental illness that enables people to live in the community and exercise their freedoms.[6] Mental health services were subsequently integrated with general health services, and psychiatric services were decentralized. In the 1950s and 1960s, almost 80 percent of beds in Ontario's psychiatric hospitals were closed. Within 20 years, a number of observers began to recognize that, "without the necessary community services in place, deinstitutionalization was a disaster."[7] Arguably, society still has not risen to meet the challenge of providing adequate community mental health supports.

13. The 1988 report, "Building Community Support for People: A Plan for Mental Health in Ontario," by the Provincial Community Mental Health Committee, reflected an important shift towards a community-based approach to mental health services in the province.[8] It was followed by a series of other provincial reports, programs, and initiatives. However, it is clear that Ontario's community-based approach to mental health treatment is far from comprehensive or adequate. Many express the view that more beds in psychiatric treatment facilities and better funding for community supports are needed.

2. *Types of mental health services in Toronto*

(a) *In-patient and out-patient counselling and treatment facilities*

14. The provision of mental healthcare services occurs in a variety of settings, both on an in-patient and out-patient basis. For the most serious crises, Toronto has 16 psychiatric facilities designated under the *Mental Health Act* "for the observation, care and treatment of persons suffering from mental disorder."[9] These facilities provide some or all of the following services: in-patient care, out-patient care, day care,

---

[4] Provincial Human Services and Justice Coordinating Committee, "HSJCC Info Guide: Strategies for Implementing Effective Police-Emergency Department Protocols in Ontario" (April 2013) at 6, online: HSJCC <http://www.hsjcc.on.ca/Provincial/Planning%20and%20Priorities/Strategies%20for%20Implementing%20Effective%20Police -Emergency%20Department%20Protocols% 20in%20Ontario.pdf> [HSJCC, "Effective Protocols"].

[5] Diana Ballon, "Looking Back: Reflections on Community Mental Health in Ontario" (2014), online: Canadian Mental Health Association Ontario <http://ontario.cmha.ca/network/looking-back-reflections-on-community-mental-health-in-ontario/>.

[6] *Ibid*.

[7] *Ibid*.

[8] The Provincial Community Mental Health Committee, *Building Community Support For People: A Plan for Mental Health in Ontario* (Toronto, ON: Queen's Printer for Ontario, 1988), online: Canadian Mental Health Association Ontario <http://ontario.cmha.ca/files/2011/06/grahamreport.pdf>

[9] *MHA*, *supra* note 2, s. 1.

emergency services, ongoing consultative services, and educational services to patients and the wider community.[10] These facilities include many of Toronto's major hospitals.

(b) *Mental health crisis intervention*

15. Specialized services are provided in situations that require urgent medical or psychological attention for people with serious mental illnesses. This range of services includes the Service's MCIT units, comprised of a police officer and a mental health nurse; other crisis intervention teams such as the peer-based team operating out of the Gerstein Centre; hospitals' psychiatric emergency teams within their emergency departments; and various help and support lines, all of which provide some form of emergency help to people in crisis.[11] The topic of crisis intervention teams is addressed in more detail in Chapter 11 (MCIT and Other Models of Crisis Intervention).

(c) *Short-term crisis support beds*

16. Short-term crisis support beds are an important resource in responding to people in crisis. These 47 beds provide time-limited emergency housing coupled with high-intensity care for people in crisis. Thirty-four of these beds are designated for people in crisis who have had recent or current involvement with the criminal justice system. They are available at four community mental health organizations in Toronto: Cota Health, CMHA Toronto, the Gerstein Centre, and Reconnect Mental Health Services.[12] These organizations provide services that include psychiatric assessment, monitoring, treatment, symptom stabilization, and assistance with securing access to case management and long-term housing.

17. Each of the four community mental health organizations operating short-term crisis support beds maintains one free bed for use by the TPS, should it be needed by an officer encountering a person in crisis. Although in principle these short-term crisis support beds can function as an effective means of diverting people in crisis away from the criminal justice system and toward treatment, I have heard that these beds are often unavailable.

(d) *Mental health case management*

18. Mental health case management services consist of individualized assessments of needs for people with serious mental illness. Case managers assess individuals' community treatment needs and coordinate their various services and supports, direct

---

[10] Ontario Ministry of Health and Long-Term Care, "Health Services in Your Community: Designated Psychiatric Facilities under the Mental Health Act" (13 January 2014), online: Ontario Ministry of Health and Long-Term Care <http://www.health.gov.on.ca/en/common/system/services/psych/designated.aspx>.

[11] Mental Health Helpline, "Types of Mental Health Services in Ontario" (2014), online: ConnexOntario <http://www.mentalhealthhelpline.ca/Search/ServiceTypes> [Mental Health Helpline, "Services"]; St. Joseph's Health Centre Toronto, "Crisis & Intervention", online: St. Joseph's Health Centre Toronto <http://www.stjoe.on.ca/programs/mental/emerg.php>; Canadian Mental Health Association Ontario, "Are You in Crisis?" (2014), online: Canadian Mental Health Association Toronto <http://toronto.cmha.ca/mental-health/find-help/are-you-in- crisis/>; St. Michael's Hospital, "Mental Health: Psychiatric Emergency Service" (2014), online: St. Michael's Hospital <http://www.stmichaelshospital.com/programs/mentalhealth/emergency.php>.

[12] Community Resource Connections of Toronto, "Short term residential beds (safe beds)" (23 October 2008), online: Community Resource Connections of Toronto <http://www.crct.org/choices/show.cfm?id=376>.

them to available resources, provide supportive counselling, and monitor and evaluate the effectiveness of the services provided. This task includes coordinating services mandated by any Community Treatment Orders—an order from a doctor that requires a person to receive treatment while living in the community.[13] Case management services are provided by mental health support organizations, such as CMHA Toronto and Cota Health, among others.[14]

(e) *Assertive Community Treatment Teams*

19. Some hospitals and community treatment organizations operate Assertive Community Treatment Teams (ACT Teams), which coordinate professionals from several care-giving disciplines, such as social workers, nurses, vocational specialists, occupational therapists, psychiatrists, peer support workers, and addictions specialists. These professionals provide proactive outreach, individualized psychiatric treatment, medication, and ongoing and continuous mental health services to individuals, including monitoring and evaluation of patients. These ACT Teams aim to support individuals in their recovery, and to help these individuals develop the ability to live in the community. There are 13 ACT Teams in Toronto.

(f) *Peer-support and self-help*

20. One of the themes frequently expressed over the course of this Review is the importance of enabling people who experience mental health issues to help themselves through their own crises, and for them to play an active role in their own treatment and recovery.

21. Mental health-focused clubhouses, drop-in centres, and other organizations that promote self-help, support people with persistent mental illnesses by bringing people together through restorative activities that focus on their strengths and abilities instead of their illness.[15] These organizations vary in their formality, structure, and membership, as some require an application and evaluation, while others are casual meeting places open to everyone.

22. People who have experienced mental health issues often work proactively alongside staff, rather than as passive patients who receive services. This model seeks to demonstrate to members that people with mental illness can lead productive lives and make a contribution to the community.[16] These organizations may provide a range of services, including: community support and case management services; a structured

[13] Mental Health Helpline, "Services", *supra* note 11.

[14] Canadian Mental Health Association Toronto, "Case Management Services" (2014), online: Canadian Mental Health Association Toronto <http://toronto.cmha.ca/programs_services/case-management/>; COTA Health, "Mental Health Case Management", online: COTA Health <http://www.cotainspires.ca/extension.php?docex=276>.

[15] It is my understanding that, in the mental health context, a "clubhouse" is an organization with a defined membership that usually provides psychosocial rehabilitation services across a range of social, vocational, housing, and recreational services and activities, and helps members liaise with other mental health service providers. A "drop-in" is usually a less formal organization, without a defined membership, but which may provide some or all of the same services that a "clubhouse" does, on a more ad hoc basis.

[16] Clubhouse International, "How Clubhouses Can Help" (2014), online: Clubhouse International <http://www.iccd.org/how.html>.

work day with activities that support recovery; education, employment, social, and recreational programs; and assistance in securing housing.[17]

(g) *Vocational and employment supports*

23. A range of organizations provide employment supports for people with serious mental illness, including job development, creation, and employer outreach; skills development and training; job search skills and placement; planning and career counseling; and leadership training.[18]

(h) *Abuse services*

24. Specialized counselling, treatment, and support services are provided to people who have experienced or are currently experiencing abuse, including people who have suffered family violence and child witnesses.[19]

(i) *Housing support and special care*

25. Some housing supports, incorporating different levels of care, are available to people with mental illness depending on their level of need. However, I understand that the supply of housing supports does not meet the existing need, and as a result, it is very difficult to secure housing supports.

26. Some housing supports include treatment, counselling, and rehabilitative social and recreational services. Homes are also available to provide long-term residential care to individuals with serious mental illness discharged from psychiatric hospitals who require 24-hour supervision and assistance.[20]

27. Beyond housing programs that provide supervision and care, there is an array of programs designed to help people with mental illness, who are homeless or are at risk of being homeless, to secure housing. These programs include individualized assessments of needs and planning for how those needs can be met, connecting individuals with landlords and various forms of public housing and rent supplements available to people with mental illness; advocating for adequate public housing supports, and teaching life skills necessary to live alone without care.[21]

28. As discussed in greater detail below, access to adequate affordable housing is an important and effective component of treating mental illness, because homelessness can exacerbate existing mental health problems. A home provides some stability and control over one's daily life and routine, enabling people to concentrate on treating their illness.

---

[17] Mental Health Helpline, "Services", *supra* note 11.

[18] *Ibid*.

[19] *Ibid*.

[20] CMHA Ontario, "Housing and Mental Illness" (2014), online: CMHA Ontario <http://ontario.cmha.ca/public_policy/housing-and-mental-illness/>.

[21] Mental Health Helpline, "Services", *supra* note 11.

3. *Accessibility of information regarding mental health services*

29. The importance of accessible, comprehensive information on mental health services to both the TPS and the public cannot be overstated. One senior health practitioner estimated that there are over 400 mental health-related organizations in Toronto alone. Access to information regarding each organization, its specific services, location, hours, and other pertinent details is an important need, both to enable the TPS to help people in crisis and to enable people to seek help themselves.

30. Several stakeholders noted that a comprehensive database listing all mental health-related organizations in Toronto does not exist. Maintaining a complete and up-to-date database is a significant undertaking.

31. ConnexOntario is Ontario's most comprehensive directory of information regarding mental health services. In addition to an online directory, it operates three confidential telephone helplines and one-on-one online chats to advise people regarding available help for mental health issues, drug and alcohol issues, and problem gambling issues. ConnexOntario aims to maintain an up-to-date, accurate database of available services, how those services are accessed, and how long the wait to access the services may be.[22] However, the Review has been told that ConnexOntario omits certain organizations in Toronto, and lacks information regarding the current capacity of organizations to take on new patients.

32. The Vancouver Police Department's (VPD) "Dashboard" system is an innovative, user-friendly software tool, implemented in collaboration between the VPD and Vancouver Coastal Health, which integrates police and mental health information into a single database, which is then used by police officers in the field. Its key features include: (a) an aerial view of the city that charts the location of all mental health resources, with icons indicating different types of resources; (b) up-to-date information on average wait times in all emergency departments at psychiatric facilities, including specific information on average wait times for *Mental Health Act* apprehensions; (c) data on the distribution of patients to different psychiatric facilities by the police; (d) officers' input on whether mental health issues were a factor in any given call, for future records; and (e) data on the city's top repeat users of emergency mental health services, as defined by, among other things, whether they are clients of ACT teams, whether they have been apprehended under the *Mental Health Act* in the last 15 days, whether they have had negative police contact in the last 15 days, whether they have committed a violent or substance-related offence in the last 60 days, or have caused a disturbance or the VPD has observed other suspicious behaviour in the last 60 days.[23]

33. Of course, any sharing of mental health information with the police has to be done with appropriate privacy safeguards and in a manner that respects physician-patient confidentiality. Furthermore, sharing of mental health information must be

[22] ConnexOntario, "About us" (2014), online: ConnexOntario <http://www.connexontario.ca/Home/About>.

[23] Staff Sergeant Howard Tran, Vancouver Police Department, "Data Collection and Collaborative Measures of Success & Outcomes" (Presented to CACP/MHCC Conference, Toronto, ON, 2014) [unpublished]; "Emergency Wait Times: Vancouver, Richmond and North Shore Emergency Department wait times" (2014), online: <http://www.edwaittimes.ca/WaitTimes.aspx>.

done in a manner that limits any further use and disclosure of that information to other government agencies. Mental health information shared by healthcare providers must only be accessed and used by the TPS in its capacity as part of the mental health treatment framework. Privacy concerns regarding the sharing of mental health information are discussed in greater detail below.

34. The TPS operates a separate Community Referral Police Access Line to provide police officers with assistance when interacting with any individual above the age of 16 who is believed to be "emotionally disturbed," at significant risk of involvement with the criminal justice system, and who has not been apprehended under the *Mental Health Act*. This line can connect officers and members of the public with short-term residential beds at community mental health organizations, referrals to the Mental Health and Justice Prevention Program operated by four community mental health organizations, and referrals to other community mental health services.[24]

35. Other telephone help lines for use by the police and members of the public exist as well. For example, the Gerstein Centre operates a telephone support line for people in crisis that is also available for police officers to consult regarding mental health services available to people in crisis who they encounter.[25]

4. *Government involvement*

36. Programs by various arms of government are involved in addressing the needs of people in crisis in some way. The activities of the Ontario Ministry of Community Safety and Correctional Services (MCSCS), Ministry of Health and Long-Term Care (MHLTC), and other levels of government set out below, demonstrate the necessity of greater cooperation and coordination to address the complex underlying causes that lead to serious police interactions with people in crisis.

(a) *Ontario Ministry of Community Safety and Correctional Services*

37. MCSCS is significantly involved in the legislative and regulatory areas applicable to this Review, and its engagement is active and evolving. MCSCS publishes the Ontario Policing Standards Manual to assist police services in meeting requirements under the *Police Services Act*[26] and its regulations by providing guidelines and sample board policies.

38. The Manual includes "LE-013 Police Response to Persons who are Emotionally Disturbed or have a Mental Illness or a Developmental Disability," which sets out basic guidelines for Ontario police services' policies and procedures in interacting with people in crisis, using police powers under the *Mental Health Act*, taking people in crisis to hospitals, and providing training that touches on interactions with people in crisis and

[24] Toronto Police Service, Procedure 06-04 "Emotionally Disturbed Persons" (Toronto, ON: Toronto Police Service, 2010) [TPS, "Procedure 06-04"].

[25] Gerstein Centre, "Our Service", online: Gerstein Centre <http://www.gersteincentre.org/>.

[26] R.S.O. 1990, c. P.15.

how to recognize common mental illnesses.[27] This guideline is meant to help police services implement their obligations under section 29 of Reg. 3/99 under the *Police Services Act* ("Adequacy and Effectiveness of Police Services"), which requires police services boards to have a policy on the police response "to persons who are emotionally disturbed or have a mental illness or a developmental disability." The guideline also assists police services in implementing their obligation under section 13(1)(g) of the regulation, which requires Chiefs of Police to establish procedures in respect of the aforementioned people.[28] The MCSCS also regulates the weapons that police officers in Ontario can carry and deploy, including conducted energy weapons, discussed further in Chapter 12 (Equipment).

39. Further, the MCSCS oversees the Ontario Police College, which conducts new constable training for all police services in the province. As discussed in greater depth in Chapter 7 (Training), at the Ontario Police College, new constables are given introductory training on the subject of responding to people in crisis. The OPC, in partnership with CAMH and St. Joseph's Health Care London, developed a detailed manual on policing people in crisis titled, "Not Just Another Call," that emphasizes the different issues at play and the skill set that is needed in order to manage this complex area of police work.[29]

40. Finally, the MCSCS is actively engaged in developing best practices in policing people in crisis. In May 2012, the Honourable Madeleine Meilleur, then Minister of Community Safety and Correctional Services, announced that the Ministry would undertake a review of police interactions with persons with mental illness.[30] This review is ongoing.[31] The Ministry has completed the first phase of evidence gathering, including current practices and legislation in Ontario, best practices from other jurisdictions, and the past 25 years of recommendations from Coroner's juries in Ontario. MCSCS is currently pursuing stakeholder engagement on the issue. Any recommendations for legislative or other changes are expected in spring 2015.

(b) *Ontario Ministry of Health and Long-Term Care*

41. The issue of police interactions with people in crisis is not merely one of policing. Its root causes cannot be addressed without tackling the need for more comprehensive care for people with mental illness. Accordingly, Ontario's Ministry of Health and Long-

---

[27] Ministry of Community Safety and Correctional Services, *Policing Standards Manual (2000)*, LE-013 "Police Response to Persons who are Emotionally Disturbed or have a Mental Illness or a Developmental Disability" (Toronto, ON: Ministry of the Solicitor General, 2000).

[28] *Adequacy and Effectiveness of Police Services*, O. Reg. 3/99, ss. 13(1)(g), 29.

[29] Ontario Police Colleges, Centre for Addiction and Mental Health & St. Joseph's Health Care London, *Not Just Another Call...Police Response to People with Mental Illnesses in Ontario* (Sudbury, ON: Centre for Addiction and Mental Health, Queen's Printer for Ontario and Regional Health Care, London, 2004), online: Ontario Association of Chiefs of Police <http://www.oacp.on.ca/Userfiles/Files/NewAndEvents/PublicResourceDocuments/2004_Not%20Just%20Another%20Call_%20Police%20Response%20to%20People%20with%20Mental%20Illnesses%20in%20Ontario.pdf>.

[30] Cary Mills, "Ontario to review how police respond to the mentally ill" *The Globe and Mail* (18 June 2012), online: The Globe and Mail <http://www.theglobeandmail.com/news/toronto/ontario-to-review-how-police-respond-to-the-mentally-ill/article4104611/>.

[31] Public Safety Canada, "Review of Police Interaction with Persons with a Mental Illness (Details)" (5 March 2014), online: Public Safety Canada <http://www.publicsafety.gc.ca/cnt/cntrng-crm/plcng/cnmcs-plcng/ndx/dtls-eng.aspx?n=63>.

Term Care has a significant role to play in addressing this issue. In June 2011, MHLTC released "Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy."[32] The first three years of the Strategy focused on child and youth mental health. To achieve the Strategy's goals, 18 service collaboratives that are designed to improve transitions between health services and to better coordinate services for children and youth have been established across the province. The one service collaborative centred on Toronto is focused on linkages between community services, healthcare, and the justice system. It aims to coordinate services that address a wide array of issues, including crisis support, pre-charge diversion and arrests, remand or bail orders and post-charge diversion, and discharge planning and release from correctional services.[33] These coordination projects are still in their early stages.

42. The next phase of the MHLTC's Strategy is planned to expand on the initiatives for children and youth mental health to include transitional age youth, adults and people with addictions. It is planned to address issues related to housing, employment, and contact with the justice system, as well as to build on prior works related to mental health and addictions.[34]

43. However, a variety of stakeholders within and outside mental health treatment organizations highlighted that MHLTC has demonstrated a concerning inattentiveness to the issue of police interactions with people in crisis. Many stakeholders have expressed concern that MHLTC habitually does not send a representative to attend Coroner's Inquests regarding shootings of people who may have suffered from mental illness. A general theme that emerged from our consultations is that MHLTC is much less involved in this issue than MCSCS. This theme is often expressed in conjunction with remarks on the lack of coordination within the mental health system.

(c) *Other arms of government*

44. The involvement of other arms of government to address this complex issue is necessary as well. For example, in recent years it has become increasingly accepted that access to adequate affordable housing is an important and effective component of treating mental illness, as homelessness can exacerbate existing mental health problems.[35] Without a home to provide a degree of stability and control, managing

---

[32] Ontario Ministry of Health and Long-Term Care, *Open Minds, Healthy Minds* (Toronto, ON: Queen's Printer for Ontario, 2011), online: Ontario Ministry of Health and Long-Term Care <http://www.health.gov.on.ca/en/common/ministry/publications/reports/mental_health2011/mentalhealth.aspx>.

[33] Centre for Addiction and Mental Health, "Systems Improvement through Service Collaboratives" (2014), online: Centre for Addiction and Mental Health <http://servicecollaboratives.ca/>.

[34] Select Committee on Mental Health and Addictions, *Final Report – Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians* (Toronto, ON: Legislative Assembly of Ontario, 2010), online: Legislative Assembly of Ontario <http://www.ontla.on.ca/committee-proceedings/committee- reports/files_pdf/Select%20Report%20ENG.pdf>; Minister's Advisory Group on the 10-Year Mental Health and Addictions Strategy, "Respect, Recovery, Resilience: Recommendations for Ontario's Mental Health and Addictions Strategy" (December 2010), online: Minister of Health and Long-Term Care <http://www.health.gov.on.ca/en/common/ministry/publications/reports/mental_health/mentalhealth_rep.pdf>.

[35] Mental Health Commission of Canada, "Beyond Housing: At Home/Chez Soi Early Findings Report – Volume 3" (Fall 2012), online: Mental Health Commission of Canada <http://www.mentalhealthcommission.ca/English/system/files/private/document/Housing_At_Home_Early_Findings_Report _Volume_3_ENG.pdf>.

mental illness can be impossible. The availability of affordable housing is shaped by all levels of government—federal, provincial and municipal.

45. In recent years a "housing first" approach to addressing mental illness has gained increasing acceptance. These programs provide housing to people who suffer from mental illness, and once housed, these programs provide them with treatments and supports of their choosing.[36] The key shift in thinking is that the stability that housing security provides is a crucial building block to mental health treatment, and therefore, it must come first. The Government of Canada allocated $110 million to the Mental Health Commission of Canada to run its At Home/Chez Soi program, which implemented a "housing first" approach for more than 1,000 people with mental illness in five cities across Canada from 2009 to 2013.[37] Findings from this pilot project demonstrate that "housing first" is not only an effective means of stabilizing people with mental illness and ameliorating homelessness, but it is also a more efficient use of public funds for treating mental illness than other approaches because it reduces demands on other more costly services.[38]

B. The role of the TPS in serving people in crisis

46. As mentioned above and elsewhere in this Report, a key theme expressed during the Review is that the high volume of police interactions with people in crisis is in large part a function of the failure of the mental health system to provide adequate community-based treatment for mental illness. In this section, I discuss the manner in which TPS serves people in crisis.

1. *Serving people in crisis is a core part of policing in Toronto*

47. Though police officers are not healthcare workers, the role of the police as the most frequent emergency responder for people in crisis leads to the unavoidable conclusion that police officers in Toronto form a part of the spectrum of care, in tandem with other participants in the mental healthcare system, described in broad strokes above. A 2013 report by the MCIT Steering Committee characterized the police and mental health system's dual responsibility for addressing the needs of people in crisis as follows:

> It is important to recognize that mental illness is not, in and of itself, a police problem. However, a number of issues caused by or associated with people with mental illness often become police issues. ... Law enforcement personnel are routinely the first line of response for situations involving mentally ill people in crisis and as a result, officers may have assumed the role of "street-corner psychiatrists" by default. Neither the mental health system nor the law enforcement

[36] *Id.* at 11.

[37] *Id.*

[38] *Id.* at 6.

> system can manage mental health crises in the community effectively without help from the other.[39]

48. To illustrate the significance of police interactions with people in crisis to the overall mandate of the Service, as set out in Chapter 3 (Context), in 2013 TPS officers were dispatched to 20,550 calls for service involving an "emotionally disturbed person," 8,384 of which resulted in an apprehension under the *Mental Health Act*. These numbers are roughly consistent from year to year, and are also likely understated, because not every call involving a person in crisis is classified as an "EDP call" for two reasons: first, it can be difficult to tell at the outset whether a person is in crisis in some situations; and second, calls are classified by type when they reach the 911 call-takers at TPS Communications Services, an early stage at which it is often not known whether the call involves a person in crisis. Still, using only the "EDP" number, more than one in every 50 calls to which a TPS officer is dispatched involves a person in crisis, and approximately one in every 100calls to which an officer is dispatched will result in that officer temporarily suspending a person's liberty under the *Mental Health Act*.

49. Police are a significant presence in the lives of people with mental illness. A study by the Mental Health Commission of Canada estimates that, as a general rule of thumb, two out of every five people with mental illness have been arrested in their lifetime, three in every ten people with mental illness have had the police involved in their "care pathway," and one in seven referrals to emergency psychiatric inpatient services involves the police.[40] Though these statistics are not specific to Toronto, they are nonetheless useful in understanding the role of the police in the community of people with mental illness.

50. In light of these facts, it is clear that calls involving people in crisis are a core part of policing.

51. When people fall through the gaps in the mental health system, they may be caught by the criminal justice system, which is not a desirable outcome from a human rights perspective. As a society, by choosing not to provide adequate care for mental illness, we risk criminalizing mental illness. The Toronto Police Service has established several initiatives to ameliorate this concern, in order to divert people in crisis who come into contact with the police away from the criminal justice system and back toward treatment, where possible.

2. *Mental health and the TPS business plan*

52. The TPS has explicitly recognized that serving people in crisis is an important aspect of fulfilling its mandate. Acting on a recommendation from the Toronto Police Service Board (TPSB) Mental Health Sub-Committee, the TPS annual business plan now

---

[39] City of Toronto Mobile Crisis Team Coordination Steering Committee, *MCIT Program Coordination in the City of Toronto* (Toronto, ON: Toronto Central Local Health Integration Network, 2013) at 8 [City of Toronto, *MCIT Coordination*].

[40] J. Brink, *et al*., *A Study of How People with Mental Illness Perceive and Interact with the Police* (Calgary, AB: Mental Health Commission of Canada, 2011) at 29, online: <http://www.mentalhealthcommission.ca/English/system/files/private/Law_How_People_with_Mental_Illness_Perceive_Inte ract_Police_Study_ENG_1_0.pdf> [Brink, *Mental Illness*].

contains a section that addresses the Service's role in interacting with people in crisis as one of the "Service Priorities." The 2013 Business plan states, "[t]he requirement for Service members to better understand and more effectively address the immediate and specific needs of these individuals is a priority for the Service".[41] It then sets out four specific goals for the TPS in this area, and performance objectives for each goal: (a) "ensure safe outcomes for all emotionally disturbed persons during interactions with the police"; (b) develop reliable data collection and analysis; (3) "enhance member training for professional and respectful interactions with emotionally disturbed persons"; and (4) enhance coordination of services offered by police and community service agencies.[42]

53. The Service's recognition that serving people in crisis is important to its mandate is not only significant for its own sake, but also because these statements of priorities are intended to guide TPS and TPSB decision-making with regard to the allocation of resources.[43]

3. *TPS framework for responding to people in crisis*

54. As stated above, whether or not police have sought out a role as part of the spectrum of mental healthcare, the Service's involvement with people in crisis is an unavoidable part of its role as an emergency responder. As a result, TPS officers need to be equipped to fulfill their role within the mental health system. Below, I discuss TPS procedures governing response to incidents involving a person in crisis and the units or groups of officers within the TPS that have the most significant contact with people in crisis.

(a) *Procedures governing response to emergencies*

55. Procedure 10-01 "Emergency Incident Response," sets out the Service's general approach to responding to emergencies, including people in crisis.[44] Emergencies are divided into three categories, with differing response measures. A level 3 emergency is a disaster affecting a significant portion of the population, which may persist for a long period of time and may require an extensive recovery period. A level 2 emergency is an emergency incident that exceeds a division's normal operational resources and requires additional support or multiple agency coordination at the site, as well as some degree of external support. These incidents may continue for an extended period of time and require a command post to be set up on-site. Level 1 emergencies constitute the vast bulk of emergencies the Service addresses, and include general response activities and resources. Members of the Service respond quickly to the report of an emergency situation to gather information, assess the situation, and determine whether additional members or a specialized response is required. These emergencies are most often

[41] Toronto Police Service, *Toronto Police Service: 2013 Business Plan* (Toronto, ON: Toronto Police Service, 2013) at 22.

[42] *Ibid*.

[43] *Id.* at 14.

[44] Toronto Police Service, Procedure 10-01 "Emergency Incident Response" (Toronto, ON: Toronto Police Service, 2010).

resolved in a short period of time using resources available at the divisional level.[45] Almost all calls involving a person in crisis are level 1 emergencies.

56. Under Procedure 10-01 the first member of the Service arriving at the scene of an emergency incident is to "take charge of the scene" and assume the "role of initial Incident Commander."[46] The first responding officer must assess the site and determine an approach that minimizes risk, as well as assess the situation and notify the Communications Operator of key details such as the type of incident, location, potential hazards, any need for additional officers, specialized units, or supervisory officers, and whether Emergency Medical Services or Toronto Fire Services are required.[47] This first officer on scene also assigns officers to complete other necessary functions, such as securing a perimeter, clearing access routes, ensuring relevant people are assisted to safety, and performing first aid where necessary.[48]

57. After being briefed by the first officer on scene, the first Supervisory Officer responding to an incident is required to assess the need to assume the role of Incident Commander, reassess the situation, advise the Communications Operator of any new information, and notify the divisional officer in charge, among other things.[49]

58. Procedure 10-01 also directs all members to comply with any procedure addressing the specific incident, if applicable. Procedure 06-04 "Emotionally Disturbed Persons" sets out procedures for situations where officers observe verbal or behavioural cues that provide them with reasonable cause to believe a person is apparently suffering from a "mental disorder" or is in crisis. The procedure governs police interaction with such people under the police powers set out in the *Mental Health Act*, as well as any subsequent transport and admission to psychiatric facilities made pursuant the Act.[50] Below, I discuss the specific roles that are set out in Procedure 06-04 and elsewhere for different officers and units when responding to people in crisis.

(b) *Communications Services*

59. TPS Communications Services is the unit of the Service that is central to organizing officers' response to all calls for service. The roughly 230 Communication Operators, who rotate between the duties of 911 call-takers and police dispatchers, are responsible for the flow of information among officers and between different units. Call-takers receive calls from people who dial 911 and dispatchers communicate with officers on the ground, coordinating their efforts, directing them to incidents, and giving them all available information. Often TPS call-takers will be the first point of contact between a person in crisis and the police, as many people in crisis call 911 requesting help.

---

[45] *Id.* at 3.

[46] *Id.* at 6.

[47] *Id.* at 6.

[48] *Id.* at 6.

[49] *Id.* at 7.

[50] TPS, "Procedure 06-04", *supra* note 24.

60. When Communications Services receives information regarding a person in crisis, either from a 911 call or from an officer in the field, it notifies various personnel as required by the individual situation. Relevant factors determining who Communications Services must notify include: whether the person in crisis is armed, violent, or threatening suicide; whether any shots have been fired; and whether there are explosives or other hazardous materials involved, among other things. The Emergency Task Force, discussed below, is notified of all calls involving a person in crisis, including all incidents where a person is threatening suicide and all incidents involving a barricaded person.[51]

(c) *Front line officers*

61. The majority of calls involving a person in crisis (or "emotionally disturbed person") that the Service addresses every year are handled by front line officers. A call involving a person in crisis is a Priority 1 call, meaning that Communications Services is required to dispatch two armed officers to respond.[52]

62. When responding to a call involving a suspected person in crisis, an officer must conduct relevant background checks specified by the procedure to determine if the person involved has a firearms license or any firearms registered to them, or any history of violence or weapons use.

63. When encountering a suspected person in crisis, an officer determines whether he or she needs to make an apprehension under the *Mental Health Act* or make an arrest. The officers are instructed to consult with the MCIT, if a unit is available.[53] Similarly, if the officer determines that an arrest for an offence or an apprehension under the *Mental Health Act* is not warranted, officers are directed to contact the MCIT, where available.[54] If the MCIT is not available, and the suspected person in crisis is 16 or older, the officer is directed to contact the Community Referral Police Access Line to assess the options best-suited to addressing the needs of the person in crisis. If the person in crisis is under 16 years of age, officers must determine if the child is in need of protection under the *Child and Family Services Act*.[55]

64. Where there are sufficient grounds to apprehend a suspected person in crisis under section 17 of the *Mental Health Act*, described below, officers must: conduct specified background checks, apprehend the individual, transport the person to one of Toronto's 16 designated psychiatric facilities, and upon arrival at the facility, bring any medications currently prescribed to the person to the nursing supervisor, among other things.[56] Similar steps are taken where officers are asked to apprehend a suspected person in crisis on the basis of a form signed by a physician or justice of the peace.[57] In

[51] Toronto Police Service, "Communications Services Directives regarding/involved EDP's" [*sic*] (Toronto, ON: Toronto Police Service, undated) at C.6.1.6.

[52] TPS, "Procedure 06-04", *supra* note 24.

[53] *Id.* at 1, 5-6.

[54] *Id.* at 6.

[55] *Id.* at 6.

[56] *Id.* at 6.

[57] See *MHA*, *supra* note 2, ss. 15, 16.

addition, officers must obtain the original form, obtain background information from the complainant, conduct other relevant background checks, and notify the ETF if the background checks reveal a history of violence or the presence of a weapon.[58]

65. Upon arriving at the psychiatric facility, the officers must remain with the person in crisis until the facility accepts custody over her or him. A facility accepts custody when it arranges for its staff to take charge of the individual, or when the person is taken for an assessment, discussed below. If the officers are held up or expect to be held up at the facility for over one hour, as is frequently the case, officers must notify a Supervisory Officer.[59]

(d) *Supervisory officers*

66. As stated above, under Procedure 10-01, the first Supervisory Officer to respond to a call assesses the incident, consults with the first officer on the scene, and decides whether to assume the role of Incident Commander. Supervisors are automatically notified of every "EDP call" but whether they are sent to the call depends on their availability.

67. In all other circumstances, it is up to the discretion of first responding officers whether they require additional support. In these circumstances, these officers can request the attendance of a Supervisor.

68. In light of the fact that currently only front line supervisory officers, the ETF and supervisors of high-risk units carry conducted energy weapons (CEWs), officers responding to calls involving a person in crisis who is wielding a weapon or is otherwise perceived to be dangerous often request the attendance of a Supervisory Officer.[60] This gives officers the option of using a CEW if the incident evolves in a manner in which the officers conclude that the CEW is the most appropriate use of force. The circumstances under which a CEW should be used are addressed in further detail in Chapter 12 (Equipment).

(e) *Emergency Task Force*

69. The Emergency Task Force, the Service's tactical unit assigned to deal with high-risk situations such as hostage takings, barricaded persons, risky arrests, terrorism threats, warrant service, and protection details, also monitors all calls involving a person in crisis, including incidents where suicide prevention skills may be needed.[61] The ETF decides which incidents involving people in crisis warrant its intervention, although the ETF is aware that these incidents often unfold too quickly for it to be able to arrive on-

[58] TPS, "Procedure 06-04", *supra* note 24 at 6-7.

[59] *Id.* at 1.

[60] High-risk units include Public Safety and Emergency Management, the Intelligence Division, Organized Crime Enforcement (including Hold-Up and Toronto Drug Squad) and the Provincial Repeat Offender and Parole Enforcement (ROPE) and Fugitive Squad carry Conducted Energy Weapons. See Chief William Blair, "#P47Annual Report: 2013 Use of Conducted Energy Weapons" (Report presented to the Toronto Police Services Board, 13 March 2014).

[61] TPS, "Communications Services", *supra* note 51 at C.6.1.6; Toronto Police Service, Procedure 10-05 "Incidents Requiring the Emergency Task Force" (Toronto, ON: Toronto Police Service, 2011) at 3.

scene from its central location. The Review has been told that the ETF aims to attend all incidents involving a person in crisis where the person is barricaded; however, the ETF assesses whether they have the capacity to attend that call based on its own availability. All calls involving a barricaded person receive a high priority.

70. The mandate of this Review includes examining policies, procedures and practices relating to the ETF. I discussed the role of the ETF with several of the individuals with whom the Review team met, and reviewed data and documentation regarding the ETF. Overall, in its dealings with people in crisis, and more broadly, the ETF is widely viewed as highly trained and effective, and indeed as a model of successful de-escalation, containment and non-violent resolution of incidents. There were no stakeholder submissions that recommended improvements to the ETF. None of the five shootings of people in crisis in the 2002-2012 period that are referenced in Chapter 3 (Context) involved the ETF, and the Review was advised that, in its history, the ETF has fatally shot two people in crisis, both of whom had taken hostages. On the whole, my impression from all of the information received is that the primary significance of the ETF in connection with the subject matter of this Review is that this skilled unit can be looked to for guidance in teaching other members of the Service how best to handle encounters with people in crisis.

(f) *Mobile Crisis Intervention Teams*

71. As set out above and discussed in greater detail in Chapter 11 (MCIT and Other Models of Crisis Intervention), Mobile Crisis Intervention Teams are officer and nurse pairings that provide a second response to people in crisis after the first responding officers have ensured that the incident is safe enough to involve a civilian nurse. MCIT units also do follow-up calls with individuals, make apprehensions under the *Mental Health Act*, and transport people to mental health facilities.

72. Unlike the ETF, which must be notified by Communications Services of all calls involving a person in crisis, it is not mandatory to notify the MCIT from the outset of such a call. Under Procedure 06-04, it is only mandatory for first responding officers to notify the MCIT once they have already arrived at the call. All procedural statements regarding notification of, and consultation with, the MCIT are stated with the caveat "if available," presumably in recognition of the fact that there are insufficient MCIT services to meet the needs of Toronto.[62] As a practical matter, I have heard that when it is determined that an incident is unlikely to be dangerous, the MCIT may act as a first response, either alone or as a co-first response with a Primary Response Unit.

73. In recent years the MCIT has handled roughly 11 percent of calls coded by the TPS as involving an "emotionally disturbed person." This number can be expected to increase in the coming years, as one additional full-time MCIT unit and three additional part-time units are being added to the existing five units to provide some degree of MCIT coverage across all of Toronto. Several stakeholders expressed the view that these additions would not address the totality of demand for the unique services that the

[62] TPS, "Procedure 06-04", *supra* note 24.

MCIT provides. This issue is addressed in greater detail in Chapter 11 (MCIT and Other Models of Crisis Intervention).

C. Points of intersection between the mental health system and the TPS

74. As a result of the overlapping connections between the mental health system and the police in addressing the needs of people in crisis mentioned above, the importance of building bridges, maximizing cooperation, and facilitating communication between TPS and the mental health system cannot be overstated. Below, I discuss the primary current intersections between the mental health system and the TPS.

1. *Apprehensions under the Mental Health Act*

75. Officers are given the power to apprehend people in crisis and bring them to a physician for evaluation. One prominent person in the field characterized officers acting pursuant to their powers under the *Mental Health Act* as "psychiatric ambulances," and a primary mechanism for connecting people in crisis with needed care. This view is supported by other experts in the field.[63]

76. As mentioned in Chapter 3 (Context), section 17 of the *Mental Health Act* gives all police officers in Ontario the power to apprehend persons acting in a disorderly manner in order to take them for examination by a physician, where the person: (a) has threatened or is threatening bodily harm to himself or herself, (b) has behaved or is behaving violently towards another person, (c) has caused or is causing another person to fear bodily harm, or (d) has shown or is showing a lack of competence to care for himself or herself, and where the officer is of the opinion that the person is suffering from a mental disorder that will likely result in serious bodily harm to that person, another person, or serious physical impairment of that person.[64]

77. Physicians and justices of the peace have similar powers under sections 15 and 16 of the *Mental Health Act* to order the psychiatric examination of a person.[65] Physicians can also order that a person be brought in for examination if he or she has reasonable cause to believe that a person subject to a Community Treatment Order has failed to comply with his or her obligations under that order.[66] When a physician or justice of the peace orders a person to be examined, police officers are often called on to apprehend the person concerned and bring them to a specified psychiatric facility for examination.

78. TPS Procedure 06-04 "Emotionally Disturbed Persons," discussed above, governs situations where officers are acting pursuant to their powers under the *Mental Health Act*, including when they are directed by a physician or justice of the peace to apprehend a person under a form. The procedure sets out a process governing police interaction

[63] Brink, *Mental Illness*, *supra* note 40 at 26.

[64] *MHA*, *supra* note 2, s. 17.

[65] *Id.*, ss. 15, 16.

[66] *Id.*, s. 33.3.

with, and apprehension of, "emotionally disturbed persons," and their subsequent admission to psychiatric facilities.[67]

2. *Emergency room transfer of care procedures*

79. Lengthy transfer of care procedures in emergency rooms at many of Toronto's psychiatric facilities are both an obstacle to efficient care for people in crisis, and symptomatic of the uncoordinated relationship between the police and the mental health system. In addition to wasting scarce police resources, these extended delays aggravate the stigma associated with mental health issues by forcing individuals to wait under police supervision, often in handcuffs. Below, I discuss these issues and highlight some possible ways in which they may be addressed.

80. Section 33 of the *Mental Health Act* stipulates that a police officer or other person who takes a person apprehended under the *Mental Health Ac*t to a psychiatric facility must remain at the facility and retain custody of the person until the facility accepts custody.[68] As discussed above, and in Chapter 11 (MCIT and Other Models of Crisis Intervention), though emergency room practices vary, officers and MCIT units often have to wait hours before the hospital will take custody of the individual who they brought in. In certain divisions, the average emergency department wait time is in excess of two hours.[69] The Review was told that wait times can stretch up to eight hours. The Human Services Justice Coordinating Committee Ontario has also reported two to eight hour waits for police officers in emergency departments.[70] Regrettably, these long wait times can create a disincentive for police to bring people in crisis into the mental health system for treatment.

81. Emergency department coordination between TPS and many of the 16 individual psychiatric facilities in Toronto is ineffective. Every minute that an officer or MCIT unit spends waiting in a hospital emergency department is time that the officer or MCIT unit cannot spend helping someone else. These visits also become unnecessarily arduous and anxious experiences that exacerbate the condition of the person in crisis.[71] One officer has stated, "Persons suffering from mental health conditions are not happy to be in police custody and often do not understand why they are there. The stigma of being seated in an ER [emergency room or department] under police guard, often in restraints, adds to the stress of the situation."[72] Similarly, an emergency department staff person has stated, "There is perceived stigma created by having police officers wait

[67] TPS, "Procedure 06-04", *supra* note 24.

[68] *MHA*, *supra* note 2, s. 33.

[69] City of Toronto, *MCIT Coordination*, *supra* note 39 at 11.

[70] Human Services and Justice Coordinating Committees are multidisciplinary committees that operate at the provincial, regional and local level to address issues for people with a serious mental illness, developmental disability, acquired brain injury, drug and alcohol addiction, or fetal alcohol syndrome, who come into contact with the criminal justice system. HSJCCs are discussed in greater detail below. See HSJCC, "Effective Protocols", *supra* note 4 at 5.

[71] *Id.* at 7.

[72] *Ibid.*

with individuals with mental health concerns—this reinforces the notion that they are dangerous when that is not true."[73]

82. Several examples of effective emergency department coordination with the police exist. St. Joseph's Healthcare Hamilton and Mount Sinai Hospital in Toronto have each developed protocols to expedite the hospitals' procedures for assuming custody of a person in crisis brought to the emergency department by the police. In addition, the Human Services and Justice Coordinating Committee Ontario has published a guide to implementing effective coordination.

83. Emergency departments in most hospitals will not assume custody over a patient apprehended under the *Mental Health Act* until a physician evaluates the patient brought in by the police. They take the position that the patient cannot be prevented from leaving the hospital if the police have left and the doctor has not yet seen the patient.

84. In 2012, the Hamilton Police Service and St. Joseph's Healthcare Hamilton developed a protocol to reduce lengthy police wait times in the emergency room, which had averaged 3.5 hours nine times out of ten. According to the new protocol, after a 30-minute wait in the emergency room, an officer can rate the individual's risk level. If the officer determines that the person is a low risk to her or himself, hospital staff, and the public, the officer and an emergency room nurse can sign the form confirming transfer of care to the hospital. The patient is then monitored by the hospital's security staff. The officer is on call to return to the hospital if the individual proves too difficult for hospital security staff to manage.[74]

85. Similarly, at Mount Sinai Hospital in Toronto, the emergency department operates under a practice that they adapted from the Emergency Medical Services' hospital transfer of care procedures. The physician does not have to assume care in order to complete the transfer of care. Nurses can facilitate the transfer of care by first asking the officer or MCIT unit to fill out a form with key details regarding the patient, and then by asking that hospital security staff watch over the patient until the patient is seen by a physician. This type of transfer is permitted except in rare cases where the patient is incapable of being controlled by hospital security staff. The physician may call the officers or MCIT unit that filled out the form with follow-up questions as they arise. As a result, a majority of the time police officers or MCIT units at Mount Sinai Hospital's emergency department are relieved from waiting within 45 minutes of their arrival. Similar practices are in the process of being introduced at some, but not all, of Toronto's psychiatric facilities.

86. Hospitals in the Toronto Central Local Health Integration Network (LHIN), which comprise eight of the 16 psychiatric facilities to which the TPS brings people in crisis, have recently agreed to a protocol outlining best practices for the transfer of care

[73] *Ibid*.

[74] Inspector Randy Graham & Sarah Burtenshaw, OT Reg (Ont), "Collaborative Projects: Hamilton Police Service and St. Joseph's Healthcare Hamilton" (presented at the CACP/MHCC Conference, 25 March 2014), online: Canadian Association of Chiefs of Police <http://www.cacp.ca/media/events/efiles/1465/Burtenshaw_&_Graham.pdf> .

of people in crisis from TPS to the hospital. These protocols attempt to reduce wait times and distribute the volume of patients brought to each facility so that available resources can be used most efficiently. It is hoped that, by standardizing emergency department transfer of care procedures along the lines of the model used at Mount Sinai Hospital, officers will limit their current practice of taking a majority of people in crisis to a small number of psychiatric facilities. The TPS and the psychiatric facilities alike would benefit from greater cooperation and communication in assessing how best to distribute people in crisis between facilities so that people can be brought to facilities with available resources.

87. The Human Services and Justice Coordinating Committee Ontario, discussed below, has published a guide on strategies for implementing effective emergency department protocols for interacting with police. This guide is a valuable resource to be considered alongside the best practices of Mount Sinai Hospital and St. Joseph's Healthcare Hamilton.[75] Among other things, the HSJCC Ontario recommends:

(a) providing cross-sectoral training for police officers and hospital staff about mental health apprehensions;

(b) officers calling ahead to the emergency department when en route with a person in crisis to allow the emergency department to begin to make necessary preparations;

(c) arranging a "quiet room" or other waiting area for police-accompanied visitors to the emergency department;

(d) having adequate staff to manage mental health crisis situations in the emergency department;

(e) designating a liaison in the emergency department to work with police officers when they arrive with a person in crisis;

(f) establishing a written agreement between police services and hospitals that sets out specific procedures, expectations, and respect for patient rights, including privacy rights; and

(g) conducting routine monitoring and evaluation of the protocols put in place, and making any changes warranted.[76]

88. I did hear of an approach adopted in one TPS division under which MCIT units that bring a person in crisis to the emergency department are relieved from waiting with that individual by another officer at the request of the Staff Sergeant. While this

[75] HSJCC, "Effective Protocols", *supra* note 4.

[76] *Id.* at 8.

approach frees up the valuable MCIT unit that is in short supply, this practice is not an overall solution to emergency department wait-times.[77]

3. *Mobile Crisis Intervention Teams and their oversight*

89. A key resource at the intersection of the mental health system and policing are the Mobile Crisis Intervention Teams, discussed in greater depth in Chapter 11 (MCIT and other Models of Crisis Intervention). To manage MCIT and expand its services across Toronto, the TPS must engage with at least 10 healthcare-based organizational partners. Funding for MCIT police officers is provided by the TPS, while funding for MCIT nurses is provided by one or more of four Toronto-area Local Health Integration Networks that oversee the relevant partner hospital. The MCIT partnerships with St. Michael's Hospital, St. Joseph's Health Centre, and Toronto East General Hospital are funded by the Toronto Central LHIN; the partnership with North York General Hospital is funded by the Central LHIN; the partnership with Humber River Regional Hospital is funded by both the Central and the Central West LHINs; and the partnership with the Scarborough Hospital is funded by the Central East LHIN.[78]

90. In October, 2012, the Toronto Central LHIN established an MCIT Coordination Steering Committee to institutionalize the management and coordination of the MCIT partnerships. The purpose of the committee is to lead the development of a standardized model for MCITs in Toronto that includes integration with the continuum of crisis care and other local mental health services. It examines the current state of MCIT and studies ways in which the program can be expanded in a manner that meets the needs of the population using crisis services.[79] The Steering Committee is co-chaired by TPS Deputy Chief Michael Federico and Rob Devitt, CEO of Toronto East General Hospital, and includes representatives from the following stakeholders: Toronto Police Service, current MCIT officers and nurses, the three relevant LHINs, Mental Health and Addictions Services Access, Emergency Medical Services, the Acute Care Alliance, the City of Toronto Mental Health Promotion Program, and mental health and addictions crisis services.[80]

4. *Officers in charge of mental health coordination*

91. Divisional Mental Health Liaison Officers are senior constables within the TPS who coordinate with external mental health organizations and groups on issues at the intersection of mental health and policing at the local level, such as apprehensions under the *Mental Health Act*, and emergency department wait times. They attend all local Human Services and Justice Coordinating Committee meetings.

---

[77] In Ottawa, psychiatrists and constables that are part of the city's Mental Health Crisis Intervention Units conduct field visits and consults at the homes of individuals in need. While not a solution to wait times at hospitals, these at -home examinations avoid the need to see a psychiatrist in hospital at all, preserving those resources for emergency situations. See Ottawa Police Service, "Policies, Training, Procedures & Equipment – Use of deadly force/response to emotionally disturbed persons" (Ottawa, ON: Ottawa Police Service, 2013) at 2-4.

[78] Toronto Police Service, "Mobile Crisis Intervention Teams (MCIT)" (2014), online: Toronto Police Service <http://www.torontopolice.on.ca/community/mcit.php>.

[79] Toronto Police Service, "Toronto Police Response to Emotionally Disturbed Persons" (2013) at 5, online: Toronto Police Service <http://www.torontopolice.on.ca/community/tps_response_to_edp.pdf>.

[80] *Ibid*.

92. Procedure 06-04 directs Divisional Mental Health Liaison Officers to coordinate any divisional community mental health needs through community service providers; liaise with mental health professionals in the community and ensure the division's officers are aware of services in the community; liaise with the Mental Health Coordinator, who is the officer in charge of community mobilization with respect to vulnerable persons; and, finally, ensure that hospitals in the division have a sufficient supply of forms for transferring care.[81]

93. The TPS Mental Health Coordinator is a central resource person who directly oversees the Service's mental health portfolio. Under Procedure 06-04, the Mental Health Coordinator is directed to liaise with all Divisional Mental Health Liaison Officers, MCIT units, psychiatric facilities, and other external agencies in regard to issues related to mental health.[82] The Mental Health Coordinator also attends all regional and provincial Human Services and Justice Coordinating Committee meetings on behalf of the TPS.

94. Both of these roles are intended to serve an external consultation and coordination function.

5. *Human Services and Justice Coordinating Committee*

95. TPS plays an active role in Toronto's and Ontario's Human Services and Justice Coordinating Committees. These are multidisciplinary committees that address systemic coordination issues for people who come into contact with the criminal justice system who have a serious mental illness, developmental disability, acquired brain injury, drug and alcohol addiction, or fetal alcohol syndrome. These Committees bring together healthcare service providers and representatives from the criminal justice system to "find solutions to the problem of the criminalization of people with the defined unique needs" and "to develop a model of shared responsibility and accountability in dealing with this group of individuals at points of intersection with the justice system."[83] These committees were established in the late 1990s and operate at the provincial, regional and local levels.

96. Deputy Chief Federico, his executive officer, and Constable Diana Korn-Hassani, TPS Mental Health Coordinator and MCIT Coordinator, represent the Service at regional and provincial HSJCC meetings.

6. *The Mental Health Sub-Committee and the involvement of the mental health community*

97. A significant development in the interaction between the TPS and members of the community of people who have mental health issues is through the Mental Health Sub-Committee of the Toronto Police Services Board (TPSB). Through membership on the Sub-Committee, people with lived experience of mental illness have become

[81] TPS, "Procedure 06-04", *supra* note 24 at 8.

[82] *Id.* at 9.

[83] Provincial Human Services and Justice Coordinating Committee, "Goal and Objectives of the Provincial HSJCC", online: HSJCC <http://www.hsjcc.on.ca/Provincial/SitePages/Default.aspx>.

involved in TPS efforts in this area. The Mental Health Sub-Committee was established in 2009 to examine the complex policing issues related to mental health. It is designed to be a mechanism to facilitate ongoing dialogue with the community and other mental health-related stakeholders in order to enable the TPSB to address mental health issues in an informed manner.[84]

98. As mentioned in Chapter 3 (Context), the Sub-Committee's composition is an important mechanism through which the perspective of those who have experienced mental health issues is brought to bear. The Sub-Committee is co-chaired by a leading advocate on behalf of those with mental health issues and by the Chair of the TPSB. Members also include representatives from mental health treatment organizations, the TPSB, the Service, and the wider community.

99. One of the Sub-Committee's main initiatives has been its community consultation process, conducted through public meetings and written submissions, concerning the Service's potential expansion of use of CEWs. The Sub-Committee produced a report that summarizes its consultations, and recommended that CEW use not be expanded at this time. The report raised key concerns, including the position that CEWs should not be considered a substitute for de-escalation and communication, and that there is a paucity of medical evidence regarding the health effects of CEWs, among other concerns.[85] The majority of deputants supported that view.

100. The Sub-Committee has also played an active role in reviewing, and recommending improvements to, training and the Service's initiatives for helping people in crisis, including the MCIT.

101. In spite of the positive effort undertaken to create the Mental Health Sub-Committee, a wide variety of stakeholders and others who spoke to the Review expressed the view that there still is insufficient contact between people with mental illness and individual police officers outside of ordinary policing duties. Many people suggested that there is a mutual stigma between people with mental illness and police officers, which can be reduced if the two groups spend more time with each other and become more familiar on an individual level.

7. *Information sharing, privacy, and physician-patient confidentiality*

102. Information-sharing issues are an obstacle to effective coordination between the TPS and the mental health system with respect to people in crisis. Individuals have a reasonable expectation of privacy in their healthcare information, as protected by the *Personal Health Information Protection Act, 2004* (PHIPA),[86] and healthcare institutions must protect physician-patient confidentiality.

---

[84] Alok Mukherjee, "Submission from Community Members of the Board's Mental Health Sub-Committee Regarding Expanded Deployment of Conducted Energy Weapons" (Report presented to the Toronto Police Services Board, 8 October 2013), online: Canadian Mental Health Association <http://ontario.cmha.ca/files/2013/11/agendadoc.pdf> at 13-14.

[85] *Id.* at 16-17.

[86] *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3, Sch. A.

103. The issue of sharing mental health information is a controversial and sensitive issue. It would be useful if TPS officers were able to receive mental healthcare information in situations involving a person in crisis, with the caveat that strict limitations need to be placed on the use and subsequent disclosure of that information in order to respect patient privacy. Some measures for information sharing may require legislative or regulatory change. This is an area of cooperation that requires all interested groups, including policing, civil liberties, mental healthcare, and people who have experienced mental illness, to come together to find a way forward. Their common goal should be to give the police access to all information that could enable them to help people in crisis while respecting individuals' privacy by limiting other uses of that information.

104. As discussed above, it is clear that in certain circumstances, many of which arise in serving people in crisis, the Toronto Police Service carries out a role that is integral to mental healthcare services, and in effect, police officers become part of the care pathway for people in crisis.

105. As discussed in Chapter 11 (MCIT and Other Models of Crisis Intervention), one of the tensions in the MCIT model is that there are two separate sources of information: the police database and the healthcare system. A point of uncertainty that warrants resolution is whether people in crisis may benefit if MCIT officers and nurses are permitted to share information with each other that they access from their respective positions within the police and healthcare system. In practice, it may be impracticable not to share this information if the MCIT unit is to function efficiently and in the best interests of the person in crisis.

106. There are some circumstances, formalized through legislation, where individual healthcare providers are permitted to share healthcare information among healthcare providers. The Information and Privacy Commissioner of Ontario emphasizes the concept of the "circle of care" that, while not a defined term in the PHIPA, is "commonly used to describe the ability of certain health information custodians to assume an individual's implied consent to collect, use or disclose personal health information for the purpose of providing healthcare."[87] The key point is that, as a general rule, organizations that are health information custodians, as defined in PHIPA, can share individual healthcare information with other health information custodians for the purposes of the provision of healthcare services.[88] This is one example of a situation where people in crisis would benefit from interested parties coming together in a constructive manner to build greater cooperation.

107. The recent Coroner's Inquest into the death of Douglas Minty produced a recommendation for an experiment that could assist people who may find themselves in crisis to share their healthcare information with the police, while also respecting their

[87] Ann Cavoukian, *Circle of Care: Sharing Personal Health Information for Health-Care Purposes* (Toronto, ON: Information and Privacy Commissioner, Ontario, 2009) at 5, online: Information and Privacy Commissioner, Ontario <http://www.ipc.on.ca/images/Resources/circle-care.pdf>.

[88] It may well require a legislative change for TPS to be considered a health information custodian and therefore eligible to be considered part of the circle of care. *Id.* at 19.

privacy rights. The Coroner's Jury recommended that the Government of Ontario consider establishing a voluntary registry for vulnerable persons, with due consideration to privacy rights, that would only be accessible to emergency responders in the event of a crisis situation.[89] This registry could include a consent to access the individual's healthcare information or history in a crisis situation. Efforts can be made to promote the registry within community organizations in order to encourage its adoption. In this cooperative manner, people who foresee that they may be in crisis in the future can voluntarily give the police advance access to their healthcare information for the purposes of addressing a potential future crisis. Because it is voluntary, this approach would likely not address the needs of all people in crisis, but it could be a positive step in the right direction.

II. Overview of Issues Highlighted by Stakeholders

A. The mental health system

108. One of the most common themes emanating from the submissions of a wide variety of stakeholders from all communities consulted, including those at the highest levels of the healthcare system, was that resources devoted to mental health treatment and community supports, housing supports, outpatient teams, social work, peer support and other resources are inadequate. Several stakeholders directly linked these inadequate supports to the high volume of crisis calls and apprehensions under the *Mental Health Act*. One stakeholder from the healthcare system succinctly stated:

> as a community and as a society, we need to look beyond police roles and also determine whether better access to mental health and addiction services could prevent future tragedy. Enhanced, timely and smooth access to community and hospital based crisis services, early intervention programs, justice diversion programs, community case managers, supportive housing, recreational and employment opportunities and anti-stigma strategies are some examples of services that can either prevent individuals going into crisis and/or adequately support those when they are in crisis.

109. That stakeholder concluded that the task of effectively minimizing the use of lethal force by the TPS with people in crisis rests squarely with both the TPS and the mental health system. To focus on what the TPS should do in isolation, separate from the mental health system, may result in only short-term solutions. To ensure a sustainable solution, the mental health system must also play a key role.

110. Some stakeholders went further to suggest that, in considering jail diversion mechanisms, it is also necessary to consider how to lower the number of apprehensions

[89] The lethal encounter between Douglas Minty and the Ontario Provincial Police did not occur in the City of Toronto, but the recommendation discussed is nonetheless relevant. See Office of the Chief Coroner, *Verdict of Coroner's Jury: Inquest in the death of Douglas Minty*, "Jury Recommendations" (Toronto, ON: Queen's Printer for Ontario, 2014) at recommendation 8.

under the *Mental Health Act*, as any deprivation of an individual's liberty is a serious act. These stakeholders noted that funding for adequate community supports and mental health treatment is therefore crucial in preventing crises and avoiding the need to deprive individuals of their liberty.

B. The Toronto Police Service

111. It is important to note that several of the healthcare organizations that made submissions began by thanking the Toronto Police Service for its professional and kind handling of the vast majority of people in crisis, and for safely transporting these individuals to psychiatric facilities in Toronto. These stakeholders recognize that the role of the TPS under the *Mental Health Act* is, in part, that of an ambulance acting without the assistance of medical professionals. One such stakeholder suggested that it may be useful for the TPS and psychiatric facilities to formally acknowledge this *de facto* situation as a starting point for achieving greater cooperation.

112. One community mental health organization highlighted that the onus is often placed on the police to attend to the needs of a person in crisis, help connect them to the appropriate mental health services, and resolve any conflicts in community settings in a peaceful manner, all within the context of a deficient mental health system. The stakeholder concluded, "clearly, this is an unreasonable expectation."

113. One stakeholder suggested that the TPS develop toolkits or other resource materials with information on mental illness and available resources for officers to give to people in crisis or their family members.

114. Finally, a stakeholder highlighted the importance of TPS call-takers and dispatch personnel obtaining as much information as possible, especially regarding whether a call involves a person in crisis, and subsequently communicating that information to officers on the ground. This stakeholder suggests that training for call-takers and dispatch personnel could be honed to focus on better ways to seek and incorporate this information.

C. Points of intersection between the mental health system and the TPS

115. Many stakeholders noted the need to streamline emergency department procedures for transferring care of someone brought to the psychiatric facility under the *Mental Health Act*. One healthcare stakeholder noted that the healthcare system's failure to recognize that a person brought to the psychiatric facility is a patient experiencing a medical emergency is reflected in the gross delay, often of many hours, that the patient experiences before the hospital accepts care over the patient from the police. Psychiatric emergencies seem to be the only medical emergency that the healthcare system defers to non-medical professionals for management for such a long period at the outset of the emergency. This stakeholder recommended that hospitals should consider patients brought in by TPS officers under the *Mental Health Act* to require immediate medical attention. Further, this stakeholder noted that the lack of a provincial protocol guiding the transfer of care of people in crisis from police to

psychiatric facilities is a considerable failing on the part of the healthcare system. This protocol should set out a service time standard for transferring care, the information that should be communicated, when restraints are to be used and how assessments are to be conducted.

116. Some of the hospitals in Toronto that receive psychiatric patients in their emergency departments commented that, at times, it seems that the TPS needs to better educate its officers about the nature of their role under the *Mental Health Act* and the authority of the hospital in conducting transfer of care assessments and procedures. An issue that has been raised is that officers may require further education on their role in the healthcare setting and on the importance of respecting the privacy inherent to the physician-patient relationship.

117. Some community mental health organizations suggested that the TPS foster more extensive partnerships with community mental health organizations, as the police, mental health treatment, and community social services cannot effectively address the needs of people in crisis while operating in silos. As noted in Chapter 3 (Context), the forging of such partnerships was one of the three recommendations relating to "emotionally disturbed persons" in the 1997 Use of Force Committee Final Report.

118. Several stakeholders recommended cross-sector training between the TPS, mental health organizations and social service agencies to enhance mutual understanding and coordination of roles. Several stakeholders also suggested that the TPS needs to be more proactive in educating officers about the full range of mental health resources at their disposal, especially in regard to community mental health resources and other social services. Representatives from these organizations can come to TPS divisions to speak to officers about what their organizations do, and how they can work together.

119. Stakeholders from all sides of the issue, including some civil liberties organizations, acknowledge that it is possible to find a solution to sharing healthcare information with the police to help in situations involving a person in crisis while also being respectful of that individual's privacy rights. A key part of this solution should be the development of a protocol that places clear limits on the circumstances under which that information can be shared as between mental healthcare organizations and the police, and also imposes clear limits on the use and further disclosure of that information to other government agencies. Practices that involve further sharing of healthcare information with other government agencies can have the effect of unduly limiting the individual's rights in other circumstances. For example, the Review has learned that police-observed mental health information that is placed in police databases can have the effect of limiting the individual's mobility at times because it is shared with Canada Border Services. Such widespread sharing of healthcare information cannot be tolerated in any protocol developed to access healthcare information in order to help people in crisis.

III. Recommendations

120. Before setting forth recommendations on the issues discussed in this chapter, I believe it is important to pause, and as one stakeholder said, to look beyond the role of the police in order to consider the availability of improved access to mental healthcare and other services, to prevent tragedies involving people in crisis in encounters with the police. There are a myriad of factors that can prevent individuals from going into crisis, and, if they do, a variety of factors affect how they can be effectively helped. These factors include enhanced, timely, and better access to community- and hospital-based crisis services, early intervention programs, justice diversion programs, supportive housing, anti-stigma policies, and so on.[90]

121. All this illustrates the fact that police officers are involuntarily drawn into mental health and related fields when dealing with a person in crisis. To make real improvements in this area, many of the recommendations called for in this section of the Report should be directed at agencies, institutions, and indeed governments—whether municipal, provincial, or federal—and not at the police. But my mandate does not permit this, nor does the TPS have direct control or responsibility over many of these issues. Yet, if these matters are not addressed, we will not achieve the elimination of tragedies that have resulted. In short, the police are limited in what they can do even if they improve their role in ways advocated in this Report.

122. In view of this sobering reality, I have expressed some of my recommendations by urging the TPS to take a leading role to advocate needed improvements in the many surrounding areas that impact people in crisis. As noted above, the TPS is ideally suited to play this role, and I sincerely hope its advice is followed.

123. I recommend that:

> **RECOMMENDATION 1**: The TPS create a comprehensive police and mental health oversight body in the form of a standing inter-disciplinary committee that includes membership from the TPS, the 16 designated psychiatric facilities, the three Local Health Integration Networks covering Toronto, Emergency Medical Services, and community mental health organizations to address relevant coordination issues, including:
>
> (a) Sharing Healthcare Information: developing a protocol to allow the TPS access to an individual's mental health information in circumstances that would provide for a more effective response to a person in crisis. This protocol must respect privacy laws and physician-patient confidentiality, and should address:
>
> i. whether, in consultation with the Government of Ontario, the concept of the "circle of care" for information sharing can be expanded to include the police, in circumstances beneficial to an individual's healthcare interests;

[90] Cross-reference para.109

ii. how healthcare, treatment and planning information with respect to people with repeated crisis interactions with the police can be shared with the TPS while respecting all relevant privacy and physician-patient confidentiality concerns; and

iii. more specifically, how healthcare information shared with the TPS can be segregated from existing police databases and therefore prevented from subsequently being passed on to other law enforcement, security and border services agencies. Healthcare information should continue to be treated as such, and not as police information;

(b) Voluntary Registry: the creation of a voluntary registry for vulnerable persons, complementing the protocol recommended in (a), which would provide permission to healthcare professionals to share healthcare information with the police, only to be accessed by emergency responders in the event of a crisis situation and subject to due consideration to privacy rights;

(c) Mutual Training and Education: how psychiatric facilities, community mental health organizations, and the TPS can benefit from mutual training and education;

(d) Informing Policymakers: informing policymakers at all levels of government, in the aim of making the mental health system more comprehensive;

(e) Advocacy: advocating more comprehensive and better-funded community supports for people with mental illness. This would be a multi-party initiative led by the mental health sector. It should include, among other things, planning for community treatment supports upon discharge from the hospital, and the creation of more "safe beds" in shelters for people in crisis, to be used when they do not meet the criteria for apprehension under the *Mental Health Act* but need assistance to stabilize their crisis, and including;

(f) Reducing Emergency Department Wait Times: a standardized approach to reducing emergency department wait times for police officers bringing in a person in crisis and transferring care to the hospital. Some relevant measures to be considered include:

i. developing a standard transfer of care protocol that minimizes emergency department wait times, and across Toronto's 16 psychiatric emergency departments. This protocol may build on existing efforts underway;

ii. providing cross-sectoral training for officers and emergency department staff about apprehensions under the *Mental Health Act* and transfer of care;

iii. ensuring adequate communication between officers and emergency departments when en route with a person in crisis to allow the emergency department to make necessary preparations;

iv. arranging a separate waiting area for police-accompanied visitors to the emergency department;

v. having adequate staff to manage mental health crisis situations in the emergency department;

vi. designating a liaison in the emergency department to work with police officers when they arrive with a person in crisis;

vii. developing a protocol between police services and hospitals that sets out specific procedures, expectations, and respect for patient rights;

viii. conducting routine monitoring and evaluation of the protocols put in place, and making any changes warranted;

ix. developing a protocol for how psychiatric facilities' emergency department capacities can be effectively communicated to officers in a timely manner; and

x. developing a protocol to address how people apprehended under the *Mental Health Act* can be equitably distributed among Toronto's 16 psychiatric facilities to ensure the best medical treatment and shortest emergency department wait times; and

(g) Other Matters: any other matters of joint interest.

RECOMMENDATION 2: The TPS more proactively and comprehensively educate officers on available mental health resources, through means that include:

(a) Mental Health Speakers: inviting members of all types of mental health organizations to speak to officers at the divisions;

(b) Technological Access to Mental Healthcare Resources: considering the use of technological means, similar to Vancouver's "Dashboard" system, to efficiently communicate to officers a comprehensive up-to-date list or map of available mental health resources of all types

in their area. Such an easily accessible reference tool should aggregate information on all community supports, in addition to major psychiatric facilities; and

(c) Point of Contact: working with mental health organizations to identify key resource people or liaisons, so that every TPS officer has a contact in the mental health system that they feel comfortable contacting for advice and who is able to knowledgeably give that advice.

RECOMMENDATION 3: The TPS amend Procedure 06-04 "Emotionally Disturbed Persons" to provide for the mandatory notification of MCIT units for every call involving a person in crisis.

RECOMMENDATION 4: The TPS, either through the Mental Health Sub-Committee of the Toronto Police Services Board or another body created for this purpose, consider ways to bridge the divide between police officers and people living with mental health issues. This initiative, in furtherance of the formal commitments recommended in Recommendation 5, and building on the mandate for community-oriented policing placed on all police services in Ontario under section1 of the *Police Services Act*, may include:

(a) Divisional Meetings: inviting members of the community of people who have experienced mental health issues into Divisional meetings to speak with officers;

(b) Community Gathering Places: officers building collaborative relationships with people who have experienced mental health issues at drop-ins, clubhouses, and other gathering places; and

(c) Leadership: the TPS Mental Health Coordinator and Divisional Mental Health Liaison Officers facilitating the initiatives in subsections (a) and (b), as well as other relationship-building and de-stigmatizing programs.

CHAPTER 5

Police Culture

CHAPTER 5. POLICE CULTURE

Table of Contents

Page

I. THE CURRENT SITUATION 117

A. The role of police culture 117
B. Forming and changing police culture 118
C. The culture of the Toronto Police Service 119
(1) Selected positive elements of TPS culture 120
(2) Areas for improvement 122

II. OVERVIEW OF ISSUES HIGHLIGHTED BY STAKEHOLDERS 124

III. RECOMMENDATIONS 125

Statement of TPS commitments relating to people in crisis 125

Chapter 5. Police Culture

1. This chapter addresses the role that police culture plays within the Toronto Police Service, as it relates to the issues addressed in this Review.

2. Although the topic of police culture is not one of the enumerated topics in my mandate, the issues posed by police culture are embedded within many of the enumerated topics, and it arises in some form in each of the other chapters of this Report. In this chapter, I address some overarching issues relating to TPS culture.

3. When I refer to police culture, I mean the prevailing attitudes, beliefs and values of members of the Service. The culture of the TPS is manifested in the way that members treat one another, including the various pressures that members exert on one another to conform to a certain manner of behaving and speaking, both inside and outside the TPS. The culture is also manifested in the way that members of the TPS treat those outside the organization with whom they interact as part of their work, and in the approach and methods used by members in carrying out their work.

4. This chapter is structured around the following topics. First, I discuss in broad terms the role that police culture plays in determining police behaviour. I then discuss some of the key factors that help to mold police culture over time, and I comment on what must occur in order to modify police culture in a proactive manner. The next section of the chapter is a discussion of key elements of the TPS culture that I observed and was informed about that are relevant to the subject matter of the Review. The culture of the Toronto Police Service includes many salutary elements that deserve to be acknowledged and reinforced. Along with my discussion of these positive elements, I also address the elements of TPS culture that, as is the case in every organization, merit examination to see if they can be improved.

I. The Current Situation

A. The role of police culture

5. A statement that the Review heard from several people, including not only outside stakeholders, but also senior members of the TPS, is that “culture eats training.”

6. In other words, regardless of how effective a training regime may be, the training will not cause the desired behaviour if the attitudes, beliefs, and values of the majority of people in the organization are inconsistent with the training. As a practical matter, formal police training is relatively brief, and occurs largely at the police colleges. Culture, on the other hand, surrounds police officers at their workplace, and is present in all interactions. Culture must align with the training in order for the training to be effective over the longer term. The pressure to conform to the prevailing culture is significant, and the lessons of training will be ineffective if they conflict with the practice in the field and the expectations of fellow officers and supervisors.

7. It is for this reason that, although proper training is critical and should continue to be improved as discussed in Chapter 7 (Training), equal if not greater attention must be given to the work environment, which is the primary focus of this chapter and of Chapters 4 and 8-13 of this Report.

B. Forming and changing police culture

8. How, then, do police attitudes, beliefs, and values get formed—other than through training? In part, they are formed by the prevailing attitudes, beliefs, and values in society. Thus, for example, as Canadian society has seen improvements relating to the perception of women and minorities in recent decades, the TPS has seen similar trends in its culture.

9. Nevertheless, there are clearly some differences between TPS culture and societal culture more generally. Obvious examples include the para-military command structure of the Service, and the necessity for the police to resort to force in certain circumstances. Another notable difference is that officers of the Toronto Police Service, like all police officers, hold themselves out to society as exemplars of honourable conduct, bravery, and public service. It is, in fact, these latter commitments that contribute to the strength of the negative public response to actions by police officers who do not meet the high standards they have set for themselves.

10. TPS culture is forged and maintained by a variety of influences. Some influences centre around specific people, including leaders such as the Chief of Police, deputy chiefs, and unit commanders. At the divisional level, key leadership roles are played by coach officers, platoon sergeants, and influential fellow officers. The attitudes, beliefs, and values of people in these leadership positions have a major influence on other members of the Service, influencing these other members to develop similar views and approaches, whether as a result of formal command, implied expectation, feelings of loyalty, or otherwise.

11. Another important influence on TPS culture is the organization's formal value structure, as expressed through its Vision Statement and Mission Statement, its ethical principles, and its Standards of Conduct. The extent to which the TPS implements these values at a practical level can have a significant effect on the self-perception of those within the Service, and on the trust and confidence of the public in the Service.

12. At a more subtle level, but arguably no less important, the Service's procedures and standard practices influence the way that TPS members view their environment and the people with whom they interact. Procedures and practices by their nature give priority and importance to the issues addressed in them, thus sending a message as to the relative unimportance of matters not covered. They also dictate how TPS members are required to comport themselves.

13. Finally, the positive and negative reinforcements that are in place to encourage and deter certain behaviours are also relevant in setting TPS culture. Positive reinforcements include promotions (and the criteria for promotion), awards, and other recognitions, as well as less visible factors such as peer acceptance, rapport with more

senior officers, and the status associated with particular roles within the Service. Negative reinforcements include disciplinary sanctions, negative notations in one's personnel file, disapproval of senior officers, low status assignments, and peer pressure to conform.

14. Changing the culture of any group of people is a gradual process. Its effectiveness is, at the early stages, difficult to discern—analogous to changing the direction of a ship. A single change may at first seem ineffective. But over time, and cumulatively, a series of small changes can produce a definite shift in behaviour.

15. In order to proactively change organizational culture, the first step is to identify the cultural feature (the attitude, belief, or value) that is viewed as being in need of change, and the reasons for the change. The next step is to design a series of incentives, both positive and negative, to encourage members of the organization to change. The incentives may be simply informational—showing, for example, that a belief is based on inaccurate factual assumptions. The incentives may also be more substantive such as the incentives described above. But incentives alone are insufficient. They must be brought alive by leaders at all levels of the organization. There must be leadership not only at the top, but throughout the Service, including at the divisional and platoon level. Changes in culture occur where people actually live and work.

16. The leaders within the organization must help members understand why they should want to change their behaviour by persuading them of the rightness of the goal sought to be attained. Members should not feel that they are being directed to act a certain way solely because of outside criticism or political concerns. Rather, they should come to their own conclusion that the behaviour they are being asked to adopt is effective, honourable, professional, and fair. When that happens, the cultural trait becomes normalized—it becomes an expected, appropriate part of the environment. Eventually, it becomes socially unacceptable not to have that trait.

17. One can think of racial equality as a simple but obvious example of this phenomenon. Not very long ago in our country, it was socially acceptable to treat members of certain racial groups inequitably on the purported basis that they were somehow different or less deserving. Our legislatures even passed laws to this effect. Today, it is wholly unacceptable to treat people in such a way. This is a huge change in culture. And what a significant and beneficial change it is. The point to be emphasized from this example is that changing group culture is entirely achievable, and the gains can be very significant indeed.

C. The culture of the Toronto Police Service

18. The culture of the TPS has both positive and negative elements. The Review received a considerable amount of information about both.

19. It is important, in describing the Service's culture, not to transform stories about particular events involving the police into generalizations about the culture of the entire organization. The Review heard first-hand accounts of great heroism by individual TPS officers, and also first-hand accounts of abusive and disrespectful conduct by individual

officers against vulnerable citizens. However, my conclusion is not that the TPS culture as a whole is either entirely heroic or entirely abusive. Cultural traits are more subtle.

20. In the paragraphs that follow, I set out my observations and understanding regarding features of the general TPS culture that are relevant to the Review. I begin with a discussion of selected positive elements of the culture, of which there are many. I then move on to discuss some areas for improvement.

1. *Selected positive elements of TPS culture*

21. Mental health awareness: As discussed above, the TPS has undertaken a number of initiatives in the past 20 years to focus on the proper police response to people in crisis, including studies like the Use of Force Committee Final Report and this Review, training initiatives and the introduction of the MCIT program.[1] It is apparent that attitudes within the TPS relating to people in crisis have changed over time. People in crisis are now a strong focus of police attention. The TPS has taken steps to try to dispel stereotypes and misinformation about mental illness by, for example, integrating the perspectives of people with lived experience of mental illness into the training program.

22. Both positive and negative reinforcement of this attitudinal shift can be found in TPS governance documents. For example, the TPS has adopted a statement of seven Core Values. One of the core values is Fairness, which is described as requiring TPS members to treat everyone in an impartial, equitable, sensitive, and ethical manner. Similarly the core value of Respect is defined in part as requiring TPS members to show understanding of peoples' differences.[2] The TPS Code of Conduct[3] confirms that it is Discreditable Conduct (a form of misconduct that is subject to disciplinary sanction) for a police officer to "fail to treat or protect a person equally without discrimination with respect to police services because of that person's...disability."[4]

23. Wellness: The Service's internal culture of mental health wellness is reasonably strong. Several individuals with whom the Review team met commented on the significant improvements in the wellness culture over the past 15 years, as exemplified by a number of initiatives that include the hiring of in-house police psychologists, the requirement of mandatory meetings with the psychologists for some high-risk personnel, and several other initiatives, which are discussed in more detail in Chapter 9 (The Mental Health of Police Personnel). There is more openness within the organization today than there was previously, and members feel more comfortable discussing mental health issues. This is an ongoing evolution, but some individuals noted that there is still more room for improvement.

---

[1] For a more detailed review of these initiatives, see Chapter 3 (Context).

[2] Toronto Police Service, *Service Governance Standards of Conduct* (Toronto, ON: Toronto Police Service, 23 December 2013) at 7-8 [TPS, *Service Governance Standards*]. See also Toronto Police Service, "Mission Statement" (2014), online: Toronto Police Service <http://www.torontopolice.on.ca/careers/mission-core.php>.

[3] Which is adopted from the Code of Conduct set out as a Schedule to O. Reg. 268/10 under the *Police Services Act*, R.S.O. 1990, c. P.15.

[4] TPS, *Service Governance Standards*, *supra* note 2 at 12.

24. Accountability: The TPS is increasingly embracing technological tools that reflect a commitment to public accountability—most notably in the area of cameras (in-car cameras, cameras in police cells, and a new initiative relating to body-worn cameras, as discussed in Chapter 12 (Equipment)), as well as other recording devices such as lapel microphones for front line officers.

25. Service: The TPS has an institutional focus on public service. One overt illustration of this focus arose in the 1990s, when the name of the organization was changed from the Metropolitan Toronto Police Force to the Metropolitan Toronto Police Service, in order to reflect the greater emphasis on service. The motto of the TPS is "to serve and protect." The TPS Mission Statement describes the Service's dedication to delivering police services in partnership with its communities, and the TPS Vision Statement expresses the Service's commitment to delivering police services that are sensitive to the needs of its communities, involving collaborative partnerships and teamwork to overcome all challenges. The Vision Statement states that the TPS measures its success by the satisfaction of its members and its communities.[5]

26. Institutional leadership and continuous self-improvement: The TPS Vision Statement expresses the Service's commitment to "being a world leader in policing through excellence, innovation, continuous learning, quality leadership and management."[6]

27. The Service recently reaffirmed this vision, with particular reference to bias-free policing that is respectful of human rights, in the Report relating to Phase II of the Police and Community Engagement Review (PACER Report) that was publicly released in October 2013.[7] The vision statement of the PACER Report is that "the Toronto Police Service will be a world leader in bias-free police service delivery."[8] The report confirms that the Service "is continuously striving to find the right combination of strategies that protect the public and promote human rights," and that "it is critical for the Service to continue to support its Members by providing the necessary tools and training required for the delivery of police services in a bias-free manner."[9]

28. Honourable and professional conduct: As a para-military organization, the TPS has a strong focus at a formal level on ensuring honourable and professional conduct. This is manifested in a number of ways, including through the TPS Standards of Conduct and the disciplinary system that enforces the standards. Within the Foreword from the Chief of Police that is included with the Service Governance documentation that is provided to TPS members, the paramount importance of honour and professionalism is succinctly summarized:

---

[5] *Id*. at 7.

[6] *Ibid*.

[7] Toronto Police Service, *The Police and Community Engagement Review (The PACER Report): Phase II – Internal* (Toronto, ON: Toronto Police Service, 2013), online: Toronto Police Service Board <http://www.tpsb.ca/The%20PACER%20Report.pdf> [TPS, *PACER Report*].

[8] *Id*. at 5.

[9] *Id*. at 4, iv.

> I want to impress upon you the necessity of maintaining the public's trust and the grave implications for all of us if it is lost. Actions by members that break the law and violate the public trust diminish the public's perception of the professionalism of the police and tarnish the reputation of the Service.
>
> As a member of the Service, the single most important role you fulfil is maintaining the trust and support of the public. In every interaction with members of the public or co-workers, you must conduct yourself lawfully, professionally and ethically. You must always be able to articulate the reasons and grounds for your actions. Ultimately, you are responsible for ensuring that your conduct is above reproach.[10]

29. This statement is, of course, a formal statement of TPS culture, and cannot on its own determine the informal culture of the organization. However, in discussions with many individuals from the TPS over the course of the Review, it became apparent that, virtually without exception, all of these TPS members believe strongly in the values of honour and professionalism. This alone does not signify that the Service is without flaws or that there are not exceptions. But, it does show that the TPS builds on a strong cultural foundation as it continues to seek to self-improve through the process initiated by this Review and otherwise.

2. *Areas for improvement*

30. It became apparent through the course of the Review that, consciously or not, many members of the TPS share certain beliefs and attitudes that are somewhat unhelpful. A list of pertinent examples follows. It should be emphasized that, although these elements of the culture do seem to be somewhat pervasive, they are by no means universal. Moreover, many TPS members hold a mixture of both helpful and less helpful beliefs and attitudes at the same time. The existence of these cultural features does not signify failure by the TPS, but identifying them will assist the Service in charting a course that will hopefully overcome them.

31. Deaths are inevitable: Many members of the TPS assume that police shootings of people in crisis cannot be avoided. This leads to an apparent lack of enthusiasm for efforts designed to make changes that seek to minimize the number of deaths. On the one hand, given the repeated occurrence of such shootings over the years, this attitude could be viewed as simply realistic rather than pessimistic. And I do not attribute malice to those who hold this attitude. On the other hand, it is clear from the results of this Review that there are things that can be done to try to minimize the need for lethal force, and that could, in fact, save lives. When every death is one too many, it is important to maintain an attitude of optimism and hope, and to do everything reasonably possible to try to improve.

[10] TPS, *Service Governance Standards*, *supra* note 2 at 1.

32. The TPS cannot do more: A related assumption linked to the above attitude about the inevitability of police shootings is that the TPS is already at the forefront of effective policing in relation to people in crisis, and it cannot reasonably do more than it already does. This attitude is driven in part by a feeling of frustration because, although the TPS does in fact do more in the area of policing and mental health than some other police services, the TPS continues to be criticized at inquests and otherwise for not doing enough. My conclusion is that the TPS is neither entirely a leader nor entirely a follower in this area. It has taken important steps, some of which are innovative, but it should not become complacent. There is still room to improve.

33. Policing is not social work: Some members of the Service appear to believe that there should be a separation between police work, on the one hand, and social work and the provision of mental healthcare, on the other. They resist the fact that the job of a police officer inherently involves a social work aspect and a mental healthcare aspect as part of the "service" component of the TPS's role in society. Related to this view is a perception by some officers that the work of units like the Mobile Crisis Intervention Team (MCIT) is less important, and does not involve true policing. This is by no means a universally held view, but it does seem to be an undercurrent within the TPS culture.

34. Bad conduct by some officers is inevitable: Many members of the TPS appear to hold the view that, although the vast majority of TPS officers conduct themselves properly, there will always be a small number of officers who will fail to do so, to the detriment of all. This is a somewhat nihilistic attitude, in line with the assumption that deaths are inevitable. The underlying premise of all the recommendations in this Report is that this type of attitude must be rejected.

35. Officer safety takes priority over the safety of the subject: A theme that is seen reflected in attitudes as well as in some training materials is that the safety of the police officer takes priority over the safety of the person in crisis. This is an incorrect premise. The life of the officer and the life of the person in crisis are equally important. While it is true that the police officer has a duty to protect the public and that, to do so, the officer must protect himself or herself, it is equally true that the officer has a duty to protect the person in crisis. That person is no less human, no less deserving of protection.

36. The duty to de-escalate is less important than other duties: While no TPS member expressed this view overtly, it is apparent from TPS practices that the duty to de-escalate is not treated as being as important as certain other duties. For example, in investigations by the TPS Professional Standards Unit into incidents involving the use of lethal force by police, it is apparent that, on at least some occasions, officers are not investigated for failure to de-escalate in accordance with applicable procedures.

37. Rejecting criticism: The TPS is a fairly insular institution. It is subjected almost daily, in the media and otherwise, to criticism of its actions. Much of the criticism, although perhaps not malicious, is ill-informed and not conveyed in a spirit of reasonable dialogue. Consequently, members of the TPS feel as though the Service has to regularly defend itself against unfair allegations of wrongdoing. The result appears to be a generalized assumption that criticism of the TPS by people outside of the Service is unhelpful, and that only members of the TPS truly understand the requirements of

policing. That is an unfortunate attitude. It hinders self-improvement efforts, and limits the receipt of valuable input from outsiders.

38. Reticence to speak: The para-military command structure of the TPS makes more junior members of the Service reluctant to speak out about issues of concern when they are in the presence of more senior members. There appears to be a concern among lower ranking officers that they will be viewed as insubordinate for openly questioning anything about the Service, and that they may suffer negative consequences in some form. This is an unfortunate feature of TPS culture because it stifles innovation as well as organizational self-examination and self-criticism.

II. Overview Of Issues Highlighted by Stakeholders

39. There were a number of stakeholder submissions that focused on the issue of police culture. Most, but not all, were focused on areas of proposed improvement.

40. With regard to positive features of TPS culture, one stakeholder specifically thanked TPS officers for their professional and kind handling of the vast majority of persons identified as "emotionally disturbed." Another remarked on the consistent professionalism and enlightened attitude that officers displayed when dealing with people in crisis.

41. One of the most common themes regarding police culture that we heard from stakeholders of all perspectives is that training and education are easily overcome by police culture. If the Service's culture is not open to implementing particular aspects of training, that training will not find its way into police practice. This is the idea of "culture eats training," referenced earlier in this chapter.

42. With regard to features of the TPS culture that were viewed as unhelpful, some stakeholders expressed the view that some police officers do not consider responding to calls involving people in crisis as "real" police work.

43. Many organizations noted that there is an emphasis in police culture on forceful responses—asserting and maintaining control over every situation, subject and scene, quickly and definitively. They expressed the view that this approach can undercut officers' effectiveness in de-escalating a situation, especially one involving a person in crisis. Forceful responses can escalate a situation involving a person in crisis, who often needs time and space. These stakeholders suggested that use of non-threatening behaviour, rather than loud, dominant, and controlling behavior, may be more effective in addressing the needs of people in crisis.

44. A group of stakeholders highlighted that, as in society more generally, police culture is affected by stigma associated with mental illness. These stakeholders submitted that stigma has the effect of both creating a barrier to officers' willingness to help and empathize with people in crisis, and reducing officers' inclination to seek help for their own mental health issues.

45. Some stakeholders noted that police officers are generally "hyper-vigilant" at all times, wondering where the next problem will come from. It was suggested that many officers may benefit from help in managing their stress.

46. Several stakeholders also believe that the Service has demonstrated a strong tendency to protect itself, reject criticism, and ostracize serving members who voice concerns about specific incidents or about the need for self-improvement within the TPS more generally.

III. Recommendations

47. In one sense, as I have indicated, all of the recommendations in this Report are to some degree about police culture.

48. For example, the recommendations in Chapter 6 (Selection of Police Officers) are concerned with identifying new police recruits who possess an optimal set of personal characteristics, and selecting officers for specialized roles based on similar considerations. This is all about creating culture by selecting the right people.

49. In a similar way, the recommendations in Chapter 8 (Supervision) focus on ensuring that the lessons of training are reinforced in the work environment by the leadership of coach officers and supervisory officers, and by the practices observed within platoons and divisions. The recommendations in Chapter 12 (Equipment) are concerned in large part with ensuring an enhanced culture of accountability (in the case of body-worn cameras), or ensuring a proper level of accountability in relation to certain forms of equipment (in the case of conducted energy weapons). Similar issues of police culture are addressed in the recommendations found in the chapters on the mental health system, training, mental wellness of police, use of force and MCIT. Positive and negative reinforcements are addressed throughout the Report, as are various recommendations for ensuring effective leadership.

50. I have therefore not set out in this chapter all of the recommendations that are designed to have an influence on police culture, since that would encompass most of the recommendations in the Report. It is important to recognize that many of the recommendations in the other chapters are specifically intended to help address some of the less helpful elements of police culture described above. I would, however, make the following recommendation that relates to many of the points raised in this chapter.

51. I recommend that:

Statement of TPS commitments relating to people in crisis

> **RECOMMENDATION 5:** The TPS prepare a formal statement setting out the Service's commitments relating to people in crisis and, more broadly, relating to people experiencing mental health issues. The statement should be made public and treated as of equal weight to the Service's Core Values. Among the commitments listed, the Service should consider including the following items:

(a) A commitment to preserving the lives of people in crisis if reasonably possible, and the goal of zero deaths;

(b) A commitment to take all reasonable steps to attempt to de-escalate potentially violent encounters between police and people in crisis;

(c) A commitment by the Service to continuous self-improvement and innovation relating to issues of policing and mental health;

(d) A commitment to eliminating stereotypes and providing education regarding people with mental health issues;

(e) A commitment to involving people with mental health issues directly, where appropriate, in initiatives that affect them, such as police training, and the development of relevant police procedures;

(f) A commitment to working collaboratively with participants in the mental health system (individuals, community organizations, mental health organizations and hospitals);

(g) A commitment to institutional leadership in the area of policing and mental health, and to becoming a pre-eminent police service in this field; and

(h) A commitment to fostering a positive mental health culture within the TPS.

CHAPTER 6

Selection of Police Officers

CHAPTER 6. SELECTION OF POLICE OFFICERS

Table of Contents

Page

I. THE CURRENT SITUATION 129

A. New constable selection and screening 129
(1) The process for new constable selection 129
(2) The role of Psychological Services in new constable selection 130
(3) Issues with the role of Psychological Services 131
(4) Education 133
(5) Lived experience and community orientation 134
(6) Certification in mental health first aid 134

B. Assessments of candidates for specialized roles 134
(1) The Emergency Task Force 135
(2) Critical Incident Response Team 135
(3) Issues in assessments for specialized roles 136
(4) Conflict between counselling and screening roles 136

C. Psychological Services' capacity constraints and institutional structure 137

II. OVERVIEW OF ISSUES HIGHLIGHTED BY STAKEHOLDERS 137

III. RECOMMENDATIONS 138

The hiring of new constables 138
Working group regarding Psychological Services 139

Chapter 6. Selection of Police Officers

1. This chapter discusses the current screening and selection practices for recruiting new constables, assessments of candidates for specialized roles within the Service, and the current capacity constraints and institutional structure of TPS Psychological Services.

2. The job of policing is nuanced, variable, and complex. It is important to hire new constables who are best able to meet those complex demands. As set out in Chapter 8 (Supervision), as part of the legislative framework governing police services in Ontario, it is deliberately made difficult to dismiss, suspend or otherwise discipline police officers. The legislation is designed to protect the independence of the police officer, as a holder of a public office. If the TPS wants its officers to exhibit certain traits, such as empathy, compassion or healthy attitudes toward people with mental illness, it is important to select for these traits in the hiring process, since some of the ordinary methods of shaping and correcting the conduct of an organization's employees are not available to a police service like the TPS.

I. The Current Situation

A. New constable selection and screening

1. *The process for new constable selection*

3. The TPS uses the Constable Selection System (CSS), which is a selection standard licensed from the Ontario Association of Chiefs of Police (OACP) to individual police services. The purpose of the CSS is to provide a standardized approach to new constable selection across the province that is fair, objective, and consistent with professional best practice. The CSS proceeds in three stages: (a) a pre-interview assessment; (b) a competency interview and completion of a personal history questionnaire; and (c) a post-interview assessment, including psychological testing and an interview with a police psychologist.

4. Candidates applying to be a police officer must meet the basic requirements set out in the *Police Services Act*: candidates must be a Canadian citizen or permanent resident of at least 18 years of age, be physically and mentally able to perform the duties of the position, have successfully completed four years of secondary school, and be of good moral character and habits.[1] In addition, candidates must have no criminal convictions, possess a valid driver's license, possess a valid OACP Certificate,[2] and pass a security clearance check, background investigation, and credit and reference checks.[3] All of these requirements are assessed before candidates are selected for interviews.

---

[1] *Police Services Act*, R.S.O. 1990, c. P.15, s. 43(1) [*PSA*].

[2] This Certificate requires successful testing for physical readiness, analytical thinking, written communication, vision, hearing, and satisfactory response to scenarios shown in a video simulation.

[3] Toronto Police Service, "Frequently Asked Questions" (2014), online: Toronto Police Service <http://www.torontopolice.on.ca/careers/uni_faq.php#q02>.

Finally, all candidates must possess a current certification in CPR and first aid by the time an offer of employment is given.[4]

2. *The role of Psychological Services in new constable selection*

5. An important part of the constable selection process is psychological testing and a psychological interview. The interpretation of this testing and the psychological interview may be conducted either by one of the Service's two in-house psychologists in the Psychological Services unit, or contracted out to other psychologists if the application volume exceeds the capacity of TPS Psychological Services. Only candidates that have shown promise at the two earlier stages of the evaluation process will be selected for psychological evaluation.

6. All candidates selected for psychological evaluation must complete a personal history questionnaire and two well-established psychological tests: the Minnesota Multiphasic Personality Inventory 2 (MMPI-2) and 16 Personality Factor (16PF). The tests are slightly modified by the TPS psychologists to omit questions that may be prohibited by the Ontario *Human Rights Code*.[5] The MMPI-2 is one of the most commonly used tests of adult personality traits and psychopathology.[6] The 16PF test is another widely-used test to analyze 16 primary personality traits and the "big five" secondary personality traits in adults.[7]

7. These tests, though useful, have limitations. The OACP Constable Selection System's "Guidelines for Psychologists" recommend that the results of MMPI-2 tests should be considered invalid under certain circumstances. Without delving into excessive detail regarding testing methods, the Review been informed that it is not an uncommon result in psychological testing of recruit candidates for the tests to be deemed invalid. As a result, the TPS psychologists exercise both caution and discretion in the interpretation of test results whenever the test may not be considered valid pursuant to the CSS guidelines. In this circumstance, their hiring recommendation may be based on the psychological interview alone.

8. Through the above tests and the psychological interview, the psychologists screen for the following traits, among others: problem-solving abilities, self-confidence, communication, flexibility, stress tolerance, self-control, ability to build relationships, emotional insight, empathy, tolerance of diversity, and patience. Psychologists also screen for measures of past and present psychopathology, and other undesirable psychological traits that may interfere with the safe and effective discharge of the duties

---

[4] *Ibid.*

[5] Carol Vipari & Cathy Martin-Doto, *Psychologist Guidelines – New Constable Psychological Screening Evaluations* (Toronto, ON: Toronto Police Service, 2013) [Vipari & Martin-Doto, "Psychologist Guidelines"]; *Human Rights Code*, R.S.O. 1990, c. H.19.

[6] Martin Sellbom, Gary L. Fischler & Yossef S. Ben-Porath, "Identifying MMPI-2 Predictors of Police Officer Integrity and Misconduct" (2007) 34:8 Criminal Justice and Behavior 985.

[7] Heather E.P. Cattell & Alan D. Mead. "The Sixteen Personality Factor Questionnaire (16PF)" in Gregory J. Boyle, Gerald Matthews & Donald H. Saklofske, eds., *The SAGE Handbook of Personality Theory and Assessment* (Los Angeles, CA: SAGE Publications, 2008) 135 at 136. The 16primary personality traits are: warmth, reasoning, emotional stability, dominance, liveliness, rule-consciousness, social boldness, sensitivity, vigilance, abstractedness, privateness, apprehension, openness to change, self-reliance, perfectionism, and tension. The "big five" secondary personality traits are: openness to experience, conscientiousness, extraversion, agreeableness, and neuroticism.

of a police constable. Furthermore, a continuum of risk associated with alcohol consumption may be used as a guide in determining whether a candidate's level of alcohol use is of significant concern. The psychologists are directed to be mindful of cultural and linguistic diversity concerns, and the limitations of the tests in light of that diversity.[8]

9. From these tests and the psychological interview, the psychologist makes a recommendation regarding the hiring of a candidate, based on the psychologist's assessment of the candidate's ability to perform the essential functions of a police constable. Recommendations fall under the categories of "Suitable," "Suitable with Concerns," or "Not Suitable."[9]

10. A written report summarizing the results of the evaluation and the psychologist's recommendation is forwarded to the TPS Employment Unit. Any concerns regarding possible psychopathology or the suitability of a candidate for hire must be described in the report. Where possible, the psychologists identify a means by which an officer conducting a background check may obtain further information that may confirm or satisfy any suitability concerns identified in the course of the psychological evaluation.

11. The Review was told that the TPS has not hired an individual identified by a screening psychologist as "Not Suitable," since the Service first hired an in-house psychologist in 2005 to manage the psychological screening process.

3. *Issues with the role of Psychological Services*

12. In light of the Service's limited power to dismiss, suspend or otherwise discipline officers for misconduct, the role of Psychological Services in screening out psychopathology and screening in for desirable traits such as emotional intelligence, empathy, tolerance of diversity, and patience—traits that are crucial to meeting the complex demands of modern policing—is all the more important. However, the role of Psychological Services in the decision-making process for new constable selection is more limited than, in my view, it should be.

13. In conducting a psychological evaluation of a recruit candidate, Psychological Services does not have access to the applicant's complete file. Psychological Services has access only to the applicant's psychological test results and basic personal information. The psychologist's recommendation could be better informed by a more complete understanding of the candidate, her or his background, and strengths and concerns that others in the organization have noted at previous stages of the recruitment process.

14. After the evaluation, the psychologists have no further involvement in the new constable selection process beyond the submission of their written report to the TPS Employment Unit. This raises the issue of whether further involvement of Psychological Services is appropriate. I am of the opinion that a key advantage of using psychological screening is the psychologist's depth of insight into the candidate. At the same time,

---

[8] Vipari & Martin-Doto, "Psychologist Guidelines," *supra* note 5.

[9] *Ibid.*

because psychological testing is not an exact science, it is helpful to incorporate the psychologists' impressions and concerns through dialogue as part of the constable selection process.

15. Accordingly, greater involvement of the psychologists at the decision-making stages of constable selection would allow the psychologists to provide a more nuanced assessment of candidates, in light of the strengths and weaknesses of the assessment methodology. This is particularly true for candidates assessed as "Suitable with Concerns." A discussion of the psychologists' concerns and how they can be addressed may be fruitful. Furthermore, this subsequent involvement would provide Psychological Services with an important feedback mechanism, allowing them to better understand how the Employment Unit addresses their recommendations and how their assessment practices can be improved.

16. It may be useful for the TPS to model involvement of Psychological Services in new constable selection after Psychological Services' involvement in selection of officers for the Emergency Task Force (ETF) and for the International Police Operations Branch (IPOB). As set out below, the psychologists undertake a similar screening process with respect to candidates for internal selection for the ETF and the IPOB, and forward their recommendations to the Unit Commander. However, after the psychologists submit their recommendations, they are invited to review their recommendations and the limitations thereof with the selection committee and to work collaboratively with the selection committee to clarify questions or concerns related to the suitability of candidates for the assignment.

17. A related issue is the contracting out of psychological assessments to other psychologists. We understand that it has become necessary to contract out some of the psychological assessments for recruit candidates because of capacity constraints of the two TPS in-house psychologists. Current sentiment within the TPS is that it is operating with too few officers.[10] As a result, when new hiring is permitted by Toronto City Council, there is strong pressure to conduct the process as quickly as possible so that new officers can be hired, trained and deployed as soon as possible. This push can overwhelm Psychological Services' in-house capacity, forcing the TPS to contract out the majority of psychological screening work and thereby sacrifice the expertise that an in-house psychologist accumulates.

18. While the TPS psychologists have established precise guidelines to ensure that psychologists retained on contract perform their job skillfully, respectfully and effectively, psychologists on contract may still lack the in-house psychologist's wealth of knowledge and depth of understanding of TPS and its culture.

[10] Kelly Grant, "Blair wary as Toronto police board freezes budget without layoffs" *The Globe and Mail* (10 December 2012), online: The Globe and Mail <http://www.theglobeandmail.com/news/toronto/blair-wary-as-toronto-police-board-freezes-budget-without-layoffs/article6188756/>.

4. *Education*

19. A number of individuals within the TPS expressed the view that the best officer candidates are those who have completed post-secondary education. Research in the field demonstrates that a candidate with a higher level of education is likely, in many respects, to be better prepared to carry out the duties of a police officer, including interacting with people in crisis.

20. Contemporary policing, especially in large cities, is "a demanding balancing act in a highly diverse and complex world, one in which officers must have a grasp of social forces, ethics" and the intricacies of applicable legislation.[11] Many researchers have found that university education results in an improved appreciation of the ethical issues inherent to policing and the social and legal complexities involved.[12] Overall, higher education results in a "more professional, less dogmatic approach to police work."[13]

21. Several studies have found that higher education "significantly reduced the likelihood of [the use of] force occurring."[14] One study found that, with respect to one U.S. police service, university-educated police officers are statistically more likely to make "psychiatric referrals" than their less educated colleagues. Conversely, those with lower levels of education were more likely to make an arrest.[15]

22. This greater degree of understanding has positive effects for the police. For example, several studies have indicated that when police officers are less authoritarian as a product of greater sensitivity, knowledge and understanding, the result is that police services receive fewer complaints regarding police conduct.[16]

23. Furthermore, it may be useful to actively recruit graduates from specific educational programs that teach skills desirable to providing a compassionate response to people in crisis, such as nursing or social work. It should not be a requirement that all police officers have this education, but a greater emphasis on hiring more officers with these and similar educational backgrounds may assist in shifting the culture of the Service as a whole to provide a greater emphasis on treating people in crisis with compassion.

---

[11] Teresa C. LaGrange, "The Role of Police Education in Handling Cases of Mental Disorder" (2003) 28:1 Criminal Justice Review 88 at 91 [LaGrange, "Police Education"], cited in Terry G. Coleman & Dorothy Cotton, *Police Interactions with Persons with a Mental Illness: Police Learning in the Environment of Contemporary Policing* (Ottawa: Mental Health Commission of Canada, 2010) at 59 [Coleman & Cotton, *Police Learning*].

[12] For relevant literature see note 71 of Coleman & Cotton, *Police Learning*, *id.* at 59.

[13] LaGrange, "Police Education", *supra* note 11 at 88, cited in Coleman & Cotton, *Police Learning*, *supra* note 11 at 60.

[14] Jason Rydberg & William Terrill, "The Effect of Higher Education on Police Behavior" (2010) 13:1 Police Quarterly 92 at 92; Michael G. Aamodt, *Research in Law Enforcement Selection* (Boca Raton, FL: BrownWalker Press, 2004); James P. McElvain & Augustine J. Kposowa, "Police Officer Characteristics and the Likelihood of Using Deadly Force" (2008) 35:4 Criminal Justice and Behavior 505; William Terrill & Stephen D. Mastrofski, "Situational and Officer-based Determinants of Police Coercion" (2002) 19:2 Justice Quarterly 215. All sources cited in LaGrange, "Police Education", *supra* note 11, cited in Coleman & Cotton, *Police Learning*, *supra* note 11 at 60.

[15] LaGrange, "Police Education", *supra* note 11 at 106, cited in Coleman & Cotton, *Police Learning*, *supra* note 11 at 60.

[16] LaGrange, "Police Education", *supra* note 11 at 88, cited in Coleman & Cotton, *Police Learning*, *supra* note 11 at 60.

24. Though existing evidence indicates that higher education is beneficial to policing, it is important to note that higher education is no guarantee of a superior police officer, and many exemplary officers do not have a higher education. It is simply one important factor that can be considered in aiming to hire the people most capable of carrying out the duties and responsibilities of a police officer.

5. *Lived experience and community orientation*

25. Many individuals with whom the Review met suggested that it would be useful for the TPS to place a greater emphasis on recruiting candidates who have had significant contact with people with lived experience of mental illness. Candidates who have made significant contributions through community service may also be better prepared to serve the community as police officers. The former have a unique familiarity with people in crisis, and the latter have demonstrated their commitment to the core "service" ideal of policing. Both groups demonstrate desirable attitudes toward people who are in crisis or are otherwise in need of help.

6. *Certification in mental health first aid*

26. As noted above, in order to apply for a position as a new constable, candidates have to be trained in certain skills. For example, all candidates must be trained in driving a car and must possess a valid driver's license. All candidates must also be trained in, and certified to perform, CPR and first aid. This raises the applicability of the Mental Health First Aid (MHFA) course offered through the Mental Health Commission of Canada, and whether all new constables should be required to complete the MHFA course before they begin their service. MHFA is a 12-hour course that provides a foundation in mental illness, signs and symptoms thereof, and strategies for interacting with people in crisis.[17]

27. In light of the frequency with which front line police officers encounter people in crisis, MHFA certification would be useful both as a minimum level of education for new recruit candidates, and as a signal to applicants that dealing with people with mental health issues is a central part of a police officer's role.

B. Assessments of candidates for specialized roles

28. In addition to conducting psychological assessments for new constable recruitment, the TPS psychologists conduct assessments of candidates for the ETF, of TPS members requesting involvement in the peer support Critical Incident Response Team (CIRT), and of officers being considered for secondment to overseas policing missions through the Royal Canadian Mounted Police's International Peace Operations Branch. Officers in the ETF interact with people in crisis, and those in the CIRT help officers respond to potentially traumatic events. Both are relevant to this Review.

[17] Mental Health First Aid Canada, "Course Information" (2011), online: <http://www.mentalhealthfirstaid.ca/EN/course/Pages/default.aspx>.

1. *The Emergency Task Force*

29. Psychological screening evaluations for the ETF are conducted for the most promising candidates that emerge from the initial screening and assessment processes for the role. These psychological evaluations consist of both personality and cognitive testing, as well as a comprehensive interview with a TPS psychologist that lasts on average 2.5 hours. The psychologist is asked to rule out both psychopathology and other personality or cognitive variables that would interfere with the safe and effective discharge of the duties of an ETF officer, in a manner similar to the screening for new constable selection.

30. Key psychological competencies for an ETF officer include: a stable mood and ability to remain calm under stress and conditions of extreme fatigue;[18] good aptitude with teamwork; an ability both to follow and lead; an ability to put aside personal differences; dedication to the job without grandstanding; a personal sense of ethics and justice; a commitment to the mission and work of the ETF; sufficient self-esteem to accept responsibility for his or her actions, including the fatal deployment of a weapon; an interest in personal challenge and growth; willingness to use emotional supports, both within and beyond the team; patience and low impulsivity; intelligence, with strong analytical thinking ability; precision and attention to detail; sustained and selective attention skills; ability to take initiative; and flexible thinking.

31. In the case of evaluations of ETF candidates, the TPS psychologists do not provide a report for the selection committee to review, but rather are invited to review the results of the psychological assessments and their recommendations with the ETF selection committee in person. This discussion enables the psychologists to communicate any concerns raised in relation to the suitability of candidates for the duties of an ETF officer, and to discuss with the selection committee whether and how these concerns may be alleviated. As noted above, I am of the view that this second stage of involvement for the psychologists provides a greater opportunity for consideration of their insights. The implementation of a similar second stage for psychologist involvement during the new constable selection process may allow for increased collaboration and a more open dialogue between the selection committee and the psychologists.

2. *Critical Incident Response Team*

32. As discussed in more detail in Chapter 9 (The Mental Health of Police Personnel), the Critical Incident Response Team is a peer support team of TPS members who volunteer to help their peers debrief traumatic incidents and manage their emotional responses to those incidents. All civilian and uniformed members of the TPS who volunteer for assignment to the CIRT are required to complete a psychological screening evaluation as part of the selection process and an interview with a psychologist that lasts

[18] The Newark Police Department also requires that Emergency Response Team (ERT) applicants have a "proven record of remaining calm in situations involving severe physiological and psychological stress". However, related Newark Police Department policies do not indicate any formal psychological screening procedures with respect to ERT applicants. See Newark Police Department, *Emergency Operations Manual*, "Emergency Response Team Standard Operating Procedures" (Newark, NJ: Newark Police Department, undated) at 11.

up to two hours. The tests used in this evaluation also include a significant focus on current psychological health and well-being and measures of emotional intelligence.

33. Though the involvement of the psychologists in the CIRT is relatively recent and evolving, the psychologists now have direct involvement in the administrative oversight of the CIRT. This provides them with the opportunity to have even greater input and some decision-making authority with respect to future selection decisions for CIRT positions.

3. *Issues in assessments for specialized roles*

34. Psychological Services currently has no involvement in selection of candidates for some other positions within the TPS that have important mental health aspects.

35. Notably, the TPS psychologists have no formal relationship with the Mobile Crisis Intervention Teams (MCIT). It seems odd that there is no relationship between the two key mental health arms of the TPS, and that the psychologists have no role in selecting personnel for the MCIT given their important role in interacting with people in crisis. Additionally, MCIT teams may find it useful to access the psychologists as a resource for advice in carrying out their duties. It may also be useful for Psychological Services to play a role in MCIT training.

36. Psychological Services likewise has no involvement in selecting supervisory officers and coach officers. As discussed in Chapter 5 (Police Culture), the leadership of the TPS plays a central role in molding the culture of the organization, and in influencing the conduct of TPS members. Accordingly, it is important to ensure that the most suitable candidates, who demonstrate the highest levels of emotional intelligence, empathy, tolerance of diversity, and patience, are promoted to positions of influence over other officers.

37. The TPS psychologists can play a unique and valuable role in identifying officers for promotion who demonstrate desirable traits that will enable the TPS to continue to develop a culture that is more focused on respect for officers' mental health, and the mental health of the society that the TPS serves.

4. *Conflict between counselling and screening roles*

38. Careful attention must be given to avoiding conflicts of interest for the TPS psychologists. Members of the TPS may feel there is a conflict between the psychologists' role as therapeutic counsellors under the Psychological Wellness Program, discussed in Chapter 9 (The Mental Health of Police Personnel), and their role in screening officers for new positions within the service. An officer may not feel comfortable developing a relationship of trust with the psychologist as a counsellor, when the same psychologist may play a role evaluating the officer's professional advancement within the Service.

39. The Review was advised that the conflict issue is addressed by separating the psychologists' screening and counseling roles. If a psychologist is in a counselling

relationship with a TPS member, the psychologist will not carry out a screening function for that officer, and instead the other TPS psychologist will carry out the screening function. Every officer with whom the psychologists meet is provided with a detailed written and verbal explanation of the psychologists' exact roles within the Service. This explanation includes an overview of their procedures for managing potential conflicts, which includes maintaining separate files and maintaining confidentiality.

C. Psychological Services' capacity constraints and institutional structure

40. In light of the discussion above, and especially in light of the recommendations in this chapter and Chapter 9 (The Mental Health of Police Personnel) that relate to expanding the role of TPS psychologists, it appears that the current staffing of two in-house TPS psychologists is insufficient to meet the needs of the Service's members.[19] The TPS is to be commended for recognizing the important role that psychologists can play in the Service. But based on what I have learned, Psychological Services is at capacity, and unless capacity is expanded, the psychologists cannot be asked to do more than they currently do without risking a decline in the quality of service provided.

41. The psychologists have a significant role to play on the operational side of policing. The implementation of the recommendations in this chapter would result in an expansion of this role. It may therefore be beneficial for the TPS to consider amending its organizational structure so that Psychological Services reports directly or on a dotted-line basis to a Deputy Chief. Psychological Services is currently under the purview of the Director of Human Resources. It is important to ensure that the perspective of the psychologists and the goals they seek to achieve are given sufficient prominence within the organization.

II. Overview of Issues Highlighted by Stakeholders

42. The Review heard from some stakeholders that TPS should screen out candidates who display attitudes that show stigma toward people with mental illness as well as psychological tendencies toward self-interest, low empathy, enjoyment of power or control over others, anger management issues, and premature use of force or firearms. These stakeholders recommended that psychological testing should be used to identify officers who consider the use of force as a last resort, who are confident in their ability to address situations that pose a risk to their own security, and who have strong communication and listening skills. Some stakeholders suggested that these assessments should be periodically applied on an ongoing basis throughout officers' careers.

43. Several stakeholders suggested that applicants for new constable positions should be tested for use of performance-enhancing drugs such as steroids or testosterone supplement therapy. These drugs and supplements can affect a person's mood, attitude, and reactions to events. As a result, they can change the manner in which an officer

[19] City of Toronto, Police Services Board, "Toronto Police Service – 2014 Operating Budget Request" (Toronto: City of Toronto, 2014), online: <http://www.toronto.ca/legdocs/mmis/2014/bu/bgrd/backgroundfile-65495.pdf)>.

engages with a person in crisis as well as an officer's empathy, patience, and willingness to attempt de-escalation before resorting to using force. Some stakeholders suggested this screening should also take place periodically throughout officers' careers.

44. Other stakeholders emphasized that the new constable recruitment process should be changed to recruit for specialization and individual skills. Several stakeholders emphasized that the current system for hiring new constables as generalists does not give sufficient preference to candidates with areas of expertise that a police service might need, including social, technical, language or management skills, cultural awareness, or experience and comfort in interacting with people in crisis. It was suggested that the Service's generalist hiring practices may not suit the various and specialized roles that a police service is asked to fulfill in order to effectively serve a modern and complex society. Even if the TPS does not hire individuals specifically for certain roles, it was noted that valuing diversity of experience, education, and skills in hiring will provide the Service with a greater depth of talent to fill more specialized roles later in officers' careers.

III. Recommendations

45. I recommend that:

The hiring of new constables

RECOMMENDATION 6: The TPS change mandatory application qualifications for new constables to require the completion of a Mental Health First Aid course, in order to ensure familiarity and some skill with this core aspect of police work.

RECOMMENDATION 7: The TPS give preference or significant weight to applicants who have:

(a) Community Service: engaged in significant community service, to demonstrate community-mindedness and the adoption of a community service mentality. Community service with exposure to people in crisis should be valued;

(b) Mental Health Involvement: past involvement related to the mental health community, be it direct personal experience with a family member, work in a hospital, community service, or other contributions; and

(c) Higher Education: completed a post-secondary university degree or substantially equivalent education.

RECOMMENDATION 8: The TPS amend its application materials and relevant portions of its website to ensure that applicants for new constable

positions are directed to demonstrate in their application materials any qualifications relevant to Recommendation 7.

RECOMMENDATION 9: The TPS consider whether to recruit actively from certain specific educational programs that teach skills which enable a compassionate response to people in crisis, such as nursing, social work, and programs relating to mental illness.

RECOMMENDATION 10: The TPS direct its Employment Unit to hire classes of new constables that, on the whole, demonstrate diversity of educational background, specialization, skills, and life experience, in addition to other metrics of diversity.

RECOMMENDATION 11: The TPS instruct psychologists, in carrying out their screening function for new constable selection, to assess for positive traits, in addition to assessing for the absence of mental illness or undesirable personality traits. In this aim, the TPS, in consultation with the psychologists, should identify a specific set of positive traits it wishes to have for new recruits and should instruct the psychologists to screen-in for those traits.

RECOMMENDATION 12: The TPS include the psychologists in the decision-making process for new constable selection, in a manner similar to their involvement in selecting officers for the ETF.

RECOMMENDATION 13: The TPS compile data to allow the Service to evaluate the effectiveness of the psychological screening tests that it has used in selecting recruits. Relevant data may include data that show what test results correlate with officers who have satisfactory and unsatisfactory interactions with people in crisis.

Working group regarding Psychological Services

46. The recommendations in this chapter and in Chapter 9 (The Mental Health of Police Personnel) provide for an expansion of the role of the TPS psychologists within the Service. The increased involvement of Psychological Services in decision-making processes is not intended to detract from the decision-making authority of current TPS officials, but rather is intended to serve as an aid to increase the quality of the information that is used to make decisions. In that aim, I recommend that:

RECOMMENDATION 14: The TPS strike a working group that includes participation from the TPS Psychological Services unit to comprehensively consider the role of Psychological Services within the TPS, including:

(a) More Information: whether the current process for psychological screening of new constables is effective and whether it could be improved, including whether TPS psychologists should be given more information about candidates to assist them in interpreting their test results;

(b) Involvement of Psychologists in other Promotion Decisions: whether Psychological Services should be authorized to conduct evaluations of, and otherwise be involved in, discussions regarding the selection processes for officer promotions within the Service, and the selection of coach officers;

(c) MCIT: whether the TPS psychologists should be involved in the selection and training of officers and nurses for the MCIT. More broadly, the TPS should consider how to facilitate a close and ongoing relationship between the psychologists and the MCIT in order to enable collaboration and information sharing between the Service's two units with a primary focus on mental illness;

(d) Organizational Structure: whether the TPS should amend its organizational structure so that Psychological Services reports directly or on a dotted-line basis to a Deputy Chief, in order to give greater recognition to the operational role that they play; and

(e) Expanding Psychological Services: how Psychological Services should be expanded to accommodate the officer selection duties and TPS members' wellness needs, as described in this Report.

CHAPTER 7

Training

CHAPTER 7. TRAINING

Table of Contents

Page

I. THE CURRENT SITUATION 143

A. Importance and impact of training..... 143
B. Legislative framework..... 144
C. Ontario Police College Training..... 145
D. Toronto Police College Training 148
(1) Recruit training at the TPC..... 149
(2) In-service training..... 150
(3) Other training 150
E. Divisional training..... 150

II. OVERVIEW OF ISSUES HIGHLIGHTED BY STAKEHOLDERS 151

III. RECOMMENDATIONS 153

Recruit training 153
In-service training..... 155
Decentralized training..... 155
Research and curriculum design 155

Chapter 7. Training

1. This chapter discusses the new recruit and in-service training provided to all TPS officers. As noted in Chapter 8 (Supervision), police officers also develop skills through their experiences while on duty and from interacting with other members of the Service. The importance of such informal education should be not overlooked, as the judgment and communications skills required to resolve situations with people in crisis cannot be acquired through formal training programs alone.

2. Other reviews, studies and inquests have considered and made recommendations regarding police training generally, and the TPS training relating to people in crisis specifically. The TPS has considered and implemented many of those recommendations as to the content and delivery method of its recruit and in-service training curricula. As a result, Toronto Police Service offers reasonably well-developed training on understanding and responding to people in crisis. This chapter makes some additional recommendations in this area, and several recommendations in other chapters also touch on training. As with other areas examined by this Review and as discussed in Chapter 5 (Police Culture), the TPS should be proud of its commitment to date in advancing training regarding people in crisis, but must continue the process of self-examination and improvement in the effort to reduce the prospect that lethal force will be used in crisis situations.

3. However, training and education are just two factors among many that influence police decision-making and conduct in interactions with people in crisis. Other factors include the Service culture, mentorship, supervision, leadership, discipline, officers' own mental, emotional and physical health, as well as other police resources and community resources—topics discussed in other chapters of this Report.

I. The Current Situation

A. Importance and impact of training

4. In the course of this Review, my team and I read many academic reports and commentaries on the link between training and police interactions with people in crisis. As two well-known researchers in the field have noted, a training curriculum is only as strong as the people who deliver it and the social context in which it is implemented.[1] Further, they highlight that the lack of standardized data about training programs and outcomes of crisis situations prevent police services and researchers from identifying the components of a curriculum that are most effective in producing positive resolutions of encounters with people in crisis. This dearth of evidence has been attributed to insufficient police service record-keeping systems, especially in primary response

[1] Terry G. Coleman & Dorothy Cotton, *Police Interactions with Persons with a Mental Illness: Police Learning in the Environment of Contemporary Policing* (Ottawa, ON: prepared for the Mental Health Commission of Canada, May 2010) at 5 [Cotton & Coleman, *Police Learning*].

policing as compared to the data reporting associated with specialized crisis intervention units.[2]

5. Training regarding mental health and crisis situations is closely related to other areas of training. Use of force training, communications tactics and education about available police, health care, and community resources must also embrace the goal of assisting people in crisis without force whenever possible. The training requirements are complex and demanding. Police must be trained not only in techniques for calming a situation or negotiating with someone in crisis, but also in the areas of recognizing crisis symptoms, assessing the physical and mental capabilities of the subject, anticipating unexpected responses to routine commands or actions, exercising discretion in decisions to apprehend, arrest or divert an individual, and combatting the effects of stigma on their decision-making.[3]

6. Academic literature highlights the importance of employing police trainers who have both expertise and credibility, of integrating mental health professionals and people with lived experience of mental illness into the curriculum, of addressing cognitive obstacles like stigma and bias, and of tailoring training to meet the needs of particular cohorts and communities.[4] The TPS seeks to incorporate many, if not all, of these critical factors into the recruit and in-service training delivered at the Toronto Police College (TPC). The challenge for the Service is to ensure that its lessons resonate with officers and become ingrained in their day-to-day interactions and decision making.

B. Legislative framework

7. The *Police Services Act* sets minimum training standards for Ontario police officers. Under the Act, the Solicitor General must monitor municipal police services like the TPS to ensure adequate police services are provided to the community and ensure police services boards comply with the provincially prescribed standards. The Solicitor General is also charged with developing and promoting programs to enhance professional police practices, standards, and training.[5]

8. The Act empowers the Ontario government to make regulations prescribing standards and courses for members of police services.[6] Officers have a statutory duty to complete the prescribed training, which includes passing the Basic Constable Training Program at the Ontario Police College (OPC) within six months of being appointed.[7] However, lateral recruits who have completed an equivalent initial training and

---

[2] *Id*. at 7, 35.

[3] *Id*. at 43-45.

[4] *Id*. at 8.

[5] *Police Services Act*, R.S.O. 1990, c. P.15, s. 3(2) [*PSA*].

[6] *Id*., s. 135(1).

[7] *Id*., s. 42(1).

probationary period in another Canadian jurisdiction may be exempted from this requirement, or asked to complete other specified courses or examinations.[8]

9. On being hired by the TPS, new recruits follow three courses of formal training:

(a) two weeks of orientation at the TPC;

(b) twelve weeks of basic constable training at the OPC; and

(c) six weeks of further training at the TPC.

10. Although the 20-week program is intensive, it is shorter than what is required for some other police services, such as the RCMP. Police recruits have to learn a comprehensive and complex set of skills in a condensed timeframe, from legislation to emergency driving, and from software use to weapons tactics. The powers and responsibilities they study and exercise are very important, especially since the misuse of their authority can deprive an individual of liberty or security of the person. Indeed, the failure to react to crisis situations in accordance with training lessons can endanger the lives of the person in crisis, police officers and members of the public.

C. Ontario Police College Training

11. The OPC is established by the *Police Services Act* for the training of officers in Ontario.[9] The Provincial Policing Standards Manual requires the OPC to ensure all recruits achieve competence in a number of areas. Some of the skills relevant to responding to people in crisis include:

(a) basic communications skills, including rapport development, and active listening;

(b) mental illness awareness and communication skills, including conducting mediations, creating voluntary compliance, and defusing aggressive behaviour; and

(c) appropriate judgment with respect to weapons, practical experience making use of force choices under realistic circumstances, race relations sensitivity, confidence and restraint, ability to debrief encounters in order to discuss threat perceptions, communication skills, knowledge of tactical and less-than-lethal force options, and ability to discern whether the force used was justified.[10]

12. The OPC provides the Basic Constable Training Program to new recruits hired by the TPS. This program educates recruits about the laws and procedures that front line officers are required to follow, with particular emphasis on the core functions of police

[8] *Id*., s. 44(2); O. Reg. 36/02, s. 1.

[9] *PSA*, *supra* note 5, s. 3(3).

[10] Ministry of Community Safety and Correctional Services, *Policing Standards Manual*, AI-012A "Use of Force" Appendix A – Ontario Police College Guidelines (Ontario: Ministry of Community Safety and Correctional Services, 2004), ss. 3, 7.

services identified in the *Police Services Act*, crime prevention, law enforcement, assistance to victims of crime, public order maintenance, and emergency response.[11] The Basic Constable Training Program uses simulation exercises, classroom discussion, and case studies to teach skills in a range of areas, including:

(a) conducted energy weapons (CEWs);

(b) community policing;

(c) critical incident stress management;

(d) defensive tactics;

(e) diversity and professional practice;

(f) ethics;

(g) evidence;

(h) provincial and federal statutes;

(i) leadership;

(j) race relations;

(k) Special Investigations Unit; and

(l) use of force.[12]

13. The recruit training curriculum at the OPC includes classroom lectures and practical scenarios. Recruits take a course on the purposes, styles and components of effective verbal and non-verbal communication. The three goals of police communication are to ensure a standard professional approach, prevent conflicts from escalating, and de-escalate situations.[13]

14. New recruits are also taught conflict prevention skills, including respecting a subject's personal space, empathetic listening, empowering and cooperating with an individual to find resolution options, and explaining the reasons behind an officer's actions.[14] These skills are further explored in the OPC module on responding to people with "mental disturbances." The OPC instructs recruits on symptoms of mental illness and other factors that can cause the same symptoms, communicating with people who

---

[11] *PSA*, *supra* note 5, s. 4(2).

[12] Ontario Ministry of Community Safety and Correctional Services, "Patrol and Basic Constable Training" (2014), online: Ontario Ministry of Community Safety and Correctional Services <http://www.mcscs.jus.gov.on.ca/english/police_serv/OPC/BasicConstableTraining/OPC_BCT_html.html>.

[13] Ontario Police College, "Basic Constable Training: Tactical Communication Course Training Standards" (2001) at 6 [OPC, *Communication*].

[14] *Id*. at 6, 13; Ontario Police College, "Basic Constable Training: Officer Safety Course Training Standards" (2013) at 27.

are hallucinating or suicidal, and on demonstrating empathy.[15] Mental health professionals are invited to provide input into this training.

15. The OPC gives new recruits a detailed guide on working with people in crisis, a resource that has been praised for its ongoing utility for on-duty officers.[16] The guide was created in partnership with the Centre for Addiction and Mental Health and St. Joseph's Health Care Centre in response to recommendations from the inquest into the death of Lester Donaldson in Toronto in 1994. In addition to providing a listing of community resources, the guide identifies signs and symptoms of mental illnesses, strategies for de-escalation, and key provisions of the *Mental Health Act*.[17]

16. Practical role-playing scenarios at the OPC include scenarios simulating: communicating with people in crisis and determining whether there are grounds for apprehension pursuant to the *Mental Health Act*, assessing the threat posed by people in crisis including where the threat involves a weapon, and determining what kind of assistance the person requires.[18] These scenarios are based on real-life events that were examined at coroners' inquests.

17. Trainers evaluate recruits on their exercise of judgment during practical scenarios. The evaluation considers the subject's behaviour, the use-of-force option selected, whether the trainee recognized a threat and whether the participant positioned him or herself appropriately to manage threats. The evaluation considers whether the trainee communicated well with his or her role-playing partner and whether he or she transitioned between different force options as appropriate. Notably, while the effective use of the "Police Challenge" is a subject of evaluation, there is no explicit measure of the recruit's ability or willingness to engage in other forms of communication with a subject.[19] The Police Challenge is an instruction or warning issued by police in order to secure the compliance of a subject, discussed in more detail in Chapter 10 (Use of Force). It is interesting and somewhat concerning that recruits are not evaluated on forms of communication that are designed to achieve de-escalation without confrontation.

18. Another notable feature of the evaluation framework is that recruits are graded on whether they are able to legally justify the use-of-force option selected. That approach raises a concern about whether new officers are being taught that it is acceptable to meet minimum legal standards rather than achieve the optimum result. In

---

[15] *Id*. at 28-29; OPC, *Communication*, *supra* note 13 at 23-25;

[16] Cotton & Coleman, *Police Learning*, *supra* note 1 at 21. To view the guide, see Ontario Police Colleges, Centre for Addiction and Mental Health & St. Joseph's Health Care London, *Not Just Another Call...Police Response to People with Mental Illnesses in Ontario* (Sudbury, ON: Centre for Addiction and Mental Health, Queen's Printer for Ontario and Regional Health Care, London, 2004), online: Ontario Association of Chiefs of Police <http://www.oacp.on.ca/Userfiles/Files/NewAndEvents/PublicResourceDocuments/2004_Not%20Just%20Another%20Call_% 20Police%20Response%20to%20People%20with%20Mental%20Illnesses%20in%20Ontario.pdf>.

[17] Ron Hoffman, "Police Training delivered at the Ontario Police College on responding to persons with mental disorders" (September 2013).

[18] OPC, *Communication*, *supra* note 13 at 28.

[19] Ontario Police College, "Officer Safety Judgment Evaluation Form" (undated) [OPC, "Safety Form"].

my view, police training should aim to meet best practices and professional standards of excellence, and not only to justify one's actions based on minimum legal standards.

19. Although not every recruit participates in every practical training scenario, those who observe an exercise must participate in the debriefing afterward. The debriefing addresses issues such as the threat that was presented, the circumstances that were considered by the trainee and those that ought to have been considered, the options available in the situation and the quality of the decisions made by the participant. Recruits are required to describe what steps should have been taken if the scenario continued and to hear how the individual role-playing as the person in crisis perceived the officer's actions. Trainees must also articulate what their goals were in handling the situation, and whether those goals changed as the scenario developed.[20]

20. A trainee will fail to meet the required standard if, during the scenario, he or she lost self-control, applied an inappropriate force option in the circumstances, failed to transition effectively between force options, or failed to react as required, among other critical performance measures.[21]

D. Toronto Police College Training

21. The TPC provides both in-service and new recruit training, as well as managing areas of armament, curriculum development and e-learning. The College operates out of the following seven administrative sections:

(a) armament, which sets firearms and tactical training standards for the Service, provides instructor training and specialized courses in firearms and CEWs, and analyzes Use of Force and CEW Reports;

(b) community policing, which delivers training to all recruits, lateral entries, auxiliary officers and new coach officers, including in the areas of human rights, ethics, professionalism, customer service, wellness, and diversity;

(c) investigative training, which provides instruction in general investigative techniques, major case management, interviewing skills, plainclothes work, motor vehicle accident reconstruction, crime scene analysis, sexual assault, child abuse, domestic violence, drugs, and sudden deaths;

(d) in-service training, which reinforces essential skills through interactive discussions and practical exercises in officers' annual refresher training, including tools to de-escalate aggressive behaviour, to select the most appropriate use-of-force option, and to respond to "emotionally disturbed persons;"

(e) leadership and business systems, which train supervisors in leadership, management principles, and professional development upon promotion.

[20] Ontario Police College, "Debriefing Process", October 2008.

[21] OPC, "Safety Form", *supra* note 19.

This branch also offers refresher courses, coordinates first aid and occupational health and safety training, and provides information technology and software education;

(f) learning development and standards, which coordinates electronic and adult learning, trainer accreditation, and quality assurance; and

(g) police vehicle operations, which trains officers on the use of cars, motorcycles, all-terrain vehicles, and bicycles.[22]

22. The TPC uses a variety of training and evaluation methods, including classroom lectures and written tests, simulations of incidents in which police have to react to filmed events and communicate with a partner, live scenarios in indoor and outdoor settings, and firing range exercises. Mental health issues are addressed in many formats, including instruction on the *Mental Health Act*, lectures from mental health professionals on the symptoms and medications commonly associated with various mental illnesses, panel discussions or videos representing the perspectives of people with lived experience of mental illness, and scenarios involving people in crisis armed with weapons. The in-service training program also includes video testimonials from members of the Service who have family members with mental health issues.

23. The recruit and in-service mental health training curricula are developed in consideration of real life scenarios from the TPS and other jurisdictions. The Service incorporates such practical learning opportunities in at least five ways. First, the TPC reviews recommendations resulting from inquests into fatalities involving encounters with Service members when designing training curricula. Second, the TPC considers input from the TPS Use of Force Committee on trends, concerns and best practices regarding officer use of force. Third, the TPS consults with other law enforcement agencies in Canada and internationally to identify trends in policing and training, best practices, and innovative course design and delivery. Fourth, the TPS Use of Force Analyst compiles statistics on incidents and outcomes and provides both the Service and the Toronto Police Services Board with annual trend and data analyses. These analyses can be incorporated into both classroom and scenario training at the TPC. Fifth, the training curricula are influenced by members' survey responses and by the trainers' own experiences in the field.

1. *Recruit training at the TPC*

24. New recruits are introduced to many of the concepts addressed in this Report during the two-week orientation at the TPC. They participate in sessions on invisible disabilities, human rights, ethics, professional standards, working with different communities, and the Service's Employee Family Assistance Program, among others.[23]

---

[22] Toronto Police Service, "Toronto Police College" (2014), online: Toronto Police Service <http://www.torontopolice.on.ca/college/>.

[23] Toronto Police College, "Course Training Standard: Pre-Ontario Police College Basic Constable Training Course – Community Policing Section" (2013).

25. When recruits return from the Basic Constable Training Program at OPC, they receive further training at the TPC in several areas, including ethics, professional standards and "emotionally disturbed persons." Training on occupational health and safety includes education on critical incident stress, a subject discussed in Chapter 9 (The Mental Health of Police Personnel). New members also participate in practical scenarios that address issues such as responding to a person in crisis, assessing threats and using proportionate force, and employing appropriate communications skills. Participants then debrief the encounters and discuss any concerns that arose.[24]

2. *In-service training*

26. As noted in Chapter 12 (Equipment), officers are required to re-qualify annually on their use of all issued equipment, including batons, OC spray, firearms, and, where applicable, CEWs. Officers receive additional classroom and scenario training during the annual in-service sessions, as well as through e-learning platforms, in areas such as legislation, human rights, and mental illness, although they are not required to re-qualify on communication or negotiation skills.[25]

27. In-service training builds on officers' skills in exercising judgment, communication, self-control and professionalism. The practical scenarios require officers to make decisions in stress-inducing environments, to demonstrate their skill in threat perception and to respond proportionately to the threat and circumstances. Recognizing subject behaviour, responding to people in crisis, de-escalation and containment options are all addressed as part of judgment training.[26]

3. *Other training*

28. The TPC also offers courses for newly promoted supervisors of various ranks, and remedial training that addresses work performance issues for specific officers. For example, before the Chief of Police may make a work performance complaint against an officer, the officer must be offered remedial assistance that would improve his or her performance, including training.[27] As discussed in Chapter 10 (Use of Force), Use of Force Reports are collected and used to identify individual and group training requirements. The unit commander of an officer who requires additional training in an area must submit a form to the TPC unit commander detailing the issue, and the TPC will then schedule the required training in accordance with unit-specific guidelines.[28]

E. Divisional training

29. The TPS offers regular in-service training within divisions. Each division has a sergeant responsible for training for the members of the five platoons (or shifts) within the division. Platoons have training days every five weeks, with access to a Live Link TV

---

[24] Toronto Police College, "Course Training Standard: Post-Aylmer Basic Constable Training Course – Community Policing Section" (2013).

[25] Toronto Police College, "Course Training Standard: In-service training course – Uniform"(2013).

[26] *Ibid*.

[27] Regulation 268/10 s. 29(3).

[28] Toronto Police Service, Procedure 15-01 "Use of Force and Equipment" (Toronto, ON: Toronto Police Service, 2013).

Network Training program of recorded materials, live panel discussions, and tests. The sergeants who run the discussion and test portions receive training in basic facilitation skills. Several programs offered on platoon training days have involved skills for dealing with people in crisis, such as dispelling mental health myths, indicators of mental illness, de-escalation approaches, community resources, and updates on the *Mental Health Act*.

30. Platoons also have the opportunity to discuss current service and safety issues during shorter, more frequent sessions held at the beginning of some shifts. In what are described as Roll Call sessions, the platoon supervisor will make a short presentation, followed by a guided discussion period and the distribution of resource materials. Several sessions have addressed issues concerning people in crisis, such as field assessments under the *Mental Health Act*, community resources for people who are not subject to apprehension under the *Mental Health Act*, instruction on how to secure a scene while awaiting the Emergency Task Force, and protocols surrounding firearms at crisis calls.

II. Overview of Issues Highlighted by Stakeholders

31. Although many of the submissions made to the Review suggested that revisions or additions to training are needed, several individuals and organizations from multiple perspectives acknowledged that the current educational curriculum for TPS officers is sophisticated. In particular, the mental health training offered by the TPC has been praised because it is informed by inquest recommendations, mental health professionals, and people (both officers and subjects) with lived experience of mental illness.

32. The Review received copies of many recent coroners' inquest recommendations, substantially all of which recommended more training, or more specific training. The Review heard that additional recruit and in-service training days would allow the TPS to provide more in-depth education on mental health issues, communications techniques, and non-lethal responses to assaultive behaviour. More fundamentally, however, some organizations suggested that a profession so essential to public safety needs a substantially longer training period, akin to the university education and apprenticeship periods required of doctors, nurses, accountants, and other professionals. In contrast, other stakeholders suggest it is not necessary to lengthen training, but that current programming can be improved.

33. A number of stakeholders acknowledged that increased training would require a significant investment in resources, with returns difficult to measure in isolation from various other factors discussed in this Report, such as culture, supervision, officer wellness, and community mental health resources. This is not to say that training cannot be refined or that existing recommendations for improvement should not be implemented. Nor does this acknowledgement dismiss the views of those who suggest that the resources required to increase training would be recouped if changes resulted in fewer deaths, in turn lowering the need for investigations, inquests, and reviews.

However, the Review also heard that longer training means taking officers out of the field, which can be a problem for public safety and effective policing.

34. As discussed above, it is important to acknowledge the interrelationship between training and the other variables that affect the behaviour of officers and the individuals they are called to assist. In light of that multi-faceted framework, many of the Review's recommendations regarding training are discussed in other chapters, such as the consideration of requiring mandatory mental health first aid certification as addressed in Chapter 6 (Selection of Police Officers), and offering crisis intervention training to a larger proportion of officers as discussed in Chapter 11 (MCIT and Other Models of Crisis Intervention).

35. That interrelationship was also reflected in many of the submissions made to the Review. More than one stakeholder suggested that use of force training has not changed in over two decades. This critique appears to be directed more at the Use of Force Model and guidelines implemented by the Province,[29] and less at the curricula at the OPC or TPC, which clearly have changed in that time period. The information given to the Review demonstrates that police training in areas such as use of force, people in crisis and mental health issues is continually analyzed, updated and refined. In fact, training was referred to by one stakeholder as a "moving target" because it changes so frequently that it is difficult to measure its effectiveness. Other stakeholders have pointed to the introduction of the crisis resolution course, training on mental illnesses and symptoms and involvement of people with lived experience of mental illness as positive changes in recent years.

36. The Review received some very specific suggestions, including modifying the practice of teaching officers to shoot at a subject's chest in order to reduce the likelihood of death from shootings. However, this change would also decrease the likelihood that an officer would hit the subject when shooting, potentially endangering the officer and members of the public.

37. Other comments involved the curriculum design process at the TPC, including a perception that the police hierarchy does not facilitate upstream feedback on training programs or encourage constructive criticism from within the Service. A related concern was raised that trainers at the police colleges are not consulted when curriculum changes are being considered. Another stakeholder echoed the suggestion of academics in this field that training should be customized to reflect officers' varying educational, professional, and life experience.

38. A further suggestion was to improve the education officers receive on civil mental health legislation~~in~~cluding officers' obligations, options and opportunities for discretion. These comments stem from the fact that thousands of apprehensions are made each year under the *Mental Health Act* and result in transfers of care to hospitals.

39. At the divisional level, the Review heard that the availability of decentralized training may depend on the approach taken by supervisors responsible for a particular

[29] See Chapter 10 (Use of Force).

platoon or division. For example, one stakeholder expressed concern that officers may not be given time by unit commanders to complete mandatory online training modules. Decentralized training is important to reinforce the mental health and de-escalation education that officers receive at the TPC. For example, an officer may be influenced by his or her peers and immediate supervisors regarding the judgment used to distinguish a person in crisis who requires assistance from an individual intending to engage in violent criminal behaviour.

40. Some submissions urged that police training needs to further emphasize de-escalation while others suggested a research study was needed to evaluate whether de-escalation training improves the outcomes of interactions with people in crisis. Curriculum design and delivery at the TPC and divisional levels could involve a wider spectrum of perspectives, from people with mental health issues and their families, to officers with crisis intervention experience and mental health professionals, including hospital staff who must stabilize crisis situations without weapons. It was suggested that de-escalation skills be evaluated not just during training but also as part of annual performance reviews.

III. Recommendations

41. Before making recommendations on the issue of training, I wish to mention that I believe that the overall recruit and in-service training that TPS officers receive is very good in many respects, and reflects improvements over time. However, my mandate requires me to consider whether further improvements can be made, and I believe there remains room for improvement.

42. I recommend that:

Recruit training

RECOMMENDATION 15: The TPS place more emphasis in its recruit training curricula on such areas as:

(a) Containment: considering and implementing techniques for containing crisis situations whenever possible in order to slow down the course of events and permit the involvement of specialized teams such as ETF or MCIT as appropriate;

(b) Communication and De-escalation: highlighting communication and de-escalation as the most important and commonly used skills of the police officer, and the need to adjust communication styles when a person does not understand or cannot comply with instructions;

(c) Subject Safety: recognizing the value of the life of a person in crisis and the importance of protecting the subject's safety as well as that of the officer and other members of the public;

(d) Use of Force: making more clear that the Use of Force Model is a code of conduct that carries (i) a goal of not using lethal force and (ii) a philosophy of using as little non-lethal force as possible; and that the Model is not meant to be used as a justification for the use of any force;

(e) Firearm Avoidance: implementing dynamic scenario training in which a recruit does not draw a firearm, as a means of emphasizing the non-lethal means of stabilizing a situation and reducing the potential for over-reliance on lethal force;

(f) Fear: including discussions of officers' fear responses during debriefings of practical scenarios that required de-escalation and communication techniques to defuse a crisis situation;

(g) Stigma: addressing and debunking stereotypes and stigmas concerning mental health. For example, the TPC could build on its use of video presentations involving people with mental health issues by adding interviews with family members of people who have encountered police during crisis situations and police officers who were present during a crisis call that resulted or could have resulted in serious injury or death;

(h) Experience and Feedback: incorporating mental health and crisis situations into a larger number of practical scenarios to provide recruits with more exposure to, and feedback on, techniques for resolving such situations; and

(i) Culture: laying the foundation for the culture the TPS expects its officers to promote and embody, and preparing recruits to resist the aspects of the existing culture that do not further TPS goals and values with respect to interactions with people in crisis.

RECOMMENDATION 16: The TPS consider whether officers would benefit from additional tools to assist them in responding to crisis calls, such as a quick-reference checklist for dealing with people in crisis that reminds officers to consider: whether the person is demonstrating signs of fear versus intentional aggression; whether medical, background and family contact information is available; whether alternative communication techniques are available when initial attempts at de-escalation are unsuccessful; whether containment of the person and the scene is a viable option; and whether discretion should be used in determining whether to apprehend, arrest, divert or release the person in crisis.

RECOMMENDATION 17: The TPS consider whether the 20-week recruit training period should be extended to allow sufficient time to teach all topics and skills required for the critically important work of a police officer.

In-service training

RECOMMENDATION 18: The TPS consider placing more emphasis, within the existing time allocated to in-service training if necessary, on the areas identified in Recommendation 15.

RECOMMENDATION 19: The TPS consider requiring officers to re-qualify annually or otherwise in the areas of crisis communication and negotiation, de-escalation, and containment measures.

RECOMMENDATION 20: The TPS consider whether to tailor in-service mental health training to the needs and experience levels of different audiences, such as by offering separate curricula for officers assigned to specialty units or divisions with high volumes of crisis calls.

Decentralized training

RECOMMENDATION 21: The TPS consider how decentralized training can be expanded and improved to focus on such issues as:

(a) Platoon training: increasing opportunities for officers to engage in traditional and online mental health programming within their platoons;

(b) Exposure: providing officers with in-service learning exercises that involve direct contact with the mental health system and community mental health resources; and

(c) Peer learning: instituting a model of peer-to-peer education within divisions, such as discussions with officers who have experience with mental health issues in their families, who have worked on an MCIT, who received Crisis Intervention Team (CIT) training, or who have other related experience.

Research and curriculum design

RECOMMENDATION 22: The TPS collaborate with researchers or sponsor research in the field of police education to develop a system for collecting and analyzing standardized data regarding the effectiveness of training at the TPC, OPC and the divisional levels, and to measure the impact that improvements in training have on actual encounters with people in crisis.

RECOMMENDATION 23: The TPS consider whether a broader range of perspectives can be considered in designing and delivering mental health training, for example, by involving TPS psychologists, Police College trainers, additional consumer survivors, mental health nurses and community agencies who work with patients and police.

CHAPTER 8

Supervision

CHAPTER 8. SUPERVISION

Table of Contents

Page

I. THE CURRENT SITUATION 158

A. Provincial standards of supervision 158
B. The TPS structure and demographics 158
(1) Supervisors 160
(a) Sergeant/detective, staff sergeant/detective sergeant, inspector 160
(b) Staff inspector, superintendent, staff superintendent 161
(c) Divisional hierarchy 161
(2) Coach officers 162
C. Debriefing 164
(1) Standards and training 164
(2) Advantages 165
(3) Concerns 166
D. Performance evaluations 166
E. Discipline 167
(1) Applicable legislation 167
(a) Misconduct 169
(b) Penalties 170
(2) Disciplinary Hearings Office 171
(3) Internal reviews of incidents involving serious bodily harm or death 171
F. Comparison to other police services 172

II. OVERVIEW OF ISSUES HIGHLIGHTED BY STAKEHOLDERS 173

III. RECOMMENDATIONS 173

Coach officers and supervisors 173
Debriefing 174
Mental health champions 175
Discipline 175
Rewards 176
Performance reviews and promotion 176
De-escalation requirements 177

Chapter 8. Supervision

1. In this chapter, I consider the framework for supervision of TPS members that is in place within the TPS. Supervision serves two main purposes. First, it ensures compliance with TPS procedures and other Service Governance requirements. Second, supervision should be used to provide guidance and support to officers. By supervision, I mean not only formal supervision by commanding officers, but also informal supervision through coach officers and peers.

2. Leadership and effective mentorship are essential in order to ensure that the Service's training programs carry over into practice. The Toronto Police College (TPC) and Ontario Police College (OPC) offer reasonably sophisticated training on mental illness and people in crisis, as discussed in Chapter 7 (Training).[1] This training needs to be reinforced by members' colleagues, mentors and supervisors during their day-to-day duties. An effective system of positive and negative reinforcement—for officers and for supervisors—is an essential element of creating a culture that enhances, rather than "eats," training. As one stakeholder put it, supervisors need to lead, not just supervise.

3. Before beginning my discussion of supervision within the TPS, I should note that this chapter is concerned only with the internal supervision and oversight of TPS members. It does not examine the supervisory roles of the Toronto Police Services Board (TPSB), the Special Investigations Unit (SIU), or other external oversight bodies with jurisdiction over the TPS.

I. The Current Situation

A. Provincial standards of supervision

4. O. Reg. 3/99 ("Adequacy and Effectiveness of Police Services") and the Ontario Policing Standards Manual require the Chief of Police to ensure that supervision is available to every member of the Service during his or her shift at any time of day.[2] The Chief of Police has two primary responsibilities regarding supervision and oversight: to ensure that supervisors have the requisite knowledge, skills and abilities to supervise; and to establish procedures on supervision, including the circumstances under which a supervisor should be contacted and should attend an incident.[3] Supervisors, in turn, are mandated to monitor and ensure their junior officers' compliance with legislation, regulations, and TPS policies and procedures.

B. The TPS structure and demographics

5. The structure of the Toronto Police Service consists of a vertical hierarchy of officers and a horizontal classification of command areas. New recruits enter the Service as constables, and must progress from fourth class to first class constables before they

[1] See Chapter 7 (Training).

[2] *Adequacy and Effectiveness of Police Services*, O. Reg. 3/99, s. 10 [*Adequacy and Effectiveness*]; Ontario Ministry of Community Safety & Correctional Services, *Policing Standards Manual* (February 2012) [MCSCS, *Policing Standards*].

[3] *Adequacy and Effectiveness*, *id.*, ss. 10, 29; MCSCS, *Policing Standards*, *id.* at LE-025 Supervision.

can be considered for further promotion.[4] Generally, a constable may be considered for reclassification to the next class of constable at the time of his or her annual performance review, barring any performance or disciplinary concerns. An officer with at least one full year of experience as a first class constable may apply to be promoted to a supervisory-level position such as detective, sergeant, detective sergeant and staff sergeant. Supervisors can in turn be promoted to senior officers, whose ranks include inspector, staff inspector, superintendent, and staff superintendent. The ranks of deputy chief and Chief of Police are the highest senior officers in the TPS.

6. The supervision provided at the divisional and platoon level is a critical influence on Service members. As discussed in Chapter 3 (Context), the vast majority of uniformed officers are assigned to divisional policing and specialty units.[5] The TPS has previously identified staff development as a key priority: as more senior members retire, the Service will have to promote qualified personnel to fill supervisory, management, and specialized positions. It is crucial that the Service select the right people in supervisory roles because these officers will be responsible for ensuring more junior officers are given sufficient instruction, coaching and supervision. In particular, the TPS is concerned that primary response officers receive training that enables them to perform their duties effectively.[6]

7. A TPS report from 2011 noted that its supervisors face a significant challenge regarding officers in two age groupings: those over the age of 40, who require continued opportunities for challenge and development in a job they have performed for many years; and those under the age of 40, who, as compared to their older counterparts, are described by the TPS as being more educated, technologically literate, diverse, individualistic, and self-interested. The younger cohort is also said to demonstrate less loyalty to the workplace and less deference to their superior officers, and to carry increased expectations for rapid promotion and organizational accommodation for work-life balance.[7]

8. In 2003, the Ferguson Report concluded that one of the most significant problems facing the TPS is lack of supervision, which stems from the promotion of people to management positions without sufficient training and resources.[8] The Ferguson Report linked inadequate supervision to the potential for misconduct and corruption, a lack of confidence in the promotional process, and unethical behaviour.[9]

---

[4] Toronto Police Service, *Policy & Procedure Manual*, 4-10 "Uniform Promotional Process – Up to and Including the Rank of Inspector" (Toronto, ON: Toronto Police Service, 2008) at 3.

[5] Toronto Police Service, *Planning for the Future... Scanning the Toronto Environment* (Toronto, ON: Toronto Police Service, 2011) at 200, 294.

[6] *Id.* at 216.

[7] *Id.* at 200. The Las Vegas Metropolitan Police Department offers an innovative approach to staff retention - supervisors double as career counsellors, providing advice to officers on a voluntary basis. Training for the Career Development Program includes the following: general counselling techniques; tools for assessing an employee's knowledge, skills and abilities; awareness of best practices in other jurisdictions; and knowledge of internal opportunities and outside resources. See Las Vegas Metropolitan Police Department, *Partners with the Community*, 5/101.50 "Career Development Program" at 206 [Las Vegas, *Partners*].

[8] George Ferguson, *Review and Recommendations Concerning Various Aspects of Police Misconduct, Volume I,* Commissioned by Julian Fantino, Chief of Police, Toronto Police Service (January 2003) at 23 [Ferguson, *Review*].

[9] *Id.* at 24-25.

9. The Review heard that people "do what is inspected, not what is expected." Accordingly, officer training must be reinforced through attentive supervision, mentoring, and disciplinary consequences for breaches of procedures and other Service Governance standards. Although the TPSB and senior management of the TPS set procedural expectations for all members, supervisors at the divisional level have the most frequent and direct contact with the majority of officers, and thus have the greatest opportunity to encourage compliance with procedures, through both positive and negative measures.

1. *Supervisors*

(a) *Sergeant/detective, staff sergeant/detective sergeant, inspector*

10. TPS Procedure 14-10 sets out the standard process for promoting officers to the supervisory ranks of sergeant, detective, staff sergeant, detective sergeant, and inspector.[10] Once an officer applies for promotion, his or her unit commander must provide an assessment. The candidate must also take a written examination, and be interviewed by a promotional panel.

11. The minimum requirement for promotion includes a clear disciplinary record for the previous two years, a clear criminal record, use of force qualification, and a commitment to uphold the Service's core values. Officers who are subject to criminal, misconduct, or harassment investigations can participate in the process, but they will not be promoted unless the complaint is resolved in their favour. Officers who have served as first class constables for at least one year may apply for promotion to sergeant/ detective. Sergeants or detectives who have completed the probationary period in that position are eligible to apply for promotion to staff sergeant or detective sergeant, respectively. Staff sergeants and detective sergeants may apply for vacancies at the inspector level after one year in their positions.[11]

12. Unit commanders must verify a candidate's eligibility and assess the applicant's competencies pursuant to the TPS Competency Dictionary, the Service's core values, and the officer's experience, skills, abilities, contribution to the TPS, past and present performance, and performance potential in the sought-after rank.[12] The promotional panel will assess the same criteria in making a decision, and will have access to the candidate's personnel file and application. Before an interview, a background and security check of the applicant is performed and the appropriate command officer may be consulted. The promotional panel's evaluation accounts for 60% of the weight in the promotional process.[13] All promotions are approved individually by the TPSB.

---

[10] Toronto Police Service, *Policy & Procedure Manual*, 4-10 "Uniform Promotional Process – Up to and Including the Rank of Inspector" (Toronto, ON: Toronto Police Service, 2008).

[11] *Ibid*.

[12] *Id*. at 3.

[13] *Id*. at 5.

13. The TPS provides a two-part supervisory leadership course to newly-promoted probationary sergeants.[14] The two parts are divided by at least three months of field experience and are taught in conjunction with Humber College. The course addresses several topics, including diversity, value-based leadership, emotional intelligence, strategic thinking, conflict management, social psychology and influence, communications, supervisor reports, police discipline, human resources, team building and wellness. The participants are asked to submit evaluations of the course, and focus groups are held with sergeants one year after their promotions to assess the impact the course had on the way they do their jobs.

(b) *Staff inspector, superintendent, staff superintendent*

14. TPS Procedure 14-11 sets out the process for promotion to staff inspector, superintendent, and staff superintendent. Members who have reached the rank of inspector are eligible for promotion under this procedure. Similar to the procedure described above, the minimum requirement for applicants includes, among other factors, a clear disciplinary record for the previous two years. Officers who are subject to criminal, misconduct or harassment investigations are able to participate in the process, although they will not be promoted unless the complaint is resolved in their favour. Candidates are required to interview with panels comprised of the Chief of Police, two or more deputy chiefs and the Chief Administrative Officer. The TPSB or a designate must approve all recommendations for promotion under this Procedure.[15]

(c) *Divisional hierarchy*

15. The unit commander of each division is responsible for managing all personnel assigned to the division. The unit commander is supported by one inspector and several staff sergeants and other supervisory officers who are assigned to one of the five platoons —a platoon is effectively one shift—within each division. The staff sergeants and sergeants assigned to each platoon are responsible for the performance and conduct of their subordinate officers. Constables report to front line sergeants who, in accordance with the TPS chain of command, report to division staff sergeants. Staff sergeants report to the inspector and unit commander, who are the senior management team at each Division.

16. The TPS Standards of Conduct give supervisors responsibility for the conduct, performance, and discipline of subordinate officers. This oversight role includes ensuring that officers are properly trained and familiarized with their duties and functions, and providing constructive guidance to subordinates whenever required. Supervisors must ensure that apparent breaches of TPS procedures or legislative duties

[14] Toronto Police Service, *Course Training Standard: Training and Education*, HU0011, "Supervisory Leadership Course, Part Two" (Toronto, ON: Toronto Police Service, 2009).

[15] Toronto Police Service, *Policy & Procedure Manual*, 4-11"Uniform Promotion Process to Staff Inspector, Superintendent and Staff Superintendent" (Toronto, ON: Toronto Police Service, 2008).

are investigated, and report up the chain of command any unusual occurrences during their shifts.[16]

2. *Coach officers*

17. Coach officers provide field training to new police recruits who are transitioning from training to full duties as a fourth class constable.[17] Officers in this role act as mentors, teachers, and supervisors for new constables. The Review heard about the critical role coach officers can play in a new constable's development, and the importance of selecting officers best suited to this role in order to reinforce the training and culture intended by the TPS senior management.

18. Coach officers are certified by completing a training course, which is offered by institutions such as the OPC and internally at the TPC. Coach officers must conform to the Service's core values of honesty, integrity, fairness, respect, reliability, team work, and positive attitude.[18]

19. The TPS Uniform Coach Officer course includes training on ethics, integrity and diversity. In particular, the course addresses the importance of ethical and professional behaviour and integrity and fairness when working with and reviewing new recruits. Further, issues of personal bias as well as integrity and motivation in a leadership context are discussed during the course. TPS coach officer training is an introduction to the fundamentals of supervision and management.[19]

20. Coach officers are taught how to conduct performance evaluations, basic counselling methodologies, solving problems related to personnel management, and the discipline process, among other skills.[20]

21. Coach officers have the following responsibilities toward their trainees: facilitating diverse and meaningful learning experiences, explaining TPS procedures, reviewing the responsibilities of various members of the Service, providing feedback, and ensuring that new officers have the necessary orientation to perform their duties. They must also monitor and report on the progress of trainees, advising platoon supervisors of any issues that arise regarding specific trainees.[21]

22. The OPC Coach Officer Manual outlines the requisite performance indicators used to evaluate trainees.[22] These performance indicators include many of the critical skills identified in other chapters of this Report:

---

[16] Toronto Police Service, *Service Governance Standards of Conduct* (Toronto, ON: Toronto Police Service, 23 December 2013), s. 2.2.1.

[17] Ontario Police College, "Police Trainee Field Training Manual" (Aylmer, ON: The Ontario Police College, 2009) at 6 [OPC, *Manual*].

[18] Toronto Police Service, *Course Training Standard*, TM0027 "Community Policing Section, Uniform Coach Officer" (January 2013) at 6.

[19] *Id.* at 3-5.

[20] *Id.* at 15-16.

[21] OPC, *Manual*, *supra* note 17 at 10.

[22] *Ibid.*

(a) knowledge of applicable laws;

(b) verbal communication skills (demonstrating professionalism with the public, preventing conflict, de-escalating volatile situations, using appropriate tone and active listening, and building rapport);

(c) written communication skills;

(d) knowledge of TPS structure and procedures;

(e) knowledge of community composition and resources;

(f) officer safety;

(g) use of force;

(h) police vehicle operations;

(i) commitment (empathy and desire to help others, personal initiative, and professional discipline);

(j) self-confidence (leadership, knowledge of strengths and limitations, and reliance on support systems);

(k) mental preparedness (visualizing and role playing scenarios and mentally preparing for critical activities);

(l) focus (common sense, practical resolutions, and controlling the pace of crisis situations); and

(m) seeking feed-back and conducting self-evaluations.[23]

23. The OPC Coach Officer Manual provides advice on improving trainees' performance in each skill area, including rehearsing plans of action based on calls heard on the radio or before performing a particular task, providing additional exposure to the public on foot patrol or by meeting with community leaders, and practising how to differentiate behavioural levels within the Ontario Use of Force Model (described in Chapter 10 (Use of Force)). The Manual further recommends debriefing after every call, providing positive feedback when deserved, and discussing successful calls in order to reinforce effective performance patterns.[24]

24. Although new recruits are not required to attend every kind of call listed in the Manual during their probationary period, their coach officer must at least walk them through the issues and responses for each kind of call that is not directly encountered.[25]

[23] *Id*. at 13-14.

[24] *Id*. at 136.

[25] *Id*. at 6.

Calls involving people in crisis are among the kinds of calls listed in the OPC Manual to which trainees are expected to get exposure.

25. Coach officers can have a critical influence on new members of the Service because they have daily contact with new officers and possess primary responsibility for ensuring trainees become competent in all performance areas within their first months of duty. Coach officers can enhance TPC and OPC training by walking their trainees through realistic crisis scenarios, ensuring new recruits are exposed to calls involving people in crisis, and debriefing the positive and negative actions and outcomes of every situation.

26. However, because of the influence the coach officers hold over new members, some commentators have said that a coach officer who adopts the wrong approach can "undo six months of training in half an hour." Coach officers hold the discretion to focus trainees' attention on "hard skills" involving use of force and, if not properly educated themselves, can perpetuate negative stereotypes about people in crisis. In such cases, trainees could be given ineffective guidance on how to handle calls involving people in crisis, or deprived of information about available mental health resources that can assist them in effectively handling such calls. Given what is at stake, it is essential that TPS selects its coach officers from among a pool of candidates best suited to enhancing standardized training and instilling a progressive, respectful Service culture.

27. The Review was advised that there is no formal mechanism for evaluating the effectiveness of coach officer training. As such, it is difficult to measure the real-world benefits of a program that appears carefully considered and well-intentioned on paper.

C. Debriefing

1. *Standards and training*

28. The Ontario Policing Standards Manual requires that the TPS set out debriefing processes for teams involved in the following areas: containment, tactical, hostage rescue, major incident command, crisis negotiation, explosives, marine, canine, and public order.[26] However, there is no provincial requirement that primary response units debrief after incidents involving people in crisis, or that divisional supervisors conduct debriefings with officers following crisis situations.

29. The Review heard that there is currently no systematic framework for debriefing incidents involving primary response officers and people in crisis. While there is the Critical Incident Response Team (CIRT) for more serious incidents (as discussed in Chapter 9 (The Mental Health of Police Personnel), the role of CIRT is focused primarily on helping officers with traumatic stress rather than debriefing learning points from the incident.

[26] MCSCS, *Policing*, *supra* note 2, ER-001-ER-010, PO-001 "Emergency Response" and "Public Order Maintenance" (March 2010) at Appendix 1, 2-3.

30. All TPS members are trained in the techniques and process of debriefing through their participation in classroom education and dynamic training scenarios at the OPC and the TPC, including as part of annual in-service training at the TPC. Incident debriefing is explicitly linked to the issue of officer mental health, and is taught as a component of critical incident stress in the OPC's firearm training course. The TPC's annual requalification training includes debriefing as part of its judgment development training, specifically with respect to powers of arrest, threat perceptions, communication skills, tactics, less-than-lethal force options, and justification for use of force, among other topics.[27]

2. *Advantages*

31. The importance of debriefing incidents—both those that end positively and those that could have had a better outcome—is well-recognized in much of the literature considered by the Review.

32. Regular debriefing is essential to reinforcing the messages taught by the OPC and TPC. Debriefing can be done informally by an officer's partner or team member immediately after a less-serious incident, or conducted formally by a supervisor or in a group in response to a more serious encounter. Ultimately, what matters is that real-world incidents are used to emphasize the conduct expected of an officer, foster high professional standards, discuss lessons learned, and explore the officer's perceptions of the subject, situation, and available responses.

33. At an individual level, debriefing provides officers with an opportunity to examine decisions made during encounters that are often fast-paced and charged with high levels of anxiety for everyone involved. If their decision-making during crisis situations differed from their training, debriefing allows officers to assess the reasons for that difference, and to consider how those choices may have affected the outcomes.

34. Conversely, if officers do not have the opportunity to debrief an encounter they had with a person in crisis, they may develop less constructive de-escalation techniques. The danger is that a lack of self-analysis or external feedback will lead to poor responses that are reinforced through repeated behaviour. The Review heard that there is also the possibility that an officer who is not debriefed after an incident with a negative outcome may "self-justify" his or her actions by developing an alternative recollection of the situation—a result that neither helps the officer develop skills, nor helps the TPS as a whole, since the institution's success is largely dependent on public confidence.

35. An officer who is given the opportunity to debrief after successfully de-escalating a crisis situation may receive immediate, positive feedback that will reinforce his or her training and instincts with respect to effective communication techniques. Similarly, the information collected by supervisors on members with effective crisis de-escalation skills could be used to inform future performance reviews, promotional assessments, and service awards.

---

[27] Toronto Police College, "Course Training Standard: In-service training course – Uniform" (2013) at 7, 9, 21, 23.

36. At an institutional level, regular debriefing of police encounters with people in crisis can assist the TPS in refining its procedures, training, and supervisory practices to respond to trends in conduct or knowledge gaps of its members. The information collected from debriefing sessions could be aggregated and anonymized, then analyzed to identify training and supervisory needs across the Service, or within particular divisions. Although the TPS carefully scrutinizes recommendations that result from inquests and issue-specific external reviews, these mechanisms can take significant time to reach conclusive results. A more systemic approach to debriefing all kinds of incidents may provide the TPS with prompt feedback on the particular needs of its members. Such an approach could engage both traditional in-person debriefing sessions and technology-based feedback applications.

3. *Concerns*

37. A major concern for the TPS in connection with debriefing is confidentiality. The actions of TPS members can be the subject of disciplinary proceedings, civil lawsuits, and SIU/criminal proceedings, in addition to attracting media attention. If the notes or recollections of officers participating in debriefings are compellable as evidence in litigation, the resulting chill could prevent candid discussions of decision-making in crisis situations and thwart the intended benefits of the debriefing process.

38. By way of example, the Metropolitan Police Service in London, England has a mandatory debriefing policy after all incidents involving serious injury or death, including paperwork that must be filed by a unit commander after any situation in which an armed unit was deployed. Supervisors are responsible for debriefing subordinate officers to identify both individual training and organizational learning opportunities. However, the Metropolitan Police Service has encountered controversy with the Independent Police Complaints Commissioner with respect to disclosure of debriefing materials in criminal proceedings.

39. Another concern relating to debriefing is that the debriefing process may re-traumatize officers involved in more serious traumatic events. Encounters with people in crisis that result in death or serious injury can have serious mental health effects on police officers. The purpose of debriefing is to examine the judgment used under the circumstances and to learn from both mistakes and successes, in turn developing the individual officer and the Service more broadly.

40. An officer experiencing critical incident stress or other related effects could be further traumatized by the debriefing experience, which would defeat one of the primary goals of the exercise. In those cases, it may be preferable to debrief an incident with first responders or supervisors who attended the scene but were less directly involved with the person in crisis. Officers most directly affected by the incident might not be required to participate, either at all, or until they regained their own mental or emotional health.

D. Performance evaluations

41. New constables undergo a series of performance evaluations with their coach officers and supervisors during their initial months of service. Further, all members of

the TPS must participate in an annual performance review, which involves a written evaluation by their supervisors. Supervisors must rank officers as to whether they meet, exceed, or do not meet expectations in a variety of performance categories, including personal, technical and core competencies. Supervisors are expected to discuss with the officer his or her responsibilities and development plan, as well as ensure that he or she has received sufficient human rights training.[28]

42. There are also opportunities for informal feedback and evaluation, such as debriefing incidents that occurred during a shift or reviewing Use of Force Reports to identify training needs. However, it is difficult to implement quality controls on these measures because each supervisor may use these opportunities with varying frequency and levels of focus.

43. The Review heard that the Service faces challenges in making the annual performance review process constructive and meaningful for members. Officers may not take evaluations seriously unless they are accompanied by positive or negative consequences, such as promotions, awards, training requirements, or disciplinary measures. As discussed below, the legislative framework for police discipline and dismissal makes it difficult for the TPS to correct performance through disciplinary action. In this respect, the Service differs from most other professions, where it is understood that poor performance can lead to dismissal, even when the individual has not been disciplined or found guilty of misconduct.

44. The performance review process can be used to ensure that officers receive positive reinforcement for appropriately de-escalating situations with people in crisis. Such skills should be evaluated and noted in the review process, and officers who have excellent de-escalation and communication skills should be recognized at the divisional and service-wide levels. Similarly, performance reviews that reflect the quality of officers' skills in managing mental health crises could be very useful in the promotional process. De-escalation and communication skills, as well as experience, should be considered when assessing candidates for promotion to higher ranks and specialty units.

E. Discipline

1. *Applicable legislation*

45. The *Police Services Act* (PSA) governs complaints against officers made to the Office of the Independent Police Review Director (OIPRD) and to the TPS directly.[29] Regardless of whether the OIPRD refers complaints against officers to the Chief of Police, a member of the public makes a local complaint to the TPS, or the Chief of Police makes a complaint about a TPS member, the issue is dealt with through internal discipline procedures. The focus of this section is on those internal procedures.

---

[28] Toronto Police Service, 809 "Uniform Performance Appraisal and Development Plan: Constable" (Toronto, ON: Toronto Police Service, 2012); see also *Toronto Police Service, Uniform Performance Appraisal and Development Plan – User Guide* (Toronto, ON: Toronto Police Service, 2002).

[29] *Police Services Act*, R.S.O. 1990, c. P-15 [*PSA*]; *Public Complaints - Local Complaints*, O. Reg. 263/09 [*Complaints*].

46. Upon receipt of a complaint from a member of the public against a police officer, the Chief of Police must ensure an investigation is conducted and must review a written report of the findings.[30] If the complaint is unsubstantiated, the Chief of Police must notify the complainant, the officer and the OIPRD that no action will be taken.[31] If the investigation reveals misconduct that is not "of a serious nature," the Chief of Police may resolve the complaint informally with the consent of the complainant and the officer.[32] Similarly, local complaints can be addressed by way of alternative dispute resolution with the consent of the officer and the complainant.[33] Penalties imposed by way of informal resolution are expunged from the officer's employment record after two years if there are no subsequent findings of misconduct.[34] If the report provides reasonable grounds to believe the officer's conduct constitutes misconduct or unsatisfactory work performance, the Chief of Police "shall hold a hearing."[35]

47. The Chief of Police may make a complaint about any member of the TPS other than a deputy chief and, subject to approval by the TPSB, may ask another police service to conduct the investigation of such a complaint.[36] When a complaint is made against the Chief of Police or a Deputy Chief of Police, the TPSB is required to review the matter.[37] If the Board finds the impugned conduct may constitute misconduct, unsatisfactory work performance, or an offence under a provincial or federal law, the OIPRD must investigate and issue a written report.[38] Upon receipt of the OIPRD report, the TPSB has the same powers to dismiss the complaint, resolve it informally, or refer the issue to a hearing.[39]

48. This Review is not focused on complaints filed by members of the TPS against their colleagues. However, the 2003 the Ferguson Report did note that it is critical to create a safe environment for whistle blowers in order to establish a proactive system for detecting misconduct within the Service.[40] The kind of culture shift required to prevent the stigmatization of officers who report misconduct perpetrated by their peers will take time and commitment from senior management. This process can be aided, however, by including information in internal training and reference material on how to make a complaint or report misconduct committed by another officer. TPS must also hold supervisors accountable for failing to identify and rectify behaviour that falls short of the expected standards, especially with respect to incidents involving people in crisis.

---

[30] *PSA*, *id.*, s. 66(1).

[31] *Id.*, s. 66(2).

[32] *Id.*, s. 66(4).

[33] *Complaints*, *supra* note 29, s. 4.

[34] *PSA*, *supra* note 29, s. 66(12).

[35] *Id.*, s. 66(3).

[36] *Id.*, s. 76(1)(4).

[37] *Id.*, s. 69(1).

[38] *Id.*, s. 69(2).

[39] *Id.*, s. 69(4)(8)(9).

[40] Ferguson, *Review*, *supra* note 8 at 27.

(a) *Misconduct*

49. Pursuant to the PSA, a police officer is guilty of misconduct if he or she:

(a) violates a prescribed code of conduct;

(b) violates the provision concerning political activity;

(c) engages in secondary activities without the Chief of Police's permission and is aware that the activities may contravene the Act;

(d) resigns during emergency contrary to the provisions of the Act;

(e) attempts to harass or intimidate any other person in relation to a complaint;

(f) contravenes the legislative provisions regarding inducing misconduct, withholding services, trade union membership, or dealing with money, personal property or firearms; or

(g) contravenes regulations regarding equipment, use of force, uniforms, police pursuits, or records.[41]

50. Ontario has enacted a Code of Conduct for police officers.[42] Breaches of the Code are considered misconduct for the purposes of the PSA. The Code includes prohibitions against:

(a) Discreditable Conduct, including: the failure to treat or protect persons equally without discrimination on the basis of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status or disability; oppressive conduct towards an inferior officer; incivility toward the public or another officer; and criminal conduct;

(b) Insubordination;

(c) Neglect of Duty;

(d) Deceit;

(e) Breach of Confidence;

(f) Corrupt Practice;

(g) Unlawful or Unnecessary Exercise of Authority, including making unlawful or unnecessary arrests, and using unnecessary force;

[41] *PSA*, *supra* note 29, s. 80.

[42] *Code of Conduct*, being sch. of O. Reg. 268/10.

(h) Damage to Clothing or Equipment; and

(i) Consuming Drugs or Alcohol in a Manner Prejudicial to Duty.[43]

51. The Review received samples of internal reports of use of force-related misconduct investigations. Without commenting on the specific circumstances relating to any particular incident, it can be stated that the primary focus of the reports appeared to be whether the force employed met the minimum standards for legal justification. There was little emphasis on whether de-escalation techniques had been attempted, or whether the force used was as minimal as possible under the circumstances. The reports considered whether some applicable procedures were followed, but not all.

52. This focus on justifying the use of force employed by the officer can negatively affect both the Service culture and the efficacy of oversight bodies. The failure to focus on de-escalation can reinforce the idea within the TPS that the primary consideration for officers is what level of force can be justified after the fact, rather than whether force can be avoided by employing different tactics. It may well be that some officers need to see disciplinary measures taken for failing to attempt the use of de-escalation techniques in order for TPS members to appreciate more broadly the importance the Service places on avoiding death and injury, especially when called to assist people in crisis.

53. If internal investigative reports do not address these issues, TPS senior management and, in some cases, the TPSB, may not be able to assess whether the policies and procedures in place are adequate, and whether members are sufficiently held to account for breaches of those policies and procedures. Such reports could be more useful to both the TPS and the Board if they considered all procedures applicable to the incident (including, for example, the de-escalation requirements under the procedure relating to "Emotionally Disturbed Persons"), whether the officers involved met the standards of each of those procedures, and whether the Service's procedures should be amended or supplemented to encourage officers to perform to the high standard expected of them. Further, misconduct investigation reports should review operational considerations such as whether an appropriate chain of command was established at the incident, whether the scene and subject were contained as much as possible, whether each officer present knew what role he or she was to play in resolving the situation, whether the appropriate supervisors were dispatched to the incident, and whether those supervisors arrived promptly.

(b) *Penalties*

54. If found guilty of misconduct, an officer may be: dismissed; offered the opportunity to resign instead of being dismissed; demoted for a specific period and in a specific manner; suspended without pay for up to 30 days; directed to forfeit up to three days' pay; or directed to forfeit up to 20 days off.[44] Alternatively, the officer may be given a reprimand or directed to participate in particular training or a specific activity.

---

[43] *Ibid*.

[44] *PSA*, *supra* note 29, s. 85(1).

Further, a hearing officer may impose any combination of these penalties.[45] The Board has the same power of discipline with respect to findings of misconduct against a Chief of Police or deputy chief.[46]

55. Although a finding of misconduct may be entered on the member's employment record, no reference to the allegations or the hearing can be included. The record of misconduct cannot be considered "for any purpose relating to his or her employment" unless it was proved "on clear and convincing evidence" or the member resigned before the matter was finally determined.[47]

56. The Chief of Police may suspend, with pay, an officer suspected of or charged with misconduct or a provincial or federal offence until the final disposition of the matter. An officer may be suspended without pay if convicted of an offence and sentenced to a term of imprisonment, even if the conviction or sentence is under appeal.[48]

2. *Disciplinary Hearings Office*

57. The Disciplinary Hearings Office has been delegated the Chief of Police's responsibilities to conduct disciplinary proceedings pursuant to Part V of the PSA.[49] The tribunal adjudicates allegations of serious breaches of the PSA, including breaching the Code of Conduct. The mandate of the Disciplinary Hearings Office includes ensuring that all disciplinary hearing processes are inclusive, transparent, fair and equitable. Most proceedings are open to the public unless they involve public security or personal/ financial matters, and decisions are rendered in writing. However, the evidence adduced at a disciplinary hearing is protected from disclosure for use in civil proceedings.[50]

3. *Internal reviews of incidents involving serious bodily harm or death*

58. Pursuant to Ontario Regulation 267/10 under the PSA, the Chief of Police must launch an investigation regarding any incident of which the Special Investigations Unit (SIU) has been notified.[51] As such, the Chief of Police must commission an investigation every time a member of the Service is involved in an event resulting in death or serious bodily harm to a member of the public. The purpose of the investigation is to review the Service's policies and procedures, and the conduct of the officers involved in the incident.[52] The SIU is still considered the lead investigator in these circumstances but the results of the respective investigations are delivered to different bodies. The SIU

[45] *Id*., s. 85(7).

[46] *Ibid*.

[47] *Id*., s. 85(9).

[48] *Id*., s. 89(1).

[49] *Id*., s. 94(1).

[50] *Id*., s. 83(7)(8)(9).

[51] *Conduct and Duties of Police Officers Respecting Investigations by the Special Investigations Unit*, O. Reg. 267/10, s. 11(1).

[52] *Id*., s. 11(2).

reports its findings to the Attorney General.[53] In contrast, the Chief of Police gives his report to the TPSB, along with any action taken or recommended as a result of the incident.[54] This is known as the Chief of Police's section 11 report, in reference to the provision number in the regulation. As noted in Chapter 2 (Mandate, Independence, Scope and Methodology), this Review was commissioned by Chief Blair in connection with his obligations under section 11 relating to the incident involving Mr. Yatim, but this Report does not address the circumstances specific to that particular event.

F. Comparison to other police services

59. Several North American police services have implemented performance monitoring strategies, including early intervention systems. In Las Vegas, the Early Identification and Intervention Program is a non-disciplinary tool that requires supervisors to input data into a "dashboard" that helps identify incidents and patterns that may result in diminished work performance. Front-line supervisors review their subordinates' dashboards monthly to identify any red flags based on performance indicators and thresholds established by a central committee. Supervisors may intervene to ensure a member whose performance raises a red flag receives any necessary support, training or other assistance. The goal of the program is to reduce liability and risk exposure to the employee and the department as a whole, while at the same time ensuring supervisory accountability.[55]

60. Similarly, the Los Angeles Police Department has developed a data-based early intervention system aimed at identifying and correcting behaviours that are likely to lead to misconduct. The LAPD's Risk Management Information System gathers data on a daily basis regarding, among other things, every individual officer's arrests, crime reports, citations issued, pedestrian and vehicle stops, complaints, uses of force, vehicle pursuits or collisions, commendations, weapon qualifications, and attendance. This data is then compared on a daily basis against thresholds established by standard deviations from their peer group within the service. Supervisors are automatically notified of officers whose activities deviate too far from the mean, and they are authorized to take remedial action to correct the behaviour.[56]

61. Rather than having a disciplinary or punitive purpose, such early intervention systems assist police services in monitoring and, if necessary, remediating the performance, skills and readiness for duty of all officers. The systems are based on institutional learning about the behaviours that have previously resulted in misconduct or workplace health concerns. At the same time, they are forward looking in purpose, aimed at preventing unnecessary harm to police officers or members of the public and ensuring compliance with legislation and policies.

---

[53] *Id*., s. 11(4).

[54] *Ibid*.

[55] Las Vegas, *Partners*, *supra* note 7 at 208.

[56] David R. Doan, Deputy Chief (ret), Los Angeles Police Department, "Managing Risk Through Technology: Officer Early Intervention Systems" (Presented to the 37th Annual I.A.C.P. Law Enforcement Information Management Training Conference & Technology Exposition, Scottsdale, Arizona, 23 May 2013).

II. Overview of Issues Highlighted by Stakeholders

62. Many of the individuals and organizations—both within and outside the TPS—who wrote to and met with the Review offered comments on the structure of supervision within the TPS. Some submissions recommended enhanced emphasis on the role of TPS procedures in guiding street-level decision making, suggesting that currently procedures are used mostly to justify conduct after an incident. Others suggested that the current police hierarchy is not conducive to upstream feedback on supervisors or training. The importance of debriefing encounters with people in crisis was repeatedly noted, and many stakeholders recognized the need to protect the debriefing process from disclosure in criminal and civil litigation in order to promote truthful, constructive dialogue.

63. The Review received many submissions requesting that supervisors reinforce de-escalation and broader crisis training at the divisional level through debriefing, recognitions for effective approaches to crisis situations, and regular discussions of the different techniques for dealing with people in crisis. Stakeholders further suggested that communication and de-escalation skills should be given more emphasis in performance reviews and consideration for promotions. An innovative proposal was made to implement one dedicated mental health supervisor in each division—a highly trained individual who could champion mental health issues within the division, facilitate debriefing, training and other discussions on responses to people in crisis, and act as a resource for officers. Such a role could be incorporated into the mental health liaison position that already exists at the divisional level, but is currently focused on coordinating with external community agencies.

III. Recommendations

64. I recommend that:

Coach officers and supervisors

> **RECOMMENDATION 24:** The TPS further refine its selection and evaluation process for coach officers and supervisory officers to ensure that the individuals in these roles are best equipped to advise officers on appropriate responses to people in crisis; in particular, that the TPS:
>
> (a) Consider requiring additional mental health training and/or experience for candidates interested in coach officer and sergeant positions, such as CIT training or MCIT experience;
>
> (b) Create an evaluation mechanism through which officers can provide anonymous feedback on their coach officers or supervisors, including feedback on their skills regarding people in crisis; and
>
> (c) Ensure performance evaluation processes for supervisors include evaluation of both their skills regarding mental health and crisis response, as well as their monitoring of their subordinates' mental health and wellness;

Debriefing

RECOMMENDATION 25: The TPS create a Service-wide procedure for debriefing, including the debriefing of incidents involving people in crisis and incidents involving use of force, which includes consideration of such factors as:

(a) Discretion: the circumstances under which debriefing is mandatory, as opposed to when it is subject to the discretion of the appropriate supervisor;

(b) Participants: which members should participate in the debriefing process, particularly where there is a risk of re-traumatizing an officer suffering from critical incident stress;

(c) Institutional Learning: how the learning points from the debriefing can be shared with other members of the Service;

(d) Process: the appropriate circumstances, methods and selection of appropriate personnel for debriefing incidents that involved people in crisis, whether they were resolved successfully or resulted in unsatisfactory outcomes;

(e) Timing: how to create an expectation that debriefs will be conducted immediately after an incident, where appropriate, to encourage learning through debriefs without the fear of resulting sanctions;

(f) Self-analysis: whether the incident was resolved with the least amount of force possible, as well as whether the officer experienced fear, anxiety and other psychological and emotional effects during the encounter, and techniques for coping with those effects while trying to de-escalate a situation;

(g) Direct Feedback: direct feedback to officers on incidents that could have been resolved with less or no force, including whether the officer considered inappropriate circumstances or failed to consider appropriate factors and any alternative force options that could have been employed;

(h) Critical Incident Response: the importance of conducting debriefs in a manner that respects officers' mental health needs following an incident of serious bodily harm or lethal force, and the role of the Critical Incident Response Team;

(i) Stigma: how to foster discussions regarding stereotypes or misconceptions about people in crisis that may have contributed to the officer's decision-making during the crisis situation; and

(j) Valuing the Role of Debriefs: methods for creating a culture of debriefing and self-assessment within the Service, rather than a systemic perception of debriefing as a routine administrative duty.

RECOMMENDATION 26: The TPS develop a procedure that permits debriefing to occur on a real-time basis despite the existence of a Special Investigations Unit (SIU) investigation. The TPS should work with the SIU and appropriate municipal and provincial agencies to craft a procedure that does not interfere with external investigations, and that maintains the confidentiality of the debriefing process in order to promote candid analysis and continuous education.

Mental health champions

RECOMMENDATION 27: The TPS develop a network of mental health champions within the Service by appointing at least one experienced supervisory officer per division with experience in successfully resolving mental health crisis situations to:

(a) provide formal and informal divisional-level training, mentoring and coaching to other officers;

(b) lead or participate in debriefings of mental health crisis calls when appropriate;

(c) provide feedback to supervisors and senior management on officers who deserve recognition for exemplary conduct when serving people in crisis and those who need additional training or coaching;

(d) meet periodically with other mental health champions at various divisions to discuss best practices, challenges, and recommendations; and

(e) report to the appropriate deputy chief or command officer on the above responsibilities.

Discipline

RECOMMENDATION 28: The TPS establish an appropriate early intervention process for identifying incidents of behaviour by officers that may indicate a significant weakness in responding to mental health calls. Relevant data would include: propensity to draw or deploy firearms unnecessarily; use of excessive force; lack of sensitivity to mental health issues; insufficient efforts to de-escalate incidents; and other behaviours.

RECOMMENDATION 29: The TPS review its discipline procedure with regard to the following factors:

(a) Consistency: whether appropriate consequences are consistently applied to penalize inappropriate behaviour by officers in connection with people in crisis;

(b) Appropriate Penalties: whether officers who demonstrate conduct inconsistent with the role of a police officer are appropriately disciplined, including through suspension without pay or removal from their positions when appropriate;

(c) Supervisory Responsibility: whether there are appropriate disciplinary consequences for supervisors who fail to fulfil their duties to identify and rectify weaknesses in training or performance by officers subject to their oversight;

(d) Use of Force Reports: whether the information recorded in previous Use of Force Reports could be used in determining the appropriate level of discipline in particular incidents involving excessive use of force; and

(e) Legislative Reform: whether the factors listed above require the TPS to work with the provincial government to modify legislative or regulatory provisions.

Rewards

RECOMMENDATION 30: The TPS create incentives for officers to put mental health training into practice in situations involving people in crisis, and to reward officers who effectively de-escalate such crisis situations. In this regard, the TPS should consider inviting community organizations or other agencies to participate in determining division-level and Service-wide awards for exceptional communications and de-escalation skills.

Performance reviews and promotion

RECOMMENDATION 31: The TPS consider revising the process for performance reviews and promotions to:

(a) establish an explicit criterion that experience with people in crisis will be considered in making promotion decisions within the Service;

(b) place a greater emphasis on crisis de-escalation skills such as communication, empathy, proper use of force, patience and use of mental health resources; and

(c) determine the appropriate use of information contained in Use of Force Reports in assessing an officer's performance and suitability for promotion or particular job assignments.

De-escalation requirements

RECOMMENDATION 32: The TPS enforce, in the same way as other TPS procedures, those procedures that require an officer to attempt to de-escalate, such as Procedure 06-04: Emotionally Disturbed Persons. In particular:

(a) Professional Standards investigations under Section 11 of Regulation 267/10 under the *Police Services Act* should investigate whether applicable de-escalation requirements were complied with and, if not, a finding of contravention of Service Governance and/or misconduct should be made;

(b) in appropriate cases, officers who do not comply with applicable de-escalation requirements should be subject to disciplinary proceedings; and

(c) supervisory officers should be formally directed to (i) monitor whether officers comply with applicable de-escalation requirements, and (ii) take appropriate remedial steps, such as providing mentoring and advice, arranging additional training, making notations in the officer's personnel file, or escalating the matter for disciplinary action.

CHAPTER 9

The Mental Health of Police Personnel

CHAPTER 9. THE MENTAL HEALTH OF POLICE PERSONNEL

Table of Contents

Page

I. THE CURRENT SITUATION 180

A. The need to support officers' psychological wellness 180
B. Workplace mental health standard 182
C. Psychological wellness resources for TPS members 182
(1) The Psychological Wellness Program 183
(2) Employee and Family Assistance Program 185
(3) Response to traumatic incidents 185
(4) Other forms of peer support 186
D. In-service monitoring 187
(1) Fitness for duty evaluations 187
(2) The role of supervisory officers 188

II. OVERVIEW OF ISSUES HIGHLIGHTED BY STAKEHOLDERS 190

III. RECOMMENDATIONS 190

Chapter 9. The Mental Health of Police Personnel

1. This chapter discusses the current state of mental health initiatives for members of the Toronto Police Service, including the Service's psychological wellness program, its approach to critical incident response debriefings, the availability of peer support and the steps taken to monitor officer mental health.

2. As one stakeholder has noted, when a police officer encounters a person in crisis, everyone is in crisis~~in~~cluding the officer, who must overcome his or her own physiological stress and fear in order to help and protect the person in crisis, while also ensuring the public's safety and his or her own safety.

3. To have the confidence, openness and empathy needed to engage calmly with a person in crisis using the minimum force necessary, TPS officers must be mentally healthy themselves. Yet a portion of TPS officers will inevitably experience mental health issues. While estimates for the prevalence of mental illness in Canada vary as a result of divergences in definitions and research methodology, it is indisputable that mental health issues are common in Canadian society.[1] Police officers are no more immune to such issues than others. Rather, because they must deal on a day-to-day basis with some of the most saddening features of human nature, it appears that police are more likely than the average person to experience mental health difficulties.

4. I have concluded that officer mental wellness is important to dealing effectively with people in crisis and potentially reducing the number of violent confrontations. It is best for all concerned if psychological wellness issues affecting police officers are identified and treated before they affect an officer's fitness for duty.

I. The Current Situation

A. The need to support officers' psychological wellness

5. Exposure to trauma is an inherent feature of police work. While the mental health effects of police work have not been comprehensively studied, existing data suggest that they can be significant. One recent study found that police officers in Canada "are exposed to a fairly unique set of stressors and face a different set of challenges at work than most employees," challenges which include the pressure to take

[1] Toronto's Centre for Addiction and Mental Health estimates that in any given year, one in five Canadians experiences a mental health or addiction problem. See Centre for Addiction and Mental Health, "Statistics on Mental Illness and Addictions" (2012), online: Centre for Addiction and Mental Health <http://www.camh.ca/en/hospital/about_camh/newsroom/for_reporters/Pages/addictionmentalhealthstatistics.aspx>. The Canadian Mental Health Association estimates that one in five Canadians will experience a mental illness in their lifetime. See Canadian Mental Health Association, "Fast Facts about Mental Illness" (2014), online: Canadian Mental Health Association <http://www.cmha.ca/media/fast-facts-about-mental-illness/>. The Mental Health Commission of Canada similarly estimates that in any given year, one in five people in Canada experiences a mental health problem or illness. See Mental Health Commission of Canada, "The Facts" (2012), online: Mental Health Commission of Canada <http://strategy.mentalhealthcommission.ca/the-facts/>. The Mood Disorders Society of Canada estimates that at any given time 10.4 percent of Canadians are living with a mental illness. See Mood Disorders Society of Canada, "Quick Facts: Mental illness and addiction in Canada" (Nov. 2009), online: Mood Disorders Society of Canada <http://www.mooddisorderscanada.ca/documents/Media%20Room/Quick%20Facts%203rd%20Edition%20Referenced%20Plai n%20Text.pdf>.

on work that falls outside their mandate, multiple competing and constantly changing demands, understaffing, the complexity of navigating the criminal justice system, and managing the expectations of the public.[2] Moreover, this study does not touch on another challenge unique to policing: the inherent dangers of police work.

6. According to several studies, mostly from the U.S., officers commonly suffer from significant psychological issues. One study found that approximately one-third of police officers who are exposed to work-related traumatic incidents develop significant post-traumatic symptoms and other complex psychological issues that can interfere with their duties and responsibilities as a police officer.[3] Another study found that at least 25 percent of police officers meet the standard clinical criteria for alcohol abuse.[4]

7. Officers and their domestic partners consistently report that the policing occupation is a significant source of stress in their relationship, impacting their lives at home.[5] Post-traumatic stress disorder and elevated rates of alcohol abuse may cause increased aggression. Police families have been shown to have higher rates of domestic violence than the wider civilian population.[6]

8. Officers can also have difficulty asking for help. Fear of stigmatization, negative job consequences, and perceptions of personal weakness and failure all impede police officers from seeking help that they may need.[7] As a result of the police working environment, there is evidence from a U.S. study that the rate of police suicide is approximately 1.5 times that of the general population.[8]

9. Although these statistics are not drawn from Toronto, they are relevant to a general understanding of the stresses and pressures that are characteristic of policing and of the obstacles to supporting and strengthening the psychological wellness of officers. Police wellness and assistance programs must overcome these obstacles to ensure that officers are mentally well enough to manage their complex duties and responsibilities.

---

[2] Linda Duxbury & Christopher Higgins, *Caring for and about those who serve: Work-life conflict and employee well being within Canada's Police Departments* (Ottawa, ON: Sprott School of Business, Carleton University, 2012) at 34, online: Sprott School of Business <http://sprott.carleton.ca/wp-content/files/Duxbury-Higgins-Police2012_fullreport.pdf>.

[3] I.V. Carlier, R.D. Lamberts & B.P.R. Gersons, "Risk factors for posttraumatic stress symptomatology in police officers: a prospective analysis" (1997) 185:8 J Nerv Ment Dis 498 at 498-506.

[4] Robyn Gershon, *National Institutes of Justice Final Report: "Project Shields"* (Baltimore, MD: Johns Hopkins University, 2000) at 16, online: National Criminal Justice Reference Service <https://www.ncjrs.gov/pdffiles1/nij/grants/185892.pdf>.

[5] Ellen Kirschman, *I Love a Cop: What Police Families Need to Know* (New York: Guilford, 1997) at 3-16; Peter Finn & Julie Esselman Tomz, *Developing a Law Enforcement Stress Program for Officers and Their Families* (Washington, D.C.: U.S. Department of Justice Programs, National Institute of Justice, 1996) at xiv, 6-7, 14-16, online: National Criminal Justice Reference Service <https://www.ncjrs.gov/pdffiles/163175.pdf>.

[6] P.H. Neidig, H.E. Russell & A.F. Seng, "Interspousal aggression in law enforcement personnel attending the FOP biennial conference" (Fall/Winter 1992) National Fraternal Order of Police Journal at 25-28.

[7] Eugene R. D. Deisinger, *Final Grant Report of the Law Enforcement Assistance and Development Program: Reduction of Familial and Organizational Stress in Law Enforcement* (Rockville, MD: National Institute of Justice, National Criminal Justice Reference Service, 2002), online: National Criminal Justice Reference Service <https://www.ncjrs.gov/pdffiles1/nij/grants/192277.pdf> ; Laurence Miller, "Tough guys: psychotherapeutic strategies with law enforcement and emergency services personnel" (1995) 32:4 Psychotherapy Theory Research & Practice 592.

[8] Dell P. Hacket, "Suicide and the Police" in Dell P. Hackett & John M. Violanti, eds., *Police Suicide: Tactics for Prevention* (Springfield, IL: Charles C. Thomas Publishing Limited, 2003) 7 at 7-15.

B. Workplace mental health standard

10. In 2013, the Mental Health Commission of Canada and three Canadian standards organizations published a national workplace mental health standard known as the "National Standard of Canada for Psychological Health and Safety in the Workplace - Prevention, Promotion and Guidance to Staged Implementation" (the Standard).[9]

11. The Standard aims to help organizations create psychologically healthy and safe workplaces by preventing harm to employee psychological health and promoting psychological well-being. As noted in the Standard, psychological health and safety "is embedded in the way people interact with one another on a daily basis, is part of the way working conditions and management practices are structured, and the way decisions are made and communicated."[10]

12. The Standard emphasizes that every organization should establish, document, implement and maintain a psychological health and safety management system to which senior management and employees must commit. This system should be confidential and respectful of privacy rights. The organization should establish psychological health and safety objectives for relevant job functions and measure progress in achieving those targets.[11]

13. While the TPS does have a multi-faceted Wellness Program that deals with a variety of health issues for members (including nutrition, weight loss, smoking cessation and other wellness goals), the TPS does not currently have a comprehensive psychological health and safety management system. The Service also does not have a comprehensive statement on psychological wellness for its officers. While the Standard is an excellent general guideline for establishing a psychological occupational health and safety system for all organizations, the TPS may find it useful to refine it (perhaps in consultation with the Standard's authors) in order to facilitate its application to police services.

C. Psychological wellness resources for TPS members

14. The TPS offers four primary psychological wellness resources to members of the Service: (1) the Psychological Wellness Program, which consists of: (a) mandatory psychological wellness visits with the in-house TPS psychologists for a subset of members whose jobs have been determined to place them at an elevated risk of a psychological operational stress injury; and (b) the option of voluntary consultation with a TPS psychologist for members who do not benefit from mandatory visits; (2) the availability of psychological counselling with a trained counsellor or psychologist external to the Service through the Employee and Family Assistance Plan (EFAP); (3) critical incident response; and (4) peer support groups.

---

[9] Mental Health Commission of Canada *et al.*, *National Standard of Canada: Psychological Health and Safety in the Workplace ¬- Prevention, Promotion and Guidance to Staged Implementation* (Mississauga, ON: Canadian Standards Association & Bureau de normalisation, 2013), online: Mental Health Commission of Canada <http://www.mentalhealthcommission.ca/English/node/5346>.

[10] *Id*. at 1.

[11] *Id*. at 5-14.

1. *The Psychological Wellness Program*

15. The TPS Psychological Wellness Program is provided by the Service's in-house psychologists in the Psychological Services unit, and has both mandatory and voluntary components.

16. Members of TPS teams who regularly engage in activities that place them at an elevated risk for the development of a mental health-related operational stress injury are required to meet with a TPS psychologist at least annually. Attendance at these meetings is mandatory, although members cannot be compelled to disclose information to the psychologist if they do not wish to do so. The contents of these visits are private and confidential, subject only to the psychologist's duty to warn and protect if the individual poses a risk of harm to himself or herself, or anyone else.

17. Members of the TPS who currently participate in the Psychological Wellness Program include:

(a) child exploitation investigators in the Sex Crimes unit, seen twice per year;

(b) technical crimes investigators in the Intelligence unit, seen twice per year;

(c) Emergency Task Force gun team members;

(d) forensic identification investigators and civilian photo technicians;

(e) undercover officers in the Drug Squad, Undercover Operations, and Intelligence units;

(f) collision reconstruction specialists in the Traffic Services unit;

(g) communications operators (all 911 call-takers and dispatchers) in the Communications Services unit;

(h) all members of the TPS who have been deployed overseas, seen immediately upon their return, and three, six, and 12 months post-deployment; and

(i) child abuse specialists working at the Child and Youth Advocacy Centre.[12]

18. Currently, there are 614 members of the Service that fall within these nine categories. Mandatory wellness visits for these members occupy the bulk of Psychological Services' capacity.

19. All other TPS members are permitted to seek counselling from the TPS psychologists on a voluntary basis.

[12] Carol Vipari & Cathy Martin-Doto, *Psychologist Guidelines – New Constable Psychological Screening Evaluations* (Toronto, ON: Toronto Police Service, 2013), Appendix A.

20. As discussed in Chapter 5 (Police Culture), the culture of the Service with respect to mental health has improved significantly in recent years. However, a variety of people within the TPS have told the Review that a degree of stigmatization of mental illness persists, and that some officers are hesitant to access psychological counselling because it is believed that the need for counselling represents a sign of weakness.

21. In this regard, the Review learned that the mandatory nature of wellness visits for the nine specified high-risk units is an important factor that enables TPS members within these units to feel comfortable making use of counselling resources, especially in their initial visits. Imposing a requirement to attend for counselling removes some of the stigma, hesitation, and cultural resistance associated with psychologist visits. Once officers are in the habit of seeing a psychologist, there appears to be an acceptance and enthusiasm for the practice.

22. Notably, the majority of TPS members—including all front line officers who form part of primary response units (PRUs)—do not benefit from mandatory wellness meetings with the TPS psychologists. They must proactively request them.

23. Yet PRU officers clearly have stressful and potentially dangerous jobs, and are at risk of a mental-health related operational stress injury. These officers have the most frequent contact with people in crisis. Many of these officers are also among the most inexperienced members of the Service—still in the formative years of their careers, and susceptible to a variety of influences and stresses. The Review has also learned that the most junior officers can be among the least likely to be prepared to show vulnerability or to seek help.

24. There is a compelling body of opinion suggesting that such officers' mental health needs should be monitored and treated early, to ensure that mental health issues do not grow into significant problems that can affect the individual officer and the Service as a whole.

25. While the availability of resources to fund psychological wellness visits may be an impediment to their implementation, the value of mandatory psychological visits in helping PRU officers and in fostering the growth of a culture that emphasizes mental health and wellness is clear. This is especially so for officers in their first years of service at the TPS.

26. Another group of TPS members who would benefit from mandatory wellness visits are supervisory officers, who cannot be expected to fulfill their role in a fully effective way if they have mental health issues of their own that are not treated. Psychological counselling is also educational: supervisory officers who participate in counselling will be more conscious of the mental health issues that PRU officers commonly face, and more aware of the signs and symptoms of these issues. These officers will learn the language of mental health more fluently, having applied it to their own experiences.

2. *Employee and Family Assistance Program*

27. All TPS members have access to the TPS Employee and Family Assistance Program (EFAP), provided through contract with an external provider.

28. The EFAP supports employees and their immediate family members in assessing and resolving work, health, and other wellness issues of all types, including providing counselling.[13] As is the case with voluntary wellness visits to the TPS in-house psychologists, members must specifically seek out this resource.

3. *Response to traumatic incidents*

29. This Report addresses the debriefing of incidents in two contexts: as part of a cycle of continuous learning from individual situations, and as a wellness resource in the aftermath of traumatic incidents. The former type of debrief involves a discussion of the events that occurred in order to improve future practices, as discussed in Chapter 8 (Supervision). The latter type of debrief, discussed in this chapter, is concerned with helping officers address stresses arising from traumatic incidents.

30. Members of TPS who are involved in traumatic critical incidents take part in several stages of debriefing in addition to being directed to other treatment, if the case requires it. A traumatic critical incident is considered to be any incident during which a member of the Service experiences, witnesses or is confronted with serious injury, death or mass casualties; any incident in which the member's life has been imperilled or threatened; or any other situation which is recognized at the time to have the potential to significantly interfere with a member's ability to function professionally or personally.[14]

31. TPS Procedure 08-04 "Members Involved in a Traumatic Critical Incident," sets out the procedures, resources and obligations of different members of the Service in response to the wellness needs that may arise from a critical incident.[15]

32. The Critical Incident Response Team (CIRT) is a team of peer support volunteers. These members are specially trained by and coordinated through the Service to respond to incidents where a Service member experiences physical and psychological symptoms related to his or her involvement in a traumatic incident, such as traffic collisions or an incident involving sudden death.[16]

33. Initially, members who have experienced a critical incident participate in a "defusing session," which is an immediate informal meeting attended by an individual

---

[13] Shepell fgi, "Employee and Family Assistance Programs" (2014), online: Shepell fgi <http://www.shepellfgi.com/EN-CA/Products%20and%20Services/EmployeeAssistanceProgram/index.asp>.

[14] Toronto Police Service, Procedure 08-04 "Members Involved in a Traumatic Critical Incident" (Toronto: Toronto Police Service, 2013) at Appendix "A": Critical Incident Stress Handout. [TPS, "Procedure 08-04"].

[15] *Ibid*.

[16] *Id*. at 2. In Clearwater, Florida, spouses of officers and their families are invited to take part in debriefing sessions because the Clearwater Police Department acknowledges that officers often take stress from such incidents home with them. See Clearwater Police Department, Number 192 "Line of Duty Death – Critical Incident Stress Debriefing" (Clearwater, FL: Clearwater Police Department, 2001) at ss. 192.40.

TPS member or a group of TPS members involved in a traumatic critical incident, to assess the need for further assistance. This session is no longer than 30 minutes, and is normally led by two Peer Support Volunteers. Attendance is mandatory, but participation in the discussion is voluntary. One of the TPS psychologists may also attend these "defusing sessions."[17]

34. A few days later, Service members take part in a more formal "debriefing session." At this session, which lasts over two hours, Service members discuss their reactions to the traumatic event, in confidence, with a TPS in-house psychologist and CIRT members. In light of the investigatory mandate of the Special Investigations Unit (SIU) and the fact that the psychologists can be subject to a subpoena in a criminal proceeding, the facts of the traumatic event itself are not discussed at these sessions. However, members discuss any stresses they are feeling or symptoms they are experiencing, and strategies to manage them. Most often, a TPS in-house psychologist will lead this session.[18]

35. Keeping in mind that almost any traumatic event has potential to cause stress to an officer and to affect that officer's ability to function professionally or personally, supervisory officers are required to assess each traumatic critical incident to determine the appropriate level of support needed. If an officer requests the assistance of the Critical Incident Response Team, the CIRT must be contacted by a supervisor.[19] Follow-up sessions and medical referrals are made on a case-by-case basis.

36. It is notable that officers in supervisory roles and officers' peers are required to assist and support a fellow officer in response to critical incident stress,[20] but that there is no similar express requirement where an officer is experiencing a mental health problem that is not directly linked to a specific traumatic incident, unless it raises fitness for duty concerns, discussed below.

4. *Other forms of peer support*

37. In addition to the CIRT, the Service fosters the growth of internal peer support networks among its officers. Procedure 14-18 "Internal Support Network (ISN)" sets out the framework for the establishment and operation of these peer support groups.[21] ISNs are "voluntary self-support networks designed to help specific, self-identified groups share information and experiences, and provide mentoring and guidance so that members can develop personally and professionally."[22] ISNs can be based on any of the grounds covered by the Ontario *Human Rights Code*, any other approved affiliation, or any combination thereof.[23]

---

[17] TPS, "Procedure 08-04," *supra* note 14 at Appendix "A": Critical Incident Stress Handout.

[18] *Ibid*. In cases where the mandate of the Special Investigations Unit has been invoked, a psychologist always leads this debriefing.

[19] *Id*. at 3.

[20] *Id*. at 6.

[21] Toronto Police Service, Procedure 14-18 "Internal Support Network (ISN)" (Toronto, ON: Toronto Police Service, 2013).

[22] *Id*. at 1.

[23] *Ibid*.

38. These groups are intended to provide informal peer mentoring and coaching, networking, team-building, support and encouragement, planning and implementation of social, cultural or educational opportunities, development of professional skills, and general information sharing.[24]

39. The TPS currently has ISNs providing peer support to Aboriginal, Black, disabled, East Asian, female, Filipino, LGBTQ, and South Asian members of the Service.

40. There is currently no ISN designed specifically to provide peer support to officers who have been involved in traumatic incidents such as those involving the use of lethal force. The Review heard that, in addition to support from the CIRT, there is informal peer support for officers involved in such incidents—for example, officers may reach out to one another on an ad hoc basis to provide mutual support.

41. A practice adopted by some other police services is to establish an anonymous telephone service that allows officers to call for peer counselling, in the aim of minimizing officer resistance to psychological counselling.[25]

D. In-service monitoring

42. Supervisory officers within the TPS are currently required to monitor officers' fitness for duty. However, "fitness for duty" from a mental health perspective is a relatively low standard within the Service, and there is no formal requirement for supervisory officers to monitor the psychological wellbeing of members more broadly, or to take proactive steps to assist them in getting appropriate mental healthcare.

43. Officers in supervisory roles are in a unique position to influence other officers and the culture of the Service as a whole. Ideally, these individuals should be attuned to the mental health of the officers whom they supervise, in order to serve in a mentoring role and to promote an environment in which officers' mental health needs are effectively addressed. This can help ensure that issues are addressed before they become significant problems of misconduct that require discipline.[26]

1. *Fitness for duty evaluations*

44. TPS Procedure 08-02 "Sickness Reporting" states that it is the responsibility of each officer in charge to ensure that a fitness for duty assessment is requested from the Medical Advisory Services (MAS) unit of the TPS when it is apparent to the officer in charge that an officer has an illness or injury that is affecting or may reasonably be expected to affect the officer's performance of his or her duties.[27]

---

[24] *Ibid*.

[25] For example, the Las Vegas Metropolitan Police Department, 5/110.22 "Police Employees Assistance Program" (Las Vegas, NV: Las Vegas Metropolitan Police Department).

[26] Martin I. Kurke & Ellen M. Scrivner, *Police Psychology into the 21st century* (Mahawah, NJ: Lawrence Erlbaum Assoc, 1995) at 59 [Kurke & Scrivner, *Police Psychology*].

[27] Toronto Police Service, Procedure 08-02 "Sickness Reporting" (Toronto, ON: Toronto Police Service, 2011) [TPS, "Procedure 08-02"].

45. If an officer is subject to a fitness for duty evaluation, he or she must attend the evaluation and comply with the recommendations of the Medical Advisor. Officers who do not comply with the fitness for duty process are subject to disciplinary proceedings. MAS has the sole authority to decide whether an officer's physical or mental illness or injuries render the officer incapable of carrying out his or her duties, and to decide when an officer is capable of returning to his or her duties. This determination must be made in good faith and not in an arbitrary manner.[28]

46. This evaluation, performed by a primary care physician at Medical Advisory Services (MAS), includes both medical and psychological screenings. However, the Review was advised that the evaluating physician often has no specialized psychological training. If the physician decides it is appropriate, MAS can retain an external psychologist to undertake a psychological assessment.

47. Ideally, the mental health needs of TPS members should not be addressed for the first time at a stage when the member's fitness for duty is being questioned. It is clearly preferable if warning signs are identified early, and treatment mechanisms are implemented, to avoid the need for a fitness for duty evaluation and potential reassignment or suspension.

2. *The role of supervisory officers*

48. The current role played by supervisory officers in monitoring officers' mental health issues is quite limited.

49. TPS Procedure 08-01 "Employee and Family Assistance Program" provides for assistance to officers and their families experiencing personal problems or stresses.[29] Under this procedure, as noted, officers pursue help voluntarily. Neither this procedure, nor Procedure 08-02 "Sickness Reporting," specifically gives supervisory officers the task of monitoring officers' well-being or suggesting help in circumstances that do not raise "fitness for duty" concerns.[30]

50. Though the definition of "fitness for duty" in the sickness reporting procedure includes mental health, the procedure contains no specific mandate for supervisory officers to monitor members' mental health in order to identify problems that do not yet raise fitness for duty concerns, but for which members might nonetheless benefit from help.

51. In contrast, Procedure 08-05 "Substance Abuse," sets out a more nuanced framework to address addiction and substance abuse issues.[31] The Service's approach to substance abuse issues places a greater emphasis on continual monitoring, treatment, collegial support, and encouragement. A similar approach may benefit officers experiencing significant stresses or other mental health issues.

---

[28] *Ibid*.

[29] Toronto Police Service, Procedure 08-01 "Employee and Family Assistance Program" (Toronto, ON: Toronto Police Service, 2013).

[30] *Ibid*; TPS Procedure 08-02, *supra* note 27.

[31] Toronto Police Service, Procedure 08-05 "Substance Abuse" (Toronto, ON: Toronto Police Service, 2012).

52. Under the substance abuse procedure, all officers at all levels must, upon becoming aware of another officer's possible substance abuse problem, "encourage the officer to seek assistance voluntarily before work performance or safety is affected," "give immediate assistance, if required, and intervene by notifying a supervisor whenever a member's behaviour creates a safety hazard," and "follow up, if required, to provide the member with proper support and encouragement to resolve the problem."[32] When supervisory officers become aware of an officer who exhibits work performance concerns that may be related to substance abuse, supervisory officers are given comprehensive monitoring duties, including to:

(a) "determine if there are any immediate fitness for duty or safety concerns;"

(b) "discuss performance concerns and expectations" with the officer;

(c) encourage the officer "to seek assistance, where appropriate;"

(d) advise the officer of "options available for assistance" including the EFAP and MAS;

(e) "follow up, if required, to provide the member with the proper support and encouragement;" and

(f) "provide heightened performance monitoring."[33]

53. No similar procedure exists with respect to other mental health concerns.

54. Because supervisory officers are not specifically tasked with monitoring officers' overall mental health except in the case of fitness for duty concerns, the degree to which early intervention is undertaken in practice is largely dependent on the attitude and approach of individual unit commanders and other supervisory officers, as well as coach officers. The Review was advised by several individuals that, as a general matter, the Service's culture does not emphasize ongoing monitoring, correction, learning, and counselling with respect to mental health issues. As a result, problems are usually addressed only when they become significant or worse.

55. Part of the issue is that officers are concerned that they will suffer adverse professional consequences if they identify a need for help, or if supervisors intervene to suggest help. It is important to an effective mental health culture of continuous treatment and learning to ensure that members of the Service are encouraged to view mental healthcare as helpful and non-threatening.[34]

[32] *Id.* at s. 5.

[33] *Id.* at ss. 7, 10.

[34] Kurke & Scrivner, *Police Psychology*, *supra* note 26 at 59.

II. Overview of Issues Highlighted by Stakeholders

56. Several stakeholders emphasized that TPS officers cannot be expected to achieve the best possible outcome in interactions with people in crisis if officers are suffering from psychological injury themselves. Those in "helping professions," who often witness pain and suffering as part of their jobs, are at risk of "compassion fatigue" or vicarious trauma. However, those in the helping professions can also be the least likely to ask for help themselves.

57. One stakeholder credited the TPS for its voluntary EFAP. However, the same stakeholder expressed the view that many TPS employees refuse to access EFAP services, as they fear that this will jeopardize their jobs or make them otherwise appear weak to their co-workers. This stakeholder quoted one police officer, who stated, "most officers will not speak to anyone at the EFAP—can you imagine what it is like knowing that they will tell others about what's happening to you. It is just far too risky, police officers are not supposed to show weakness—we are not supposed to be emotionally disturbed." This stakeholder recommended more informal peer support groups among officers, kept within ranks so officers can feel safe in expressing themselves.

58. Another stakeholder emphasized the need for peer support groups within police services. Such groups allow for officers to speak openly about their shared experiences and collectively support each other. Officers learn coping mechanisms from people with similar experiences and, in the process, they often come to recognize that seeking help for psychosocial injuries is not a weakness. Peer support can also help reduce stigma associated with mental health issues. A comprehensive set of peer support programs may include traditional one-on-one support, facilitated groups, as well as innovative holistic programs that incorporate training into support programming. I understand that there are organizations that are expert in this field that would be pleased to work with the TPS to develop peer support training and programs specific to their needs.

III. Recommendations

59. I recommend that:

RECOMMENDATION 33: The TPS create a formal statement on psychological wellness for TPS members. This statement should:

(a) acknowledge the stresses and mental health risks that members face in the course of the performance of their duties;

(b) confirm the Service's commitment to providing support for members' psychological wellness;

(c) emphasize the importance of members attending to their mental health needs;

(d) emphasize the importance of members monitoring the mental health of their colleagues, and assisting colleagues to address mental health concerns;

(e) emphasize the role of supervisory officers in monitoring the mental health of those under their command, and in intervening to assist where appropriate;

(f) set out the psychological wellness resources available to members of the Service; and

(g) be accessible online and used in training at all levels of the Service.

RECOMMENDATION 34: The TPS consider whether to establish a comprehensive psychological health and safety management system for the Service.

RECOMMENDATION 35: The TPS provide a mandatory annual wellness visit with a TPS psychologist for all officers within their first two years of service.

RECOMMENDATION 36: The TPS consider providing less frequent periodic mandatory wellness visits with a TPS psychologist or other counsellor for all police officers, or, if it is not immediately possible to provide wellness visits to all officers, for any officer who works as a first responder, coach officer, or supervisory officer. The TPS should also encourage all officers to seek counselling voluntarily.

RECOMMENDATION 37: The TPS promote a greater understanding of the role and availability of the TPS psychologists, the EFAP and peer support groups as confidential resources that officers are encouraged to make use of to help them stay mentally healthy.

RECOMMENDATION 38: The TPS consider whether it would be helpful to establish an Internal Support Network for people who have experienced a shooting or other traumatic incident, or more generally to help officers with work-related psychological stresses.

RECOMMENDATION 39: The TPS consider creating a new procedure, substantially modelled after Procedure 08-05 "Substance Abuse," to address members' mental health, and specifically to require officers in supervisory roles to monitor for mental health concerns of TPS members under their command, in order to identify means of providing help for mental health issues before a fitness for duty issue arises.

RECOMMENDATION 40: The TPS provide officers in supervisory roles with training specific to monitoring other officers' psychological wellness and guiding preventive intervention where it is warranted.

CHAPTER 10

Use of Force

CHAPTER 10. USE OF FORCE

Table of Contents

Page

I. THE CURRENT SITUATION 194

A. Provincial use of force standards 194
(1) Minimum adequacy standards & MCSCS Standards Manual 194
(2) LE-013 Police Response to Persons who are Emotionally Disturbed or have a Mental Illness or a Developmental Disability 195
(3) AI-012 Use of Force 196
(4) The Use of Force Model 196
(a) Assess/plan/act 197
(b) Perception and tactical considerations 199
(c) Force options 199
(d) Communication 199

B. Legal constraints on police use of force 200

C. TPS procedures regarding use of force 202
(1) Use of Force Procedure 202
(2) The Police Challenge 203
(3) Use of Force Review Committee 204
(4) Procedure regarding notification of the ETF 204

D. Comparative use of force models 205
(1) IACP Model Use of Force Policy 205
(2) IACP Model Policy on Responding to Persons with Mental Illness or in Crisis 205
(3) UN principles on use of force 207
(4) Comparison to other police services 208
(5) Comparison to unarmed professions 210

E. Difficulty in comparing statistics regarding use of force 211

II. OVERVIEW OF ISSUES HIGHLIGHTED BY STAKEHOLDERS 212

III. RECOMMENDATIONS 213

Improving the Use of Force Procedure to reflect best practices 213
Updating the Use of Force Procedure 214

Chapter 10. Use of Force

1. The use of force by police should always be a last resort. Resolving conflicts through communication rather than force is the goal. The TPS approach to situations involving people in crisis should therefore seek to minimize force altogether and, above all, avoid lethal force wherever possible. The challenge, and one of the most critical requirements for police, is to know how to de-escalate a crisis involving a person who, as a result of what is effectively a transient or permanent mental disability, may not respond appropriately (or at all) to standard police commands.

2. This chapter sets out the provincial regulatory framework for the use of force in Ontario, describes legal constraints on police use of force, and reviews TPS use-of-force procedures. I note what I consider to be some weaknesses in the provincial Use of Force Model, and some areas of TPS procedure and practice that would benefit from improvement. I also consider comparative use of force models used by police in other jurisdictions, and used by professions other than the police. One of my central conclusions is that the TPS Use of Force Procedure should be updated to reflect the best practices established by external bodies in the areas of de-escalation, to provide better protection of the lives of subjects, and to avoid force in interactions with people in crisis.

I. The Current Situation

A. Provincial use of force standards

3. Enacted pursuant to the *Police Services Act* (PSA), O. Reg. 926 ("Equipment and Use of Force") sets out provincial requirements for the use of force, including approved weapons, training, reporting, and specifications for handguns.[1] The Regulation prohibits a police officer from using force against another person unless he or she has completed the prescribed training course and annual use of force requalification training. An officer must complete a Use of Force Report when he or she uses physical force that results in an injury requiring medical attention, draws a handgun in the presence of the public, discharges a firearm, points a firearm, or uses a weapon (including a police dog or horse) on another person.[2]

4. An officer is not authorized to draw a handgun, point a firearm, or discharge a firearm unless he or she has reasonable grounds to believe such action is necessary to protect against the loss of life or serious bodily harm. An officer may not fire a warning shot or fire at a moving vehicle unless its occupants pose an immediate threat of death or grievous bodily harm by means other than the vehicle itself.[3]

1. *Minimum adequacy standards & MCSCS Standards Manual*

5. Police services boards and police services must adopt policies and procedures that provide for the minimum adequacy standards set out in O. Reg. 3/99 ("Adequacy

[1] *Equipment and Use of Force*, R.R.O 1990, Reg. 926 [*Reg. 926*].

[2] *Id.*, ss. 4, 14.5.

[3] *Id.*, s. 9.

and Effectiveness of Police Services"), enacted pursuant to the PSA.[4] As discussed in Chapter 8 (Supervision), the Ministry of Community Safety and Correctional Services (MCSCS) maintains a Policing Standards Manual (the Manual) that contains advisory guidelines to assist police services and their boards with implementing the provisions of the PSA and its regulations.[5] The Manual is published by the Solicitor General of Ontario. For each topic covered, the Manual sets out a sample board policy and police services guidelines regarding the purpose and implementation of the policy. Only those sections of the Manual most relevant to the mandate of the Review are discussed here.[6]

2. *LE-013 Police Response to Persons who are Emotionally Disturbed or have a Mental Illness or a Developmental Disability*[7]

6. The sample board policy on responding to people who are emotionally disturbed or have a mental illness addresses three areas:

(a) police should work with community members, agencies, health care providers, and government agencies to address service issues relating to people who have a mental illness;

(b) the Chief of Police shall establish procedures that address the police response to persons who are emotionally disturbed or have a mental illness; and

(c) the police service shall ensure that its skills development and learning plan addresses training and sharing information with members about local protocols, conflict resolution, and use of force in situations involving persons who may be emotionally disturbed or may have a mental illness.[8]

7. The police service guidelines that accompany the sample policy suggest that local procedures should require communications operators (that is, 911 call-takers and dispatchers) to provide officers with any known information about the person's medical and medication history, any history of violence, any involvement with community agencies or local health care providers, and any previous contacts between the police and the person. The guidelines further suggest that local policies address steps for officers and communications personnel to obtain assistance from another agency, either by referral or in a collaborative manner. Training should cover the relevant provisions of the *Mental Health Act*,[9] the *Substitute Decisions Act*,[10] the *Health Care Consent Act*,[11]

---

[4] *Adequacy and Effectiveness of Police Services*, O. Reg 3/99, s.3 [*Adequacy and Effectiveness*]; See generally *Reg. 926*, *supra* note 1, ss. 3-35.

[5] Ontario Ministry of Community Safety and Correctional Services, *Policing Standards Manual* (2000) [MCSCS, *Policing Standards*].

[6] Chapters 12 (Equipment) and 7 (Training) discuss Provincial Policing Standards guidelines regarding the equipment, and training in officer safety, communication, and physical control techniques, that must be provided to officers.

[7] Enacted pursuant to *Adequacy and Effectiveness*, *supra* note 4, ss. 13(1), 29.

[8] MCSCS, *Policing Standards*, *supra* note 5.

[9] *Mental Health Act*, R.S.O. 1990, c. M.7.

[10] *Substitute Decisions Act, 1992*, S.O. 1992, c. 30.

as well as how to recognize common mental illnesses, and techniques to provide assistance to families of people with mental illness or in crisis.

3. *AI-012 Use of Force*

8. The provincial police services guidelines recommend minimum standards for training in officer safety, communication and physical control techniques as well as equipment use, issues that are set out in more detail in separate chapters of this Report.[12] Training must comply with the Ministry's approved use of force options, which include officer presence, communication, physical control techniques, intermediate weapons, and lethal force.

9. The Manual recommends that annual handgun requalification training include the following minimum components:

(a) 1 hour classroom training on use-of-force legislation and reporting requirements (among other topics);

(b) 1.5 hours proficiency training; and

(c) 1.5 hours judgment development training designed to develop decision-making skills in stressful situations. This training may include role playing and simulations, and should involve debriefing after practical exercises on threat perceptions, communication skills, tactics used, less-lethal force options, and justification for amount of force used, among other topics.[13]

10. The Manual dictates that use-of-force reports should be used only to identify individual and group training requirements or organizational policy requirements. The guidelines recommend that use-of-force policies require that the information collected in use of force reports not be placed in an officer's personnel file.

4. *The Use of Force Model*

11. The MCSCS Police Service Guidelines on use of force indicate that the Chief of Police "should ensure that training on the use of force is in the context of the Use of Force Model currently used in Ontario."[14] The Ontario Use of Force Model (shown in Figure 1) is a graphic representation of the process and factors through which a police officer decides what tactics to use to control a potentially dangerous situation. The Ontario model is itself based on a national use of force model.[15]

---

[11] *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A.

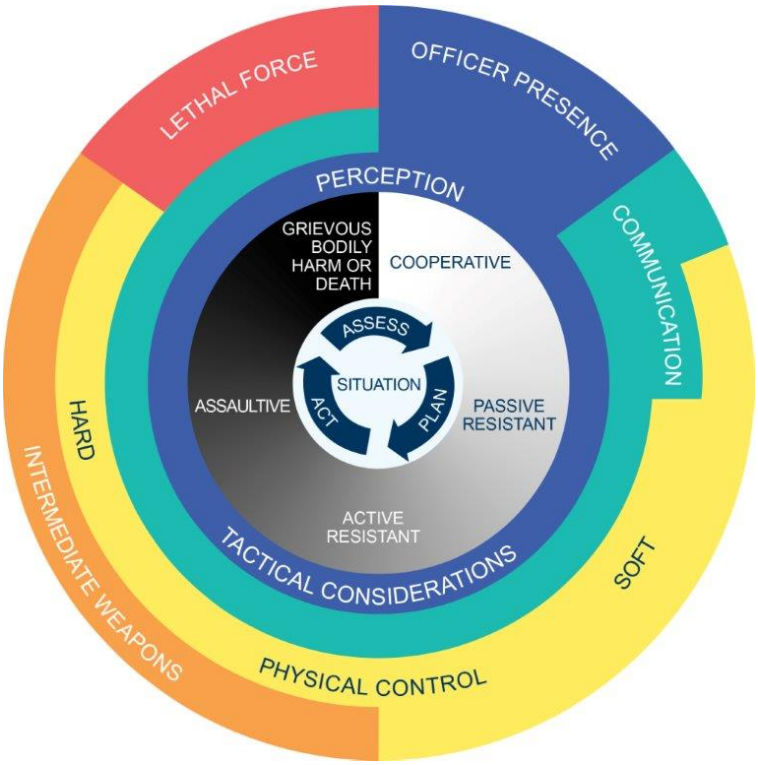
[12] See Chapters 12 (Equipment) and 7 (Training).

[13] MCSCS, *Policing Standards*, *supra* note 5, s. 25.

[14] *Id*., s. 5.

[15] Toronto Police Service, *Use of Force and Equipment*, 15-01 "Use of Force" (Toronto, ON: Toronto Police Service, 2013), Appendix A [TPS, "Procedure 15-01"].

Figure 1. The Ontario Use of Force Model



12. The Use of Force Model is based on six principles:

(a) the primary responsibility of a police officer is to preserve and protect life;

(b) the primary objective of any use of force is to ensure public safety;

(c) police safety is essential to public safety;

(d) the Use of Force Model does not replace or augment the law;

(e) the Model was constructed in consideration of the law; and

(f) the Model does not dictate policy to any agency.

(a) *Assess/plan/act*

13. The Model is also referred to as a use of force "wheel" because it is represented as several concentric circles of considerations and actions available to an officer in dealing with any situation. The Model is centred around a continuous core of three types of officer thinking and decision-making: assess, plan, and act. That core is surrounded by rings indicating the officer's perception of the subject behaviour, communication, physical control techniques, and weapons.

14. The assess/plan/act core is intended to be dynamic and continuous in response to a situation. The Model recognizes that "behaviour (and response option) can change from co-operative to assaultive (or from communication to lethal force) in a split second without passing through any other behaviour or force options."[16]

15. When assessing a situation, an officer is to consider what he or she perceives to be the subject's abilities, including physical strength, proximity to weapons, intoxication, and emotional state. The assessment phase also requires a consideration of whether the seriousness of the situation requires the officer to act immediately or whether the officer can create more time in the situation and more distance between the subject and others.

16. With respect to assessing the safety of the situation, the guidelines that accompany the Ontario Use of Force Model list several signs that indicate a potential attack by a person on an officer. Several stakeholders submitted to the Review that this list of potentially dangerous behaviour includes virtually all conduct other than immediate compliance with police commands, and may lead an officer to perceive a threat when a person is exhibiting non-violent symptoms of a mental illness or a crisis.

17. The potential attack signs listed in the Model include, among other things, the following types of behaviour that may be symptomatic of an emotional or mental crisis:

(a) ignoring the officer;

(b) repetitious questioning;

(c) aggressive verbalization;

(d) emotional venting;

(e) refusing to comply with a lawful request from an officer;

(f) ceasing all movement;

(g) invasion of personal space of the officer;

(h) adopting an aggressive stance; and

(i) hiding.

18. The guidelines describe the subject's behaviour as central to the officer's continuous assess/plan/act process. Resistant behaviour may be passive or active, and affects the officer's response to the person. Resistance is described as refusal to cooperate with direction, either verbally or by "consciously contrived" physical inactivity. Active resistance may include pulling, walking or running away from, as well as walking toward an officer.

[16] *Id*., Appendix B at 2.

19. Although it is beyond the scope of this Review to consider whether all of those factors have been known to precede an attack on a police officer, it does appear that symptoms of crisis, and even displays of fear, may be perceived by an officer trained in the Use of Force Model as aggressive behaviours warranting an escalated police response.

(b) *Perception and tactical considerations*

20. Perception and tactical considerations form the ring between the assess/plan/act core and the range of police responses to the subject's behaviour. The Model guidelines indicate that an officer's perception of the subject, the situation, and the accompanying tactical considerations are a group of conditions that mediate between the inner two circles of the Model and the responses available to the officer. Given that several force options may be used at the same time, the training materials that accompany the Model note that communication overlaps with other use of force options in the outer ring. However, communication is not incorporated into the perception stage of the Model.

(c) *Force options*

21. The outer area of the Use of Force Model represents the force options available to an officer in a potentially dangerous situation. The accompanying guidelines indicate that use-of-force options range from an officer's presence (which may itself induce compliance) to communication skills, physical control, intermediate weapons and use of lethal force. The guidelines describe communication as "verbal and non-verbal communication to control a situation," but give only one example of using communication to ensure compliance, which is to speak the Police Challenge[17] when an officer draws his or her firearm in response to a threat to life or bodily harm from another person. Other types of communication, designed to achieve de-escalation (and thus compliance) through dialogue and reassurance, are not suggested.

(d) *Communication*

22. The Model appears to separate communication from the continuous process of assessment and planning at the centre of the Model, as well as the initial factors of perception and tactical considerations that assist officers when assessing a situation and planning a response. Although one stakeholder submitted that communication does not have to be graphically represented as its own stage because it encircles the entire process, the training materials that accompany the Model indicate that communication is considered at the outset of the use-of-force analysis, not the outset of the assessment by the officer.

23. The Use of Force Model characterizes communication as one of the response options available to an officer. However, communication with a person in crisis—beyond loudly and forcefully stated instructions to comply—is relevant to the entire use-of-force assessment and response process. Attempts at calm dialogue with a person in

[17] The Police Challenge is the verbal instruction given to a person in order to obtain compliance with police commands. Toronto police officers are trained to say "Police – Don't Move." The Police Challenge and its implications are described in further detail below.

crisis, such as asking how the police can help or what the person is experiencing, should form part of the assessment function, as they may assist police in determining that person's abilities, intentions, and foreseeable conduct. It may also help the police understand whether that person poses a threat to himself or herself or others and what kind of response is required, both from the police and from other community or medical resources.

24. There is no doubt that many TPS officers employ such communication in their interactions with people with mental health issues, other people in crisis, and other subjects of police response. The Review heard from many people within the TPS that front line officers practice de-escalation on a daily basis, and are familiar with how to de-escalate. While I have no doubt that this is largely true, it is clear that there have been lethal encounters between police and a person in crisis in which de-escalation was an option that was not fully explored. Yet it is at precisely these moments that de- escalation matters most.

25. In this regard, the Ontario guidelines incorporated into the TPS Use of Force Procedure do not emphasize communication and de-escalation techniques as imperative to all stages of the police response to crisis situations. Even in light of the continuous nature of the Model—which suggests that behaviours and responses do not necessarily escalate (or de-escalate) in an incremental manner—there is surprisingly little focus on the need to attempt various methods of communication before using physical force or a weapon on a person.

26. I should note, too, that the use-of-force "wheel" (Figure 1) that forms part of the provincial Use of Force Model is not a particularly effective or intuitive visual aid. The goal of a graphic diagram should be to convey information more effectively than words, but the use-of-force wheel arguably achieves the opposite effect. The Review heard from several individuals about the importance of providing police officers with visual aids, helpful acronyms, simple rules and short checklists that are easily remembered in the field, and particularly in a moment of crisis. It is questionable whether the wheel serves that function. While the TPS does not have the authority to modify the wheel diagram itself (which is part of the provincial regulatory framework), the Service is not bound to use only the wheel. It would be helpful for the TPS to develop a helpful aid or a set of simple rules for officers in the field that puts greater emphasis upon de-escalation and communication as part of the use-of-force analysis.

B. Legal constraints on police use of force

27. The mandate of this Review does not extend to analysis of individual incidents involving use of lethal force, or to the jurisprudence on police use of force in the criminal, civil or disciplinary context. However, it is helpful to summarize the limits that have been placed on police use of force by legislation and applicable jurisprudence before examining TPS practices and procedures specifically.[18]

[18] For a detailed outline of these concepts, see Ian D. Scott, "Legal Framework of Use of Force by Police in Ontario" (2008) 53 Crim. L. Q. 331.

28. The *Criminal Code* limits the acceptable level of force used by police officers acting under legal authority.[19] Police officers may, acting on reasonable grounds, use force to prevent the commission of certain offences,[20] to prevent a breach of peace, [21] to suppress a riot,[22] and "to do anything in the administration or enforcement of the law."[23] The force used must be proportionate, or reasonably necessary, in the circumstances.[24] The Supreme Court of Canada has explained that police actions should not be judged against a standard of perfection, but in light of the exigent circumstances of dangerous and demanding work and the obligation to react quickly to emergencies.[25]

29. An officer may not use force that can cause grievous bodily harm[26] or death unless he or she believes on reasonable grounds that it is necessary to preserve life, to prevent the infliction of grievous bodily harm on anyone, or to prevent escape of a person to be arrested if the officer believes that the person poses a risk to the life or safety of anyone and cannot be subdued in a less violent manner.[27]

30. Specifically, the reasonableness of the grounds for an officer's use of force should be judged both objectively (from the perspective of an average police officer) and subjectively (from the perspective of the particular officer who used force). The level of force must be "reasonable in light of circumstances faced by the police officer."[28]

31. Police officers may also be held civilly liable for injuring or killing members of the public in the course of their duties. Under the law of negligence, for example, police officers owe a duty of care to members of the public when carrying out their duties. Police must act reasonably and within their statutory powers, according to the circumstances of the situation. This standard contemplates that officers must exercise discretion in their duties, and will not be held liable for conduct that falls within the range of reasonableness.[29] Courts must further consider the essential function

---

[19] *Criminal Code*, R.S.C., 1985, c. C-46 [*Criminal Code*]. Actions must be "authorized by law" in order for the provisions in the Criminal Code to apply. This language is broad enough to include actions that are authorized under either statute of the common law.

[20] *Id*., s. 27.

[21] *Id*., ss.30-31.

[22] *Id*., ss. 32-33.

[23] *Id*., s. 25(1). This provision provides the legal authority for officers to use force in a number of situations. These include the power to effect an arrest without warrant, which is authorized by law under ss. 494-495 of the Code, or the power to frisk a suspect incident to arrest, which is authorized under common law. The common law duties of police officers were described by the Supreme Court of Canada as the "preservation of the peace, the prevention of crime, and the protection of life and property." See *R. v. Godoy*, [1999] 1 S.C.R. 311 at para. 15.

[24] *Criminal Code*, *supra* note 19, s. 26. ("Everyone who is authorized by law to use force is criminally responsible for any excess thereof according to the nature and quality of the act that constitutes the excess").

[25] *R. v. Nasogaluak*, 2010 SCC 6 at para. 35.

[26] Grievous bodily harm has been defined in a leading case as a "serious hurt or pain." See *R. v. Bottrell* (1981), 60 C.C.C. (2d) 211 (B.C.C.A.).

[27] *Criminal Code, supra* note 19, s. 25(3).

[28] *Crampton v. Walton*, 2005 ABCA 81 at para. 42.

[29] *Hill v. Hamilton-Wentworth Regional Police Services Board*, 2007 SCC 41 at paras. 29-34, 79.

performed by police officers and the urgent contexts in which they must make decisions and take actions.[30]

32. Police service policies and procedures can be considered self-imposed standards of care, the breach of which may be considered by courts in determining whether an officer met the standard of care owed to a member of the public. However, breach of a policy or procedure does not necessarily equate to a breach of the civil standard of care.[31] Similarly, the *Police Services Act* requires officers to comply with a Code of Conduct in their duties. An officer may be disciplined for misconduct, including breach of statutory duties or provisions of the Code of Conduct.[32] However, internal disciplinary sanctions are not determinative of an officer's civil liability in negligence.

C. TPS procedures regarding use of force

1. *Use of Force Procedure*

33. The policies and procedures of the TPS on the use of force are informed by the provincial framework described above. The TPS Use of Force Procedure is premised on the protection of life and safety of police officers and the public.[33] Police officers have a responsibility to use only that force which is reasonably necessary to bring an incident under control effectively and safely.

34. The TPS Procedure emphasizes that the Ontario Use of Force Model is an aid to help officers understand their use of force options and to promote the continuous assessment of every situation. The Model is not intended to be a justification for use of force, or to prescribe a specific response for any situation.

35. The TPS Procedure describes the *Criminal Code* provisions authorizing necessary, reasonable use of force for the purpose of law enforcement, and the intermediate force options available to officers, including batons, OC spray, and CEWs.[34] Police are entitled to use Service-issued less-lethal weapons in order to prevent themselves from being overpowered when violently attacked, to prevent a prisoner escaping custody, to disarm an apparently dangerous person armed with an offensive weapon, to control a potentially violent situation when other force options are not viable, and for any other lawful and justifiable purpose.[35] The Procedure further authorizes officers to use weapons of opportunity—that is, weapons found at a scene rather than those issued to officers by the TPS—when none of the approved options is available or appropriate to defend themselves or members of the public.[36]

---

[30] *Prior v. McNab* (1976), 16 O.R. (2d) 380 at 388-389; *Fetterly v. Toronto Police Service* (3 December 2010) Ontario Superior Court of Justice, Penny J., [unreported] at 21-22 [*Fetterly*].

[31] *Doern v. Phillips* (1994), 2 B.C.L.R. (3d) 349 at para. 69 (S.C.); *Fetterly*, *id*. at 19.

[32] See Chapter 8 (Supervision) for a further discussion of disciplinary procedures within the TPS.

[33] TPS, "Procedure 15-01", *supra* note 15 at 1.

[34] See generally *Criminal Code*, *supra* note 19, ss. 25-27; TPS, "Procedure 15-01", *supra* note 15 at 4.

[35] TPS, "Procedure 15-01", *supra* note 15.

[36] *Ibid*.

36. The Use of Force Procedure authorizes an officer to use deadly force—force intended or likely to cause death or grievous bodily harm—against a fleeing suspect if the officer reasonably believes that the "person to be arrested takes flight to avoid arrest; the force is necessary for the purpose of protecting the peace officer, the person lawfully assisting the peace officer or any other person from imminent or future death or grievous bodily harm; [and] the flight cannot be prevented by reasonable means in a less violent manner."[37] Police are not permitted to fire warning shots or to shoot at motor vehicles unless the occupants pose an immediate threat of death or grievous bodily harm to another person by means other than the vehicle itself. Further, the Procedure requires officers to avoid confrontation, contain the scene and disengage when tactically appropriate.

37. After discharging a firearm, an officer is required to notify his or her supervisor, who must complete a Firearm Discharge Report. The officer-in-charge and the duty inspector must also be alerted in accordance with the TPS chain of command. A Firearm Discharge Investigator from the Professional Standards unit of the Service is then appointed to investigate the incident.[38]

38. Use of Force Reports must be filed following an incident in which an officer employs a force option, including the display of a CEW[39] or handgun, or the use of physical force that requires medical attention. The reports are reviewed by supervisors to identify training needs and are submitted to the trainers at the Toronto Police College with requests for additional training, as needed. Consistent with the Ontario standard, the TPS Procedure is clear that Use of Force Reports may not be recorded in an officer's personnel file or considered during promotional or job assignment reviews.

2. *The Police Challenge*

39. The Police Challenge is a prescribed instruction or warning to be employed with the aim of getting a person to comply with the police. Although the Challenge may take several forms depending on the police service and the behaviour the officer encounters, TPS officers are trained to say "Police Dont Move" clearly and loudly when encountering a person with a weapon and before or simultaneously with drawing their own firearm. The rationale for the Police Challenge relates both to the officer and the subject.

40. With respect to the former, when an officer is in a high-stress situation such as an encounter with a person with a weapon, his or her fine motor skills are diminished. Short, practised commands are easier to remember and articulate when an officer is combatting his or her own fear response while assessing the subject and the situation and reacting to the circumstances, which could include drawing a weapon.

---

[37] *Id*., 4-5.

[38] See also Toronto Police Service, *Use of Force and Equipment*, 15-04 "Service Firearms" (Toronto, ON: Toronto Police Service, 2013) (which sets out the restrictions on drawing and discharging firearms on duty, and reporting and supervisory obligations when a firearm is discharged).

[39] See also Toronto Police Service, *Use of Force and Equipment*, 15-09 "Conducted Energy Weapons" (Toronto, ON: Toronto Police Service, 2012) and Chapter 12 (Equipment) for further information on the restrictions and reporting requirements concerning CEWs.

41. With respect to the person subject to police attention, the Review heard that use of clear, short commands is viewed by police as being most effective in gaining compliance from a subject who may be agitated, in crisis, dealing with his or her own fear response, and processing significant stimuli, including the presence of police. The rationale for such standard commands is that people are told exactly what they have to do in order to avoid, or stop, the police use of force.

42. Individuals suffering from auditory hallucinations or other crisis symptoms may have difficulty comprehending any instructions from a police officer. This raises the question of whether the Police Challenge is effective when used in encounters with some people in crisis. One police trainer expressed the view that repetition of the Police Challenge may get through the various other stimuli facing a person in crisis more effectively than lengthier or less direct methods of communication. Conversely, some stakeholders suggested that the repetitive shouting of "Don't Move" is inconsistent with the need to attempt de-escalation and to use compassion when responding to people in crisis who may be struggling to regain a sense of control over their actions and surroundings.

3. *Use of Force Review Committee*

43. The Service has established a Use of Force Review Committee, which is composed of members from both Area and Central Field Command, the Emergency Task Force (ETF), the Toronto Police College, the Professional Standards Investigative Unit, and the Public Safety and Emergency Management Unit. The Committee reviews policy and training related recommendations from the professional standards unit after a Firearm Discharge Report is filed, and reviews other use of force incidents to assess the effectiveness of the Service's training, practices, and associated governance. The Committee reports its findings to the TPS Senior Management Team, but no formal reports or minutes of proceedings are published.

4. *Procedure regarding notification of the ETF*

44. As discussed in Chapter 4 (The Mental Health System and the Toronto Police Service), the ETF must be notified of certain incidents involving people in crisis, such as suicide intervention calls. In those circumstances, the ETF decides whether to attend the scene, based on the nature of incident and the ETF's availability. If the ETF is dispatched, the role of the primary response officers is to control and contain the scene until the ETF arrives. Unless there is an immediate danger to life, those first responders are not permitted to enter the scene. However, primary response units are instructed to obtain as much information as possible pending the arrival of the ETF, including the person's identity, physical description, mental and physical condition, previous history of interactions with police, and access to weapons.

45. Similarly, the ETF may be requested to attend in high risk incidents, which may include a situation involving an armed or violent person in crisis. The role of the

primary response officers is to control and contain the scene and gather information about the individual pending the arrival of the ETF.[40]

D. Comparative use of force models

1. *IACP Model Use of Force Policy*

46. The International Association of Chiefs of Police (IACP) has produced several model documents and background papers regarding police use of force and interactions with persons with mental illness or in crisis. The IACP Model Policy on Use of Force requires that officers use only the force that reasonably appears necessary to effectively bring an incident under control while protecting the lives of the officer and others. Officers are authorized to use deadly force to protect the officer or others from a reasonably believed threat of death or serious bodily harm, or to prevent the escape of a fleeing violent individual where there is probable cause to believe the individual will pose a significant threat of death or serious physical injury to others. Similar to the TPS policy, officers are not permitted to discharge firearms at moving vehicles unless a person in the vehicle is immediately threatening the officer or another person with deadly force.[41]

47. The IACP notes that the most important component of regulating the use of force is first-line supervision. According to the IACP, use of force can range widely from verbal coercion to lethal force, so police need a variety of tactics and equipment to respond appropriately to any given situation. These tactics include skills in verbal persuasion. In addition to firearm proficiency testing, the IACP recommends routine instruction and periodic testing on a police service's specific use-of-force policy, including practical exercises in making decisions regarding use of deadly force.[42]

2. *IACP Model Policy on Responding to Persons with Mental Illness or in Crisis*

48. The IACP Model Policy on Responding to Persons with Mental Illness or in Crisis recommends that officers receive training to recognize behaviour that is indicative of mental illness or crisis. Those behaviours include strong fear, extremely inappropriate behaviour, abnormal memory loss related to common facts, delusions, hallucinations of any of the senses, and a belief that one is suffering from extraordinary, impossible physical maladies.[43]

49. In addition to the indicia of mental health issues or crises, the IACP model document sets out several risk assessment factors for officers to consider. These include

---

[40] Toronto Police Service, *Emergencies & Hazardous Incidents*, 10-05 "Incidents Requiring the Emergency Task Force" (Toronto, ON: Toronto Police Service, 2011) at 3.

[41] International Association of Chiefs of Police National Law Enforcement Policy Centre, Model Policy on Use of Force (Alexandria, VG: International Association of Chiefs of Police National Law Enforcement Policy Centre, February 2006).

[42] *Ibid*.

[43] International Association of Chiefs of Police National Law Enforcement Policy Centre, Responding to Persons Affected by Mental Illness or in Crisis: Concepts and Issues Paper (Alexandria, VG: International Association of Chiefs of Police National Law Enforcement Policy Centre, January 2014).

the availability of weapons, statements by the person that suggest violence, a personal history of violence under similar circumstances, the person's level of self-control (such as level of agitation, ability to communicate, ability to sit still, rambling thoughts), whether the person is begging to be left alone, the person's frantic assurances that one is alright, and the overall volatility of the environment. The policy notes that a person who does not exhibit dangerous behaviour before the police arrive may be less likely to be violent toward the officer.[44]

50. If a person in crisis appears to pose a threat to himself or herself or to others, the IACP suggests calling for back-up and taking steps to calm the situation. Recommended de-escalation techniques include eliminating emergency lights and sirens, dispersing crowds, assuming a quiet non-threatening manner, avoiding physical contact with the person, reassuring the person that the police are there to help, communicating to try to understand what is bothering the person, relating concern for the person's feelings, and talking about topics that ground the person in reality. The model policy suggests using a low tone of voice, refraining from threatening arrest, and taking time to assess the situation. The IACP emphasizes that time is an ally in such crisis situations, and may be used to gather information from the person's family or acquaintances, as well as to request professional assistance to help calm and treat the person. Even where the person is taken into custody, the IACP model policy emphasizes the continued use of de-escalation techniques and communication skills. The policy further suggests that police avoid using restraints, where possible and safe, to avoid agitating a person in crisis who is being taken into custody.[45]

51. Similarly, the IACP notes that most calls involving people with mental health issues result from behaviours or symptoms associated with crisis, not from criminal conduct. This reality requires a more thoughtful approach that does not contradict the need to ensure officer safety during such calls. To this end, the model policy recommends an approach that establishes police as helpers, not enforcers—the uniform always implies that an officer can use force, so this aspect of the police role does not need to be emphasized. The IACP notes that one officer's actions may have a long-term effect on the person's perception of police, so treating a person in crisis with respect and humanity may reap a long-term benefit for other officers as well as for the individual. Rather than characterizing communication as a passive or non-action approach, the policy describes active listening and frequent communication to understand the person's concerns as a control strategy that helps de-escalate or defuse agitation, fear and anger.[46]

52. Although many of the Ontario guidelines and TPS procedures on use of force are similar to those proposed by the IACP, they are not identical. Some notable differences between the two models are set out in Table 1 below.

[44] *Ibid.*

[45] *Ibid.*

[46] *Ibid.*

Table 1. IACP Model Policies v. Ontario guidelines/TPS Procedures

Topic	IACP	Ontario/TPS
Mental health indicators	Training on behaviours indicative of mental illness or crisis	Training that many behaviours indicative of mental health crisis precede attacks on officers
	Training that most mental health calls result from crisis, not criminal activity	Training to respond to subject's behaviour, not mental state
De-escalation	Multiple de-escalation techniques, and methods of communicating with person in crisis	Communication considered a use-of-force option; minimal focus on different methods of communication, non-verbal de-escalation techniques
	Police to establish themselves as helpers, not enforcers; communication as a control strategy	Police Challenge is the only communication example provided

3. *UN principles on use of force*

53. The United Nations has articulated international standards regarding conduct and the use of force by police. These include the UN Basic Principles on the Use of Force and Firearms by Law Enforcement Officials,[47] and the UN Code of Conduct for Law Enforcement Officials.[48] The UN recognizes law enforcement as a social service of great importance, and the significance of protecting the life and safety of police. The Code of Conduct authorizes use of force only when strictly necessary and to the extent required to fulfill the officer's duty. The Code of Conduct requires due respect for human rights and consideration of the ethical issues that relate to the use of force on civilians. In light of its focus on avoiding lethal force, the UN recommends that officers be equipped with a variety of weapons as well as defensive equipment such as shields and bullet proof vests.

54. The UN Basic Principles require initial screening of officers to ensure they have the appropriate moral, physical, and psychological attributes for the role, and also recommend periodic review of these qualities. Training should include discussion of police ethics and human rights, alternatives to the use of force, and methods of persuasion, negotiation and mediation. The UN further requires discipline and

[47] United Nations Congress on the Prevention of Crime and the Treatment of Offenders, Basic Principles on the Use of Force and Firearms by Law Enforcement Officials, UNDOC, 8th, 1990 [UN, *Basic Principles*].

[48] Code of Conduct for Law Enforcement Officials, GA Res 34/169, UN GAOR, 34th Sess., (1979) 185 [UN, *Code of Conduct*].

accountability for any unauthorized use of force, both for an officer who uses excessive force and for supervisors who ought to have known of the conduct and did not take all possible measures to prevent the occurrence.[49] The UN Code of Conduct similarly requires officers to report violations of human rights or service procedures by their colleagues within the chain of command to prevent harm to others.[50]

55. One does not find within the Ontario Use of Force Model or in TPS procedures the same degree of emphasis on avoiding the use of lethal force as is found in the UN standards. Although the Use of Force Model incorporated into the TPS Use of Force Procedure clearly sets out the legal threshold at which an officer is justified in using lethal force, the Model and the TPS procedures do not emphasize to the same extent as the UN standards the gravity of a decision to use a lethal weapon on another person. There is, quite appropriately, a focus on preserving the life of a police officer in a potentially violent confrontation. However, the objective of preserving the life of the subject, even where the use of a lethal force option may be legally justified, is not detailed in the Ontario or TPS materials.[51]

4. Comparison to other police services

56. Several North American police services have developed policies and procedures for improved communication and force avoidance when interacting with people in crisis. For example, the Lafayette Parish Sheriff's Office in Louisiana has a dedicated policy detailing communication and apprehension strategies to minimize force and aggression.[52] This policy emphasizes officer empathy and concern for people in crisis, and recommends that officers gently indicate that their only intention is to help the subject.[53] The Brandon Police Service in Manitoba employs a use-of-force model that emphasizes social control (officer presence) and verbal control (persuasion and advice) throughout the use-of-force continuum.[54]

57. Some police services have also developed reporting policies that contribute to decreased use of force. In Lafayette, Louisiana, officers are required to report any interaction with a person in crisis, whether an apprehension is made or not, and are forbidden from using prejudicial language such as "out of control," or "psychologically disturbed" in their reports.[55] Such a policy promotes positive discourse in the Service and contributes to a culture that is less antagonistic to people in crisis.

58. The Metropolitan Police Service of London, England is well known as an urban police agency that is predominantly unarmed. Only officers who are part of specific

---

[49] UN, *Basic Principles*, *supra* note 47, s. 24.

[50] UN, *Code of Conduct*, *supra* note 48 at 187.

[51] For a policy that emphasizes the gravity of use of force effectively, see e.g. Fort Worth Police Department, 306.00 "Use of Force" (Fort Worth, Texas: Fort Worth Police Department) at 306.01 ("use of a fire arm is in all probability the most serious act in which a police officer will engage, and has the most far-reaching consequences for all parties involved...")

[52] Lafayette Parish Sheriff's Office, Enforcement, LPSO 321 "Handling Mentally Ill Persons" (Lafayette, Louisiana: Lafayette Parish Sheriff's Office, 2012) [Lafayette, "Handling"].

[53] *Id*., at 4.

[54] Brandon Police Service, "Use of Force Model" (Brandon, MB: Brandon Police Service, 2005).

[55] Lafayette, "Handling", *supra* note 52 at 4 [emphasis in original].

armed units ~~a~~approximately 10% of the 30,000 member police service ~~a~~re issued firearms. When CEWs were first introduced in London, they were similarly issued only to armed "reactionary force" units—less than 10% of total officers in the service.

59. London's armed units are deployed to an incident only by command supervisors. In planning the appropriate response to a situation, supervisors consider human rights legislation and the objective of doing everything possible before resorting to the use of force. First responders are equipped with batons and pepper spray (but not firearms), and rely more on verbal communication than weapons to resolve crisis situations when there is insufficient time for an armed unit to attend the scene.

60. Incidents involving subjects with firearms in London are relatively infrequent, compared to the situation in North American cities. Police officers in London are trained that anyone with a firearm may be a person in crisis, triggering the need to gather more information about the issues facing the person, to establish a rapport with the individual, and to call in negotiators if necessary. First responders are trained to spend time building rapport with a person for the further purpose of delaying the situation long enough for supervisors and special units to attend the scene and determine the options for resolution. To facilitate information gathering, London police have access to a 24/7 phone line that can provide health records and diagnoses about an individual who has been involved with the mental health system. Mental health nurses are also available in the police communications control room to advise first responders remotely on what to expect from a subject based on the information retrieved from health records, and how best to approach the person.

61. The Metropolitan Police Service has created a separate Territorial Support Group that, among other roles, responds to incidents involving edged weapons. This Group is not armed with firearms, but is equipped with shields and CEWs. Group members receive special public order training, which includes techniques for de-escalation and overpowering an armed subject without resort to a firearm or other weapon. Notably, in London, unless there is evidence of a broader risk to the public, police with firearms are typically not deployed to situations involving edged weapons.

62. London has a mandatory debriefing policy that requires debriefing after all incidents involving serious injury or death, including debrief paperwork that must be filed by a unit commander after any situation in which an armed unit was deployed. Supervisors are responsible for debriefing junior officers to identify both individual training and organizational learning opportunities.[56] However, the Review learned that there is conflict between the Metropolitan Police Service and its Independent Police Complaints Commissioner with respect to the disclosure of debriefing materials in criminal proceedings, a tension that is addressed in Chapter 8 (Supervision).

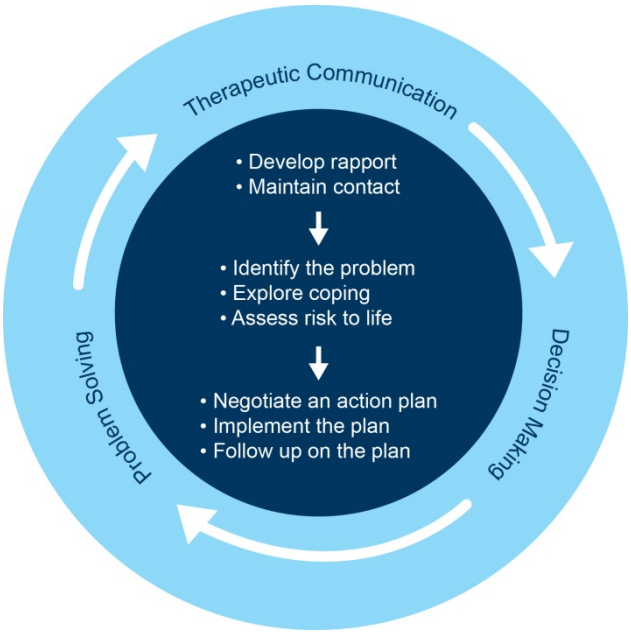
[56] Note also that Metropolitan Police officers are subject to a two-year probationary period, and officers must have a minimum of five years' experience before they can volunteer for any armed unit.

5. *Comparison to unarmed professions*

63. The Review received information from members of the mental health profession and consumer survivors with respect to the techniques used in community facilities, clinics, and hospitals to resolve situations with people in crisis. These techniques do not involve the use of weapons, and often do not involve resort to physical restraints. Even where an individual in crisis has a weapon, medical professionals start with verbal de-escalation attempts before proceeding to physical techniques. For example, mental health hospitals regularly encounter "Code White" situations in which a patient becomes aggravated and uncooperative, and may wield an improvised weapon. Although verbal de-escalation is not effective every time, it is the starting point for all situations.

64. The Registered Nurses Association of Ontario has issued a Nursing Best Practice Guideline for Crisis Intervention.[57] The Guideline incorporates a crisis intervention model—which may usefully be contrasted with the Ontario Use of Force Model—aimed at identifying the event that precipitated the crisis, assessing the patient's perception of the event, the patient's level of functionality and distress, and previously attempted coping mechanisms. The goal of crisis intervention for nurses is to return the patient to his or her pre-crisis level of emotional, occupational and interpersonal functioning. A visual depiction of the Nursing Best Practice Guideline for Crisis Intervention is shown in Figure 2.

Figure 2. Nursing Best Practice Guideline for Crisis Intervention



[57] Registered Nurses Association of Ontario, "Crisis Intervention: Nursing Best Practice Guideline – Shaping the future of Nursing" (March 2006), online: Registered Nurses Association of Ontario <http://rnao.ca/sites/rnao-ca/files/Crisis_Intervention.pdf>.

65. Communication is central to every stage of this crisis intervention model, from developing rapport with the patient and identifying the problem to creating and implementing a plan of action.[58]

66. As the Review heard with respect to the Metropolitan Police Service, when professionals dealing with people in crisis have no option to use lethal force, they are more likely to default to verbal de-escalation and develop multiple communications techniques to resolve a crisis situation.

E. Difficulty in comparing statistics regarding use of force

67. As discussed in Chapter 3 (Context), between 2002 and 2012, TPS use of lethal force involving members of the public ranged from one to five incidents per year. For Ontario as a whole, the Special Investigations Unit reports a range of 1 to 10 lethal incidents per year resulting from police use of firearms against members of the public.[59]

68. It is difficult to compare the use of force of Canadian municipal police services not only because of challenges in obtaining data from those sources, but also because police services collect and report different information, and code their data differently. Thus, the Review was not able to compare TPS data regarding police use of force in encounters with people in crisis with the same information from other cities. Further, the criteria for assessing mental illness continue to evolve, which may affect how various police services record calls involving people in crisis at different times.

69. At the same time, some notable comparators stand out, without the need for detailed statistical analysis. For example, the Review was informed that the Metropolitan Police Service in London has been involved in shooting four people in crisis in the last 10 years—in a city of 8 million people. This compares with five lethal shootings of people in crisis in Toronto in the 2002-2012 period, with Toronto having only a third of the population of London. Although the absence of a "gun culture" in England is often cited as a relevant factor when considering use of lethal force by London police more generally, it should be irrelevant when considering encounters with people in crisis specifically. There is no reason to believe that London has fewer people in crisis than Toronto, or that people in crisis in London are less dangerous than in Toronto, yet police in London are involved in substantially fewer lethal shootings of people in crisis than the TPS.

70. The Rand Corporation, a policy research institution, has issued a report canvassing best practices in measuring police performance.[60] The Rand Report notes the importance of comparing performance across police agencies to determine how a service is performing relative to similar agencies. The Report recommends using data from multiple agencies to create a standard comparator and "synthetic controls" against

---

[58] See e.g. *id*. at 25-29.

[59] Ontario Special Investigation Unit, "Special Investigations Unit Annual Report, 2011-2012: Shaping Civilian Oversight" (2012), online: Ontario Special Investigation Unit <http://www.siu.on.ca/pdfs/siu_ar_2011-12_eng_final.pdf> at 17.

[60] Robert C. Davis, "Selected International Best Practices in Police Performance Measurement" (2012), online: RAND Corporation http://www.rand.org/pubs/technical_reports/TR1153.html [Davis, "Best Practices"].

which to measure performance. There are several ways to measure police performance, including the extent to which service members use force sparingly and fairly to minimize shootings and treat people equally, and the level of "customer satisfaction" of the people police serve.[61] Given that it can be difficult to accurately measure performance based on a police service's records alone, some experts recommend other measures such as surveys of the community, of those who interact with police and of officers.[62] Used in connection with citizen complaints and other internal records, a service may be able to create a database of information that can be used as an early warning system for inappropriate use of force.[63] Further, the effective use of the data collected may improve police culture by encouraging officers to strive for higher levels of accomplishment.[64]

II. Overview of Issues Highlighted by Stakeholders

71. The Review received submissions from several organizations and individuals which addressed the current provincial Use of Force Model, use-of-force policies within Ontario and the TPS, and recommendations for reforms. The Review also received comparative use-of-force policies and procedures, such as those produced by the International Association of Chiefs of Police, the UN, and police services in other jurisdictions, some of which were described above.

72. The Review received suggestions for changes to the Use of Force Model. For example, both a former police officer and a relative of a person shot by police during a crisis suggested changes to the current training that shots must be fired to the chest to stop individuals. Another relative of a person with mental illness shot by police suggested improvements to training for officers on how to deal with individuals who do not respond in a typical way to yelled commands. Others suggested that police should better incorporate information about an individual's mental illness or crisis state and input from the subject's family into the assessment of the appropriate use of force.

73. One organization expressed concern that misconceptions about mental health symptoms can distort police perceptions of the risk posed by people in crisis. That organization suggested reviewing the Ontario Use of Force Model with a human rights lens to combat adverse effects of the Model on people in crisis. Another stakeholder expressed dismay that the Use of Force Model has changed minimally since its introduction in 1993, and suggested that this is indicative of minimal change in police training in the area of use of force.

74. Several individuals raised concerns that the focus on ensuring officer safety has overshadowed the need to protect the lives of subjects and bystanders. One mental health care provider suggested that the Use of Force Model should better emphasize the

---

[61] *Id*. at 2-3 (Davis describes customer satisfaction as "services to the public above and beyond crime fighting," and writes that, "[p]roviding good service to citizens increases police legitimacy.")

[62] See e.g. Dr. Johann Brink et al., *A Study of How People with Mental Illness Perceive and Interact with the Police* (Calgary, AB: Mental Health Commission of Canada, 2011).

[63] Davis, *supra* note 60 at 6.

[64] *Id*. at 12.

well-being of the subject and encourage officers to seek third-party assistance—such as from the MCIT—before moving through the use-of-force stages.

75. The Review received a wide range of other submissions relating to use of force, including a request for additional data collection and analysis of use-of-force trends, and a suggestion that the TPS should set a goal of zero harm in all police interactions. The Review also received submissions in favour of disarming primary response officers of handguns.[65] A number of organizations suggested that the TPS should provide rewards for effective de-escalations and better recognize officers who do not use force in controlling a situation.

76. Although some stakeholders felt that de-escalation should be included in the training and analysis of every stage of the Use of Force Model or should be considered a threshold requirement before any use of force is considered, another argued that communication is already part of crisis management and does not need to be considered a separate step in the use of force model.

77. Of particular note, the Review heard concern from several sources that the indicia of aggressive behaviour listed in the current Use of Force Model effectively encourage *escalation* of the situation, because only complete compliance will be considered control of the situation. Those stakeholders suggested that this approach fails to consider the inability of a person in crisis to comprehend and physically comply with an officer's command. A mental health services provider noted the difficulty that some police officers have with waiting or doing nothing, and expressed concern that slow-moving situations involving people in crisis may encourage agitated officers to escalate the situation themselves in order to move on to other calls.

III. Recommendations

78. I recommend that:

Improving the Use of Force Procedure to reflect best practices

> **RECOMMENDATION 41**: The TPS revise its Use of Force Procedure to supplement the Ontario Use of Force Model and guidelines with best practices from external bodies such as the IACP, the United Nations and other police services in order to:
>
> (a) incorporate approaches to minimizing the use of lethal force wherever possible;
>
> (b) increase the emphasis placed on the seriousness of the decision to use lethal force in response to a person in crisis;

[65] The suggestion to disarm front line police officers of handguns engages issues much broader than the use of lethal force in situations involving people in crisis, and would require research and analysis well beyond the scope of this Report.

(c) further emphasize lethal force as a last resort to be used in crisis situations only where alternative approaches are ineffective or unavailable;

(d) articulate the importance of preserving the lives of subjects as well as officers wherever possible;

(e) recognize indicators of mental health crises as symptoms rather than threats to officer safety;

(f) acknowledge that many mental health calls result from crisis symptoms rather than criminal behavior;

(g) emphasize that police responding to people in crisis are usually required to play a helping role, not an enforcement role; and

(h) articulate that communication with a person in crisis should be a default technique in all stages of assessing and controlling the situation and planning a response.

Updating the Use of Force Procedure

RECOMMENDATION 42: The TPS regularly update its Use of Force Procedure to reflect best practices and the results of further research into the most effective means of communicating with people in crisis. In this regard, the TPS should seek alternative approaches for officers when a person in crisis does not appear to comprehend or have the ability to comply with the Police Challenge; and consider consulting with provincial agencies, the Ontario Police College, mental health experts, consumer survivors, and others with specialized experience to ensure that the Use of Force Procedure reflects best practices.

CHAPTER 11

MCIT and Other Models of Crisis Intervention

CHAPTER 11. MCIT AND OTHER MODELS OF CRISIS INTERVENTION

Table of Contents

Page

I. THE CURRENT SITUATION 217

A. Toronto's Mobile Crisis Intervention Teams 217
(1) Origins of Toronto's MCIT 217
(2) The MCIT model 218
(3) Existing MCIT coverage 219
(4) Selection and training of MCIT officers and nurses 222
(5) MCIT officers' career progression 223
(6) Advantages of the MCIT model 223
(7) Specific issues with the implementation of MCIT in Toronto 224
(8) Limitations of the MCIT model 225

B. Other models of Crisis Intervention Teams 226
(1) Vancouver's Assertive Community Treatment and Car 87 230
(2) Memphis' Crisis Intervention Teams (CIT) 231
(a) A first response by specialized police officers 231
(b) The institutional framework of the Memphis CIT model 232
(3) Hamilton's combination of CIT, MCIT and COAST 234
(4) Comparing the other models to Toronto's MCIT 235

II. OVERVIEW OF ISSUES HIGHLIGHTED BY STAKEHOLDERS 236

III. RECOMMENDATIONS 237

Crisis Intervention Teams 237
The Mobile Crisis Intervention Team 238

Chapter 11. MCIT and Other Models of Crisis Intervention

1. Toronto's Mobile Crisis Intervention Teams (MCIT) are a cornerstone of the Toronto Police Service's response to people in crisis. These specialized units pair a police officer, who has received additional training regarding mental illness and dealing with people in crisis, with a mental health nurse in a marked TPS vehicle. Together the officer and nurse provide a specialized second response to TPS calls for service involving a person in crisis.

2. Toronto's MCIT program is one of a wide range of specialized crisis intervention models used throughout Canada and the United States, each of which has its own advantages and limitations.

3. In this chapter, I discuss the importance of providing a specialized response to calls involving people in crisis, and review the effectiveness of the MCIT model. Currently, there are relatively few MCIT units spread across the entire City of Toronto. This permits the TPS to provide a specialized response to only a minority of such calls. The nature of the MCIT as a second response rather than a first responder to crisis calls is also a factor that merits further consideration. I also discuss other crisis intervention models that the TPS could adopt, in tandem with the MCIT program, to complement the Service's response capabilities to best address the needs of people in crisis. I also discuss certain suggested improvements to the MCIT program.

I. The Current Situation

A. Toronto's Mobile Crisis Intervention Teams

1. *Origins of Toronto's MCIT*

4. The TPS established its first MCIT in 2000 in response to a recommendation from the 1994 Coroner's Inquest into the death of Lester Donaldson. The inquest jury recommended that the "Metropolitan Toronto Police Services Board support the development of a special response unit to respond to the mentally ill."[1]

5. The MCIT program began as a partnership between St. Michael's Hospital and the TPS, deploying a mental health nurse in tandem with a trained officer to respond to calls involving people in crisis, first in 51 Division, and subsequently expanded to 52 Division also, covering downtown Toronto. The MCIT program expanded over time. By the end of 2014, the MCIT will provide a degree of coverage to all 17 TPS Divisions, involving six partner hospitals.

6. The conceptual origins of Toronto's MCIT are found in the "Memphis Model" of Crisis Intervention Teams (CITs), first developed in 1988 in Memphis, Tennessee, and described in more detail below. The Memphis Model involves specially trained police

[1] Centre for Research on Inner City Health, *Toronto Mobile Crisis Intervention Team (MCIT) Program Implementation Evaluation Final Report* (Toronto: St. Michael's Hospital, 2014) at 2 [CRICH, *MCIT Implementation*]; Toronto Police Service, *Coroner's Inquests Involving Emotionally Disturbed Persons (EDPs) and the Toronto Police Service*, "Subsequent jury recommendations and responses" (Toronto: Toronto Police Service, 2010) at 1.

officers serving as first responders to calls involving people in crisis.[2] There are important functional differences between the Memphis Model and the MCIT, including most notably the fact that the Memphis Model is a first response model that does not include a mental health professional directly within the crisis intervention team.

2. *The MCIT model*

7. Toronto's MCIT model pairs a specially trained, uniformed police officer with a mental health nurse from a partner hospital to provide a mobile response to people in crisis. Funding for the officer is provided by the TPS and funding for the nurse is provided by the applicable Local Health Integration Network (LHIN) that oversees financing for the partner hospital.[3]

8. The framework for MCIT operations is set out in a Memorandum of Understanding (MOU) that the TPS establishes with each of its six MCIT partner hospitals. These MOUs establish the basic operating principles of an officer-nurse pairing. Referrals for MCIT services must come from TPS Communications Services (as a result of 911 calls or other calls for service) or directly from other officers in the field. MCIT nurses are responsible for triaging priority of calls when multiple calls occur simultaneously.

9. The aims of Toronto's MCIT program are to:

(a) provide prompt assessment and support to people in crisis;

(b) link people in crisis to appropriate community service if follow-up treatment is recommended;

(c) avert the escalation of a situation and potential injury to both police and people in crisis;

(d) reduce pressure on the justice system by, for example, diverting people in crisis toward treatment and minimizing officers' time handling psychiatric emergencies;

(e) reduce pressure on the healthcare system by, for example, decreasing unnecessary emergency room visits; and

(f) ensure the accountability of the program.[4]

10. In attending a call involving a person in crisis, the MCIT helps determine the appropriate course of action, which might include providing a mental health assessment, giving information, arranging community support or a community treatment referral, conducting follow-up calls with hospital clients to reduce repeat calls

---

[2] City of Toronto Mobile Crisis Team Coordination Steering Committee, *MCIT Program Coordination in the City of Toronto* (Toronto: Toronto Central Local Health Integration Network, 2013) at 8 [Steering Committee, *Coordination*].

[3] *Id.* at 11.

[4] CRICH, *MCIT Implementation*, *supra* note 1 at 2.

for service, providing voluntary transportation to a hospital for treatment, or apprehending the person for psychiatric assessment under the *Mental Health Act*.[5]

11. The MOUs specify that the MCIT is a second response. A two-officer Primary Response Unit (PRU) must first be dispatched to all calls involving a person in crisis to assess safety issues, any need for criminal charges, and the suitability of the situation for the MCIT to attend. Under the MOUs, the MCIT cannot be a first response because of the presence of the nurse who, as a civilian, cannot be put in harm's way. However, the MCIT and PRU will often arrive at a call simultaneously to expedite this process.[6] In practice, MCIT units do act as first responders when the call as dispatched clearly is not dangerous.

12. TPS Procedure 06-04 "Emotionally Disturbed Persons," sets out the circumstances under which the MCIT should be involved in a call. The policy mandates that, in responding to a call involving a suspected person in crisis, the PRU should take all necessary steps to make sure the situation is safe, determine if there is a need for immediate apprehension, and consult with the MCIT, if available. If a person in crisis does not need to be arrested or apprehended, the officers must contact the MCIT, if available.

13. In October 2012, the Toronto Central LHIN established an MCIT Coordination Steering Committee to examine the current state of the MCIT program, and design a system to standardize its practices across hospital partnerships. The Steering Committee's goals are to oversee an MCIT program that provides coverage in all areas of Toronto in a manner that meets the needs of the population, and to develop an MCIT model that efficiently integrates into the continuum of available healthcare services.[7] The Steering Committee is co-chaired by TPS Deputy Chief Michael Federico and the CEO of Toronto East General Hospital, Rob Devitt, and includes voices from the policing, emergency response, and mental health treatment communities. The Committee also seeks input from community members living with mental illness.[8]

3. *Existing MCIT coverage*

14. After the Service's initial partnership with St. Michael's Hospital in 2000 to cover 51 and 52 Divisions, the TPS expanded the MCIT program by establishing partnerships with the following healthcare centres to provide coverage for 14 of the Service's 17 divisions:

---

[5] Steering Committee, *Coordination*, *supra* note 2 at 12.

[6] Toronto Police Service, *Unit-Specific Policy Communications Services*, C-06-04, "Emotionally Disturbed Persons" (Toronto: Toronto Police Service, 2011); Steering Committee, *Coordination*, *supra* note 2 at 11.

[7] Toronto East General Hospital, *Briefing Note: Development of a City of Toronto MCIT Program* (Toronto: Toronto East General Hospital, 2013) at 2; Steering Committee, *Coordination*, *supra* note 2.

[8] The Steering Committee includes voices from TPS, current MCIT members, representatives from participating LHINs, Emergency Medical Services, the Acute Care Alliance, mental health and addictions services, and the City of Toronto Mental Health Promotion Program. In preparing its 2013 report, *MCIT Coordination in the City of Toronto*, the Steering Committee also consulted with the Empowerment Council, the Toronto Police Services Board's Mental Health Sub-Committee, and Toronto East General Hospital's Withdrawal Management Services.

(a) St. Joseph's Health Centre in 2005 to cover 11 and 14 Divisions in Central-West Toronto;

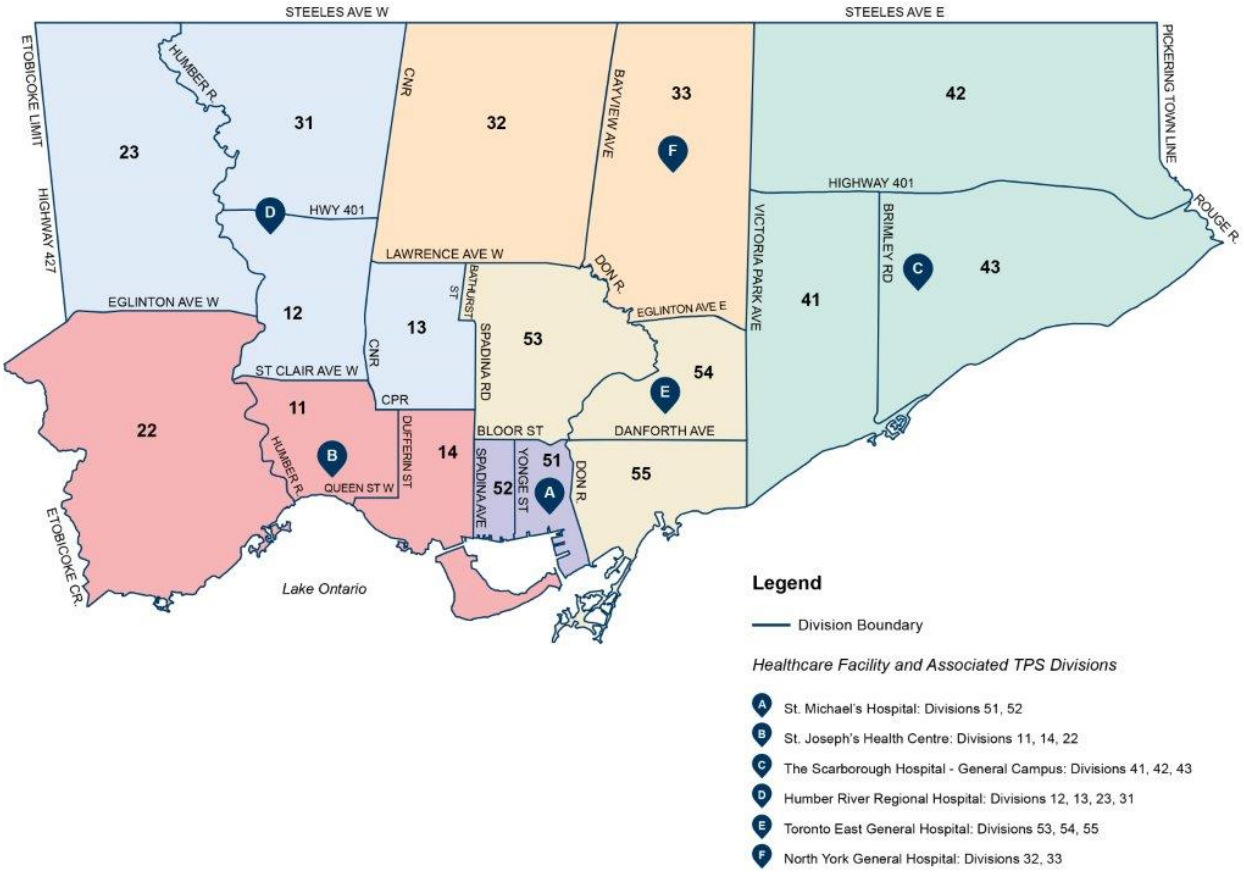
(b) The Scarborough Hospital – General Campus in 2006 to cover 41, 42, and 43 Divisions in Scarborough;

(c) Humber River Regional Hospital in 2008 to cover 12, 13 and 31 Divisions in Northwest Toronto;

(d) Toronto East General Hospital in 2013 to cover 54 and 55 Divisions in Central-East Toronto;[9] and

(e) North York General Hospital in 2014 to cover 32 and 33 Divisions in North York.[10]

Figure 2. Toronto's MCIT Service Areas and Partner Hospitals



[9] For further information on MCIT operations, divisional partnerships and geographic coverage, see Steering Committee, *Coordination*, *supra* note 2.

[10] Ron Fanfair, "MCIT Expands to North York" *TPSNews* (7 April 2014), online TPSNews <http://tpsnews.ca/stories/2014/04/mcit-expands-north-york/>.

15. In spite of the steady growth of the MCIT program, there remain significant areas of the city without permanent MCIT coverage: 22 and 23 Divisions, comprising all of Etobicoke, and 53 Division, a large section of central Toronto. These areas of the city experience high volumes of crisis calls, and often higher volumes than some areas that are currently serviced by MCIT units.[11]

16. In 2014, the TPS is expanding the MCIT program's geographic coverage on a six-month trial basis, to cover these three remaining divisions. Funding for three more mental health nurses will provide for three additional teams based out of: St. Joseph's Health Centre, which will now cover 22 Division in addition to 11 and 14 Divisions; Humber River Regional Hospital, which will now cover 23 Division in addition to 12, 13, and 31 Divisions; and Toronto East General Hospital, which will now cover 53 Division in addition to 54 and 55 Divisions. Toronto's expanded MCIT service areas are mapped in Figure 2.

17. This expansion will provide some MCIT coverage to all areas of Toronto. However, these three additional teams will only be available four days per week. On days when they are not available, a single MCIT unit will cover these expanded areas, which means they may be stretched beyond their capacity.[12] For example, on such days, the MCIT unit attached to St. Joseph's Health Centre will have to cover a territory stretching from the western boundary of Etobicoke to Spadina Avenue in the east, and from the waterfront to as far north as Eglinton Avenue.

18. MCIT units are on the road for 10-hour shifts. Hours vary depending on the demand of the community served, but generally fall between 11 a.m. and 11 p.m. Each unit adjusts its hours of operation by analyzing the number of apprehensions under the *Mental Health Act* and volume of crisis calls by time of day within the divisions that the unit covers.[13]

19. The MCIT currently responds to approximately 11% of calls categorized by the TPS as "emotionally disturbed person" (EDP) calls annually. In 2013, TPS officers were dispatched to 20,550 "EDP" calls, of which MCIT units responded to 2,330. While this information reflects a period when only 12 of the 17 TPS operational divisions had MCIT units, and the MCIT will likely respond to more calls as their geographic coverage expands, the low proportion of calls to which MCIT responded is cause for concern.

20. The low MCIT response volume can be explained by the nature of the MCIT as a second response, the restriction of these units to certain geographic areas and hours of operation, and lack of capacity. As the geographic coverage of the MCIT program is expanded without a corresponding increase in MCIT units, existing MCIT pairs will spend increased time in transit between calls and less time interacting with people in crisis. The Review was told by many people, both within and outside the TPS, that existing MCIT resources are insufficient. If there is one MCIT unit on duty and three

[11] Steering Committee, *Coordination*, *supra* note 2 at 9.

[12] CRICH, *MCIT Implementation*, *supra* note 1 at 30.

[13] Steering Committee, *Coordination*, *supra* note 2 at 13.

crises occur at the same time, in almost all cases the MCIT cannot address all three calls. As a result, front line officers still play the most significant role in managing crisis calls.

4. *Selection and training of MCIT officers and nurses*

21. Officers are selected for the MCIT program through an internal job call within the TPS when a position becomes available. The job summary requests officers who have "shown a strong ability to deal effectively with persons in crisis."[14] There are generally three to four applicants per position, though as the MCIT becomes more established, applications are increasing and recruitment is becoming more selective. The term of the position is generally, though not always, for a minimum of two years and a maximum of five. Any first class constable can apply.[15] Applicants must therefore have significant policing experience.

22. MCIT nurses are selected from within individual partner hospitals. The MCIT model job posting for nurses specifies that applicants must have a minimum of three years of recent experience in an acute mental health setting, preferably with a minimum of two years of experience in a community mental health setting. In addition, the nurse must possess several certifications directly applicable to crisis prevention and psychiatric nursing.[16]

23. The MCIT Coordination Steering Committee is in the process of standardizing the processes for the selection and oversight of MCIT officers and nurses. This is an area that is evolving through collaboration between the TPS and partner hospitals.

24. Currently, the TPS division and the partner hospital that oversee the individual MCIT unit do a preliminary vetting of candidates. Most MCIT units now use a joint hiring process where a representative from the police division participates on the partner hospital's committee for hiring MCIT nurses and vice versa. The goal is to have input from both the TPS and the partner hospital in all MCIT hiring decisions.

25. All MCIT officers and nurses attend a week-long training course, designed to familiarize the officer and nurse with each other, with the nature of their roles in partnership, and with respect to their common approach in interacting with a person in crisis. The course provides officers with an enhanced understanding of specific mental health issues and symptoms, and recommendations on how to approach persons exhibiting specific symptoms. The course is focused on information sharing, and is

---

[14] Toronto Police Service, *Position Specification Sheet*, "Mobile Crisis Intervention Team (MCIT)" (Toronto: Toronto Police Service, 2009) at 1.

[15] Newly hired constables begin as fourth class constables and progress to first class constables. Constables are considered annually for reclassification. Accordingly, first class constables have at least three years of experience; see Toronto Police Service, "Salary, Benefits, Career Development" (Toronto, Toronto Police Service, 2013), online: Toronto Police Service <http://www.torontopolice.on.ca/careers/uni_benefits.php>.

[16] Toronto East General Hospital, "Job Posting: Position Title: Registered Nurse, Department: Mental Health Services – Mental Health/Addictions," *City of Toronto MCIT Program Guideline* (February 2014).

designed to build on the de-escalation training received as part of new constable training and annual in-service training.[17]

26. As noted earlier, the Toronto Police Service's in-house psychologists have no involvement with MCIT selection or training, or in monitoring the effectiveness of the program or the TPS officers involved in it.

5. *MCIT officers' career progression*

27. An officer's service in the MCIT program is considered as equivalent to time spent as a generalist constable in terms of career progression within the Service. MCIT officers are therefore eligible for further promotion.

28. Although there are no formal job impediments to MCIT officers' promotions within the Service, I have been left with the impression from several sources that the MCIT is not a sought-after position for an ambitious officer mindful of career progression. There may be informal obstacles in the Service's culture that lead some to view the MCIT as an ineffective path for advancement. Units that fall within the more conventional image of policing, such as the Emergency Task Force, the Drug Squad, or the Homicide Squad, may be favoured. This has the potential to undermine the importance placed on softer skills that are necessary to community policing.

29. There appears to be insufficient awareness within TPS of the role that the MCIT plays and the work that these units accomplish.[18] The Review was told of examples of existing TPS officers who are unfamiliar with the MCIT and its role. This lack of knowledge inhibits the effectiveness of the MCIT program, as other officers do not make use of the MCIT's expertise in all applicable circumstances. In practice, the MCIT is not called to, or notified of, all calls involving a person in crisis. This was a key finding of the *MCIT Program Implementation Evaluation Final Report*, which called on the TPS to increase support for the units by raising awareness of the MCIT's resources and expertise among first responding officers.[19]

30. It should be noted, however, that the Review heard many positive comments from a wide variety of stakeholders about the role that the MCIT plays. I now turn to that discussion in greater detail.

6. *Advantages of the MCIT model*

31. The MCIT has three chief advantages. First, the pairing of an officer with a mental health nurse bridges the information gap between the police and the mental health systems, allowing the pair to access both police and health records to inform their response to the call. This enhanced access to information enables the team to provide a more fully informed response that can be tailored to the person in crisis.

---

[17] Toronto Police College Community Policing, *Course Training Standard*, "Mobile Crisis Intervention Team Level 1" (Toronto: Toronto Police Service, 2013).

[18] CRICH, *MCIT Implementation*, *supra* note 1 at 21-22.

[19] *Id.* at vi, 21-22.

32. Second, mental health nurses possess a depth of medical knowledge and skill in interacting with people in crisis that cannot be easily matched by a police officer. The mobile mental health nurse can deploy this knowledge in order to de-escalate situations and connect people in crisis with treatment resources.

33. Third, the specialized training given to MCIT officers, in combination with the direct working partnership formed with mental health nurses and partner hospitals, can play a significant role in reducing the stigma associated with mental illness within the Service. A large and diverse group of people who met with the Review consistently emphasized the problems posed by the mutual lack of familiarity, fear, and stigma held by both the police and the community of people who live with mental illness. Furthermore, the role of the MCIT in doing follow-up calls, days and weeks after encountering a person in crisis, allows police officers to see subjects as ordinary people living their lives, not always in crisis. As a result, the MCIT represents a significant opportunity to foster a Service culture that understands and prioritizes mental health, and cultivates more effective relationships among the police, the mental health treatment system, and people living with mental illness. The MCIT program is an extremely valuable tool in the Toronto Police Service's efforts to serve and protect people in crisis, and society at large.

7. Specific issues with the implementation of MCIT in Toronto

34. The most significant issue facing the MCIT program is capacity. As stated above, the TPS currently does not come close to meeting its goal of providing a specialized response to all calls from people in crisis. This shortcoming is the result of several factors.

35. First, the MCIT's responsiveness is impeded by its limited geographic coverage. As stated above, the recent expansion of services is addressing this issue on a trial basis, four days out of seven. Second, the MCIT's limited hours also restrict the range of calls that can be addressed by a specialized response. Currently there are no plans to change these hours. Third, an overall capacity shortage means that if several calls involving a person in crisis occur at once, only one caller can receive a specialized response. Though MCIT units are being added, the simultaneous expansion of some teams' geographic coverage means that demand for MCIT services may become more strained, not less. The Review heard from many people that there needs to be one full-time MCIT unit per TPS division. Finally, the MCIT model, as a second response, is inherently limited in the range of situations it can address, as discussed below. The combination of these four factors limits the MCIT to responding to a small minority of Toronto's crisis calls each year, as compared to the 90 percent of crisis calls addressed by the Memphis Crisis Intervention Teams, a different model of crisis intervention discussed below.[20]

36. The role of the MCIT within the TPS also needs to be strengthened. Some MCIT officer positions have been for a duration of less than two years, which means that, by

[20] In comparing statistics between police services, it is important to acknowledge that there is no standardization in the methods of data collection. Memphis and Toronto may have different metrics or procedures for classifying a call as involving a person in crisis, and may have different thresholds for recording data in different circumstances. As a result, we use these statistics only to broadly illustrate the varying outcomes of different models of crisis intervention.

the time these officers are comfortable in their roles and have developed the appropriate skill set, their tenure on the MCIT has ended. While there is value in disseminating the knowledge and experience of MCIT officers throughout TPS, frequent turnover can undercut the effectiveness of the MCIT itself.[21] It is not only a mental health training program. It is an operational unit of the Service that needs to retain expertise.

37. As mentioned above, the role of the MCIT officer is not a highly coveted position within TPS or one that is viewed as significantly helping career progression. The MCIT is not perceived as being within the traditional duties of a police officer. However, in light of the changing role of policing in our society, these perceptions must change throughout the Service, from management to front line officers.

38. Coordination between the TPS and hospitals is also a significant issue limiting the effectiveness of the MCIT program, as described in Chapter 4 (The Mental Health System and the Toronto Police Service). When officers apprehend a person in crisis under section 17 of the *Mental Health Act*, they must bring the person to a hospital for examination by a physician, who will then decide whether to issue a Form 1 Application by Physician for Psychiatric Assessment through which the psychiatric facility takes custody over the individual.[22] As noted, although practices vary, in general, officers cannot leave the hospital until the person in crisis is seen by a physician, with the result that officers are often subjected to lengthy wait times in hospital emergency departments. The wait can be up to eight hours, depending on a variety of factors, including hospital staffing, availability of beds, patient volume and priority in the hospital's emergency triage system.

39. In theory, the inclusion of mental health nurses within the MCIT unit should reduce emergency room wait times because nurses can provide assessments of people in crisis. However, the information on this point is inconclusive. Opportunities to streamline the hand-off process between the PRU or MCIT and hospital emergency departments were discussed in Chapter 4 (The Mental Health System and the Toronto Police Service). Since the MCIT is a relatively scarce resource, it may be useful to implement a protocol under which PRUs or other officers relieve MCIT units from having to wait in the emergency room, freeing them up to return to service and respond to other calls. Ultimately, what would be most beneficial is for wait times for police officers (including MCIT units) to be minimized.

8. *Limitations of the MCIT model*

40. A key limitation of the MCIT model is the fact that the officer-nurse pair can only act as a second response. In this respect, it is unfortunate that police officers without specialized training in mental health crises are required to make a crisis situation safe before the professionals most capable of managing and de-escalating that crisis–the MCIT unit—are allowed to intervene. It is highly arguable that the most capable people should be engaged from the outset.

---

[21] CRICH, *MCIT Implementation*, *supra* note 1 at 24-25.

[22] *Mental Health Act*, R.S.O. 1990, c. M-7, ss. 15, 17.

41. Clarification of the MCIT's role as a possible first responder is required. A first response by an MCIT unit is appropriate in certain circumstances, such as where an MCIT unit has had previous contact with a specific individual. It may also be useful if MCIT units are more consistently involved as a first response alongside the PRU because this will allow dissemination of expert advice, and will facilitate the quickest involvement of mental health nurses once security is assured.[23]

42. Furthermore, the Review was advised that MCIT units are not permitted to respond to crises involving drugs or alcohol. This is a significant limitation in light of the fact that mental health and addiction issues are frequently interrelated.

43. As demonstrated by the Vancouver, Memphis, and Hamilton examples discussed below, different forms of crisis response offer their own advantages and shortcomings. While the MCIT program is excellent and should be retained, at the same time it should not be assumed that the TPS is confined to using only the MCIT secondary response model. The TPS can draw on the models used by other cities to create a program complementary to the MCIT to respond to people in crisis.

B. Other models of Crisis Intervention Teams

44. In general, crisis intervention models fall into five categories, depending on the degree to which mental health professionals are directly involved in the response, and on whether the response unit is based in the police service or the mental health system.[24] A brief survey of the spectrum of models is as follows:

(a) Response by specialized police officers: This is the Memphis Model, in which a significant proportion of a police service's front line officers are given specialized training in mental illness, de-escalation, and crisis intervention techniques. The police service coordinates with the mental health system to share information and make transfer of care efficient. Mental health professionals become involved only once a person is brought to a treatment facility.[25]

(b) Police response, in consultation with mental health professionals: Some police services employ mental health professionals to provide on-site or telephone consultations to officers in the field to aid in interacting with a person in crisis. Montreal, for example, created the Urgence Psychosociale-Justice program in 1996, which is an around-the-clock phone service that enables police to call social workers who then come to

[23] CRICH, *MCIT Implementation*, *supra* note 1 at 2.

[24] Martha Williams Deane *et al.*, "Emerging Partnerships Between Mental Health and Law Enforcement" (1999) 50:1 Psychiatric Services 99.

[25] Richard H. Lamb, Linda E. Weinberger & Walter Jr. DeCuir, "The Police and Mental Health" (2002) 53:10 Psychiatric Services 1266.

the scene to assess a client's threat level, or support police in their intervention by mobilizing community resources.[26]

(c) Response by both police and mental health professionals, in partnership: This model uses a mobile response team, composed of a specially trained police officer and a mental health professional working together to respond to calls involving people in crisis. Teams can be based out of the police service or the mental health system. Toronto's MCIT and Hamilton's Crisis Outreach Assessment and Support Team (COAST) are examples.

(d) Response by mental health professionals: Some jurisdictions have response teams composed solely of mental health professionals, social workers, and other healthcare experts, without involvement of the police. Vancouver's Assertive Community Treatment (ACT) teams were an example of this model, until 2012 when the Vancouver Police Department (VPD) joined the program.

(e) Peer response teams: Some organizations bring together people who either live with mental illness or have been treated for mental illness, to provide a peer response to individuals in crisis by telephone or in person. The Gerstein Centre in Toronto is an example.

45. These models each have their own advantages and disadvantages. As a result, it is important to appreciate that they are not mutually exclusive options. They can be deployed alongside one another in a complementary manner.

46. Below I discuss three cities that have taken approaches different from Toronto's MCIT model: Vancouver's combination of ACT teams and Car 87; Memphis' CIT; and Hamilton's combination of CIT, MCIT and COAST.

47. To illustrate the diversity of response models available, I have reproduced a table provided by the Ontario Ministry of Community Safety and Correctional Services, which demonstrates the range of available response models and examples of police services that employ each model.[27] The models used in Toronto, Vancouver, Memphis, and Hamilton are bolded.

[26] Service de police de la Ville de Montréal, *Plan d'action stratégique en matière de santé mentale 2013-2015*, "L'intervention policère auprès de personnes mentalement perturbées ou en crise" (Montréal: Service de police de la Ville de Montréal, undated) at 8.

[27] This table has been modified slightly from the version provided by the Ministry of Community Safety and Correctional Services. It is not a comprehensive list of crisis response programs, but it demonstrates the variety of programs that exist.

Table 1. Mobile Crisis Teams and Other Initiatives

MOBILE CRISIS TEAMS		
Model Type	**Description**	**Police Services**
1. On-site Response from Police and Mental Health Professionals	A. A police officer and a mental health professional respond on-site together to calls from persons with mental illness.	Chatham-Kent Police, ON
		Toronto Police, ON
		Hamilton Police, ON
		Durham Regional Police Services, ON
		York Regional Police, ON
		Vancouver Police, BC
		RCMP (Surrey), BC
		RCMP (Calgary), AB
		RCMP (Edmonton), AB
		RCMP (Grand Prairie), AB
	B. Police officers partner with a mobile mental health team whose members specialize in mental health issues or are mental health professionals.	Ottawa Police, ON
		RCMP (Moncton), NB
	C. Police officers and mental health professionals form a team that provides telephone support and mobile crisis response.	Halifax Regional Police, NS
2. Crisis Outreach Assessment and Support Team (COAST)	COAST involves a multidisciplinary team of police officers and mental health professionals who conduct preliminary telephone assessments of persons with mental illnesses, and respond on-site with a mobile team when appropriate. COAST also assists clients with follow-up treatment plans.	Halton Regional Police, ON
		Hamilton Police, ON
		Niagara Regional Police, ON
		Peel Regional Police, ON
		Vancouver Police, BC[28]

[28] Vancouver's ACT program, discussed below, is very similar to the COAST program operated in Southwest Ontario. COAST programs were launched in several Ontario cities over the past 20 years, with Hamilton leading the way: Hamilton (1997), Ottawa (2001/2004), Halton (2006), Waterloo (2008), London (2012 pilot) – see Staff Sgt. Lloyd, "COAST Services – At a Glance (Halton – Hamilton – Waterloo – London – Ottawa" (Halton: Halton Regional Police, undated).

Model Type	Description	Police Services
3. Crisis Intervention Team (CIT)	CIT varies by police force, but usually involves on-site response provided by officers who have completed a specialized training program in mental illness and responding to people in crisis.	Anchorage Police, AK, USA[29]
		Connecticut State Capitol Police, CT, USA
		Georgia Bureau of Investigation, GA, USA
		Green Bay Police, WI, USA
		Memphis Police, TN, USA
		Montgomery Police, AB, USA
		Oklahoma City Police, OK, USA
		Seattle Police, WA, USA
		Hamilton Police, ON
OTHER INITIATIVES		
4. Other partnerships between Police and Mental Health Service Providers	Police and mental health service providers form partnerships to assist persons with mental illness when they are in contact with the police. This category includes information sharing protocols, partnerships for referrals, and other services. Many of the aspects of these partnerships may be subsumed as components of other models.	Kent Police, UK
		London Metropolitan Police, Borough of Hackney, UK
		Thames Valley Police, UK
5. Designated Mental Health Officer	A police officer may act as a liaison with other government agencies, police services, and community groups to develop a response strategy that addresses issues at the intersection of policing and mental illness.	Ontario Provincial Police

[29] The CIT programs listed are just a few examples. One researcher in the field advised that CIT is the most common model used in the United States, with approximately 3,000 programs in operation across the country.

1. *Vancouver's Assertive Community Treatment and Car 87*

48. Vancouver uses a combination of two crisis response programs: The ACT teams, based out of the healthcare system, provide recovery-oriented mental health services to clients with serious mental illness and possible addictions issues. At the same time, the Car 87 program, which is similar to Toronto's MCIT, focuses more on assisting people in crisis. Though their clients are in some cases the same, the two programs have different capabilities and serve different roles.

49. In 2012, the VPD joined Vancouver's ACT program.[30] An ACT team is comprised of various service providers including psychiatrists, nurses, addiction counsellors, and now the police. Officers are included on these teams in recognition of the significant role police play in the day-to-day care of people in crisis.[31] Police, while not mental health experts, do observe changes in individuals' baseline state and are often the first point of contact for people in crisis. ACT teams focus on longer-term, recovery-oriented mental health services for people who, as a result of the limitations of traditional mental health services, may have gone without appropriate treatment for an extended period of time.[32] The ACT program is less focused on responding to immediate crises.

50. The inclusion of a police officer on ACT teams allows the police and healthcare system to share information without breaching patient confidentiality. In 2013, the VPD and relevant health authorities came to an agreement that the police and criminal justice system are part of the continuum of care and share mutual clients who suffer from severe and persistent mental illness and substance abuse disorders. All partners in the ACT program agreed that the police should be considered part of the care team, regardless of whether the person in crisis is being treated by an ACT team. This enables officers who observe behavioural changes in individuals over the course of their duties to discuss treatment with health care practitioners through the lines of communication established by the ACT.[33]

51. Currently there are three ACT teams in Vancouver. A recent analysis of 32 ACT clients reveals a 50% reduction in negative police contacts as compared to the prior year, and a 70% reduction in non-urgent emergency department visits.[34]

52. In addition to the ACT program, VPD and Vancouver Coastal Health have, since 1984, operated the Car 87 program, which enables police officers who encounter a person in crisis to call for the deployment of an officer and a nurse in the same manner

---

[30] As discussed in Chapter 4 (The Mental Health System and the Toronto Police Service), Toronto has 13 ACT teams, similar to Vancouver's, however TPS does not directly participate in Toronto's ACT programs. See Vancouver Police Department, *Vancouver's Mental Health Crisis: An Update Report* (Vancouver, Vancouver Police Department, 2013) at 9 [VPD, *Report*].

[31] *Ibid*.

[32] Provincial Human Services and Justice Coordinating Committee, *Police & Mental Health: A Critical Review of Joint Police/Mental Health Collaborations in Ontario* (January 2011) at 45.

[33] VPD, *Report*, *supra* note 30 at 10-11.

[34] *Id.* at 10.

as Toronto's MCIT. Members of Car 87 can then provide an initial assessment and help connect the client to necessary resources.[35]

2. *Memphis' Crisis Intervention Teams (CIT)*

(a) *A first response by specialized police officers*

53. Like other cities transitioning away from institutionalized treatment of persons with mental illness, by the 1980s the city of Memphis, Tennessee witnessed a significant increase in police interactions with people in crisis. In response to public pressure in the aftermath of a police shooting of a young man with a history of mental illness, the Mayor of Memphis established a task force to address the issue, enlisting help from the police, psychology department heads at the University of Tennessee, the psychology department head of the Board of Education, representatives from the University of Memphis, the National Alliance for the Mentally Ill,[36] the managers of local mental health facilities, and members of the public.[37]

54. The task force examined a mobile crisis team program in California in which mental health professionals and police officers responded to people in crisis together. However, the task force determined the California model was not effective to deal with rapidly unfolding crises.[38]

55. To address the need for a rapid response, the task force identified a model that involved additional specialized mental health and crisis resolution training for some police officers (approximately 10-20% of front line officers) in combination with strengthened community partnerships.

56. Officers voluntarily apply for CIT positions and are selected according to their demonstrated interest in policing people in crisis, as determined through an interview and assessment of their work history. CIT officers maintain their patrol duties while learning new skills through CIT training, and assume the additional responsibilities of designated responder and lead officer in events involving a person in crisis.

57. CIT officers receive an additional 40 hours of specialized training in mental illness and interacting with people in crisis, beyond the training on mental illness provided to all police in basic and in-service training.[39] These officers are trained to be first responders who can use a more compassionate response to improve the safety of people in crisis, the public, other officers and themselves.[40] The result is that, within the ranks of a police service's primary response officers, there is always a significant minority of officers who have specialized mental health and crisis resolution training, who can be dispatched to address crisis calls.

---

[35] *Id.* at 7.

[36] The name of this organization was later changed to the National Alliance on Mental Illness.

[37] Michael T. Compton *et al.*, *The Crisis Intervention Team (CIT) Model of Collaboration between Law Enforcement and Mental Health* (New York: Nova Science Publishers, 2011) at 14 [Compton, *Collaboration*].

[38] *Id.* at 15.

[39] *Ibid.*

[40] *Id.* at 29.

58. While an officer is not expected to have the expertise of a mental health professional, the CIT model attempts to bridge the gap between the limited expertise of police in addressing calls involving a person in crisis, on the one hand, and on the other, the limited ability of nurses and other mental health professionals to act as a first response for a variety of reasons, including resource constraints, security risks to civilians, and the rapid timeframe in which many of these calls evolve.

(b) *The institutional framework of the Memphis CIT model*

59. Over time, 10 core elements of the CIT model have been identified that are needed for a successful program. These elements are important to the effectiveness of any crisis resolution model (not just the CIT model). The TPS should seek to incorporate them, to the extent it has not already done so, into its procedures and practices for dealing with people in crisis.

(a) Multi-disciplinary Partnerships: Multi-disciplinary partnerships between officials in law enforcement, mental health advocacy, and professional treatment organizations must be established. Police officers are able to provide assistance to individuals in need of mental health services by providing referrals or transporting clients to appropriate facilities. If strong partnerships with treatment providers do not exist, effective access to the health care system and quality treatment may be undermined. The mental health advocacy community can lend strong support to the CIT program through dedicated people whose goal is to improve the quality of life for persons with mental illness. Members of the advocacy community are liaisons who help voice ideas and concerns from the community, contributing insight from those directly affected.[41]

(b) Community Involvement: Community involvement in planning, implementation and networking is necessary. Community partnerships are essential for identifying solutions to crisis situations. Individuals within the community become stakeholders in the CIT program and must provide ongoing feedback and problem-solving to ensure its success.[42]

(c) Policies and Procedures: Policies and procedures must be amended. Police policies regarding the proper conduct of all officers, CIT-trained officers, and police call-takers and dispatchers are particularly necessary. Policies that maximize a CIT officer's discretion in responding to a crisis and in leading the intervention can be crucial, regardless of traditional chain of command based on who is the first officer on the scene.[43] Within the mental health community, policies for managing referrals from CIT officers may be put in place to potentially expedite interactions, which in turn maximizes the availability of police resources.

[41] *Id.* at 29-30.

[42] *Ibid.*

[43] *Ibid.*

(d) New CIT Positions: The roles of CIT officers, dispatchers, and coordinators need to be defined and coordinated. In addition to officers who voluntarily apply for CIT, police call-takers and dispatchers must be familiar with CIT and possess sufficient knowledge and recognition of mental health events in order to dispatch a CIT officer when appropriate. Finally, the police service should establish a CIT coordinator who serves as a liaison between the program and its stakeholders in the mental health advocacy and treatment communities regarding operation of the program.[44]

(e) Basic CIT Training: CIT training must be implemented. A centerpiece of the CIT program is a comprehensive 40-hour intensive course that equips officers with the knowledge needed to effectively respond to people in crisis. This course builds on the training given to all officers, while placing a greater emphasis on a verbal, compassionate response instead of an approach that emphasizes control. Techniques associated with the latter methodology are frequently counterproductive in de-escalating an interaction with a person in crisis, many of whom feel frightened and out of control. The course should incorporate lectures, visits to mental health treatment facilities, interaction with people with mental illnesses who are not currently in crisis, and practical scenario-based training.[45] Typically 10-20% of front line officers would receive this training. In Toronto, this would result in approximately 500 officers skilled in crisis intervention, versus the much smaller number who have received the training by participating in MCIT. CIT officers typically wear a special badge on their uniform that identifies their special skill set in the field.

(f) Transfer of Care: A designated emergency mental-health-receiving facility provides a point of emergency entry into the mental health system for people in crisis. To ensure CIT's success, the facility or facilities must provide CIT officers with minimal turnaround time and should operate on a no-refusal basis.[46]

(g) Ongoing Study: Continual evaluation and research of program performance helps to improve outcomes. These are useful tools in measuring the impact, outcomes and efficiency of a CIT program. Existing research demonstrates that CIT has been effective in developing positive perceptions and increased confidence among police officers, providing efficient crisis response times, increasing jail diversion among those with mental illnesses, improving the likelihood of treatment continuity with community-based providers, and impacting psychiatric symptomatology

[44] *Id.* at 33-34.

[45] *Ibid.*

[46] *Id.* at 35.

for those with serious mental illnesses. The research further indicates CIT reduces the frequency of injuries experienced by officers.[47]

(h) In-Service Training: In-service training must be implemented. Additional knowledge and skills training should be offered to CIT officers on a regular basis, on topics such as suicide intervention, developmental disabilities, advanced verbal skills training, advanced scenario training, and new developments in psychiatric medications.[48]

(i) Recognition: A recognition and honours system should be established. CIT officers who have served with exceptional care and compassion, ensuring the safety of themselves and others, should be recognized for their distinguished service.[49]

(j) Outreach: Through community outreach, larger coordinated efforts can be undertaken and best practices and current research can be shared.[50]

3. *Hamilton's combination of CIT, MCIT and COAST*

60. The Hamilton Police Service employs three response options—CIT, MCIT, and COAST—to address the panoply of issues that arise in helping people in crisis.

61. Hamilton's COAST program was established in 1997, based on Vancouver's ACT model, discussed above. It is centered out of St. Joseph's Health Centre in Hamilton, and sees a team of psychiatric nurses, mental health workers, social workers, occupational therapists, and plain-clothed police officers respond 24/7 to people in crisis, and assist front line officers who are conducting arrests under section 17 of the *Mental Health Act*. COAST units will attend a scene or provide expertise by phone when requested by officers. They also operate their own 24/7 telephone line that people in crisis can call for help. COAST receives approximately 4,500 requests for service annually, and handles approximately one-quarter of Hamilton's crisis calls.[51]

62. In 2006, Hamilton implemented the Memphis CIT model to supplement the capabilities of the COAST program. Hamilton's CIT officers have specialized training in mental health, and attend calls when a COAST unit is unable to respond for one of the following reasons: a barricaded person or a weapon poses a security risk to mental health professionals; a COAST unit cannot reach the scene in a sufficiently rapid timeframe; or the incident happens overnight when COAST is only available by phone.[52]

---

[47] *Id.* at 37-38; Randolph Dupont, Sam Cochran & Sarah Pillsbury, *Crisis Intervention Team Core Elements*, (Memphis: The University of Memphis School of Urban Affairs and Public Policy Department of Criminology and Criminal Justice CIT Center, 2007) at 17.

[48] Compton, *Collaboration*, *supra* note 37 at 38.

[49] *Ibid*.

[50] *Id.* at 39.

[51] Staff Sgt. Howard Tran, "Data Collection and Collaborative Measures of Success & Outcomes" (PowerPoint presented to the "Balancing Individual Safety, Community Safety and Quality of Life Conference", Canadian Association of Chiefs of Police and Mental Health commission of Canada, Toronto, 24-26 March 2014) [Tran, "Data Collection"].

[52] Hamilton Police Service, *Hamilton CIT 2007 Summary*, "Crisis Intervention Team or CIT" (Hamilton: Hamilton Police Service, 2007) at 2; "Crisis Outreach and Support Team " (Hamilton, 2014): <http://coasthamilton.ca/?page_id=57>; *ibid*.

The CIT program enables the Hamilton Police Service to provide an expert first response to the roughly 75% of calls to which COAST is unable to respond.

63. Finally, in 2013, the Hamilton Police Service established a Mobile Crisis Rapid Response Team, similar to Toronto's MCIT, but pairing a police officer with a mental health worker instead of a nurse. This initiative was designed to address the large volume of mental health calls in downtown Hamilton. It can provide a more informed response that is better suited to connecting individuals with mental health system resources than can be expected of a CIT officer.[53]

64. In addition to employing the COAST, CIT, and MCIT models of crisis response, in 2012 the Hamilton Police Service and St. Joseph's Healthcare Hamilton developed a protocol to reduce lengthy police wait times in the emergency room. As discussed in Chapter 4 (The Mental Health System and the Toronto Police Service), according to the new protocol, after a 30-minute wait in the emergency room, an officer can rate the individual's risk level. If the officer determines the client, under the supervision of hospital security staff, poses a low risk to her or himself, hospital staff, and the public, the officer and an emergency room nurse can transfer care of the patient to the hospital, and the officer can leave.

4. *Comparing the other models to Toronto's MCIT*

65. The lack of a specialized first response to crisis calls in Toronto is the most significant current gap in the Service's capability to respond to people in crisis. These events often unfold quickly, and therefore a skilled first response is an indispensable part of ensuring that a compassionate, informed and proportionate resolution is possible. Most police shootings occur within minutes of the police attending a call.

66. As noted, a key difference between the Memphis/Hamilton CIT model and Toronto's MCIT model is that, because the CIT model trains first responding officers, a large majority of calls involving a person in crisis are attended by an officer with significant expertise in interacting with people in crisis (for example, 90% of such calls in Memphis, and 75% of calls in Hamilton), while to date only approximately 11% of these calls in Toronto have been addressed by the MCIT.[54] The CIT model is the only model studied that has the potential to bridge this first response gap in a significant way.

67. A skilled first response can be put in place by implementing, on a pilot basis, the CIT model in Toronto. TPS already possesses key aspects of the 10 core elements of a CIT program. Through the MCIT Coordination Steering Committee, Toronto has established a partnership mechanism with the professional mental health treatment community. The Mental Health Sub-Committee of the Toronto Police Services Board, furthermore, provides the TPS with a mechanism for partnering with the mental health

[53] Tran, "Data Collection", *supra* note 51.

[54] Henry J. Steadman, *et al.*, "Comparing Outcomes of Major Models of Police Responses to Mental Health Emergencies" (2000) 51 Psychiatric Services 5; For a useful summary of existing research on the effectiveness of CIT, see Compton, *Collaboration*, *supra* note 37, chapters 8-11.

advocacy community. These forums can be expanded on to oversee a CIT program in addition to the MCIT program.

68. It may be that, with certain adjustments, the existing MCIT training course can be used to train officers to become CIT officers. The development and revision of MCIT and CIT training should be undertaken in consultation with the treatment and advocacy communities. It should also take into account training for COAST and the Mental Health First Aid course offered by the Mental Health Commission of Canada (MHCC), which, as noted, I recommend be required of all new constables recruited to the Service, as discussed in Chapter 6 (Selection of Police Officers).

69. The CIT model emphasizes the need for a mental-health-receiving facility. The TPS already has established relationships with six hospitals through the MCIT program, and has access to Toronto's 16 hospital emergency rooms with psychiatric capabilities. If transfer-of-care issues can be made more efficient, existing partnerships can function as emergency no-refusal receiving facilities for CIT officers.

70. Other elements of the CIT program are also needed, such as providing crisis intervention training to 10-20% of front line officers, and establishing policies and procedures that ensure effective coordination of officers and mental health professionals, both on scene and in the hospital. A research and evaluation program, a recognition and honours program, and outreach should also be established or given greater emphasis.

II. Overview Of Issues Highlighted by Stakeholders

71. Many of the stakeholder submissions that the Review received addressed the role of the MCIT, and reforms to the Service's overall approach to responding to people in crisis. A majority of submissions grappled with the issue of how to expand or reform the MCIT program in order to provide a specialized response to all calls involving a person in crisis.

72. Many stakeholders emphasized the crucial role played by the MCIT in connecting people in crisis to community health resources and other treatment streams. A consistent theme expressed by a diverse array of individuals and organizations was that the number of MCIT units, as well as their geographic and temporal scope of coverage, is inadequate. These submissions consistently advocated for MCIT coverage across all 17 TPS operational divisions, available 24 hours a day, seven days a week.

73. Some stakeholders, while noting the utility of MCIT, also emphasized the program's limitations as a second response to people in crisis, especially if there is a weapon involved. The MCIT in its current form is involved only in a small minority of these calls. These stakeholders recommended that complementary models of crisis response be explored, that enable the use of a specialized first response in crisis situations where there is a security concern. Several stakeholders mentioned the Memphis Model of CITs as one option.

74. Some stakeholders also recommended that the TPS procedure prohibiting the use of the MCIT as a first response be revisited. They noted that mental health nurses frequently address potentially dangerous people in crisis, including people who are armed, within the mental health system. Other stakeholders recommended that the TPS consider using MCIT units as a consultative resource for first responders on calls where there is a security threat, so that the nurse is not put in harm's way but his or her expertise can be harnessed to manage the response.

75. Several organizations recommended that all officers complete the MHCC's Mental Health First Aid course, mentioned above. This course provides evidence-based, credible training on symptoms of various mental illnesses, using instructors carefully selected and trained by the MHCC. This training could also play a role in developing MCIT and CIT training.

III. Recommendations

76. I recommend that:

Crisis Intervention Teams

RECOMMENDATION 43: The TPS develop a pilot Crisis Intervention Team (CIT) program, intended to complement the MCIT program, along the lines of the Memphis/Hamilton model, in the aim of being able to provide a specialized, trained response to people in crisis 24 hours per day.

RECOMMENDATION 44: The TPS fully implement the10 core elements of the Memphis/Hamilton CIT model comprehensively discussed in this Report.

RECOMMENDATION 45: The TPS should study the effectiveness of CIT officers who participate in its pilot program by analyzing, among other things:

(a) whether a greater proportion of calls involving a person in crisis are addressed by a specialized response;

(b) whether CIT officers use various forms of force less frequently than non-CIT officers;

(c) whether CIT officers feel more capable and confident in interacting with people in crisis than non-CIT officers;

(d) whether the relevant community notes a difference in the way they are treated by CIT officers versus non-CIT officers;

(e) whether the proportion of persons entering the criminal justice system who suffer from mental illness declines; and

(f) any other metrics deemed relevant.

RECOMMENDATION 46: The TPS should amend its procedures and training to enable, where appropriate, a CIT officer to take charge of a call when a person in crisis may be involved, regardless of whether they are the first officer to arrive.

The Mobile Crisis Intervention Team

RECOMMENDATION 47: The TPS establish a six-month probation period for MCIT officers, which culminates in a review, to ensure that the best-suited people are in these roles. Those who successfully complete probation should be subject to a minimum commitment of two years as part of the MCIT.

RECOMMENDATION 48: The TPS expand the availability of MCIT to provide at least one MCIT unit per operational division. The following matters related to expanding MCIT should be addressed, in cooperation with applicable Local Health Integration Networks and partner hospitals:

(a) Hours: Whether MCIT service should be provided 24 hours per day;

(b) First Response: Whether MCIT can act as a first response in certain circumstances; and

(c) Alcohol and Drugs: Whether MCIT can respond to calls involving alcohol or drug abuse.

RECOMMENDATION 49: The TPS require all coach officers and supervisory officers to attend the training course designed for MCIT officers so that they gain greater awareness of mental health issues and the role of specialized crisis response.

RECOMMENDATION 50: The TPS establish a system of awards and recognition within TPS for exemplary MCIT service as part of the overall system of recognition and awards identified in Recommendation 30.

RECOMMENDATION 51: The TPS encourage supervisory officers, coach officers, and others with leadership roles to promote awareness of the role of the MCIT program within the TPS so that all front line officers know the resources at their disposal in helping a person in crisis.

RECOMMENDATION 52: The TPS, as part of training at the platoon level, include sessions in which MCIT units educate other officers on the role of the MCIT unit and best practices for interacting with people in crisis.

RECOMMENDATION 53: The TPS consider whether to amend Procedure 06-04 “Emotionally Disturbed Persons” to identify exceptions to TPS requirements such as handcuffing, the use of in-car cameras, and other measures, in recognition that the apprehension of a person in crisis under the *Mental Health Act* differs from other types of police apprehensions.

RECOMMENDATION 54: The TPS solicit the input of MCIT members to learn from their first-hand experience, with respect to any proposed changes to the MCIT program.

CHAPTER 12

Equipment

CHAPTER 12. EQUIPMENT

Table of Contents

Page

I. THE CURRENT SITUATION 242

A. Equipment in use by the TPS 242
(1) Provincial and TPS equipment standards 242
(a) Batons 243
(b) OC spray 243
(c) Firearms 243
B. Conducted Energy Weapons 244
(1) Provincial standards 245
(a) Permitted use of CEWs 245
(b) Procedures following use of CEWs 246
(c) CEW training 246
(2) TPS procedures 247
(3) Evidence regarding health effects of CEWs 248
(a) The Goudge Report 249
(b) The Braidwood Reports 250
(c) Conclusions on the state of current scientific evidence 252
(4) Comparative police service procedures 253
(5) Conclusion on CEWs 254
C. Cameras 254
(1) Existing use of cameras 254
(2) Toronto Police Operations Centre 255
(3) Body camera pilot project 255
(4) Comparison to other police services and studies 257
D. Alternative equipment options 258

II. OVERVIEW OF ISSUES HIGHLIGHTED BY STAKEHOLDERS 258

A. Conducted Energy Weapons 258
B. Body cameras 259
C. Alternative equipment options 260

III. RECOMMENDATIONS 260

Conducted Energy Weapons 260
Body cameras 263
Alternative equipment options 264

Chapter 12. Equipment

1. This chapter reviews the equipment issued to TPS officers, with a particular focus on two relatively new tools: conducted energy weapons (CEWs), which are currently provided to supervisors and specialty units such as the Emergency Task Force but not to primary response officers; and body-worn cameras, which the TPS is currently testing in a pilot program.

2. There are both benefits and drawbacks to providing police officers with new tools such as these. On the one hand, police are better able to protect public and officer safety, and to resolve a variety of incidents without lethal force, when they are equipped with a wider range of less-lethal equipment. On the other hand, the risks associated with the use and misuse of CEWs and other less-lethal weapons cannot be ignored. Similarly, while body-worn cameras provide greater transparency and accountability regarding police interactions with the public, they raise privacy concerns that must be addressed before such cameras are issued to all officers.

I. The Current Situation

A. Equipment in use by the TPS

3. Pursuant to provincial requirements, all TPS officers are issued a baton, oleoresin capsicum (OC) aerosol spray (often referred to as "pepper spray"), and a handgun.[1] TPS procedures permit officers to use weapons of opportunity (that is, weapons found at a scene rather than those issued to officers by the TPS) when their issued equipment is unavailable or inappropriate to defend themselves or the public.[2] Handcuffs, leg restraints, and other restraints authorized by the Chief of Police, such as plastic flexible handcuffs, are permitted to control a person in custody who is violent, to transfer prisoners and to prevent escape.[3]

1. *Provincial and TPS equipment standards*

4. The Ontario government has issued guidelines regarding the use of weapons issued to police officers that the TPS must incorporate into its procedures.[4] The guidelines relating to batons, OC spray and firearms are discussed below.

---

[1] *Adequacy and Effectiveness of Polices Services*, O. Reg. 3/99; *Equipment and Use of Force*, R.R.O. 1990, Reg. 926 [*Reg. 926*]; Ministry of Community Safety and Correctional Services, *Policing Standards Manual: Use of Force Policing Standards Guidelines* (Ottawa, ON: Ministry of Community Safety and Correctional Services, November 2013), ss. 10-11 [MCSCS, *Use of Force Guidelines*].

[2] Toronto Police Service, *Use of Force and Equipment*, Procedure 15-01 "Use of Force" (Toronto, ON: Toronto Police Service, 2013) at 4 [TPS, "Procedure 15-01"].

[3] *Ibid*.

[4] *Reg. 926*, *supra* note 1. The Ontario Use of Force Model and TPS, "Procedure 15-01", *supra* note 2, discussed in Chapter 10 (Use of Force), also provide guidance to officers on the circumstances in which it might be appropriate to use different equipment to contain a situation.

(a) *Batons*

5. Provincial guidelines dictate that batons are the only impact weapons that police may use on members of the public. The batons must be rigid at all times, including when expanded, and have a minimum length of 16 inches. Officers are required to re-qualify annually on the use of a baton, including at least one hour of training, and to demonstrate competency in the appropriate context for use of a baton, stances, control techniques, blocking and striking techniques, and retaining the officer's baton when engaging with a member of the public.[5]

(b) *OC spray*

6. The Ontario guidelines provide that OC spray is a legitimate use-of-force option only when alternative force options create a risk of injury to a subject or police officers.[6] Provincial guidelines also require that OC aerosol canisters be labelled with an individual serial number, be equipped with a safety device to prevent accidental discharge, and be fastened to the officer's belt. Aerosol weapons must be replaced at least every twoyears. When an individual is sprayed, police must make all reasonable efforts to decontaminate the person at the earliest safe or practicable opportunity, and the Service is encouraged to consider equipping officers with aerosol water mist decontamination devices.[7]

7. Officers are required to re-qualify annually on the use of OC spray, which includes at least one hour of training regarding technical data on the product. This training includes education on the active ingredients and propellant, the effects of being sprayed, use-of-force legislation and case law, and the TPS procedure on aerosol weapons, as well as recent case studies of the use of OC spray. Officers must demonstrate competency in the proper application of OC spray and decontamination procedures to complete the training.[8]

(c) *Firearms*

8. Regulations made under the *Police Services Act* mandate the types of firearms and ammunition to be issued to police officers.[9] The TPS has implemented a procedure to govern the use, handling, display, transportation, and storage of Service-issued firearms by officers.[10] A separate TPS procedure applies to the use of firearms during tactical training.[11] No member of the Service is issued a handgun until he or she has

---

[5] MCSCS, *Use of Force Guidelines, supra* note 1, ss. 10-11.

[6] *Id*., ss. 12-14.

[7] *Id*., s. 13.

[8] *Id*., s. 14.

[9] See *Reg, 926*, *supra* note 1; See also MCSCS, *Use of Force Guidelines*, *supra* note 1, ss. 20-25.

[10] Toronto Police Service, *Use of Force and Equipment*, Procedure 15-04 "Service Firearms" (Toronto, ON: Toronto Police Service, 2013) [TPS, "Procedure 15-04"].

[11] Toronto Police Service, *Use of Force and Equipment*, Procedure 15-06 "Tactical Training with Firearms" (Toronto, ON: Toronto Police Service, 2007).

successfully completed the TPS training course on firearms. Officers must re-qualify annually on firearm use.[12]

9. Police officers are required to carry their handguns loaded and holstered during their shifts unless they are required to draw their firearms in the lawful performance of their duties. Pursuant to provincial regulation, the threshold for un-holstering, pointing, and firing a handgun is "reasonable grounds to believe that to do so is necessary to protect against loss of life or serious bodily harm."[13] Officers may use a firearm to call for assistance in a critical situation where there is no reasonable alternative, but may not fire warning shots.[14] An officer may not fire at a motor vehicle unless its occupants pose an immediate threat of death or grievous bodily harm by means other than the vehicle itself.[15]

10. An officer who draws or points a handgun in public is required to notify a supervisor "forthwith" and complete a Use of Force Report.[16] An officer who discharges a firearm must notify a supervisor and the Communications Centre, as well as comply with additional TPS procedures regarding use of force, the Special Investigations Unit (SIU), and critical incident stress. Supervisors must attend the scene of a shooting incident immediately and ensure that appropriate medical attention is provided. The Officer in Charge, Firearms Discharge Investigator, Officer in Charge—Duty Desk, Unit Commander, and Deputy Chief must all be notified in accordance with the TPS chain of command, and several reports must be filed.[17]

B. Conducted Energy Weapons

11. A conducted energy weapon (CEW) is a less-lethal weapon that emits an electrical current either through direct contact (drive stun mode) or through probes that are discharged from the device as projectiles and embedded in a person's skin on contact.[18] A Taser is an example of a CEW. When deployed, the weapon causes involuntary muscle spasms and a temporary loss of motor control in the target, designed

---

[12] MCSCS, *Use of Force Guidelines*, *supra* note 1, s. 25.

[13] *Reg. 926*, *supra* note 1, s. 9, as cited by TPS, "Procedure 15-04", *supra* note 10. See also Chapter 10 (Use of Force). This threshold for un-holstering a gun is similar to that found in other jurisdictions. See e.g. Fort Worth Police Department, 306.00 "Use of Force" (Fort Worth, TX: Fort Worth Police Department), s. 306.08; Clearwater Police Department, 102 "Use of Force and Firearms" (Clearwater, FL: Clearwater Police Department, 2013), s. 102.21.

[14] *Reg. 926*, *supra* note 1, s. 10(a), as cited by TPS, "Procedure 15-04", *supra* note 10. Other jurisdictions also forbid warning shots. See e.g. Montgomery County Department of Police, 131 "Use of Force" (Montgomery County, MD: Montgomery County Department of Police, 1998) at Ch III, s. E; Metropolitan Nashville Police Department, Title 11 "Use of Force" (Nashville, TN: Metropolitan Nashville Police Department, undated), s. 11.10.150; Vancouver Police Department, *Regulations & Procedures Manual*, 1.2 "Use of Force" (Vancouver, BC: Vancouver Police Department, 2011), s. 1.3; Regina Police Service, L-38 "Use of Force" (Regina, SK: Regina Police Service, 1998), s. 38.11(8).

[15] TPS, "Procedure 15-01," *supra* note 2 at 5. Other jurisdictions have a similar policy. See e.g. Vancouver Police Department, *Regulations & Procedures Manual*, 1.2 "Use of Force" (Vancouver, BC: Vancouver Police Department, 2011), s. 1.4; Regina Police Service, L-38 "Use of Force" (Regina, SK: Regina Police Service, 1998), s. 38.11(7); Longmont Police Department, 601 "Use of Force / Use of Force Reporting" (Longmont, CO: Longmont Police Department, 2013), s. 601.03 at 8.

[16] See Chapter 10 (Use of Force).

[17] TPS, "Procedure 15-04", *supra* note 10.

[18] The Expert Panel on the Medical and Physiological Impacts of Conducted Energy Weapons, *The Health Effects of Conducted Energy Weapons* (Ottawa, ON: Council of Canadian Academies and Canadian Academy of Health Sciences, 2013) at viii [*Health Effects*].

to incapacitate a person so that police can gain control of the subject. The models of CEWs that are authorized for use in Ontario automatically record electronic data regarding the date, time, number of deployments, and length of use every time the device is discharged. Further, paper with the serial number of the CEW is discharged from the device every time it is used to assist in identifying which CEW was deployed in an incident (and, therefore, which officer used the weapon).

1. *Provincial standards*

12. In 2004, the Ministry of Community Safety and Correctional Services (MCSCS) approved the use of CEWs by tactical units, hostage rescue teams and front line supervisors. In 2013, the MCSCS expanded access to CEWs by authorizing police services to determine which officers should be permitted to carry CEWs based on their local needs and circumstances.

13. The provincial government has issued detailed guidelines regarding the use of CEWs by police officers.[19] The TPS is required to ensure that all CEW training is conducted by MCSCS certified trainers who have passed the Conducted Energy Weapon Trainers course. Police services are only permitted to use two models of CEWs: the TASER M26 or the TASER X26. The TASER X26 has an optional audio/visual attachment to record the use of the CEW from the moment it is activated until it is turned off.[20] Officers who carry CEWs must follow prescribed procedures during each shift, including conducting a spark test to ensure the weapon is functioning properly.[21]

(a) *Permitted use of CEWs*

14. An officer is permitted to use a CEW if he or she believes a subject is threatening or displaying assaultive behaviour or, taking into account the totality of the circumstances, the officer believes there is an imminent need for control of a subject and the officer believes it is reasonably necessary to use a CEW. Provincial guidelines require that officers first consider whether efforts to de-escalate the situation have been effective, whether verbal commands are practical, whether the subject has followed verbal commands that have been issued, the risk of secondary injury to the person from the use of the CEW, and the capabilities of the weapon in the specific situation, including weather conditions and the presence of flammable or explosive substances.[22]

15. An officer should, where possible, use a CEW only when at least one other officer is present to provide support and attempt to restrain the subject during the activation cycle of the weapon.[23] The officer with a CEW should also first announce that he or she

---

[19] MCSCS, *Use of Force Guidelines*, *supra* note 1, ss. 15-19.

[20] Some police services in the United States require that all CEWs be equipped with these audio/visual attachments, and that, if a CEW is deployed, an officers' supervisor upload the recorded audio-visual data before the end of the shift during which the CEW was deployed. See Las Vegas Metropolitan Police Department, *Use of Force Policy*, 6/002.02 "Authorized Force Tools" (Las Vegas, NV: Las Vegas Metropolitan Police Department, undated); Metropolitan Nashville Police Department, *Use of Force*, 11.10.050 "Use of Electronic Immobilization Device Taser" (Nashville, TN: Metropolitan Nashville Police Department, undated).

[21] MCSCS, *Use of Force Guidelines*, *supra* note 1, ss. 15-19.

[22] *Id*., s. 17.

[23] *Id*., s. 18

is going to activate the CEW. Provincial guidelines state that "as with any use of force option, a conducted energy weapon should only be used as necessary to gain physical control of a subject."[24] A CEW should not be used on a person who is handcuffed, a pregnant woman, a young child, an elderly person, or someone who is visibly frail. A CEW should not be applied to sensitive areas of the body such as the head, neck or genitals. Further, officers are instructed not to use a CEW on a person who is in control of a moving vehicle.[25]

(b) *Procedures following use of CEWs*

16. Upon discharging a CEW, a police officer should inform the subject that the weapon has been used and that its effects are short-term. The person should be placed in a sitting or recovery position and a medical assessment should be obtained if the person has hit his or her head or lost consciousness after the CEW was used. A medical assessment should likewise be obtained if a CEW is used on a young child or a person who is pregnant, elderly, or frail, or if it is applied to a sensitive area or near the heart. If probes are embedded in a subject's body, they should be removed by medical personnel or a specially trained officer. Officers are cautioned to handle probes that have penetrated the subject's body with the same precautions as other biohazards. The TPS is required to establish a response protocol for post-CEW deployment medical attention by Emergency Medical Services (EMS).[26]

17. The provincial guidelines contemplate that a CEW may be used multiple times or for an extended duration. Although the CEW Operator Training Course addresses the potential dangers of multiple or extended CEW discharge on a subject, the provincial standards do not require that local police service procedures include any specific analysis or thresholds before a CEW is used more than once or for an extended period on a person.

18. Following use of a CEW, the electronic data stored in the CEW must be downloaded as soon as is practicable for audit and analysis purposes.[27]

(c) *CEW training*

19. The Provincial CEW Operator Training Course is conducted by MCSCS-certified use-of-force instructors and includes 12 hours of classroom study and scenario training. The training emphasizes officer judgment and de-escalation, and addresses issues regarding multiple uses or continuous deployments on a subject.[28] As with other weapons, officers must re-qualify annually to be authorized to carry CEWs.[29]

---

[24] *Id*., s. 18(e).

[25] *Ibid.*

[26] *Id*., ss. 18-19. For example, in Shelburne, Ontario, EMS members are invited to CEW training to familiarize themselves with the devices. See Shelburne Police Service, Appendix C - AI-012 "Use of Force" (Shelburne, ON: Shelburne Police Service, 2006).

[27] MCSCS, *Use of Force Guidelines*, *supra* note 1, s. 18.

[28] Chief William Blair, "#P259 Expanded Deployment of Conducted Energy Weapons" (Report presented to the Toronto Police Services Board, 7 November 2013) at 3 [Chief Blair, *Expanded Deployment*].

[29] MCSCS, *Use of Force Guidelines*, *supra* note 1, s. 15.

20. The guiding principles of the CEW Operator Training Course recognize that CEWs are weapons that must not be used casually. Those guiding principles include the following:

(a) the decision to use force at all is a fundamental decision that must be made before deciding which force option to use;

(b) a CEW should be used as weapon of need, not a tool of convenience;

(c) officers should not over-rely on CEWs where more effective and less risky alternatives are available; and

(d) a CEW is just one of several tools available and one part of the overall use of force procedure.[30]

2. *TPS procedures*

21. The TPS currently issues CEWs to front line supervisors and specialty teams such as the Emergency Task Force (ETF). Since the MCSCS authorized expanding access to CEWs to all officers in 2013, the Service has not expanded access to CEWs to primary response units or the Mobile Crisis Intervention Team (MCIT) since the MCSCS authorized further access in 2013. However, in November 2013, Chief Blair proposed to the Toronto Police Services Board that the Service purchase additional CEWs in order to expand deployment to two constables from each division and four officers from the Toronto Anti-Violence Intervention Strategy (TAVIS) Rapid Response Team. Such an expansion would have resulted in three sergeants and two constables on every shift having access to a CEW. The Toronto Police Services Board directed the Chief not to proceed with the proposed expansion at that time.[31]

22. The TPS procedure on CEWs identifies the device as a legitimate use-of-force option to gain control of an assaultive subject. A CEW may be used when a subject exhibits threatening behaviour and the officer believes he or she intends to carry out the threat, where a person presents an imminent risk of serious bodily harm or death, or where a person threatens or attempts suicide.[32]

23. The TPS procedure permits the use of CEWs in probe or drive stun mode.[33] The procedure also considers the un-holstering or pointing of a CEW to be a form of use, called demonstrated force presence. The TPS procedure does not address the authorization of, or restrictions on, repeated applications of a CEW on a person. The decision regarding multiple applications is made by officers on a case-by-case basis. The TPS calls paramedics to conduct medical assessments and remove probes after a CEW is discharged.

---

[30] Chief Blair, *Expanded Deployment*, *supra* note 28 at 4.

[31] *Ibid*.

[32] Toronto Police Service, Procedure 15-09 "Conducted Energy Weapon" (Toronto, ON: Toronto Police Service, 2012) at 4.

[33] *Ibid*.

24. The TPS requires supervisors to have the electronic data stored in their CEW downloaded any time it is used. The officer in charge must download this information by the end of the officer's shift, save the data electronically, and attach a hard copy to the mandatory CEW and Use of Force reports. The data must be forwarded to the Service's Use of Force Analyst within 72 hours of use.[34] Additionally, the Armament Officer of the Toronto Police College conducts regular audits of CEWs issued to members, and downloads information from the audited CEWs even if there have been no reports of use.

25. As of December 2013, 509 CEWs were issued to members of the TPS. In 2013, CEWs were used 202 times in 192 incidents, primarily by front line supervisors.[35] CEWs are used in situations involving people in crisis more frequently than for any other type of incident. Over 40% of the incidents in which CEWs were used in 2013 involved persons perceived to be suffering from an emotional or mental crisis or from the combined effects of crisis and drugs or alcohol. Officers used CEWs most frequently in response to assaultive behaviour or threats of serious bodily harm or death. However, CEWs were used in situations involving subjects who were passively resistant 13.5% of the time, and against actively resistant subjects in approximately 15% of cases. The officer reported a belief that the subject was armed in more than half of the incidents in which a CEW was used in 2013.[36]

26. The ETF has been equipped with CEWs for approximately 14 years. Statistically, the ETF accounted for approximately 18% of CEW uses in 2013.[37]

27. As CEWs cost approximately $1,500 each, it would be a large financial undertaking for the Service to equip all officers with the devices.

3. *Evidence regarding health effects of CEWs*

28. A number of scientific reviews and other reports regarding the use and health effects of CEWs have been prepared in Canada and abroad.[38] This section summarizes the principal findings of two studies—the Goudge Report[39] and the Braidwood

[34] *Id*. at 6.

[35] Chief William Blair, "#P47Annual Report: 2013 Use of Conducted Energy Weapons" (Report presented to the Toronto Police Services Board, 13 March 2014) at 33.

[36] *Id*. at 34-37.

[37] *Id*. at 33.

[38] Examples of recent reports include those prepared by the House of Commons Standing Committee on Public Safety and National Security, the Commission for Public Complaints Against the RCMP, the Office of the Police Complaint Commissioner for British Columbia, the Advisory Panel to the Nova Scotia Minister of Justice, the Saskatchewan Ombudsman, the Ontario Association of Chiefs of Police, and the Canadian Association of Chiefs of Police, among others.

[39] *Health Effects*, *supra* note 18.

Reports[40]—as they relate to the mandate of this Review. However, many of the other reports provided the Review with helpful information and conclusions.[41]

(a) *The Goudge Report*

29. In 2013, Defence Research and Development Canada requested that the Council of Canadian Academies and the Canadian Academy of Health Sciences conduct an independent, evidence-based assessment of current scientific knowledge regarding the medical effects of CEWs. The assessment was conducted by a panel of 14 experts, chaired by the Honourable Stephen T. Goudge, then of the Court of Appeal for Ontario.[42]

30. The Goudge Report noted that CEWs are typically used to facilitate arrests of uncooperative individuals. The loss of muscle control from a CEW causes the individual to fall to the ground, permitting the police to take the subdued person into custody. Although CEWs are intended to be safe and to reduce injury compared with other force options, the Goudge Report found that they are not necessarily risk free.

31. The Goudge Report concluded that the most common injuries from CEWs, such as puncture wounds from the projectile probes, are unlikely to pose serious medical risks. Although the expert panel could not reach any evidence-based conclusions on the effects of the weapon on a person's neuroendocrine, respiratory or cardiac systems, it found that the potential for death from CEW use is extremely small.

32. The Goudge Report found that CEWs are used by law enforcement agencies in all federal, provincial and territorial jurisdictions in Canada. As of 2013, there were over 9,000 CEWs in use in Canada. At least 33 deaths in Canada have been "proximal" to the use of a CEW, but the Goudge Report found that, to date, there have been no findings in Canada of death caused by a police-deployed CEW. However, there have been some coroners' reports in Canada that identified excessive exposure to CEWs as the primary cause of death while a person was in custody. Despite its extensive review of research, the Report noted the lack of a "synthesized body of evidence documenting the number of deaths related to all other use-of-force encounters to confirm or compare with this number."[43]

33. The Report noted that the medical studies completed to date on the health effects of CEWs involved healthy individuals. Studies involving CEW deployment on more heterogeneous groups (including members of vulnerable groups such as people in

---

[40] Braidwood Commission on Conducted Energy Weapon Use, *Restoring Public Confidence: Restricting the Use of Conducted Energy Weapons* (British Columbia: The Braidwood Commission of Inquiry on Conducted Energy Weapon Use, 2009) [*Restricting Use*]; Braidwood Commission on the Death of Robert Dziekanski, *Why? The Robert Dziekanski Tragedy*, (British Columbia: The Braidwood Commission on the Death of Robert Dziekanski, 2010) [*Dziekanski Tragedy*].

[41] For example, the Standing Committee on Public Safety and National Security urged the RCMP "to implement preventive methods designed to diminish the use of Taser guns during police interventions, in particular by enhancing accountability at the RCMP and improving officer training on intervention involving persons suffering from various problems, including bipolar disorder, autism and autism spectrum disorders, schizophrenia and drug addiction". See Report of the Standing Committee on Public Safety and National Security, *Study of the Conductive Energy Weapon-Taser®*, (39th Parliament, 2nd Session, June 2008).

[42] *Health Effects*, *supra* note 18.

[43] *Id*. at vii.

crisis), and regarding prolonged or repeated deployments, are required to understand better the potential effects on people of varying levels of health. In order to know the potential effects of CEWs in real-life police interactions, further study is required of subjects who are intoxicated or who are resisting police or otherwise exerting themselves physically before being subjected to a CEW current. The Goudge Report therefore recommended large-scale population-based field studies of actual police deployments in the field, with consistent, detailed collection of information on the characteristics of the subjects and the circumstances surrounding CEW use. The Goudge Report noted that many of the existing studies on health effects of CEWs have been prepared or funded by organizations that have perceived conflicts of interest, such as manufacturers of the weapons. To improve the confidence placed in study results, the Report recommended that the additional studies be conducted by independent researchers. I agree with these recommendations.

34. The need for consistent data was repeatedly highlighted in the Goudge Report, which indicated that a lack of standardization and inconsistent reporting related to police use of force in general made critical analysis difficult. The Report recommended a national database of information about use of force by police services, as well as common definitions of use of force and CEW use, and standard reporting protocols for police and medical professionals. I agree with these suggestions for standardized, consistent data reporting.

(b) *The Braidwood Reports*

35. Following the 2007 death of Robert Dziekanski after he had been subjected to CEW deployment, the British Columbia government appointed the Honourable Thomas R. Braidwood, Q.C., a retired judge of the Court of Appeal of British Columbia, to conduct an inquiry in two phases: (1) an inquiry into the use of CEWs by provincially regulated law enforcement and corrections agencies; and (2)an inquiry into the circumstances of Mr. Dziekanski's death.[44]

36. Phase one of the Braidwood Commission found that in B.C., police officers used CEWs most frequently when responding to calls concerning self-injurious behaviour (including suicide attempts), threats of violence, public disturbances and intoxication. Approximately 11% of CEW uses involved people classified as "emotionally disturbed." The behaviours that precipitated deployment frequently included active resistance, alcohol or drug intoxication, and assaults. CEWs were also used on people who were yelling and making verbal threats.

37. The B.C. data indicated that, out of approximately 1,400 uses, officers deployed CEWs more than 160 times when the subject was being cooperative or displaying passive resistance. By contrast, a CEW was used 485 times against a subject demonstrating active resistance, 669 times in response to assaultive behaviour, and only 19 times when there was a risk of grievous bodily harm or death to the police officer. The latter statistic is of interest in the debate among stakeholders about whether CEWs will

[44] *Restricting Use*, *supra* note 40; *Dziekanski Tragedy*, *supra* note 40.

be used in practice as alternatives to firearms in situations where lethal force may be authorized.

38. Similar to the submissions this Review has received, the Braidwood Commission noted the unanimous view of mental health professionals that the best practice in dealing with people in crisis is to:

> de-escalate the agitation, which can best be achieved through the application of recognized crisis intervention techniques. Conversely, the worst possible response is to aggravate or escalate the crisis, such as by deploying a conducted energy weapon and/or using force to physically restrain the subject. It is accepted that there may be some extreme circumstances, however rare, when crisis intervention techniques will not be effective in de-escalating the crisis. But even then, there are steps that officers can take to mitigate the risk of deployment.[45]

39. The Braidwood Commission identified 25 people nation-wide who died during or after an incident involving a CEW between 2003 and 2008. The Commission also found that, in 24% of uses in B.C., the subject suffered a CEW-related injury. Although the majority of injuries were minor, the Commission noted cases of lung collapse, loss of consciousness from falling and hitting one's head, facial wounds, broken ankle, and a probe dart imbedded in the subject's clavicle bone.

40. Commissioner Braidwood noted that, although it is difficult to determine whether a CEW caused a person's death, the risk of ventricular fibrillation (which can be fatal if the person is not defibrillated promptly) increases significantly if the subject has cardiovascular disease, a short skin-to-heart distance, or an implanted pacemaker or defibrillator. This risk appeared to increase when a person was subjected to multiple CEW deployments.

41. In his review of the use of CEWs in B.C. up to 2007, Commissioner Braidwood found that the number of deployments increased at a rate faster than the increase in the number of CEWs, indicating that officers chose to use the devices more often over time. The Commission found a large variation in the frequency of deployments by police services, ranging from5.2 to 130.7uses per 100,000people depending on the police service. The B.C. Transit Authority Police used a CEW six times in 2007. Troublingly, in three cases the subjects' active resistance consisted of fleeing after being stopped for a fare check.

42. The Commissioner emphasized that the actual use of CEWs among municipal and provincial police services was likely much higher than the numbers reported, making a complete analysis challenging. He urged the B.C. government to work with other provinces and the federal government to develop and fund a national research program for CEWs.

---

[45] *Restricting Use*, *supra* note 40 at 15.

43. Commissioner Braidwood found that the thresholds for both "subject matter" (the offence that the subject has committed) and "subject behaviour" (the person's conduct toward the officer or others) should be increased before the use of a CEW be considered justified. He concluded that CEWs should only be used in connection with the commission of criminal offences, not regulatory violations.

44. Further, the Commission found that the existing threshold for authorized use of CEWs against people demonstrating "active resistance" was not proportionate to the medical risks and pain the device can inflict. The Commission Report recommended that a CEW be used only when the subject is causing bodily harm or the officer is satisfied, on reasonable grounds, that the subject's behaviour will imminently cause bodily harm. Even then, the Commissioner held, an officer should not deploy a CEW unless satisfied, on reasonable grounds, that no lesser force option, de-escalation or crisis intervention technique would be effective. De-escalation efforts were emphasized for people in crisis: the Commission's Phase 1 Report recommended that officers be required to use de-escalation and/or crisis intervention techniques before deploying a CEW unless they are reasonably satisfied that such techniques will not eliminate the risk of bodily harm.

45. The Report recommended that officers be required to stop using a CEW after the first five seconds of charge in order to re-assess the situation, and that all officers equipped with CEWs be required to have an automated external defibrillator available.

46. Phase two of the Braidwood Commission reviewed the circumstances surrounding Mr.Dziekanski's death. The Commissioner noted that incidents of excessive force by police, especially incidents in which the officers involved are not completely forthright about the circumstances in their use-of-force reports and debriefings, have far-reaching repercussions. In particular, a single fatality at the hands of police can galvanize public antipathy against an entire police service, its members, and the weapon used on the subject. As the Commission Report noted, the resulting crisis of confidence can be devastating for the vast majority of police officers who do their job fairly and protect lives, as the most important weapon in the arsenal of the police is public support.[46]

(c) *Conclusions on the state of current scientific evidence*

47. The Goudge and Braidwood reports highlight the absence of authoritative research on the health effects of CEWs. Although the medical evidence is inconclusive as to a link between CEW use and death, it appears to be accepted that fatal complications are biologically possible. The paucity of reliable data regarding the effects of CEWs on individuals with medical conditions, people in crisis and subjects with prescription medications, illegal drugs or alcohol in their system makes it difficult for police to predict whether a given subject in a real-life interaction will suffer serious consequences from exposure to a CEW charge.

[46] *Dziekanski Tragedy*, *supra* note 40 at 24.

48. The absence of definitive research into the risks of CEWs for populations who are likely to encounter the police in non-criminal contexts is a problem when considering whether CEWs should be used against people in crisis. Some people with mental illness may be particularly vulnerable to the potentially serious effects of CEWs as they may present with many of the risk factors (existing medical conditions, prescription medications, substance abuse issues, high levels of agitation) when they encounter police during times of crisis. As many stakeholders have said, police are neither equipped nor expected to diagnose medical or psychological conditions. As such, first responders may not be able to identify heightened risk factors in an individual before deciding whether to employ a CEW.

4. Comparative police service procedures

49. Following the Braidwood Reports, British Columbia has adopted a stringent threshold for the use of CEWs. Officers are prohibited from discharging a CEW unless the subject is causing, or the officer has reasonable grounds to believe that the person's behavior will imminently cause, bodily harm to themselves or others. Further, a CEW can only be deployed if the officer has reasonable grounds to believe that crisis intervention and de-escalation techniques have not been or will not be effective in eliminating the risk of bodily harm and no lesser force option has been, or will be, effective in eliminating the risk of bodily harm.[47]

50. Several North American police departments have created protocols to guide officers in the matter of multiple or prolonged applications of CEWs on individuals. In Lafayette, Louisiana, an officer has the discretion to apply the CEW multiple times or for a prolonged period, but an investigation may be initiated in response to an application that exceeds 16seconds.[48] Police in Longueuil, Quebec are directed to avoid the application of a CEW for longer than 15-20seconds.[49] InTopeka, Kansas, officers are required to stop and evaluate the situation after the first application of a CEW before they are permitted to apply further CEW cycles, generally limited to a maximum of three applications.[50]

51. Several police services have taken a restrictive approach to the use of CEWs in drive stun mode (involving direct application of the CEW on the subject's skin) as a result of medical concerns such as the risk of contact burns, as well as ethical concerns. The Cleveland Division of Police recognizes that drive stun is not a preferable method of

---

[47] British Columbia, *Provincial Policing Standards*, 1.3 "Conducted Energy Weapons" (2012), s. 1.3.1 (1)-(2).This standard was developed following the Braidwood Report, which is discussed at paras. 35-46, above.

[48] Lafayette Parish Sheriff's Office, *General Orders*, "Electronic Control Device (TASER)" (Lafayette, LA: Lafayette Parish Sheriff's Office, 2011) at IX, 5 [Lafayette, "CEW Policy"].

[49] Service de Police, Agglomération de Longueuil, Série 400 « Usage de l'arme á impulsion électrique (AIE) » (Longueuil, QC: Service de Police, Agglomération de Longueuil, 2012), s. 5.1.18.3.

[50] Topeka Police Department, Order 1.3.9 "Authorized Defensive Weapons" (Topeka, KS: Topeka Police Department, 2013), s. 2(g). See also the policy in Clearwater, FL, which is similar to the Topeka policy. In Clearwater, repetitions are generally limited to three cycles. See Clearwater Police Department, 103 "Use of Force and Firearms – Use of Less Lethal Force" (Clearwater, FL: Clearwater Police Department, 2013), s. 103.7021.

CEW deployment because it is based on pain compliance.[51] Drive stun mode is permitted in Lafayette, Louisiana, but is discouraged and can be used "only to supplement the probe mode to complete the incapacitation circuit."[52] The Columbus Division of Police has developed a new deployment method called "close quarter probe deployment mode."[53] This method uses CEW probes in close proximity situations to replace the use of drive stun mode as a pain compliance approach.[54]

5. *Conclusion on CEWs*

52. As regards people in crisis in Toronto, three main questions arise regarding CEW use by police. The first is whether expanding the availability of CEWs within the TPS will save lives of people who would otherwise be shot. The second is whether expanding the availability of CEWs within the TPS will cause deaths because of possible harmful health effects of CEWs themselves. The third is whether expanding CEW use will lead to abuses and, if so, whether these abuses can be adequately controlled.

53. The answer to the first question is potentially yes. Historically, there are incidents in which people in crisis have been killed, in which a CEW might have been used instead of a firearm, possibly producing a better outcome. This fact makes expanded CEW use desirable, to ensure primary response officers have access to tools that can be used instead of a firearm. The Review heard this message from many TPS personnel, who virtually unanimously favour expanded availability of CEWs.

54. The more challenging questions are the second and third ones noted above. It is unclear, presently, to what extent CEWs may cause death, and the concern that CEWs may be abused is well-justified. Accounts of misuse of CEWs by police, albeit relatively rare statistically, are not hard to find, within the TPS and elsewhere. My conclusion is that the TPS should proceed cautiously in this area, but that it should nonetheless proceed with expanded availability of CEWs on a pilot basis, with careful safeguards to help arrive at better answers to the questions posed. My detailed recommendations on these issues are below.

C. Cameras

1. *Existing use of cameras*

55. The TPS has progressively implemented cameras to record interactions with members of the public in interview rooms, police stations, and police cars (facing both the rear seat and facing out of the windshield). In-car cameras are activated either manually by officers or automatically when a car's emergency equipment is engaged, or

---

[51] Cleveland Division of Police, 2.1.06 "Taser Electrical Weapon" (Cleveland, OH: Cleveland Division of Police, 2013) at I, E. A similar policy exists in Columbus, Ohio as well. See Columbus Division of Police, *Columbus Police Division Directive*, 3.91 "Chemical Agents and Intermediate Weapons Regulation" (Columbus, OH: Columbus Division of Police, 2012) at II, B, s. 21(e).

[52] Lafayette, "CEW Policy", *supra* note 48 at V, H. Drive Stun usage is also discouraged in Denver. See Denver Police Department, 105.00 "Use of Force Policy" (Denver, CO: Denver Police Department, 2013) at 105.03, (4), s. e.

[53] Sergeant Matthew R. Weekley, *2010 & 2011 Taser Study* (Columbus, OH: Columbus Division of Police, 2012).

[54] *Ibid*. This method avoids pain compliance, and Columbus reports a 100% success rate with this method.

when collision sensors are triggered. Officers also wear microphones on their uniforms, which record audio that can be paired with video from the in-car camera system.[55]

56. There is now broad recognition, within the TPS and in the general public, that police officers should expect to have their interactions with citizens recorded at all times. The widespread availability of video cameras on smart phones has removed police control over publicity surrounding police-public interactions and placed it in the hands of subjects, by-standers, and media outlets. The expanded availability of video footage of police interactions can enhance police accountability and transparency, while also discrediting false allegations of police brutality. However, video can also exacerbate crises of public confidence in the wake of unusual displays of police aggression or reliance on force options, especially when dealing with vulnerable people.

2. *Toronto Police Operations Centre*

57. In January 2013, the TPS began to develop a Toronto Police Operations Centre, a real-time crime centre that will maintain central, 24/7 oversight of policing operations in the city. Centre staff will be authorized to redeploy primary response officers to different divisions based on call volumes and response times, and will use more advanced technology to monitor intelligence and crime analysis operations. Such technology could permit the TPS to monitor closed-circuit television and other public video feeds, as well as GPS tracking on officers and vehicles to provide faster, more appropriate responses and assistance to crisis calls.

3. *Body camera pilot project*

58. In 2013, the TPS released its Police and Community Engagement Review (PACER) Report, which aims to ensure the Service is a world leader in bias-free policing.[56] One of the Report's 31recommendations urged the Service to "continue to leverage and monitor the In-Car Camera System currently installed in all marked police vehicles, as well as explore the possibility of equipping all uniform Officers with Body Worn Video (Body Cameras)." As of March 2014, the TPS was in the process of establishing a body camera pilot project, which is expected to launch in late 2014.[57]

59. The primary argument articulated in support of body worn cameras is that cameras enhance the accountability of officers and citizens whose conduct is recorded. Multiple field studies have demonstrated that complaints against police decrease when officers are equipped with cameras. This is in part because police have an additional incentive to treat people respectfully, and also because individuals are deterred from bringing false allegations against police officers when video evidence exists of the interaction. Similarly, field studies indicate that police use of force decreases when officers are outfitted with cameras because police know that their conduct can be

---

[55] Toronto Police Service, "In-Car Camera System (ICCS) project" (2014), online: Toronto Police Service <http://www.torontopolice.on.ca/incarcamera/>.

[56] Toronto Police Service, *Police and Community Engagement Review Report* (2013), online: Toronto Police Service <http://www.torontopolice.on.ca/publications/files/reports/2013pacerreport.pdf> at 11.

[57] *Ibid*; Toronto Police Service, "The PACER Report – Recommendations" (March 27, 2014), online: Toronto Police Service <http://www.torontopolice.on.ca/pacer/recommendation_list_update_140327.pdf>.

reviewed on the basis of objective evidence, and, therefore, there is an incentive for all participants to act calmly.

60. While video may be better evidence than witness testimony, it too can be misinterpreted. However, the increased transparency that results from recordings of contentious police encounters, combined with the potential for reduced injuries and deaths, can add public confidence in the Service's important public work.

61. Despite the benefits of body cameras, their use during police interactions with the public also carries significant privacy implications for the officers, subjects, and bystanders. The Service will have to balance individuals' rights to privacy, especially when an officer encounters people in their homes, with the need to ensure consistency and accountability by strictly limiting the circumstances in which police can deactivate the cameras. Once collected, information recorded on body cameras and uploaded to a TPS database must be subject to appropriate standards for storage, length of retention, method of destruction, access, and disclosure (or non-disclosure) to third-party agencies such as Crown prosecutors, the Canadian Police Information Centre (CPIC) database, Canada Border Services Agency, and mental health professionals.

62. Many tensions surround officer discretion in the activation or deactivation of body camera recordings. On the one hand, vulnerable groups such as people with mental illness or substance abuse problems are among the populations most concerned about respectful, accountable policing. Body cameras may serve to pacify encounters between police and the public. Both participants are aware that their words and actions will be recorded, thereby creating a more constructive environment for de-escalation and passive resolution of situations.

63. However, some people in crisis who suffer from paranoia, delusions, or similar symptoms may have their anxiety levels increased by the presence of a camera. In situations where rapport and trust are central to safe de-escalation, a well-intentioned officer's efforts could be thwarted if he or she is not given the discretion to remove or disable body camera recording. In turn, giving officers the discretion to stop recording raises concerns about misuse and accountability that can only be addressed through clear procedures and enforcement mechanisms. These procedures must set out the grounds for de-activation and strict penalties for breaches or other attempts to avoid creating a record of an interaction.

64. Developing a protocol to govern police discretion to de-activate body cameras that respects individual privacy interests is a challenging endeavor that should be done in consultation with affected stakeholder groups, including police officers, civil liberties and privacy experts, and community members. It is preferable to have these difficult conversations at the outset of the Service's consideration of body cameras rather than after TPS cameras have already collected personal information.

65. Body cameras range in cost from approximately $700 to $1,500 each. Although equipping all officers with body cameras would be a significant financial undertaking, the cost is somewhat lower than purchasing CEWs for all officers (approximately $1,500 each), and substantially lower than purchasing CEWs for all officers with audio/visual

attachments (which adds an additional $500 to the cost of each device). As is the case to some degree with expanding CEW use, there will be additional administrative costs associated with a Service-wide roll-out of body cameras. In the case of body cameras, these costs relate to developing an appropriate privacy and data security protocol, maintaining a database of recordings, and processing requests for access to the videos. Although not mutually exclusive, the option of purchasing of CEWs is often juxtaposed against the option of purchasing body cameras, in recognition of the finite resources of any police service and the differing views as to what equipment will be most effective in promoting safe police-public interactions.

4. *Comparison to other police services and studies*

66. Many police services across North America are investigating the utility of body-worn cameras. In Canada, for example, body cameras are in various stages of testing in Victoria, Edmonton, Calgary, and Ottawa. The Calgary Police Service has equipped a pilot group of 50officers with cameras since November 2012. These cameras begin recording when officers respond to calls or conduct investigations. The pilot group recorded over 2,700 videos in 10 months, 30 of which were used in court proceedings. In 13cases, the recordings led to early resolutions of criminal prosecutions without trials.

67. Ottawa has been testing body cameras after some controversy about the costs and benefits of CEW audio/visual attachments. The Ottawa Police Chief expressed concern that the camera attachments drained the CEW batteries, did not activate quickly enough, and produced low-quality video of lesser evidentiary value.

68. In 2012, the Mesa, Arizona Police Department conducted a year-long body camera study. Fifty officers, some of whom volunteered and other who were assigned to the pilot by their supervisors, were equipped with body camera systems. For the first half of the study, a mandatory camera activation protocol was implemented. For the second half, officers were given discretion to activate the camera system during calls. Notably, the volunteer officers were over 60% more likely to activate their cameras during the discretionary period than the assigned officers. However, the use rate of the cameras decreased over 40% across the entire pilot group when the officers were given discretion to activate the system. When the one-year study period was compared with the previous year's data, the pilot group demonstrated a 75% reduction in use of force complaints when the cameras were in place.[58]

69. A similar study was conducted in Rialto, California. In line with the Mesa findings, public complaints against officers decreased by 87.5% for those officers wearing body cameras while on duty, and use of force by officers in the pilot program decreased by almost 60%. The U.S. findings have prompted several police services to develop protocols that explicitly dictate when officers have discretion over the activation of their body cameras and how recordings should be retained and destroyed.

[58] Lee Rankin, Mesa Police Department, "End of Program Evaluation & Recommendations: On-Officer Body Camera System – Axon Flex, TASER International" (Mesa, AZ: Mesa Police Department, 2013).

70. The Metropolitan Police Service of London, England has indicated that its armed officers (a small percentage of overall police in London) will soon begin wearing cameras while on duty.

D. Alternative equipment options

71. Although the equipment issued to police is regulated at the provincial level, the Review learned that the TPS is continuously investigating alternative use-of-force options, including alternative weapons, and evaluating whether such equipment can reduce fatalities in police interactions. Some of the literature considered by the Review suggested non-lethal firearm options, such as beanbag shotguns or rubber bullets, as possible alternatives when dealing with people in crisis.[59]

72. For example, the Metropolitan Police Service in London, England equips its Territorial Support Group—the special team that deals with maintaining public order, including responding to incidents involving edged weapons—with shields and CEWs, but not firearms. In Toronto, ETF members are issued shields, ARWEN launchers that discharge foam or wooden bullets, tear gas canisters, CEWs, and handguns. The ETF also has access to small mobile cameras that can be used to investigate an incident environment remotely. However, the ETF is not always deployed or able to attend in time to incidents involving people in crisis armed with edged weapons.

II. Overview of Issues Highlighted by Stakeholders

A. Conducted Energy Weapons

73. Although the Review received many diverse and comprehensive submissions regarding CEWs, two major positions emerged. Several stakeholders communicated that the risk of injury or death from a CEW is lower than the risk associated with firearms, and that expanded access to these weapons will have the effect of saving lives. Further, they suggested that CEWs can reduce the risk of injury to police officers compared to firearms, batons, and physical control techniques.

74. Other stakeholders held the opposite view. They contended that CEWs will not, in practice, be used in place of firearms when police perceive an imminent threat of death or serious bodily harm. Rather, they suggest that CEWs will be used in place of less intrusive intermediate options, such as verbal de-escalation or waiting out situations where there is no immediate risk to anyone's safety. Even members of police services acknowledged that CEWs are rarely appropriate in dynamic, close-range situations (the situations in which firearms are most often used) and that there is a risk that officers will over-rely on CEWs when they are first issued. Procedures must be enforced and breaches punished in order to maintain accountability concerning the use of the weapons.

[59] Cleveland Division of Police, 2.1.02 "Beanbag Shotguns" (Cleveland, OH: Cleveland Division of Police, 2013).

75. Many of the stakeholders who hold the latter view advocated against expanding CEWs to first responders. They raised the concern that CEWs are already used disproportionately on people with addictions and mental health issues. It was suggested that only supervisors who have completed comprehensive mental health and de-escalation training should be equipped with the weapons. Several mental health organizations also pointed to the need for more research on both psychological and physical effects of CEWs before determining whether more officers should have access to the devices.

76. The appropriate threshold at which the use of a CEW may be authorized was equally subject to debate. Some stakeholders favoured maintaining the current TPS threshold (that is, that a CEW be used when the officer believes a subject is threatening or displaying assaultive behaviour or, taking into account the totality of the circumstances, the officer believes there is an imminent need for control of a subject and that it is reasonably necessary to use a CEW). They reasoned that the more stringent standard recommended by the Braidwood Commission could hinder police officers' abilities to protect lives if they are required to delay acting while assessing the immediacy of a risk of assault. The Review heard that the existing threshold permits the use of a CEW only to gain control of a subject who is at risk of causing physical harm, not to secure the compliance of an individual who is merely resistant.

77. Others urged the Service to adopt the Braidwood standard (that is, that a CEW be used only when the subject is causing bodily harm or the officer is satisfied, on reasonable grounds, that the subject's behaviour will imminently cause bodily harm, and no lesser force option, de-escalation or crisis intervention technique would be effective). Some stakeholders suggested that the same threshold be used to determine the justification for discharging both a CEW and a firearm.

78. The need for standardized data on CEW use was also reflected in the submissions provided to the Review. Organizations requested national guidelines on CEW use and consistent reporting of displays and discharges of the weapon, which would include reporting demographic information, mental state, and the behaviour of the subject prior to deployment. Further, a central database of information regarding the use of CEWs by the TPS and other services was suggested.

B. Body cameras

79. The Review received many submissions in favour of body cameras, provided appropriate privacy safeguards can be implemented. Some stakeholders indicated that a lack of direction from the provincial government on funding for body cameras could affect the Service's ability to implement them broadly. In addition to the cost of the hardware, police services will have to maintain storage and retrieval databases, as well as employ staff to upload videos and process disclosure and destruction requests.

C. Alternative equipment options

80. Some stakeholders suggested that the TPS should be equipped with shields to disarm people in crisis or de-escalate situations with a minimum of force, but others were doubtful of a shield's utility for first responders. Their concerns traced three themes: (1) that shields are too heavy and bulky, which may delay officer response time in dynamic situations or discourage officers from carrying the tools with them; (2) that shields may provide officers with a falsely heightened sense of security in dangerous situations, increasing the risk of officer injury; and (3) that the presence of a shield in a situation that could be contained by verbal or other de-escalation techniques could increase the anxiety or fear of a person in crisis and have the effect of escalating the incident.

81. Although representatives from other stakeholder groups expressed their understanding of the above concerns, the Review also heard that increasing officer confidence through the provision of additional equipment could be constructive. The escalation or de-escalation of many situations can be attributed to the fear response of both the subject and the officer involved in the incident. Some stakeholders expressed the view that officers who know they have multiple protective options (bullet-proof vests, shields) and non-lethal weapons at their disposal may be better able to manage their fear response and, rather than over-relying on such options, feel more confident taking the time to attempt various de-escalation techniques before using any force. Other stakeholders favoured a model similar to that in London, England, in which a team of officers equipped with shields and other protective or non-lethal equipment could be deployed to disarm a person in crisis of any edged weapons without resort to firearms.

III. Recommendations

82. I recommend that:

Conducted Energy Weapons

> **RECOMMENDATION 55**: The TPS advocate an interprovincial study of the medical effects of CEW use on various groups of people (including vulnerable groups such as people in crisis), as suggested by the Goudge Report.
>
> **RECOMMENDATION 56**: The TPS collaborate with other municipal, provincial, and federal police services to establish a central database of standardized information concerning matters related to the use of force, and CEW use specifically, such as:
>
> (a) the location of contact by CEW probes on a subject's body;
>
> (b) the length of deployment and the number of CEW uses;
>
> (c) any medical problems observed by the officers;

(d) any medical problems assessed by EMS or hospital staff;

(e) the time period between the use of a CEW and the manifestation of medical effects;

(f) the subject's prior mental and physical health condition;

(g) the use of CEWs per ratio of population;

(h) the use of CEWs per ratio of officers equipped with the devices; and

(i) the use of CEWs in comparison to other force options.

RECOMMENDATION 57: The TPS review, and if necessary amend, the Use of Force and CEW Report forms to ensure that officers are prompted to include all standardized information required for the database proposed in Recommendation 56.

RECOMMENDATION 58: The TPS collaborate with Local Health Integration Networks, hospitals, EMS, and other appropriate medical professionals to standardize reporting of data concerning the medical effects of CEWs.

RECOMMENDATION 59: The TPS consider conducting a pilot project to assess the potential for expanding CEW access within the Service, with parameters such as:

(a) Supervision: at an appropriate time to be determined by the TPS, CEWs should be issued to a selection of front line officers in a limited number of divisions for a limited period of time with the use and results to be closely monitored;

(b) Cameras: all front line officers who are issued CEWs should be equipped either with body-worn cameras or audio/visual attachments for the devices;

(c) Reporting: the pilot project require standardized reporting on issues such as:

i. frequency and circumstances associated with use of a CEW, including whether it was used in place of lethal force;

ii. frequency and nature of misuse of CEWs by officers;

iii. medical effects of CEW use; and

iv. the physical and mental state of the subject;

(d) Analysis: data from the pilot project be analyzed in consideration of such factors as:

i. whether CEWs are used more frequently by primary response units, as compared to baseline information on current use of CEWs by supervisors;

ii. whether CEWs are misused more frequently by primary response units, as compared to baseline information on current use of CEWs by supervisors;

iii. the disciplinary and training responses to misuses of CEWs by officers and supervisors;

iv. whether use of force overall increased with expanded availability of CEWs in the pilot project;

v. whether use of lethal force decreased with expanded availability of CEWs in the pilot project; and

vi. whether TPS procedures, training or disciplinary processes need to be adjusted to emphasize the objective of reducing deaths without increasing the overall use of force or infringing on civil liberties; and

(e) Transparency: the TPS report the results of the pilot project to the Toronto Police Services Board (TPSB), and make the results publicly available.

RECOMMENDATION 60: The TPS ensure that all CEWs issued to members (including those CEWs already in service) are accompanied by body-worn cameras, CEW audio/visual recording devices, or other effective monitoring technology.

RECOMMENDATION 61: The TPS ensure that CEW Reports are reviewed regularly, and that inappropriate or excessive uses are investigated.

RECOMMENDATION 62: The TPS discipline, as appropriate, officers who over-rely on or misuse CEWs, especially in situations involving non-violent people in crisis.

RECOMMENDATION 63: The TPS provide additional training, as appropriate, to officers who misuse CEWs in the course of good faith efforts to contain situations without using lethal force.

RECOMMENDATION 64: The TPS require officers to indicate on CEW Reports whether, and what, de-escalation measures were attempted prior to deploying the CEW.

R**ECOMMENDATION 65**: The TPS carefully monitor the data downloaded from CEWs on a periodic basis, investigate uses that are not reported by Service members and discipline officers who fail to report all uses appropriately.

RECOMMENDATION 66: The TPS periodically conduct a comprehensive review of data downloaded from CEWs and audio/visual attachments or body cameras, to identify trends in training and supervision needs relating to CEWs as well as the adequacy of disciplinary measures following misuse.

RECOMMENDATION 67: The TPS revise its CEW procedure to emphasize that the purpose of equipping certain officers with CEWs is to provide opportunities to reduce fatalities and serious injuries, not to increase the overall use of force by police.

RECOMMENDATION 68: The TPS review best practices on safety of CEWs in different modes, both from TPS personnel that are already using CEWs and from other jurisdictions that have implemented policies on permitted methods of discharging CEWs.

RECOMMENDATION 69: The TPS consider the appropriate threshold for permissible use of CEWs, and in particular whether use should be limited to circumstances in which the subject is causing bodily harm or poses an immediate risk of bodily harm to the officer or another person, and no lesser force option, de-escalation or other crisis intervention technique is available or is effective.

RECOMMENDATION 70: The TPS require that all officers equipped with CEWs have completed Mental Health First Aid or equivalent training in mental health issues and de-escalation techniques.

RECOMMENDATION 71: The TPS ensure that training on potential health effects of CEWs, including any heightened risks for people in crisis or individuals with mental illnesses, is updated regularly as the state of knowledge on the topic advances.

Body cameras

RECOMMENDATION 72: The TPS issue body-worn cameras to all officers who may encounter people in crisis to ensure greater accountability and transparency for all concerned.

RECOMMENDATION 73: The TPS develop a protocol for protecting the privacy of information recorded by body-worn cameras. The protocol should address the following matters**:**

(a) Use and Retention: The privacy protocol should address the appropriate methods of storage and length of retention of body camera recordings, limits to accessing and sharing this information,

and mechanisms through which individuals recorded can request access to, and the deletion of, information stored by the TPS;

(b) Discretion: The TPS should establish the scope of discretion for officers to disable recording, reporting measures to be taken when a camera is deactivated, and consequences of misusing that discretion. Examples include requiring officers to notify Communications Services of the reason for disabling a body camera and the duration of the deactivation, or requiring officers to file reports detailing any circumstances in which their body cameras were deactivated;

(c) Discipline: The TPS should establish and enforce clear disciplinary measures for members of the Service who do not comply with the privacy protocol and the discretionary/use protocol to be developed concerning body cameras;

(d) Balancing Interests: The TPS should investigate appropriate options for balancing an individual's right to privacy, an officer's discretion, and the need for accountability in public policing; and

(e) Collaboration: The TPS should work closely with civil liberties groups, legal advisors, consumer survivors, provincial government agencies, privacy commissioners and other appropriate stakeholders in developing the protocol.

Alternative equipment options

RECOMMENDATION 74: The TPS conduct a review of alternative equipment options and tactical approaches, including examples from other jurisdictions, to assist in further reducing the number of deaths arising from police encounters with people in crisis.

PART 3

The Next Stage

CHAPTER 13

Implementation

CHAPTER 13. IMPLEMENTATION

Table of Contents

Page

I. INTRODUCTION 268

II. REQUIREMENTS FOR IMPLEMENTATION 268

- A. Stakeholder input 269
- B. Transparency and accountability 269
- C. Respect for the role of the Chief of Police 270
- D. Respect for the role of the Toronto Police Services Board 270
- E. Leadership 270
- F. Collaborative relationships 271
- G. Resource sensitivity 271
- H. Ongoing review 272

III. RECOMMENDATIONS 272

- A. Advisory committee on implementation 272
- B. Transparency and accountability 273
- C. Leadership 274
- D. Topic-specific reviews 274
- E. Third-party cooperation and relationships 274
- F. Ongoing review 275

Chapter 13. Implementation

I. Introduction

1. This Review represents only one phase—the shortest and least demanding phase ~~in~~ the process of focused self-improvement initiated by the Toronto Police Service in August 2013 relating to police encounters with people in crisis. The Review has identified and recommended improvements in a number of areas. The recommendations are simply a foundation.

2. While the creation of this Review was itself a watershed moment for the TPS, the greatest challenge for the TPS will be implementation. For this Review to be truly meaningful, implementation is essential. Too often reports such as this one are prepared at great effort and expense, only to lay dormant, waiting in vain for someone to put the recommendations into practice. It is for this reason that I have prepared this last set of recommendations ~~ar~~guably the most important recommendations ~~d~~ealing with implementation.

3. In recommending implementation, I am aware of the inherent limitations of my own perspective on the issues addressed in this Report. I do not suggest that every recommendation must be implemented in precisely the manner in which I have articulated it, or even at all if there are good reasons for not doing so, in order for the TPS to have met the challenge of implementation. As I have noted throughout the Report, there are many areas where the specialized expertise of the TPS or other stakeholders must be brought to bear in order to determine how best to address a particular issue. The same is true at the implementation stage. As explained below, part of the process of implementation involves bringing a multi-disciplinary perspective to the issues to evaluate how each recommendation can and will be implemented.

4. Although the challenges of implementation are complex, it would be a mistake to assume that improvement is not achievable. The TPS has seen change and progress in many forms over the past decades, and there is no question in my mind, based on my many interviews with TPS members and others, that the members of the TPS genuinely do wish to do their best and to serve the citizens of Toronto as well as they possibly can. Continuous self-improvement is part of doing one's best.

5. In many respects, the TPS is already a leader among police organizations, and I encourage the Service to embrace this leadership role in the area of police encounters with people in crisis. Being a leader requires determination and initiative, but it will pay dividends not only for the TPS and the people it serves, but also for police across the country and in other jurisdictions who can learn and be inspired.

II. Requirements for Implementation

6. In my view, the following eight elements are required in order for implementation of the recommendations in this Report to be effective.

A. Stakeholder input

7. By "stakeholder input" I mean advice and information provided by those with direct involvement in the subject matter. The list of relevant stakeholders relating to the topic of policing and mental health includes not only people with mental health issues, service providers within the mental health system, and government ministries, but also members of the Toronto Police Service who deal with the issues addressed in this Report on a day-to-day basis.

8. Stakeholder input is essential for two reasons.

9. The first reason is to ensure effectiveness. Many of the issues addressed in this Report are complex. For certain issues, the best implementation decisions will require a detailed understanding of, and direct experience with, the specialized subject-matter. To take the MCIT program as but one example, it is clear that any implementation program designed to further improve the MCIT program will require direct input from the TPS officers and mental health nurses who administer the program on a daily basis, because of their in-depth understanding of the needs of the people they serve. Implementation cannot occur in the abstract, but must be grounded in the reality of people's experience. I have therefore made recommendations about how best to integrate that experience into the nuts and bolts of the implementation process.

10. The second equally important reason for stakeholder input is to ensure legitimacy. No matter how well intentioned or enlightened, change will be resisted unless those it affects believe in the legitimacy of the process that led to the change. Involving stakeholders in the implementation process seeks to meet that need ~~to~~ ensure their voices are heard and taken into account.

11. As explained below, two key mechanisms for ensuring stakeholder input into the implementation process are the creation of an advisory committee to the Chief of Police on implementation, and the involvement of stakeholders in more detailed study, examination and analysis of certain issues.

B. Transparency and accountability

12. The TPS needs to be, and to be seen to be, accountable to the citizens the organization serves. It is a public institution. The public is entitled, within reasonable limits, to know what the police are doing and why.

13. In the case of a Report such as this one, which contains a wide range of recommendations and associated resource requirements, one of the key challenges of implementation is to make decisions about priorities—about the sequence in which to implement the recommendations, about the allocation of resources, and about whether some recommendations should be implemented only at a later date or not at all. These are difficult decisions about which reasonable people may disagree.

14. From the public's perspective, it is important that there be accountability for the decisions made. There should be explanation and good reasons for the decisions. The

Report should not simply fade from public view. I have therefore recommended certain mechanisms to provide for that accountability.

C. Respect for the role of the Chief of Police

15. This Report deals extensively with the administration and operation of the TPS. Any implementation program for the Report's recommendations must recognize the ultimate decision-making authority of the Chief of Police relating to these matters as prescribed by section 41 of the *Police Services Act*, subject to oversight by the Toronto Police Services Board within the scope of its jurisdiction.

16. Although I stress the importance of advisory input from stakeholders during the implementation process, as well as the importance of partnerships with other organizations as explained below, it is the Chief of Police who has ultimate responsibility for the decisions made and I am not recommending that the chief's formal responsibility or authority be modified or constrained.

D. Respect for the role of the Toronto Police Services Board

17. This Report does not make recommendations dealing directly with the Toronto Police Services Board (TPSB). At the same time, several of the recommendations in this Report relate to TPS policies, and many if not most of the recommendations bring into play, in one way or another, the objectives and priorities of the TPS, as well as related resource implications.

18. Under the *Police Services Act*, the TPSB is responsible to establish policies for the effective management of the TPS, and generally to determine, after consultation with the Chief of Police, objectives and priorities with respect to police services in Toronto, among other things.

19. The Board plays a key role in the democratic oversight of the police, and in ensuring accountability of the police to the community that the police serves. Although I do not make specific recommendations for Board involvement in overseeing the implementation of this Report (because to do so would be beyond my mandate), the Board will undoubtedly have an important oversight role to play.

E. Leadership

20. Meaningful implementation of reforms requires leadership, of more than one type. There must be moral leadership for the reform initiative—including leadership by example and by expectation-setting at all levels. There must be organizational leadership in order to effect implementation~~t~~he creation of an infrastructure of responsibilities and accountabilities so as to ensure that all necessary steps are in fact taken. Finally, there must be institutional leadership. That is, for some of the recommendations in this Report to be implemented, the TPS as an institution will need to play an enhanced leadership role outside the organization itself.

21. I make a number of recommendations below about how to achieve these forms of leadership.

F. Collaborative relationships

22. Policing and mental health is a multi-faceted, multi-disciplinary issue. Collaborative relationships with other organizations are essential in order to address all aspects of the issue. Relationships with hospitals are important to ensure efficient delivery of services to people in crisis, and effective education of police. Relationships with those with lived experience of mental illness are needed to ensure mutual understanding and respect, and mutual support. Relationships with academic specialists are important, to ensure that the police benefit from the best thinking and the most complete information. Recommendations are therefore made below dealing with the formation and fostering of such collaborative relationships.

G. Resource sensitivity

23. Like all public institutions, the TPS has significant resource constraints, of which I am acutely aware. Implementation must be pragmatic, recognizing the limitations imposed by the scarcity of available monetary and human resources. I have sought to make recommendations that are within the realm of the possible from a resource perspective. However, it is likely that all of the recommendations in the Report may not be able to be implemented simultaneously under current resource constraints, and that the challenging decisions mentioned above relating to prioritization may need to be made, or the TPS may consider ways of implementing a recommendation that reflect its substance but consume less resources. The recommendations below recognize the need for prioritization and staging of the implementation work.

24. At the same time, it is important to recognize that the addition of targeted new expenditures may result in a net reduction in the overall strain on police resources. For example, expenses incurred in order to achieve better coordination with the mental health system may result in resource benefits such as reduced hospital wait times, shared initiatives such as the MCIT program, and better information for police officers about the most efficient handling of crisis calls.

25. What must also be considered is the staggering cost, both personal and financial, when a person in crisis is killed by police. The personal costs have been discussed above and of course are of paramount importance. Budgetary constraints cannot be treated as more important than lives. At the same time, there are financial costs that arise from the use of lethal force that should not be ignored. Our society spends huge amounts on SIU investigations, inquests, criminal proceedings, civil proceedings, mental health care costs and other expenses associated with fatal shootings. Those who make decisions about funding for police initiatives such as those recommended in this Report must consider this side of the financial coin.

H. Ongoing review

26. Finally, effective implementation of the recommendations set out in this Report would be best achieved if there is ongoing review by the TPS of the subject matter. I therefore recommend below that a follow-up public review be conducted—whether by TPS personnel, by an independent review body or by committee of interested stakeholders—in five years' time to assess the degree of success achieved and make further recommendations for improvement.

III. Recommendations

27. I recommend that:

A. Advisory committee on implementation

RECOMMENDATION 75: The Chief of Police strike an advisory committee, to advise the Chief of Police on how best to implement the recommendations contained in this Report. In this regard, I recommend:

(a) Stakeholder Membership: The advisory committee should include leading members of key stakeholder groups, including hospitals, community mental health organizations, the police and those with lived experience of mental illness;

(b) Limited Membership: The advisory committee should be of manageable size—large enough to provide adequate representation of stakeholder groups, but small enough to be efficient;

(c) Advisory Role: The advisory committee should play only an advisory role and should not have decision-making authority, unless the Chief of Police determines otherwise;

(d) Defined Role: The role of advisory committee members should be defined in clear terms at the time of the creation of the advisory committee, so that there is no misunderstanding as to their function and authority;

(e) In Camera Meetings: The discussions of the advisory committee should be held in camera in order to promote candour and collegiality, unless otherwise directed by the Chief of Police. Advisory committee members should agree as a condition of membership that they will not disclose the committee's discussions;

(f) Communications with the Public: The advisory committee and its individual members should not advocate publicly or use the media as a vehicle for seeking to persuade the Chief of Police (or the TPS more broadly) to make specific decisions, or to criticize the TPS. The advisory committee should not be a political body but rather a

true advisory body, with the effectiveness of its advice deriving from the quality of its membership;

(g) Staffing: The advisory committee should be provided with reasonable assistance by staff as needed, whether using existing TPS personnel or otherwise; and

(h) Annual Reports: The advisory committee should prepare annual reports for the Chief of Police, summarizing the state of progress in implementation, any significant divergences between the advice of the committee and the decisions taken by the TPS in the past year, and major recommendations going forward relating to implementation, prioritization, scheduling, planning, resource allocation, public reporting and related topics.

B. Transparency and accountability

RECOMMENDATION 76: In order to ensure transparency and accountability during the implementation stage, the TPS issue a public report at least annually after the date of release of this Report, with the following contents:

(a) a list of recommendations implemented in whole or in part to the date of the report, with an explanation of what was done and when;

(b) a list of those recommendations still to be implemented, with an indication of the anticipated timing of implementation;

(c) if applicable, a description of resource constraints that affect the ability of the TPS to implement any recommendations, or the timing of implementation;

(d) if applicable, a description of any other limitations on the ability of the TPS to implement any recommendations (such as lack of cooperation from other organizations, change in circumstances, etc.);

(e) if applicable, a list of recommendations that the TPS decided not to implement at all, and an explanation of the reasons for decision;

(f) if applicable, a list of recommendations that the TPS decided to implement in modified form (different from what was recommended in this Report), and an explanation of the reasons for decision; and

(g) a discussion of any significant divergences between the advice of the advisory committee and decisions made by the TPS.

C. Leadership

RECOMMENDATION 77: The Chief of Police and the Executive Management Team of the TPS play a significant leadership role in requiring implementation of the recommendations in this Report, and in encouraging (through leadership by example and otherwise) voluntary compliance.

RECOMMENDATION 78: The TPS appoint a senior officer to assume overall operational responsibility and executive accountability for the implementation of the recommendations in this Report, subject to the direction of the Chief of Police or the chief's designate.

RECOMMENDATION 79: The TPS create an implementation team, led by the senior officer identified above and composed of those TPS members charged with responsibility to implement recommendations within specified areas of the Service (e.g., within the MCIT program, within Psychological Services, within the Toronto Police College, etc.).

RECOMMENDATION 80: The Chief of Police or his delegate appoint, within each TPS division and unit, at least one TPS member formally charged with responsibility for ensuring effective implementation of the recommendations in this Report at the division or unit level.

D. Topic-specific reviews

RECOMMENDATION 81: In connection with those recommendations above that call for further study, examination and analysis of specific issues:

(a) Stakeholder Input: Where appropriate, the TPS seek to involve representatives of affected stakeholders meaningfully in the work;

(b) Deliverables: The TPS identify specific deliverables sought from those tasked with the work, and a timeframe for delivery; and

(c) Reporting Requirement: There be a regular reporting requirement for any work taking place over an extended period, whereby the senior TPS officer in charge of implementation is kept informed regarding the progress of the work.

E. Third-party cooperation and relationships

RECOMMENDATION 82: In connection with those recommendations above that call for the TPS to work with outside organizations such as government ministries, hospitals and others, the TPS take a leadership role in forging and fostering the necessary relationships.

RECOMMENDATION 83: The TPS collaborate with academic researchers, hospitals and others to evaluate the effectiveness of TPS initiatives undertaken as

a result of this Review, including, where applicable, both quantitative and qualitative evaluations.

F. Ongoing review

RECOMMENDATION 84: A follow-up review be conducted—whether by TPS personnel, by an independent review body or by committee of interested stakeholders ~~in~~ five years' time to assess the degree of success achieved in minimizing the use of lethal force in encounters between the TPS and people in crisis, and to make further recommendations for improvement. I recommend that the results of that review be made public, and that the reviewers be similarly tasked with developing recommendations for implementation.

PART 4

Appendices

APPENDIX A

List of Individuals Interviewed

Appendix A
List of Individuals Interviewed

In addition to the people listed below, the Review met with three police officers who have experienced traumatic incidents, and four family members of people who have died as a result of contact with the police. The Review also spoke with others with relevant experiences who have requested that their names be omitted. The list includes the key people involved in the Review visit to the Toronto Police College, which also involved 15 other training constables and sergeants through various demonstrations, not listed below.

	Name	Position	Institutional Affiliation
1.	Affeldt, Sheldon	Mental Health Nurse, The Scarborough Hospital/41, 42, & 43 Divisions, Mobile Crisis Intervention Team	The Scarborough Hospital
2.	Anonymous	Community Member	Sanctuary Ministries of Toronto
3.	Barton, Jay	Staff Member	Sanctuary Ministries of Toronto
4.	Beattie, Alan	Executive Director	Sanctuary Ministries of Toronto
5.	Bennett, Brent	Constable, St. Michael's Hospital/51 & 52 Divisions, Mobile Crisis Intervention Team	Toronto Police Service
6.	Bonner, Paul	Defensive Tactics Instructor	Ontario Police College
7.	Bryant, Michael	Chair	Public Accounting Council of Ontario
8.	Capponi, Pat	Lead Facilitator	Voices from the Street
9.	Chambers, Jennifer	Coordinator	Empowerment Council

	Name	Position	Institutional Affiliation
10.	Chandrasekera, Uppala	Director, Public Policy	Canadian Mental Health Association, Ontario
11.	Coleman, Terry G.	Member, Mental Health and the Law Advisory Committee Chief of Police (retired)	Mental Health Commission of Canada Moose Jaw Police Service
12.	Collins, Dr. Peter I.	Forensic Psychiatrist, Complex Mental Illness Program	Centre for Addiction and Mental Health and the University of Toronto
13.	Compton, Dr. Michael T.	Chairman of Psychiatry Professor of Psychiatry, Hofstra North Shore - LIJ School of Medicine	Lenox Hill Hospital Hofstra University
14.	Cook, Greg	Staff Member	Sanctuary Ministries of Toronto
15.	Cotton, Dorothy	Psychologist	
16.	Creek, Michael	Director of Strategic Initiatives	Working for Change
17.	Del Grande, Michael	Board Member City Councillor	Toronto Police Services Board Toronto City Council
18.	Dinning, Bethan	Articling Student (seconded)	Canadian Civil Liberties Association
19.	Doan, Karin	Manager, Mental Health Services	Toronto East General Hospital
20.	Doob, Anthony N.	Professor Emeritus of Criminology, Centre for Criminology and Sociolegal Studies	University of Toronto
21.	Dowe, Shaun	Chief Superintendent, Firearms Unit	Metropolitan Police Service (London, UK)

	Name	Position	Institutional Affiliation
22.	Draper, Che	Constable, St. Joseph's Health Centre/11 & 14 Divisions, Mobile Crisis Intervention Team	Toronto Police Service
23.	Duncan-LeCoure, Kim	Chief Instructor, Practical Skills	Ontario Police College
24.	Fabro, Sarah	Mental Health Nurse, St. Michael's Hospital/51 & 52 Divisions, Mobile Crisis Intervention Team	St. Michael's Hospital
25.	Falconer, Julian N.	Lawyer	Falconers LLP
26.	Federico, Michael	Deputy Chief, Operational Support Command	Toronto Police Service
27.	Gilbert, Scott	Superintendent and Mobile Crisis Intervention Team Project Lead	Toronto Police Service
28.	Girard, Mike	Officer Safety Instructor	Ontario Police College
29.	Goldbloom, Dr. David S.	Senior Medical Advisor Professor of Psychiatry Chair	Centre for Addiction and Mental Health University of Toronto Mental Health Commission of Canada
30.	Gordon, Tucker	Addictions Advocate	Empowerment Council
31.	Grant, Christopher	Constable, The Scarborough Hospital/41, 42, & 43 Divisions, Mobile Crisis Intervention Team	Toronto Police Service
32.	Greer, Kevin	Training Constable	Toronto Police College

	Name	Position	Institutional Affiliation
33.	Hoffman, Dr. Ron	Coordinator, Mental Health Training	Ontario Police College
34.	Korn-Hassani, Diana	Constable, Mobile Crisis Intervention Team and Mental Health Coordinator, Divisional Policing Support Unit	Toronto Police Service
35.	Lawrence, Chris	Officer Safety Instructor	Ontario Police College
36.	Lennox, Peter	Superintendent, Unit Commander	Toronto Police College
37.	Lisowski, Kevin	Training Constable	Toronto Police College
38.	Lurie, Steve	Executive Director, Toronto Branch	Canadian Mental Health Association
39.	Malone, Theresa	Mental Health Nurse, Toronto East General Hospital/54 & 55 Divisions Mobile Crisis Intervention Team	Toronto East General Hospital
40.	Marks, David	Staff Inspector, Unit Commander, Emergency Task Force	Toronto Police Service
41.	Martin-Doto, Catherine	Corporate Psychologist	Toronto Police Service
42.	McCormack, Michael	President	Toronto Police Association
43.	McLean, Barbara	Inspector, second-in-command	Toronto Police College
44.	McCraken, Nancy	Training Coordinator, Communications Services Training Unit (retired)	Toronto Police Service
45.	McDonald, Deb	Officer Safety Instructor	Ontario Police College

	Name	Position	Institutional Affiliation
46.	McKeown, Michael	Community Member	Sanctuary Ministries of Toronto
47.	Mukherjee, Alok	Chair	Toronto Police Services Board
48.	Murray, Sandy	Senior Advisor	Toronto Police Services Board
49.	Niedra, Kristina	Project Manager, Mobile Crisis Intervention Team	Toronto East General Hospital
50.	Ormston, Edward	Justice Former Chair	Ontario Court of Justice Consent and Capacity Board
51.	Ovens, Dr. Howard	Director, Schwartz/Reisman Emergency Centre Associate Professor, Department of Family and Community Medicine Lead for Emergency Medicine	Mount Sinai Hospital University of Toronto Toronto Central Local Health Integration Network, Ontario
52.	Paul, Greg	Staff Member	Sanctuary Ministries of Toronto
53.	Pillay, Sukanya	General Counsel and Executive Director	Canadian Civil Liberties Association
54.	Pringle, Andrew	Board Member	Toronto Police Services Board
55.	Quinn, Paul	Executive Director (former)	Gerstein Centre
56.	Ross, Daniel	Vice-President	Toronto Police Association
57.	Roy, Julian K.	Lawyer	Falconers LLP
58.	Scott, Ian	Former Director	Ontario's Special Investigations Unit

	Name	Position	Institutional Affiliation
59.	Sewell, John	Coordinator	Toronto Police Accountability Coalition
60.	Shields, Roslyn	Senior Policy Analyst, Office of Strategy and Partnerships	Centre for Addiction and Mental Health
61.	Sidlauskas, Peter	Constable, Toronto East General/54 & 55 Divisions, Mobile Crisis Intervention Team	Toronto Police Service
62.	Sky, Laura	Executive Director, Documentary Writer/ Researcher/Director	SkyWorks Charitable Foundation
63.	Sloly, Peter	Deputy Chief, Community Safety Command	Toronto Police Service
64.	Stavrakis, Mike	Training Constable	Toronto Police College
65.	Stefan, Conny	Mental Health Nurse, St. Joseph's Health Centre/11 & 14 Divisions, Mobile Crisis Intervention Team	St. Joseph's Health Centre
66.	Stockfish, John	Staff Sergeant, Section Head, In-Service Training Section	Toronto Police College
67.	Stone, Chris	Training Constable	Toronto Police College
68.	Stratford, Ian	Inspector, Prosecution Services	Toronto Police Service
69.	Taylor, Andrew	Program Director	Council of Canadian Academies
70.	Vipari, Carol	Corporate Psychologist	Toronto Police Service
71.	Webster, Michael	Psychologist	Centurion Consulting Services Ltd.
72.	Wilcox, Jane	Staff Superintendent, Public Safety Operations	Toronto Police Service

	Name	Position	Institutional Affiliation
73.	Wiley, Jerry	Former Senior Counsel to the Office of the Chief of Police	Toronto Police Service
74.	Wood, Kimberly	Senior Supervisor, Operations Support, Communications Services	Toronto Police Service
75.	Wretham, Brenda	Communications Operator, Training Unit (retired), Communications Services	Toronto Police Service
76.	Young, Linda	Director Maternal Newborn Child, Mental Health, Interprofessional Practice and Organizational Learning	Toronto East General Hospital
77.	Zeyen, John	Use of Force Instructor	Ontario Police College

APPENDIX B

Selected Bibliography

Appendix B
Selected Bibliography

Citation

"25 Tasers bought by Windsor police" *CBC News* (23 January 2014), online: <http://www.cbc.ca/news/canada/windsor/25-tasers-bought-by-windsor-police- 1.2508569>.

A.C. Watson, *et al.*, "Police Officers' Attitudes Toward and Decisions About Persons With Mental Illness" (2004) 55 Psychiatric Services 1.

Aaron Levin, "Police Crisis Teams Promising, but Final Verdict Not In" *Psychiatric News* (20 November 2009), online: PsychiatryOnline: <http://psychnews.psychiatryonline.org/newsarticle.aspx?articleid=113011>.

Abigail Tucker, *et al.*, *Responding to Persons with Mental Illness* (Washington, D.C.: Federal Bureau of Investigations, 2011).

Amanda Lee Myers, "Stun Gun Study by Ohio Police Targets Improvements" *The Associated Press* (13 November 2013).

Amnesty International, *'Less than Lethal'? The Use of Stun Weapons in US Law Enforcement* (London: Amnesty International, 2008).

Amy C. Watson, "Research in the Real World: Studying Chicago Police Department's Crisis Intervention Team Program" (2010) 20 Research on Social Work Practice 5.

Amy C. Watson, *et al.*, "Outcomes of Police Contacts with Persons with Mental Illness: The Impact of CIT" (2010) 37 Administration and Policy in Mental Health 4.

Amy N. Kerr, *et al.*, "Police Encounters, Mental Illness and Injury: An Exploratory Investigation" (2010) 10 Journal of Police Crisis and Negotiations 1.

Anasseril Daniel, "Commentary: Decision-Making by Front-Line Service Providers – Attitudinal or Contextual" (2004) 32 Journal of the American Academy of Psychiatry and the Law 4.

Audrey Honig & William J. Lewinski, "A Survey of the Research on Human Factors Related to Lethal Force Encounters: Implications for Law Enforcement Training, Tactics, and Testimony" (2008) 8 Law Enforcement Forum 4.

"Baltimore to Arm All City Cops With Tasers" *Fox Baltimore* (8 November 2013), online: <http://www.foxbaltimore.com>.

Basic Principles on the Use of Force and Firearms by Law Enforcement Officials, United Nations Congress on the Prevention of Crime and the Treatment of Offenders, 7 September 1990.

Bernard D. Rosketer, *et al.*, *Evaluation of the New York City Police Department Firearm Training and Firearm Discharge Review Process* (New York: RAND Center on Quality Policing, 2008).

Bernard D. Rosketer, *et al.*, *Evaluation of the New York City Police Department Firearm Training and Firearm Discharge Review Process* (New York: RAND Center on Quality Policing, 2008).

Bill Dunphy, "Has the time come for police to wear cameras?" *The Hamilton Spectator* (8 March 2013), online: The Hamilton Spectator <http://www.thespec.com>.

Braidwood Commission on Conducted Energy Weapon Use, *Restoring Public Confidence: Restricting the Use of Conducted Energy Weapons* (Vancouver: Braidwood, QC, Commissions of Inquiry, 2009).

Braidwood Commission on the Death of Robert Dziekanski, *Why? The Robert Dziekanski Tragedy* (Vancouver: Braidwood, QC, Commissions of Inquiry, 2010).

Brenda Bouw, "New wearable video cameras for police help boost Taser shares" *The Globe and Mail* (17 December 2013).

Canadian Mental Health Association, *Police and Mental Illness: Models that Work* (Vancouver: Canadian Mental Health Association, BC Division, 2005).

Carol Vipari & Cathy Martin-Doto, *Psychologist Guidelines – New Constable Psychological Screening Evaluations* (Toronto: Toronto Police Service, 2013).

Caryn Pearson, *et al.*, *Health at a Glance: Mental and substance use disorders in Canada* (Ottawa: Statistics Canada, 2013).

Centre for Research on Inner City Health, *Toronto Mobile Crisis Intervention Team (MCIT) Program Implementation Evaluation Final Report* (Toronto: St. Michael's, 2014).

Christine Hall & Kristine Vovota, *Prospective Analysis of Police Use of Force in Four Canadian Cities: Nature of events and their outcomes* (Contractor Report) (Ottawa: Defence Research and Development Canada, 2013).

Christine Hall, Kristine Votova & Donna Wood, "Prospective Analysis of Police Use of Force in Four Canadian Cities: Nature of events and their outcomes" (2013) Defence Research and Development Canada.

Compton *et al.*, "Police Chiefs', Sheriffs', and Law Enforcement Officers' Views of the Crisis Intervention Team (CIT) Program."

Council for Adult and Experiential Learning, "Servicing Adult Learners in Higher Education: Principles of Effectiveness" (Chicago: Council for Adult and Experiential Learning, 2000).

Daniel L. Ross, "Assessing Lethal Force Liability Decisions and Human Factors Research" (2013) 13 Law Enforcement Executive Forum 2.

David Marks, *ETF Taser Statistics – 1999 to 2013 (YTD)* (Toronto: Toronto Police Services).

David Marks, *Internal Correspondence – 2008 Year End Report* (Toronto: Toronto Police Services, 2008).

David Marks, *Internal Correspondence – 2009/2010 Objectives/Priorities* (Toronto: Toronto Police Services, 2009).

David Marks, *Internal Correspondence – 2011 Objectives* (Toronto: Toronto Police Services, 2011).

David Marks, *Internal Correspondence – 2012 Objectives* (Toronto: Toronto Police Service, 2012).

David Marks, *Internal Correspondence – 2013 Goals and Objectives* (Toronto: Toronto Police Service, 2013).

Debassage Inquest Report, October 8, 2010 (Toronto: Toronto Police Services Board, 2010).

Dionne Anglin, *et al.*, "Four Tarrant County Police Department Stop Taser Use" *Fox 4 News* (20 September 2013), online: MyFoxDFW.com <http://www.myfoxdfw.com>.

Donald K. Stern, *et al.*, *Commission Investigating the Death of Victoria Snelgrove* (Boston: Boston Police Commission, 2005).

Dorothy Cotton & Terry G. Coleman, "Canadian police agencies and their interactions with persons with a mental illness: a systems approach" (2010) 11 Police Practice and Research: An International Journal 4.

Dorothy Cotton and Terry Coleman, "A Study of Police Academy Training and Education for New Police Officers Related to Working with People with Mental Illness" (2008).

Dragana Kesic, *et al.*, "Use of National Force on and by Persons with Apparent Mental Disorder in Encounters with Police" (2013) 40 Criminal Justice and Behavior 3.

"Editorial: Policy body cameras: Will improve safety, but strict rules needed" Winston-Salem Journal (22 March 2014), online: Winston-Salem Journal <http://www.journalnow.com/opinion/editorials.html>.

Ellen M. Scrivner, *Controlling Police Use of Excessive Force: The Role of the Police Psychologist* (Washington, D.C.: National Institute of Justice, 1994).

Extract from the Minutes of the Meeting on April 5, 2012 (Chief's Administrative Report: Death of Sylvia Klibingaitis) (Toronto: Toronto Police Service Board, 2012).

Extract from the Minutes of the Public Meeting of the Toronto Police Services Board Held on April 19, 2012 (Toronto: Toronto Police Services Board, 2012).

Extract from the Minutes of the Meeting on April 25, 2013 (Responding to People with Mental Health Issues: Toronto Police Service Status Update) (Toronto: Toronto Police Services Board, 2013).

Extract from the Minutes of the Public Meeting of the Toronto Police Services Board Held on November 7, 2013 (Toronto: Toronto Police Services Board, 2013).

Extract from the Minutes of the TPSB Meeting, August 14, 2003 (Response to Bouku Inquest) (Toronto: Toronto Police Services Board, 2003).

Extract from the Minutes of the TPSB Meeting, August 17, 2011 (Response to Sanita Inquest) (Toronto: Toronto Police Services Board, 2011).

Extract from the Minutes of the TPSB Meeting, August 31, 2000 (Response to Amjad Inquest) (Toronto: Toronto Police Services Board, 2000).

Extract from the Minutes of the TPSB Meeting, December 13, 2001 (Response to Nairne Inquest) (Toronto: Toronto Police Services Board, 2001).

Extract from the Minutes of the TPSB Meeting, December 14, 2000 and July 20, 2001 (Response to Neuts Inquest) (Toronto: Toronto Police Services Board, 2001).

Extract from the Minutes of the TPSB Meeting, December 15, 2005 (Response to Haughton Inquest) (Toronto: Toronto Police Services Board, 2005).

Extract from the Minutes of the TPSB Meeting, December 19, 2007, March 27, July 24, 2008 (Response to Christopher-Reid Inquest) (Toronto: Toronto Police Services Board, 2008).

Extract from the Minutes of the TPSB Meeting, December 9, 1999 (Response to Nasim Inquest) (Toronto: Toronto Police Services Board, 1999).

Extract from the Minutes of the TPSB Meeting, December 9, 1999 (Response to Tabol Inquest) (Toronto: Toronto Police Services Board, 1999).

Extract from the Minutes of the TPSB Meeting, February 15, 2006 (Response to Street Inquest) (Toronto: Toronto Police Services Board, 2006).

Extract from the Minutes of the TPSB Meeting, January 21, 2010 (Response to Wallace Inquest) (Toronto: Toronto Police Services Board, 2010).

Extract from the Minutes of the TPSB Meeting, January 23, 2013 (Response to Manon Inquest) (Toronto: Toronto Police Services Board, 2010).

Extract from the Minutes of the TPSB Meeting, January 25, 2001 (Response to Ho Inquest) (Toronto: Toronto Police Services Board, 2001).

Extract from the Minutes of the TPSB Meeting, January 26, June 1, August 31, 2000 (Response to Allen Inquest) (Toronto: Toronto Police Services Board, 2000).

Extract from the Minutes of the TPSB Meeting, January 28, 1999 (Response to Howard Inquest) (Toronto: Toronto Police Services Board, 1999).

Extract from the Minutes of the TPSB Meeting, January 29, 1998 (Response to Gale Inquest) (Toronto: Toronto Police Services Board, 1998).

Extract from the Minutes of the TPSB Meeting, July 10, 2007 (Response to Francis Inquest) (Toronto: Toronto Police Services Board, 2007).

Extract from the Minutes of the TPSB Meeting, June 19, September 18, 2008 (Response to Walker Inquest) (Toronto: Toronto Police Services Board, 2008).

Extract from the Minutes of the TPSB Meeting, June 24, 1999 (Response to Au-Yeung Inquest) (Toronto: Toronto Police Services Board, 1999).

Extract from the Minutes of the TPSB Meeting, June 24, 1999 (Response to Rodrigues and Motton Inquest) (Toronto: Toronto Police Services Board, 1999).

Extract from the Minutes of the TPSB Meeting, June 24, 1999 (Response to Viveiros Inquest) (Toronto: Toronto Police Services Board, 1999).

Extract from the Minutes of the TPSB Meeting, March 22, June 21, 2001 (Response to Pribag Inquest) (Toronto: Toronto Police Services Board, 2001).

Extract from the Minutes of the TPSB Meeting, March 25, 2004 (Response to Lovell Inquest) (Toronto: Toronto Police Services Board, 2004).

Extract from the Minutes of the TPSB Meeting, March 25, 2010 (Response to Gallimore Inquest) (Toronto: Toronto Police Services Board, 2010).

Extract from the Minutes of the TPSB Meeting, March 26, 1998 (Response to Kwiechien Inquest) (Toronto: Toronto Police Services Board, 1998).

Extract from the Minutes of the TPSB Meeting, March 3, 2001, February 25, 2010 (Response to Christian Inquest) (Toronto: Toronto Police Service Board, 2010).

Extract from the Minutes of the TPSB Meeting, March 30, 2009 (Response to Gourley Inquest) (Toronto: Toronto Police Services Board, 2009).

Extract from the Minutes of the TPSB Meeting, May 18, 2006 (Response to Bozic Inquest) (Toronto: Toronto Police Services Board, 2006).

Extract from the Minutes of the TPSB Meeting, November 15, 2010 (Response to Al-Nadir Inquest) (Toronto: Toronto Police Services Board, 2010).

Extract from the Minutes of the TPSB Meeting, November 17, 2005 (Response to Topey Inquest) (Toronto: Toronto Police Services Board, 2005).

Extract from the Minutes of the TPSB Meeting, November 1999 and Jury's Verdict and Recommendations (Toronto: Toronto Police Services Board, 1999).

Extract from the Minutes of the TPSB Meeting, October 16, December 18, 2008 (Response to Fraser Inquest) (Toronto: Toronto Police Services Board, 2008).

Extract from the Minutes of the TPSB Meeting, October 19, 1999 (Response to Webb Inquest) (Toronto: Toronto Police Services Board, 1999).

Extract from the Minutes of the TPSB Meeting, October 26, 1998 (Response to Smith Inquest) (Toronto: Toronto Police Services Board, 1998).

Extract from the Minutes of the TPSB Meeting, October 26, 2000 (Response to Williams Inquest) (Toronto: Toronto Police Services Board, 2000).

Extract from the Minutes of the TPSB Meeting, September 23, 2010 (Response to Yim Inquest) (Toronto: Toronto Police Services Board, 2010).

Extract from the Minutes of the TPSB Meeting, September 28, 2000 (Response to Manzano Inquest) (Toronto: Toronto Police Services Board, 2000).

Extract from the Minutes of the TPSB Meetings on April 23, 1998 and August 27, 1998 (Toronto: Toronto Police Services Board, 1998).

Extract from the Minutes of the TPSB Meetings on April 7, July 12, September 6, 2005, January 11 and July 10, 2006 (Response to Blentzas Inquest) (Toronto: Toronto Police Services Board, 2006).

Extract from the Minutes of the TPSB Meetings on June 15, 2006 and September 20, 2007 (Response to McNeil Inquest) (Toronto: Toronto Police Services Board, 2007).

Extract from the Minutes of the TPSB Meetings on June 24, 1999 (Response to Ho-Nguyen Inquest) *and Budget Meeting on September 23*, 1999 (Toronto: Toronto Police Services Board, 1999).

Extract from the Minutes of the TPSB Meetings on November 21, 2002, March 25 and June 21, 2004 (Response to Hadley Inquest) (Toronto: Toronto Police Services Board, 2004).

Extract from the Minutes of the TPSB Meetings on November 28, 2006, January 25, March 22, July 10, 2007 (Response to Vass Inquest) (Toronto: Toronto Police Services Board, 2007).

Extract from the Minutes of the TPSB Meetings on October 19, 2006, January 25, April 26, 2007, January 21, 2010 (Response to Reodica Inquest) (Toronto: Toronto Police Services Board, 2010).

Extract from the Minutes of the TPSB Meetings, August 31, November 2000 (Response to Antidormi Inquest) (Toronto: Toronto Police Services Board, 2000).

Extract from the Minutes of the TPSB Meetings, October 19, December 9, 1999 and February 24, 2000 (Toronto: Toronto Police Services Board, 2000).

Extract from the Minutes of the TPSB Meetings, October 19, December 9, 1999 (Response to Mandy Inquest) (Toronto: Toronto Police Services Board, 1999).

Flora Matheson, *et al.*, "Assessment of Police Calls for Suicidal Behavior in a Concentrated Urban Setting" (2005) 56 Psychiatric Services 12.

Gary Codner, *The Problem of People with Mental Illness*, Guide No. 40 (Albany: Centre for Problem-Oriented Policing, 2006)

Geoffrey P. Albert, *et al.*, "Interactive Police-Citizen Encounters that Result in Force" (2004) 7 Police Quarterly 4.

George Ferguson, *Review and Recommendations Concerning Various Aspects of Police Misconduct, Volumes I and II* (Toronto: Toronto Police Service, January 2003).

Government of Canada, *The Human Face of Mental Health and Mental Illness in Canada 2006* (Ottawa: Minister of Public Works and Government Services Canada, 2006).

Greg Stewart *et al.*, *Report on Police Interactions with Persons in Mental Health Crisis*, (Portland: Portland Police Bureau, 2012).

H.J. Steadman, "A Specialized Crisis Response Site as a Core Element of Police-Based Diversion Programs" (2001) 52 Psychiatric Services 2.

Health Canada, *A Report on Mental Illness in Canada* (Ottawa: Health Canada, 2002).

Health Systems Research Unit of the Clark Institute of Psychiatry, *Best Practices in Mental Health Reform* (Discussion Paper) (Ottawa: Health Canada, 1997).

Henry J. Steadman, *et al.*, "Comparing Outcomes of Major Models of Police Responses to Mental Health Emergencies" (2000) 51 Psychiatric Services 5.

Henry J. Steadman, *et al.*, *Police Response to Emotionally Disturbed Persons: Analyzing New Models of Police Interactions with the Mental Health System* (Washington, D.C.: National Institute of Justice, 1999).

Independent Investigations Office of BC, *Annual Report 2012-2013* (Surrey, BC: Independent Investigations Office of British Columbia, 2013).

Institute for Non-Lethal Defense Technologies, *Report on the Second International Law Enforcement Forum: Minimal Force Options* (Reston: Applied Research Laboratory at the Pennsylvania State University, 2003).

International Association of Chiefs of Police, *Building Safer Communities: Improving Police Response to Persons with Mental Illness* (Alexandria, VA: International Association of Chiefs of Police, 2010).

International Association of Chiefs of Police, *Emerging Use of Force Issues: Balancing Public and Officer Safety* (Washington, D.C.: Department of Justice Office, Community Oriented Policing Services, 2005).

International Association of Chiefs of Police, *Police Psychology Reference List* (2010).

J.N. Vickers & William Lewinski, "Performing under pressure: Gaze control, decision making and shooting performance of elite and rookie police officers" (2012) 31 Human Movement Science 1.

Jack Sommers, "Taser use of knife wielders 'appropriate'" Police Oracle (14 March 2014), online: Police Oracle <https://www.policeoracle.com>.

James J. Fyfe, "The Split-Second Syndrome and Other Determinants of Police Violence." In Anne Campbell and John J. Gibbs (Eds) of *Violent Transactions: The Limits of Personality* (New York: Basi Blackwell, 1985)

James K. Stewart, *et al.*, *The Baltimore Police Department: Police-Involved Shooting of January 9, 2011* (Baltimore: Independent Review Board, 2011).

Janet R. Oliva & Michael T. Compton, "A Statewide Crisis Intervention Team (CIT) Initiative: Evolution of the Georgia CIT Program" (2008) 36 Journal of the American Academy of Psychiatry and the Law 1.

Janet R. Oliva, Rhiannon Morgan & Michael T. Compton, "A Practical Overview of De-Escalation Skills in Law Enforcement: Helping Individuals in Crisis While Reducing Police Liability and Injury" (2010) 10 Journal of Police Crisis Negotiations 1.

Jeffrey Geller, "Commentary: Is CIT Today's Lobotomy?" 36 Journal of the American Academy of Psychiatry and the Law 1.

Jeffrey Nicholl & Clay Kelly, "Can Municipalities Bear *Respondeat Superior* Liability for Failure to Adequately Train Police Officers in Crisis Intervention Techniques?" (2012) 40 Journal of the American Academy of Psychiatry and the Law 2.

Jennifer L.S. Teller, *et al.*, "Crisis Intervention Team Training for Police Officers Responding to Mental Disturbance Calls" (2006) 57 Psychiatric Services 2.

Jennifer Pagliaro, "Federal government seeks to study police use of force" *The Toronto Star* (9 December 2013), online: TheStar.com <http://www.thestar.com/news/crime/2013/12/09/federal_government_seeks_to_stu dy_police_use_of_force.html>.

Jennifer Skeem & Lynne Bibeau, "How Does Violence Potential Relate to Crisis Intervention Team Responses to Emergencies?" (2008) 59 Psychiatric Services 2.

Joel W. Godfredson, *et al.*, "Police perceptions of their encounters with individuals experiencing mental illness: A Victorian survey" (2011) 44 Australian & New Zealand Journal of Criminology 2.

Johann Brink, *et al.*, *A Study of How People with Mental Illness Perceive and Interact with the Police* (Calgary: Mental Health Commission of Canada, 2011).

Joshua A. Ederheimer, ed., *Critical Issues in Policing Series: Strategies for Resolving Conflict and Minimizing Use of Force* (Washington, D.C.: Police Executive Research Forum, 2007).

Judith Adelman, *Study in Blue and Grey: Police Interventions with People with Mental Illness* (Vancouver: Canadian Mental Health Association, BC Division, 2003).

Judy Hails & Randy Borum, "Police Training and Specialized Approaches to Respond to People with Mental Illnesses" (2003) 49 Crime & Delinquency 1.

Kelmeny Fraser, "State Police Minister Jack Dempsey confirms police may soon be wearing surveillance gear" *The Australian* (24 March 2014), online: The Courier Mail <http://www.couriermail.com.au>.

Kelly Bouchard, "Across nations, unsettling acceptance when mentally ill in crisis are killed" *The Portland Press Herald* (12 December 2012), online: PressHerald.com <http://www.pressherald.com/news/projects/Shoot-Across-nation-a-grim-acceptance-when-mentally-ill-shot-down.html?pagenum=full>.

Kris Mohandie & J. R. Meloy, "Hostage and Barricade Incidents Within an Officer-Involved Shooting Sample: Suicide by Cop, Intervention Efficacy, and Descriptive Characteristics" (2010) 10 Journal of Police Crisis Negotiations 1.

Kris Mohandie, *et al.*, "Suicide by Cop Among Officer-Involved Shooting Cases" (2009) 54 Journal of Forensic Science 2.

Leslie Sinclair, "Crisis Intervention Teams Enhance Safety of Police, Patients" *Psychiatric News* (6 July 2012).

Lisa Heslop, *et al.*, *Trends in Police Contact with Persons with Mental Illness: A Longitudinal Study 2000-2011* (London: London Police Service, 2011).

Lord Victor Adebowale, *Independent Commission on Mental Health and Policing Report* (London: Independent Commission on Mental Health and Policing, 2013)

Lori Kurtzman, "Cameras becoming part of police's uniform" *The Columbus Dispatch* (15 December 2013), online: The Columbus Dispatch <http://www.dispatch.com/content/stories/local/2013/12/15/cameras-becoming-part- of-the-uniform.html>.

"Man dies after altercation with Montreal police, with Taser used" *The [Montreal] Gazette* (12 November 2013)

Marilyn Price, "The Challenge of Training Police Officers" (2005) 33 Journal of the American Academy of Psychiatry and the Law 1.

"Mark Duggan death: Armed police to wear video cameras" *BBC News* (9 January 2014), online: <http://www.bbc.co.uk/news/uk-england-london-25663495>.

Mark R. Munetz, *et al.*, "Statewide Implementation of the Crisis Intervention Team Program: the Ohio Model." (2006) 57 Psychiatric Services 11.

Martha W Deane et al. "Emerging Partnerships Between Mental Health and Law Enforcement" (1999) 50(1) Psychiatric Services 99.

Martin Sellbom, Gary L. Fischler & Yossef S. Ben-Porath, "Identifying MMPI-2 Predictors of Police Officer Integrity and Misconduct" (2007) 34:8 Crim. Justice and Behavior 985.

Matt Schwarzfeld, *et al.*, *Improving Responses to People with Mental Illness: The Essential Elements of a Specialized Law Enforcement-Based Program* (New York: Council of State Governments Justice Center, 2008).

Melissa Reuland & Matt Schwarzfeld, *Improving Responses to People with Mental Illnesses: Strategies for Effective Law Enforcement Training* (New York: Council of State Governments Justice Center, 2008).

Melissa Reuland, *et al.*, *Improving Responses to People with Mental Illnesses: Tailoring Law Enforcement Initiatives to Individual Jurisdictions* (New York: Council of State Governments Justice Center, 2010).

Melissa Reuland, *et al.*, *Law Enforcement Responses to People with Mental Illnesses: A Guide to Research-Informed Policy and Practice* (New York: Council of State Governments Justice Center, 2009).

Melissa Reuland, *et al.*, *Statewide Law Enforcement/Mental Health Efforts: Strategies to Support and Sustain Local Initiatives* (New York: Council of State Governments Justice Center, 2012).

Melissa S. Morabito, *et al.*, "Crisis Intervention Teams and People with Mental Illness: Exploring the Factors that Influence the Use of Force" (2012) 58 Crime & Delinquency 1.

Memorandum of Understanding with Respect to the Mobile Crisis Intervention Team between Toronto Police Services Board and Toronto East General Hospital (Toronto: Toronto Police Service & Toronto East General Hospital, 2013).

Mental Health Submissions, April 19, 2012 (Toronto: Toronto Police Services Board, 2012).

Mental Health Commission of Canada, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* (Calgary: Mental Health Commission of Canada, 2012).

Michael A. Knox, "The Dynamics of Shooting Incidents" *Crime Scene Journal* (5 June 2012), online: The Crime Scene Journal <www.crimescenejournal.com/content.php?id=0005>.

Michael Compton, *et al.*, "A Comprehensive Review of Extant Research on Crisis Intervention Team (CIT) Programs" (2008) 36 Journal of the American Academy of Psychiatry and the Law 1.

Michael Compton, *et al.*, "Crisis Intervention Team Training and Special Weapons and Tactics Callouts in an Urban Police Department" (2009) 60 Psychiatric Services 6.

Michael Compton, *et al.*, "Crisis Intervention Team Training: Changes in Knowledge, Attitudes, and Stigma Related to Schizophrenia" (2006) 57 Psychiatric Services 8.

Michael T. Compton & V.H. Chien, "Factors Related to Knowledge Retention After Crisis Intervention Team Training for Police Officers" (2008) 59 Psychiatric Services 9.

Michael T. Compton et al., "System-and Policy-Level Challenges to Full Implementation of the Crisis Intervention (CIT) Model" (2010) 10 Journal of Police Crisis Negotiations 1.

Michael T. Compton, *et al.*, "Do Empathy and Psychological Mindedness Affect Police Officers' Decision to Enter Crisis Intervention Team Training?" (2011) 62 Psychiatric Services 6.

Michael T. Compton, *et al.*, "Use of Force Preferences and Perceived Effectiveness of Actions Among Crisis Intervention Team (CIT) Police Officers and Non-CIT Officers in an Escalating Psychiatric Crisis Involving a Subject with Schizophrenia" (2009) 37 Schizophrenia Bulletin 4.

Ministry of Community Safety and Correctional Services, *Basic Constable Training Course Training Standard: Officer Safety* (Toronto: Ministry of Community Safety and Correctional Services, 2013).

Basic Constable Training Tactical Communication Course Training Standards (Toronto: Ministry of Community Safety and Correctional Services, 2001).

Mobile Crisis Intervention Team (MCIT) Position Specific Sheet (Toronto: Toronto Police Service, 2009).

Nancy Hall and Camia Weaver, "A Framework for Diversion of Persons with a Mental Disorder in BC" (2008) CAMH BC Division.

National Criminal Justice Symposium, "Final Report from Re-Inventing Criminal Justice: The Fifth National Symposium" (19 January 2013)

National Institute of Justice, *How Conducted Energy Devices Work*, online: <www.nij.gov>.

National Institute of Justice, *Monitoring Police Use of Conducted Energy Devices*, online: <www.nij.gov>.

Ontario Human Rights Commission, *Count me in! Collecting Human Rights-Based Data* (Toronto: Ontario Human Rights Commission, 2009).

Ontario Human Rights Commission, *Minds that Matter: Report on the consultation on human rights, mental health and addictions* (Toronto: Ontario Human Rights Commission, 2012).

Ontario Human Rights Commission, *Policy and guidelines on racism and racial discrimination* (Toronto: Ontario Human Rights Commission, 2005).

Ontario Police College, "Police Trainee Field Training Manual" (2010).

Peta Carlyon & Sarah Farnsworth, "Coroner defends police use of force in Cassidy death" *Australian Broadcasting Corporation News* (23 November 2011), online: abc.net.au <http://www.news-australia.com/news/coroner-defends-police-use-of-force-in-cassidy-death-201111230726.html>.

PH Silverstone, *et al.*, "A Novel Approach to Training Police Officers to Interact with Individuals Who May Have a Psychiatric Disorder" (2013) 41 Journal of the American Academy of Psychiatry and the Law 3.

Police Executive Research Forum, *Critical Issues in Policing Series: An Integrated Approach to De-Escalation and Minimizing Use of Force* (Washington: Police Executive Research Forum, 2012).

Police Training Boosts Likelihood That People With Mental Illness Will Get Needed Care (8 January 2014), online: Psychiatric News Alert <http:// alert.psychiatricnews.org/2014/01/police-training-boosts-likelihood- that.html>.

Police/Mental Health Subcommittee of the Canadian Association of Chiefs of Police Human Resources Committee, *Contemporary Policing Guidelines for Working with the Mental Health System* (Kanata: Canadian Association of Chiefs of Police, 2008).

Policing Standards Advisory Committee, *Review of Conducted Energy Weapon Use in Ontario* (Committee Report) (Toronto: Ministry of Community Safety and Correctional Services, 2009).

Randy Borum, *et al.*, "Police Perspectives on Responding to Mentally Ill People in Crisis: Perceptions of Program Effectiveness" (1998) 16 Behavioral Science & the Law 4.

Report of the Joint Working Group on Mental Health Services and the Police 2009 (Dublin: Mental Health Commission, 2009).

Report of the Maryland Attorney General's Taskforce on Electronic Weapons, (Baltimore, MA: Office of the Attorney General).

Richard Frierson, "Commentary: Police Officers and Persons with Mental Illness" (2013) 41 Journal of the American Academy of Psychiatry and the Law 3.

Rick Parent, "The Police Use of Deadly Force in British Columbia: Mental Illness and Crisis Intervention" (2011) 11 Journal of Police Crisis Negotiations 1.

Robert C. Davis, "Selected International Best Practices in Police Performance Measurement" *RAND Corporation*, Technical Report Series, 2012.

Roger L. Scott, "Evaluation of a Mobile Crisis Program: Effectiveness, Efficiency, and Consumer Satisfaction" (2000) 51 Psychiatric Services 9.

Ron Bonighton, *Policing people who appear to be mentally ill* (Victoria, AUS: Office of Police Integrity, 2012).

Ron Hoffman & Laurel Putnam, *Not just another call... police response to people with mental illnesses in Ontario* (London: Centre for Addiction and Mental Health, 2004).

Ron Hoffman *et al.*, "A Pilot Study of the interRAI Brief Mental Health Screener" (2013)

Ron Hoffman, "Police Training delivered at the Ontario Police College on responding to persons with mental disorders" (Ontario Police College, 2013)

Ron Hoffman, "interRAI Brief Mental Health Screener (BMHS)" (Ontario Police College, 2007-2013).

Ronald J. MacDonald, *The First Year in Review: 2012-2013 Annual Report* (Halifax: Serious Incident Response Team, 2013).

Roy McMurtry & Alvin Curling, *The Review of the Roots of Youth Violence*, vol. 1 (Toronto: Queen's Printer for Ontario, 2008).

Sabria W. Tyuse, "A Crisis Intervention Team Program: Four-Year Outcomes" (2012) 10 Social Work in Mental Health 6.

Sam Cochran, *et al.*, "Improving Police Response to Mentally Ill People" (2000) 51 Psychiatric Services 10.

Saving Lives: Alternatives to the Use of Lethal Force by Police – Report of a Conference Held in Toronto (Toronto: Urban Alliance on Race Relations, 2002).

Sentencing of Constable Christopher Hominuk (7583): 64/2010 (2012) (Toronto Police Service Disciplinary Hearings Office).

Sentencing of Sergeant Paul Theriault (3727): 46/2008 (2011) (Toronto Police Service Disciplinary Hearings Office)

Shaamini Yogaretnam, "Police union echoes chief's comments in face of ombudsman's criticisms" *Ottawa Citizen* (7 November 2013)

Shannon Kari, "Retired judge calls for clear taser rules" *Globe and Mail* (5 October, 2013).

Special Investigations Unit, *Annual Report 2011-2012* (Toronto: Special Investigations Unit, 2012).

Special Investigations Unit, *Chief's Administrative Report: Injuries to Mr. Robert Algeo Extract from the Minutes of the TPS Board* (Toronto: Special Investigations Unit, 2009).Taser

Special Investigations Unit, *Conduct Review Procedures for TPS Personnel* (Policy & Procedure Manual) (Toronto: Toronto Police Service, 2013).

Stephanie Franz & Randy Borum, "Crisis Intervention Teams may prevent arrests of people with mental illnesses" (2011) 12 Police Practice and Research 3.

Standing Senate Committee on Social Affairs, Science and Technology, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*, Final Report (Ottawa: Parliament of Canada, 2006).

Systems Improvement through Service Collaboratives, "Terms of Reference: Justice and Mental Health Expert Panel"

"Template Handover Protocol for Patients Brought to ER by Police" (Toronto: Mount Sinai Hospital, 2014).

Teresa C. LaGrange, "The Role of Police Education in Handling Cases of Mental Disorder" (2003) 28:1 Crim. Justice Rev. 88.

Terry Coleman & Dorothy Cotton, *A Study of Police Academy Training and Education for New Police Officers Related to Working with People with Mental Illness* (Toronto: Mental Health Commission of Canada, 2008).

Terry G. Coleman & Dorothy Cotton, *Police Interactions with Persons with a Mental Illness: Police Learning in the Environment of Contemporary Policing* (Ottawa: Mental Health Commission of Canada, 2010).

Terry G. Coleman & Dorothy H. Cotton, "Reducing Risk and Improving Outcomes of Police Interactions with People with Mental Illness" (2010) 10 Journal of Police Crisis Negotiations 1.

The Expert Panel on the Medical and Physiological Impacts of Conducted Energy Weapons, *The Health Effects of Conducted Energy Weapons* (Ottawa, ON: Council of Canadian Academies and Canadian Academy of Health Sciences, 2013)

Thomas J. Aveni, *Obsolescene: The Police Firearms Training Dilemma* (Spofford, NH: The Police Policy Studies Council, 2008).

TNT – Truth ... Not Tasers, online: TruthNotTasers <http://truthnottasers.blogspot.ca>.

Tom Brown, "Proposed taser policy lacks teeth, ACLU says" *VTDigger* (2 December 2013).

Toronto Police College, *In-Service Training Section 2013 Training Program* (Toronto Police College, 2013).

Toronto Police Service, *Background Investigation Process* (Toronto: Toronto Police Service, 2013).

Toronto Police Service, *Communications Services Directives Regarding/Involved EDP's* [*sic*] C.5.5.4, C.6.1.6 (Toronto: Toronto Police Service, 2013).

Toronto Police Service, *Community Consultation on Possible Expansion of Conducted Energy Weapons (CEWs)* (Toronto: Toronto Police Services Board, 2013).

Toronto Police Service, *Coroner's Inquest into the Death of Alwy Al Nadhir* (Toronto: Toronto Police Service, 2010).

Toronto Police Service, *Policy & Procedure Manual*, 08-01 "Employee and Family Assistance Program (EFAP)" (Toronto: Toronto Police Service, 2013).

Toronto Police Service, *Professional Standards Annual Report, 2012* (Toronto Police Service, 2013).

Toronto Police Service, *Summary Data – Test Validity, Psychologist Recommendations, and New Constable Hires, 2012 Calendar Year* (Toronto: Psychological Services, Toronto Police Service, 2013)

Toronto Police Service, *The Police and Community Engagement Review (The PACER Report)*, "Phase II – Internal Report and Recommendations" (Toronto: Toronto Police Services, 2013).

Toronto Police Service, *Use of Force: Final Report* (Toronto: Toronto Police Service, 1998).

Toronto Police Service, *Response to New Organizational Structure: Psychological Services*, "Appendix A: Current Activities – Psychological Services" (Toronto: Toronto Police Service, 2013).

Toronto Police Services Board & Toronto Police Association, *Collective Agreement* (Toronto: Toronto Police Service, 2011).

Toronto Police Services Board, *Annual Report – 2010 Use of Conducted Energy Weapons* (Toronto: Toronto Police Service, 2011).

Toronto Police Services Board, *Mental Health Sub-Committee*, "Background Notes for Presentation to the Toronto Police Services Board: Mental Health Sub-Committee – Background and Overview" (Material presented to the Toronto Police Services Board, 19 April 2012) [unpublished].

Toronto Police Services Board, *Toronto Police Services Board's Mental Health Sub-Committee: Progress Report* (Toronto: Toronto Police Services Board, April 2013).

Tyler Kula, "Eight new conducted-energy weapons to be purchased for $16,000" *Sarnia Observer* (23 January 2014)

Tyler Waldman, "Police Train on Dealing with Mentally Disabled after Taser Incident" *Anne Arundel Patch* (20 September 2013), online: Patch.com <http:// annearundel.patch.com/groups/police-and-fire/p/police-train-on-dealing- with-mentally-disabled?>.

U.K., *Police Use of Taser Statistics, England and Wales, 2009 to 2011* (Home Office, 2013).

U.S., Department of Justice, Kenneth Adams, *et al.*, *Use of Force By Police: Overview of National and Local Data* (Washington, D.C.: National Institute of Justice, 1999).

U.S., Department of Justice, *Police Use of Force, Tasers and Other Less-Lethal Weapons*, (Washington, D.C.: National Institute of Justice, 2011).

U.S., Department of Justice, *Police Use of Force, Tasers and Other Less-Lethal Weapons* (Washington, D.C.: Department of Justice, 2011).

Unit-Specific Policy: Communications Services re Emotionally Disturbed Persons (Toronto: Toronto Police Service, 2011).

Uppala Chandrasekera, *Police & Mental Health: A Critical Review of Joint Police/ Mental Health Collaborations in Ontario* (Ontario Human Services and Justice Coordinating Committee, 2011).

Victim Support, *Police and Mental Health: How to get it right locally* (UK: Victim Support, 2013).

Watson et al. "Improving police response to persons with mental illness: A multi-level conceptualization of CIT" (2008) 31(4) *Int J Law Psychiatry* 359.

William J. Lewinski & Christa Redmann, "New Developments in Understanding the Behavioral Science Factors in the 'Stop Shooting' Response" (2009) 9 Law Enforcement Executive Forum 4.

William L. Harvey, "Mental Illness Responses" *officer.com* (24 February 2014), online: officer.com <http://www.officer.com>.

William P. Bozeman, "Safety and Injury Profile of Conducted Electrical Weapons Used by Law Enforcement Officers Against Criminal Suspects" (2009) 53(4) Annals of Emergency Medicine 480.

William Terrill & Eugene A. Paoline III, "Less Lethal Force Policy and Police Officer Perceptions" (2013)

Documentaries and other video materials provided by stakeholders

Policies and procedures regarding use of force, crisis intervention, mental illness, training and equipment from the following police services:

Canada

- Barrie Police Service
- Brandon Police Service
- Calgary Police Service
- Chatham-Kent Police Service
- City of Kawartha Lakes Police Service
- Halifax Regional Police
- Halton Regional Police Service
- Hamilton Police Service
- Kingston Police
- London Police Service
- Midland Police Service

- North Bay Police Service
- Orangeville Police Service
- Ottawa Police Service
- Regina Police Service
- Saskatoon Police Service
- Sault Ste. Marie Police Service
- Service de police de l'agglomération de Longueuil
- Service de police de la Ville de Laval
- Service de police de la Ville de Montréal
- Shelburne Police Service
- South Coast British Columbia Transportation Authority Police Service
- South Simcoe Police Service
- St. Thomas Police Service (Ontario)
- Stratford Police Service
- Toronto Police Service
- Vancouver Police Department
- Victoria Police Department
- Waterloo Regional Police Service
- Woodstock Police Service

United States

- Arlington Police Department
- Boston Police Department
- Cheektowaga Police Department
- City of Fort Pierce Police Department
- Clearwater Police Department
- Cleveland Division of Police
- Columbus Division of Police
- Denver Police Department
- Department of Public Safety, University of Maryland
- Fairfax County Police Department
- Fort Worth Police Department
- Honolulu Police Department
- Houston Police Department
- Hurst Police Department
- Lafayette Parish Sheriff's Office
- Las Vegas Metropolitan Police Department
- Longmont Police Department
- Louisville Metro Police Department
- Memphis Police Department
- Mesa Police Department
- Metropolitan Nashville Police Department
- Metropolitan Police Department (Washington, D.C.)

- Miami-Dade Police Department
- Minneapolis Police Department
- Montgomery County Department of Police (Maryland)
- New York City Police Department
- Newark Police Department
- Newton Police Department (Massachusetts)
- Norfolk Police Department
- Polk County Sheriff's Office (Florida)
- Prince William County Police Department
- Springfield Police Department (Missouri)
- Stockton Police Department
- Topeka Police Department
- Tucson Police Department
- Village of Glenview Police Department
- Washington State Patrol
- Wilmington Police Department (North Carolina)

APPENDIX C

List of Stakeholders that made Submissions

Appendix C
List of Stakeholders that made Submissions

In addition to the individuals and organizations listed below, three individuals made submissions to the Review on a confidential basis. Their names have been omitted.

1. Across Boundaries
2. Amnesty International Canada
3. ARCH Disability Law Centre
4. Canadian Civil Liberties Association
5. Canadian Mental Health Association
6. Capponi, Pat, Lead Facilitator, Voices from the Street
7. Centre for Addiction and Mental Health
8. Criminal Lawyers Association
9. Falconer, Julian N.; Roy, Julian; Subhan, Junaid, Falconers LLP
10. Family Association for Mental Health Everywhere (FAME)
11. Halifax Regional Police
12. Humber River Hospital
13. International Association of Chiefs of Police
14. Jakobek, Michael
15. Jivani, Jamil
16. MacIsaac, Joanne
17. McMurchy, Monte
18. Mental Health Commission of Canada
19. Ministry of Community Safety and Correctional Services
20. Ministry of Health and Long-Term Care
21. Mood Disorders Association of Ontario

22. Ontario Association of Chiefs of Police
23. Ontario Association of Social Workers
24. Ontario Human Rights Commission
25. Rosenthal, Peter, Lawyer
26. Royal Canadian Mounted Police
27. Russell, Giselle
28. Sanctuary Ministries of Toronto
29. Schizophrenia Society of Ontario
30. Service de police de la Ville de Montréal
31. St. Joseph's Health Centre
32. St. Michael's Hospital
33. The College of Physicians and Surgeons of Ontario
34. The Empowerment Council
35. Toronto East General Hospital
36. Toronto Emergency Medical Services
37. Toronto Police Accountability Coalition
38. Toronto Police Association
39. Trudell, William
40. Vancouver Police Department
41. Wasowicz, Anita

APPENDIX D

Selected Legislative Provisions

Appendix D
Selected Legislative Provisions

Statutes

Criminal Code, R.S.C., 1985, c. C-46, ss. 25(1-5), 26, 27, 30-33.

PROTECTION OF PERSONS ADMINISTERING AND ENFORCING THE LAW

Protection of persons acting under authority

25. (1) Every one who is required or authorized by law to do anything in the administration or enforcement of the law

(a) as a private person,

(b) as a peace officer or public officer,

(c) in aid of a peace officer or public officer,

or

(d) by virtue of his office,

is, if he acts on reasonable grounds, justified in doing what he is required or authorized to do and in using as much force as is necessary for that purpose.

Idem

(2) Where a person is required or authorized by law to execute a process or to carry out a sentence, that person or any person who assists him is, if that person acts in good faith, justified in executing the process or in carrying out the sentence notwithstanding that the process or sentence is defective or that it was issued or imposed without jurisdiction or in excess of jurisdiction.

When not protected

(3) Subject to subsections (4) and (5), a person is not justified for the purposes of subsection (1) in using force that is intended or is likely to cause death or grievous bodily harm unless the person believes on reasonable grounds that it is necessary for the self-preservation of the person or the preservation of any one under that person's protection from death or grievous bodily harm.

When protected

(4) A peace officer, and every person lawfully assisting the peace officer, is justified in using force that is intended or is likely to cause death or grievous bodily harm to a person to be arrested, if

(a) the peace officer is proceeding lawfully to arrest, with or without warrant, the person to be arrested;

(b) the offence for which the person is to be arrested is one for which that person may be arrested without warrant;

(c) the person to be arrested takes flight to avoid arrest;

(d) the peace officer or other person using the force believes on reasonable grounds that the force is necessary for the purpose of protecting the peace officer, the person lawfully assisting the peace officer or any other person from imminent or future death or grievous bodily harm; and

(e) the flight cannot be prevented by reasonable means in a less violent manner.

Power in case of escape from penitentiary

(5) A peace officer is justified in using force that is intended or is likely to cause death or grievous bodily harm against an inmate who is escaping from a penitentiary within the meaning of subsection 2(1) of the *Corrections and Conditional Release Act*, if

(a) the peace officer believes on reasonable grounds that any of the inmates of the penitentiary poses a threat of death or grievous bodily harm to the peace officer or any other person; and

(b) the escape cannot be prevented by reasonable means in a less violent manner.

R.S., 1985, c. C-46, s. 25; 1994, c. 12, s. 1.

Excessive force
26. Every one who is authorized by law to use force is criminally responsible for any excess thereof according to the nature and quality of the act that constitutes the excess.
R.S., c. C-34, s. 26.

Use of force to prevent commission of offence
27. Every one is justified in using as much force as is reasonably necessary

(a) to prevent the commission of an offence

(i) for which, if it were committed, the person who committed it might be arrested without warrant, and

(ii) that would be likely to cause immediate and serious injury to the person or property of anyone; or

(b) to prevent anything being done that, on reasonable grounds, he believes would, if it were done, be an offence mentioned in paragraph (a).

R.S., c. C-34, s. 27.

Preventing breach of peace
30. Every one who witnesses a breach of the peace is justified in interfering to prevent the continuance or renewal thereof and may detain any person who commits or is about to join in or to renew the breach of the peace, for the purpose of giving him into the custody of a peace officer, if he uses no more force than is reasonably necessary to prevent the continuance or renewal of the breach of the peace or than is reasonably proportioned to the danger to be apprehended from the continuance or renewal of the breach of the peace.

R.S., c. C-34, s. 30.

Arrest for breach of peace
31. (1) Every peace officer who witnesses a breach of the peace and every one who lawfully assists the peace officer is justified in arresting any person whom he finds committing the breach of the peace or who, on reasonable grounds, he believes is about to join in or renew the breach of the peace.

Giving person in charge

(2) Every peace officer is justified in receiving into custody any person who is given into his charge as having been a party to a breach of the peace by one who has, or who on reasonable grounds the peace officer believes has, witnessed the breach of the peace.
R.S., c. C-34, s. 31.

SUPPRESSION OF RIOTS

Use of force to suppress riot
32. (1) Every peace officer is justified in using or in ordering the use of as much force as the peace officer believes, in good faith and on reasonable grounds,

(a) is necessary to suppress a riot; and

(b) is not excessive, having regard to the danger to be apprehended from the continuance of the riot.

Person bound by military law
(2) Every one who is bound by military law to obey the command of his superior officer is justified in obeying any command given by his superior officer for the suppression of a riot unless the order is manifestly unlawful.

Obeying order of peace officer
(3) Every one is justified in obeying an order of a peace officer to use force to suppress a riot if

(a) he acts in good faith; and
(b) the order is not manifestly unlawful.

Apprehension of serious mischief
(4) Every one who, in good faith and on reasonable grounds, believes that serious mischief will result from a riot before it is possible to secure the attendance of a peace officer is justified in using as much force as he believes in good faith and on reasonable grounds,
(a) is necessary to suppress the riot; and
(b) is not excessive, having regard to the danger to be apprehended from the continuance of the riot.

Question of law
(5) For the purposes of this section, the question whether an order is manifestly unlawful or not is a question of law.
R.S., c. C-34, s. 32.

Duty of officers if rioters do not disperse
33. (1) Where the proclamation referred to in section 67 has been made or an offence against paragraph 68 (a) or (b) has been committed, it is the duty of a peace officer and of a person who is lawfully required by him to assist, to disperse or to arrest persons who do not comply with the proclamation.

Protection of officers
(2) No civil or criminal proceedings lie against a peace officer or a person who is lawfully required by a peace officer to assist him in respect of any death or injury that by reason of resistance is caused as a result of the performance by the peace officer or that person of a duty that is imposed by subsection (1).

Section not restrictive
(3) Nothing in this section limits or affects any powers, duties or functions that are conferred or imposed by this Act with respect to the suppression of riots.
R.S., c. C-34, s. 33.

Human Rights Code, R.S.O. 1990, c. H.19, s.1.

PART I
FREEDOM FROM DISCRIMINATION

Services

1. Every person has a right to equal treatment with respect to services, goods and facilities, without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability. R.S.O. 1990, c. H.19, s. 1; 1999, c. 6, s. 28 (1); 2001, c. 32, s. 27 (1); 2005, c. 5, s. 32 (1); 2012, c. 7, s. 1.

Mental Health Act, R.S.O. 1990, c. M-7, ss. 1, 15, 16, 17, 20.1(1)(5), 33, 33(3), 33.3.

Definitions
1.(1) In this Act,
"attending physician" means a physician to whom responsibility for the observation, care and treatment of a patient has been assigned; ("médecin traitant")

"Board" means the Consent and Capacity Board continued under the *Health Care Consent Act, 1996*; ("Commission")

"community treatment plan" means a plan described in section 33.7 that is a required part of a community treatment order; ("plan de traitement en milieu communautaire")

"Deputy Minister" means the deputy minister of the Minister; ("sous-ministre")

"health practitioner" has the same meaning as in the *Health Care Consent Act, 1996*; ("praticien de la santé")

"informal patient" means a person who is a patient in a psychiatric facility, having been admitted with the consent of another person under section 24 of the *Health Care Consent Act, 1996*; ("malade en cure facultative")

"involuntary patient" means a person who is detained in a psychiatric facility under a certificate of involuntary admission or a certificate of renewal; ("malade en cure obligatoire")

"local board of health" has the same meaning as board of health in the *Health Protection and Promotion Act*; ("conseil local de santé")

"medical officer of health" has the same meaning as in the *Health Protection and Promotion Act*; ("médecin-hygiéniste")

"mental disorder" means any disease or disability of the mind; ("trouble mental")

"Minister" means the Minister of Health and Long-Term Care or such other member of the Executive Council as the Lieutenant Governor in Council designates; ("ministre")

"Ministry" means the Ministry of the Minister; ("ministère")

"officer in charge" means the officer who is responsible for the administration and management of a psychiatric facility; ("dirigeant responsable")

"out-patient" means a person who is registered in a psychiatric facility for observation or treatment or both, but who is not admitted as a patient and is not the subject of an application for assessment; ("malade externe")

"patient" means a person who is under observation, care and treatment in a psychiatric facility; ("malade")

"personal health information" has the same meaning as in the *Personal Health Information Protection Act, 2004*; ("renseignements personnels sur la santé")

"physician" means a legally qualified medical practitioner and, when referring to a community treatment order, means a legally qualified medical practitioner who meets the qualifications prescribed in the regulations for the issuing or renewing of a community treatment order; ("médecin")

"plan of treatment" has the same meaning as in the *Health Care Consent Act, 1996*; ("plan de traitement")

"prescribed" means prescribed by the regulations; ("prescrit")

"psychiatric facility" means a facility for the observation, care and treatment of persons suffering from mental disorder, and designated as such by the Minister; ("établissement psychiatrique")

"psychiatrist" means a physician who holds a specialist's certificate in psychiatry issued by The Royal College of Physicians and Surgeons of Canada or equivalent qualification acceptable to the Minister; ("psychiatre")

"record of personal health information", in relation to a person, means a record of personal health information that is compiled in a psychiatric facility in respect of the person; ("dossier de renseignements personnels sur la santé")

"regulations" means the regulations made under this Act; ("règlements")

"restrain" means place under control when necessary to prevent serious bodily harm to the patient or to another person by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the physical and mental condition of the patient; ("maîtriser")

"rights adviser" means a person, or a member of a category of persons, qualified to perform the functions of a rights adviser under this Act and designated by a psychiatric facility, the Minister or by the regulations to perform those functions, but does not include,

(a) a person involved in the direct clinical care of the person to whom the rights advice is to be given, or

(b) a person providing treatment or care and supervision under a community treatment plan; ("conseiller en matière de droits")

"senior physician" means the physician responsible for the clinical services in a psychiatric facility; ("médecin-chef")

"substitute decision-maker", in relation to a patient, means the person who would be authorized under the *Health Care Consent Act, 1996* to give or refuse consent to a treatment on behalf of the patient, if the patient were incapable with respect to the treatment under that Act, unless the context requires otherwise; ("mandataire spécial")

"treatment" has the same meaning as in the *Health Care Consent Act, 1996*. ("traitement") R.S.O. 1990, c. M.7, s. 1; 1992, c. 32, s. 20 (1-4); 1996, c. 2, s. 72 (1, 2, 4, 5); 2000, c. 9, s. 1; 2004, c. 3, Sched. A, s. 90 (1-3).

Meaning of "explain"

(2) A rights adviser or other person whom this Act requires to explain a matter satisfies that requirement by explaining the matter to the best of his or her ability and in a manner that addresses the special needs of the person receiving the explanation, whether that person understands it or not. 1992, c. 32, s. 20 (5).

Application for psychiatric assessment

15.(1) Where a physician examines a person and has reasonable cause to believe that the person,

(a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;

(b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or

(c) has shown or is showing a lack of competence to care for himself or herself,

and if in addition the physician is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

(d) serious bodily harm to the person;

(e) serious bodily harm to another person; or

(f) serious physical impairment of the person,

the physician may make application in the prescribed form for a psychiatric assessment of the person. R.S.O. 1990, c. M.7, s. 15 (1); 2000, c. 9, s. 3 (1).

Same

(1.1) Where a physician examines a person and has reasonable cause to believe that the person,

(a) has previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in serious bodily harm to the person or to another person or substantial mental or physical deterioration of the person or serious physical impairment of the person; and

(b) has shown clinical improvement as a result of the treatment, and if in addition the physician is of the opinion that the person,

(c) is apparently suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one;

(d) given the person's history of mental disorder and current mental or physical condition, is likely to cause serious bodily harm to himself or herself or to another person or is likely to suffer substantial mental or physical deterioration or serious physical impairment; and

(e) is incapable, within the meaning of the Health Care Consent Act, 1996, of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decision-maker has been obtained,

the physician may make application in the prescribed form for a psychiatric assessment of the person. 2000, c. 9, s. 3 (2).

Contents of application

(2) An application under subsection (1) or (1.1) shall set out clearly that the physician who signs the application personally examined the person who is the subject of the application and made careful inquiry into all of the facts necessary for him or her to form his or her opinion as to the nature and quality of the mental disorder of the person. R.S.O. 1990, c. M.7, s. 15 (2); 2000, c. 9, s. 3 (3).

Idem

(3) A physician who signs an application under subsection (1) or (1.1),

(a) shall set out in the application the facts upon which he or she formed his or her opinion as to the nature and quality of the mental disorder;

(b) shall distinguish in the application between the facts observed by him or her and the facts communicated to him or her by others; and

(c) shall note in the application the date on which he or she examined the person who is the subject of the application. R.S.O. 1990, c. M.7, s. 15 (3); 2000, c. 9, s. 3 (4).

Signing of application

(4) An application under subsection (1) or (1.1) is not effective unless it is signed by the physician within seven days after he or she examined the person who is the subject of the examination. R.S.O. 1990, c. M.7, s. 15 (4); 2000, c. 9, s. 3 (5).

Authority of application

(5) An application under subsection (1) or (1.1) is sufficient authority for seven days from and including the day on which it is signed by the physician,

(a) to any person to take the person who is the subject of the application in custody to a psychiatric facility forthwith; and

(b) to detain the person who is the subject of the application in a psychiatric facility and to restrain, observe and examine him or her in the facility for not more than 72 hours. R.S.O. 1990, c. M.7, s. 15 (5); 2000, c. 9, s. 3 (6).

Justice of the peace's order for psychiatric examination

16.(1) Where information upon oath is brought before a justice of the peace that a person within the limits of the jurisdiction of the justice,

(a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;

(b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or

(c) has shown or is showing a lack of competence to care for himself or herself,

and in addition based upon the information before him or her the justice of the peace has reasonable cause to believe that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

(d) serious bodily harm to the person;

(e) serious bodily harm to another person; or

(f) serious physical impairment of the person,

the justice of the peace may issue an order in the prescribed form for the examination of the person by a physician. R.S.O. 1990, c. M.7, s. 16 (1); 2000, c. 9, s. 4 (1).

Same

(1.1) Where information upon oath is brought before a justice of the peace that a person within the limits of the jurisdiction of the justice,

(a) has previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in serious bodily harm to the person or to another person or substantial mental or physical deterioration of the person or serious physical impairment of the person; and

(b) has shown clinical improvement as a result of the treatment,

and in addition based upon the information before him or her the justice of the peace has reasonable cause to believe that the person,

(c) is apparently suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one;

(d) given the person's history of mental disorder and current mental or physical condition, is likely to cause serious bodily harm to himself or herself or to another person or is likely to suffer substantial mental or physical deterioration or serious physical impairment; and

(e) is apparently incapable, within the meaning of the Health Care Consent Act, 1996, of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decision-maker has been obtained,

the justice of the peace may issue an order in the prescribed form for the examination of the person by a physician. 2000, c. 9, s. 4 (2).

Idem

(2) An order under this section may be directed to all or any police officers of the locality within which the justice has jurisdiction and shall name or otherwise describe the person with respect to whom the order has been made. R.S.O. 1990, c. M.7, s. 16 (2); 2000, c. 9, s. 4 (3).

Authority of order

(3) An order under this section shall direct, and, for a period not to exceed seven days from and including the day that it is made, is sufficient authority for any police officer to whom it is addressed to take the person named or described therein in custody forthwith to an appropriate place where he or she may be detained for examination by a physician. R.S.O. 1990, c. M.7, s. 16 (3); 2000, c. 9, s. 4 (4).

Manner of bringing information before justice

(4) For the purposes of this section, information shall be brought before a justice of the peace in the prescribed manner. 2000, c. 9, s. 4 (5).

Action by police officer

17. Where a police officer has reasonable and probable grounds to believe that a person is acting or has acted in a disorderly manner and has reasonable cause to believe that the person,

(a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;

(b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or

(c) has shown or is showing a lack of competence to care for himself or herself,

and in addition the police officer is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

(d) serious bodily harm to the person;

(e) serious bodily harm to another person; or

(f) serious physical impairment of the person,

and that it would be dangerous to proceed under section 16, the police officer may take the person in custody to an appropriate place for examination by a physician. 2000, c. 9, s. 5.

Duty of attending physician

20.(1)The attending physician, after observing and examining a person who is the subject of an application for assessment under section 15 or who is the subject of an order under section 32,

(a) shall release the person from the psychiatric facility if the attending physician is of the opinion that the person is not in need of the treatment provided in a psychiatric facility;
(b) shall admit the person as an informal or voluntary patient if the attending physician is of the opinion that the person is suffering from mental disorder of such a nature or quality that the person is in need of the treatment provided in a psychiatric facility and is suitable for admission as an informal or voluntary patient; or
(c) shall admit the person as an involuntary patient by completing and filing with the officer in charge a certificate of involuntary admission if the attending physician is of the opinion that the conditions set out in subsection (1.1) or (5) are met. R.S.O. 1990, c. M.7, s. 20 (1); 2000, c. 9, s. 7 (1).

Conditions for involuntary admission

(5)The attending physician shall complete a certificate of involuntary admission or a certificate of renewal if, after examining the patient, he or she is of the opinion both,

(a) that the patient is suffering from mental disorder of a nature or quality that likely will result in,

(i) serious bodily harm to the patient,

(ii) serious bodily harm to another person, or

(iii) serious physical impairment of the patient, unless the patient remains in the custody of a psychiatric facility; and

(b) that the patient is not suitable for admission or continuation as an informal or voluntary patient. R.S.O. 1990, c. M.7, s. 20 (5); 2000, c. 9, s. 7 (3, 4).

Duty to remain and retain custody

33. A police officer or other person who takes a person in custody to a psychiatric facility shall remain at the facility and retain custody of the person until the facility takes custody of him or her in the prescribed manner. 2000, c. 9, s. 14.

Purposes

(3) The purpose of a community treatment order is to provide a person who suffers from a serious mental disorder with a comprehensive plan of community-based treatment or care and supervision that is less restrictive than being detained in a psychiatric facility. Without limiting the generality of the foregoing, a purpose is to provide such a plan for a person who, as a result of his or her serious mental disorder, experiences this pattern: The person is admitted to a psychiatric facility where his or her condition is usually stabilized; after being released from the facility, the person often stops the treatment or care and supervision; the person's condition changes and, as a result, the person must be re-admitted to a psychiatric facility. 2000, c. 9, s. 15.

Early termination of order for failure to comply

33.3 (1) If a physician who issued or renewed a community treatment order has reasonable cause to believe that the person subject to the order has failed to comply with his or her obligations under subsection 33.1 (9), the physician may, subject to subsection (2), issue an order for examination of the person in the prescribed form. 2000, c. 9, s. 15.

Police Services Act, R.S.O. 1990, c. P-15, ss. 1, 3(2-3), 4(2), 41, 42(1), 43(1), 44(2), 66(1-4)(12), 69(1-2)(4)(8-9), 76(1)(4), 80(1), 83(7-9), 85(1)(5)(7)(9), 89(1)(6), 94(1), 113, 135 (1).

Declaration of principles

1. Police services shall be provided throughout Ontario in accordance with the following principles:

1. The need to ensure the safety and security of all persons and property in Ontario.
2. The importance of safeguarding the fundamental rights guaranteed by the *Canadian Charter of Rights and Freedoms and the Human Rights Code*.
3. The need for co-operation between the providers of police services and the communities they serve.
4. The importance of respect for victims of crime and understanding of their needs.
5. The need for sensitivity to the pluralistic, multiracial and multicultural character of Ontario society.
6. The need to ensure that police forces are representative of the communities they serve. R.S.O. 1990, c. P.15, s. 1.

PART I
RESPONSIBILITY FOR POLICE SERVICES
SOLICITOR GENERAL

Administration of Act

3.(1) REPEALED: 2007, c. 5, s. 2.

Duties and powers of Solicitor General

(2) The Solicitor General shall,

(a) monitor police forces to ensure that adequate and effective police services are provided at the municipal and provincial levels;

(b) monitor boards and police forces to ensure that they comply with prescribed standards of service;

(c) REPEALED: 1995, c. 4, s. 4 (1).

(d) develop and promote programs to enhance professional police practices, standards and training;

(e) conduct a system of inspection and review of police forces across Ontario;

(f) assist in the co-ordination of police services;

(g) consult with and advise boards, community policing advisory committees, municipal chiefs of police, employers of special constables and associations on matters relating to police and police services;

(h) develop, maintain and manage programs and statistical records and conduct research studies in respect of police services and related matters;

(i) provide to boards, community policing advisory committees and municipal chiefs of police information and advice respecting the management and operation of police forces, techniques in handling special problems and other information calculated to assist;

(j) issue directives and guidelines respecting policy matters;

(k) develop and promote programs for community-oriented police services;

(l) operate the Ontario Police College. R.S.O. 1990, c. P.15, s. 3 (2); 1995, c. 4, s. 4 (1); 1997, c. 8, s. 2 (2, 3).

Ontario Police College continued

(3) The police college known as the Ontario Police College for the training of members of police forces is continued. R.S.O. 1990, c. P.15, s. 3 (3).

Core police services

4. (2) Adequate and effective police services must include, at a minimum, all of the following police services:

1. Crime prevention.
2. Law enforcement.
3. Assistance to victims of crime.
4. Public order maintenance.
5. Emergency response. 1997, c. 8, s. 3

PART IV
POLICE OFFICERS AND OTHER POLICE STAFF
CHIEF OF POLICE

Duties of chief of police

41.(1) The duties of a chief of police include,

(a) in the case of a municipal police force, administering the police force and overseeing its operation in accordance with the objectives, priorities and policies established by the board under subsection 31 (1);

(b) ensuring that members of the police force carry out their duties in accordance with this Act and the regulations and in a manner that reflects the needs of the community, and that discipline is maintained in the police force;

(c) ensuring that the police force provides community-oriented police services;

(d) administering the complaints system in accordance with Part V. R.S.O. 1990, c. P.15, s. 41 (1); 1995, c. 4, s. 4 (8, 9); 1997, c. 8, s. 27.

Power to disclose personal information

(1.1) Despite any other Act, a chief of police, or a person designated by him or her for the purpose of this subsection, may disclose personal information about an individual in accordance with the regulations. 1997, c. 17, s. 9.

Purpose of disclosure

(1.2) Any disclosure made under subsection (1.1) shall be for one or more of the following purposes:

1. Protection of the public.
2. Protection of victims of crime.
3. Keeping victims of crime informed of the law enforcement, judicial or correctional processes relevant to the crime that affected them.
4. Law enforcement.
5. Correctional purposes.
6. Administration of justice.
7. Enforcement of and compliance with any federal or provincial Act, regulation or government program.
8. Keeping the public informed of the law enforcement, judicial or correctional processes respecting any individual. 1997, c. 17, s. 9.

Same

(1.3) Any disclosure made under subsection (1.1) shall be deemed to be in compliance with clauses 42 (1) (e) of the Freedom of Information and Protection of Privacy Act and 32 (e) of the Municipal Freedom of Information and Protection of Privacy Act. 1997, c. 17, s. 9; 2006, c. 34, Sched. C, s. 27.

Same

(1.4) If personal information is disclosed under subsection (1.1) to a ministry, agency or institution, the ministry, agency or institution shall collect such information and subsections 39 (2) of the Freedom of Information and Protection of Privacy Act and 29 (2) of the Municipal Freedom of Information and Protection of Privacy Act do not apply to that collection of personal information. 1997, c. 17, s. 9.

Chief of police reports to board

(2) The chief of police reports to the board and shall obey its lawful orders and directions. R.S.O. 1990, c. P.15, s. 41 (2).

POLICE OFFICERS

Duties of police officer

42.(1) The duties of a police officer include,

(a) preserving the peace;

(b) preventing crimes and other offences and providing assistance and encouragement to other persons in their prevention;

(c) assisting victims of crime;

(d) apprehending criminals and other offenders and others who may lawfully be taken into custody;

(e) laying charges and participating in prosecutions;

(f) executing warrants that are to be executed by police officers and performing related duties;

(g) performing the lawful duties that the chief of police assigns;

(h) in the case of a municipal police force and in the case of an agreement under section 10 (agreement for provision of police services by O.P.P.), enforcing municipal by-laws;

(i) completing the prescribed training. R.S.O. 1990, c. P.15, s. 42 (1); 1997, c. 8, s. 28.

Criteria for hiring

43.(1) No person shall be appointed as a police officer unless he or she,

(a) is a Canadian citizen or a permanent resident of Canada;

(b) is at least eighteen years of age;

(c) is physically and mentally able to perform the duties of the position, having regard to his or her own safety and the safety of members of the public;

(d) is of good moral character and habits; and

(e) has successfully completed at least four years of secondary school education or its equivalent. R.S.O. 1990, c. P.15, s. 43 (1).

Time for completing initial training

44.(2) The police officer shall complete the initial period of training within six months of the day of appointment. R.S.O. 1990, c. P.15, s. 44 (1, 2).

Complaints about police officer's conduct

66.(1) The chief of police shall cause every complaint referred to him or her by the Independent Police Review Director under clause 61 (5) (a) to be investigated and the investigation to be reported on in a written report. 2007, c. 5, s. 10.

Unsubstantiated complaint

(2) If at the conclusion of the investigation and on review of the written report submitted to him or her the chief of police is of the opinion that the complaint is unsubstantiated, the chief of police shall take no action in response to the complaint and shall notify the complainant, the police officer who is the subject of the complaint and the Independent Police Review Director, in writing, together with a copy of the written report, of the decision and of the complainant's right under subsection 71 (1) to ask the Independent Police Review Director to review the decision within 30 days of receiving the notice. 2007, c. 5, s. 10.

Hearing to be held

(3) Subject to subsection (4), if at the conclusion of the investigation and on review of the written report submitted to him or her the chief of police believes on reasonable grounds that the police officer's conduct constitutes misconduct as defined in section 80 or unsatisfactory work performance, he or she shall hold a hearing into the matter. 2007, c. 5, s. 10.

Informal resolution

(4) If at the conclusion of the investigation and on review of the written report submitted to him or her the chief of police is of the opinion that there was misconduct or unsatisfactory work performance but that

it was not of a serious nature, the chief of police may resolve the matter informally without holding a hearing, if the police officer and the complainant consent to the proposed resolution. 2007, c. 5, s. 10.

Employment record expunged
(12) An entry made in the police officer's employment record under paragraph 2 of subsection (10) shall be expunged from the record two years after being made if during that time no other entries concerning misconduct or unsatisfactory work performance have been made in the record under this Part. 2007, c. 5, s. 10.

Complaints about municipal chief's, municipal deputy chief's conduct
69.(1) The board shall review every complaint referred to it by the Independent Police Review Director under subsection 61 (8). 2007, c. 5, s. 10.

Investigation by Independent Police Review Director
(2) If at the conclusion of the review the board is of the opinion that the conduct of the chief of police or deputy chief of police who is the subject of the complaint may constitute an offence under a law of Canada or of a province or territory, or misconduct as defined in section 80 or unsatisfactory work performance, the board shall ask the Independent Police Review Director to cause the complaint to be investigated and the investigation to be reported on in a written report. 2007, c. 5, s. 10.

Notice, no action taken
(4) If at the conclusion of the review the board is of the opinion that the conduct of the chief of police or deputy chief of police who is the subject of the complaint is not of a type described in subsection (2), the board shall take no action in response to the complaint and shall notify the complainant, the chief of police or deputy chief of police and the Independent Police Review Director in writing of the decision, with reasons. 2007, c. 5, s. 10.

Board or Commission to hold hearing
(8) Subject to subsection (9), the board shall hold a hearing into a matter referred to it under subsection (6) or may refer the matter to the Commission to hold the hearing. 2007, c. 5, s. 10.

Informal resolution
(9) If on a review of the written report the board is of the opinion that there was misconduct or unsatisfactory work performance but that it was not of a serious nature, the board may resolve the matter informally without holding a hearing if the chief of police or deputy chief of police and the complainant consent to the proposed resolution. 2007, c. 5, s. 10.

INTERNAL COMPLAINTS

Complaints by chief
76.(1) A chief of police may make a complaint under this section about the conduct of a police officer employed by his or her police force, other than the deputy chief of police, and shall cause the complaint to be investigated and the investigation to be reported on in a written report. 2007, c. 5, s. 10; 2009, c. 30, s. 57.

Investigation assigned to another police force
(4) A municipal chief of police may, with the approval of the board and on written notice to the Commission, ask the chief of police of another police force to cause the complaint to be investigated and to report, in writing, back to him or her at the expense of the police force to which the complaint relates. 2007, c. 5, s. 10.

MISCONDUCT

Misconduct
80.(1) A police officer is guilty of misconduct if he or she,

(a) commits an offence described in a prescribed code of conduct;

(b) contravenes section 46 (political activity);

(c) engages in an activity that contravenes subsection 49 (1) (secondary activities) without the permission of his or her chief of police or, in the case of a municipal chief of police, without the permission of the board, being aware that the activity may contravene that subsection;

(d) contravenes subsection 55 (5) (resignation during emergency);
(e) commits an offence described in subsection 79 (1) or (2) (offences, complaints);
(f) contravenes section 81 (inducing misconduct, withholding services);
(g) contravenes section 117 (trade union membership);
(h) deals with personal property, other than money or a firearm, in a manner that is not consistent with section 132;
(i) deals with money in a manner that is not consistent with section 133;
(j) deals with a firearm in a manner that is not consistent with section 134;
(k) contravenes a regulation made under paragraph 15 (equipment), 16 (use of force), 17 (standards of dress, police uniforms), 20 (police pursuits) or 21 (records) of subsection 135 (1). 2007, c. 5, s. 10.

Non-compellability
83.(7) No person shall be required to testify in a civil proceeding with regard to information obtained in the course of his or her duties under this Part, except at a hearing held under this Part. 2007, c. 5, s. 10.

Inadmissibility of documents
(8) No document prepared as the result of a complaint made under this Part is admissible in a civil proceeding, except at a hearing held under this Part. 2007, c. 5, s. 10.

Inadmissibility of statements
(9) No statement made during an attempt at informal resolution of a complaint under this Part is admissible in a civil proceeding, including a proceeding under subsection 66 (10), 69 (12), 76 (12) or 77 (9), or a hearing under this Part, except with the consent of the person who made the statement. 2007, c. 5, s. 10.

Powers at conclusion of hearing by chief of police, board or Commission
85.(1) Subject to subsection (4), the chief of police may, under subsection 84 (1),
(a) dismiss the police officer from the police force;
(b) direct that the police officer be dismissed in seven days unless he or she resigns before that time;
(c) demote the police officer, specifying the manner and period of the demotion;
(d) suspend the police officer without pay for a period not exceeding 30 days or 240 hours, as the case may be;
(e) direct that the police officer forfeit not more than three days or 24 hours pay, as the case may be;
(f) direct that the police officer forfeit not more than 20 days or 160 hours off, as the case may be; or
(g) impose on the police officer any combination of penalties described in clauses (c), (d), (e) and (f). 2007, c. 5, s. 10.

Calculation of penalties
(5) Penalties imposed under clauses (1) (d), (e) and (f) and (2) (d), (e) and (f) shall be calculated in terms of days if the chief of police, deputy chief of police or other police officer normally works eight hours a day or less and in terms of hours if he or she normally works more than eight hours a day. 2007, c. 5, s. 10.

Additional powers
(7) In addition to or instead of a penalty described in subsection (1) or (2), the chief of police or board, as the case may be, may under subsection 84 (1) or (2),

(a) reprimand the chief of police, deputy chief of police or other police officer;
(b) direct that the chief of police, deputy chief of police or other police officer undergo specified counselling, treatment or training;
(c) direct that the chief of police, deputy chief of police or other police officer participate in a specified program or activity;
(d) take any combination of actions described in clauses (a), (b) and (c). 2007, c. 5, s. 10.

Employment record
(9) The chief of police or board, as the case may be, may cause an entry concerning the matter, the action taken and the reply of the chief of police, deputy chief of police or other police officer against whom the action is taken, to be made in his or her employment record, but no reference to the allegations of the complaint or the hearing shall be made in the employment record, and the matter shall not be taken into account for any purpose relating to his or her employment unless,

(a) misconduct as defined in section 80 or unsatisfactory work performance is proved on clear and convincing evidence; or

(b) the chief of police, deputy chief of police or other police officer resigns before the matter is finally disposed of. 2007, c. 5, s. 10.

SUSPENSION

Suspension
89. (1) If a police officer, other than a chief of police or deputy chief of police, is suspected of or charged with an offence under a law of Canada or of a province or territory or is suspected of misconduct as defined in section 80, the chief of police may suspend him or her from duty with pay. 2007, c. 5, s. 10.

Suspension without pay
(6) If a chief of police, deputy chief of police or other police officer is convicted of an offence and sentenced to a term of imprisonment, the chief of police or board, as the case may be, may suspend him or her without pay, even if the conviction or sentence is under appeal. 2007, c. 5, s. 10.

Delegation of chief's powers and duties
94.(1) A chief of police may delegate the following powers and duties to a police officer or a former police officer of the rank of inspector or higher, a judge or retired judge, or such other person as may be prescribed:

1. Conducting a hearing under subsection 66 (3), 68 (5) or 76 (9) and taking an action under subsection 84 (1), if that subsection applies.

2. Acting under subsections 66 (4) and (10), subsection 68 (6) or subsections 76 (10) and (12). 2007, c. 5, s. 10.

PART VII
SPECIAL INVESTIGATIONS

Special investigations unit
113. (1) There shall be a special investigations unit of the Ministry of the Solicitor General. R.S.O. 1990, c. P.15, s. 113 (1).

Composition
(2) The unit shall consist of a director appointed by the Lieutenant Governor in Council on the recommendation of the Solicitor General and investigators appointed under Part III of the Public Service of Ontario Act, 2006. R.S.O. 1990, c. P.15, s. 113 (2); 2006, c. 35, Sched. C, s. 111 (4).

Idem
(3) A person who is a police officer or former police officer shall not be appointed as director, and persons who are police officers shall not be appointed as investigators. R.S.O. 1990, c. P.15, s. 113 (3).

Acting director
(3.1) The director may designate a person, other than a police officer or former police officer, as acting director to exercise the powers and perform the duties of the director if the director is absent or unable to act. 2009, c. 33, Sched. 2, s. 60 (3).

Peace officers
(4) The director, acting director and investigators are peace officers. R.S.O. 1990, c. P.15, s. 113 (4); 2009, c. 33, Sched. 2, s. 60 (4).

Investigations
(5) The director may, on his or her own initiative, and shall, at the request of the Solicitor General or Attorney General, cause investigations to be conducted into the circumstances of serious injuries and deaths that may have resulted from criminal offences committed by police officers. R.S.O. 1990, c. P.15, s. 113 (5).

Restriction
(6) An investigator shall not participate in an investigation that relates to members of a police force of which he or she was a member. R.S.O. 1990, c. P.15, s. 113 (6).

Charges
(7) If there are reasonable grounds to do so in his or her opinion, the director shall cause informations to be laid against police officers in connection with the matters investigated and shall refer them to the Crown Attorney for prosecution. R.S.O. 1990, c. P.15, s. 113 (7).

Report
(8) The director shall report the results of investigations to the Attorney General. R.S.O. 1990, c. P.15, s. 113 (8).

Co-operation of police forces
(9) Members of police forces shall co-operate fully with the members of the unit in the conduct of investigations. R.S.O. 1990, c. P.15, s. 113 (9).

Co-operation of appointing officials
(10) Appointing officials shall co-operate fully with the members of the unit in the conduct of investigations. 2009, c. 30, s. 60.

Regulations
135.(1) The Lieutenant Governor in Council may make regulations,

1. prescribing standards for police services;

1.1 establishing and governing standards concerning the adequacy and effectiveness of police services, including prescribing methods for monitoring and evaluating the adequacy and effectiveness of police services against such standards;

2. prescribing procedures for the inspection and review by the Solicitor General of police forces;

3. requiring municipalities to provide police detention facilities, governing those facilities and providing for their inspection;

4. providing for financial aid to police training schools;

4.1 prescribing additional powers and duties of the Independent Police Review Director;

5. prescribing the minimum amount of remuneration to be paid by municipalities to the members of boards who are appointed by the Lieutenant Governor in Council or Solicitor General;

6. prescribing the procedures to be followed by boards and the places at which their meetings shall be held;

6.1 governing the selection and appointment of members of boards;

6.2 prescribing courses of training for members of boards and prescribing standards in that connection;

6.3 prescribing a code of conduct for members of boards;

7. prescribing the forms of oaths or affirmations of office and secrecy for the purposes of section 32 (members of boards), section 45 (police officers), subsection 52 (6) (auxiliary members of police forces), subsection 53 (9) (special constables) and subsection 54 (8) (First Nations Constables);

8. respecting the government, operation and administration of police forces;

9. governing the qualifications for the appointment of persons to police forces and for their promotion;

10. prescribing the method for determining the amounts owed by municipalities for police services provided by the Ontario Provincial Police under section 5.1, prescribing the time when and manner in which the payments are to be made, (and, for such purposes, classifying municipalities and prescribing different methods, different times or different manners for different classes of municipalities), prescribing the interest, or the method of determining the interest, owed on late payments and governing payment credits and refunds for overpayments;

11. requiring territories without municipal organization to pay for police services provided by the Ontario Provincial Police and,

i. governing the determination of the amounts payable for those services,

ii. governing the payment of those amounts, including providing for the calculation and payment of interest and penalties,

iii. governing the collection of those amounts, including providing for payment credits and refunds for overpayments, or providing that all or part of those amounts may be collected under the Provincial Land Tax Act, 2006 as if they were taxes imposed under that Act, and

iv. for the purposes described in subparagraphs i, ii and iii, establishing different requirements for different classes of territories;

12. respecting the political activities in which municipal police officers are permitted to engage;

13. establishing the ranks that shall be held by members of municipal police forces;

14. prescribing the minimum salary or other remuneration and allowances to be paid to members of municipal police forces;

14.1 providing for the granting of service badges to members of the Ontario Provincial Police or any class thereof and for the payment of allowances to those members who are granted service badges;

15. regulating or prohibiting the use of any equipment by a police force or any of its members;

16. regulating the use of force by members of police forces;

17. prescribing standards of dress for police officers on duty and prescribing requirements respecting police uniforms;

18. prescribing courses of training for members of police forces and prescribing standards in that connection;

19. governing the conduct, duties, suspension and dismissal of members of police forces;

20. describing the circumstances under which members of police forces are permitted and not permitted to pursue persons by means of motor vehicles, and prescribing procedures that shall be followed when a person is pursued in that manner;

20.1 prescribing the nature of the information that may be disclosed under subsection 41 (1.1) by a chief of police or a person designated by a chief of police, to whom it may be disclosed and the circumstances in which it may be disclosed;

21. prescribing the records, returns, books and accounts to be kept by police forces and boards and their members;

22. prescribing the method of accounting for fees and costs that come into the hands of members of police forces;

23. prescribing a complaints process for the making of a complaint by a member of the public to a chief of police or his or her delegate, including but not limited to,

i. setting out conditions in respect of the complaint, and

ii. setting out limits respecting complaints made by the member of the public to the Independent Police Review Director under Part V in respect of the same matter;

23.1 REPEALED: 2007, c. 5, s. 12 (2).

24. establishing procedural rules for anything related to the powers, duties or functions of the Independent Police Review Director under Part V;

24.1 establishing regional or other advisory committees consisting of representatives from community groups, representatives from the policing community and any other persons who may be prescribed, for the purpose of advising the Independent Police Review Director on matters relating to his or her duties under subsection 58 (4), and respecting the appointment of such representatives and other persons to the committees;

25. defining “frivolous or vexatious” and “made in bad faith” for the purposes of paragraph 1 of subsection 60 (4);

26. prescribing a code of conduct in which offences constituting misconduct are described for the purposes of section 80;

26.1 respecting the application of Part V, with such modifications as may be specified in the regulation, to a police officer in the circumstances referred to in subsection 90 (3);

26.2 prescribing additional persons or classes of persons for the purposes of subsection 94 (1);

26.3 prescribing qualifications, conditions or requirements, if any, for the purposes of subsection 94 (2), including prescribing different qualifications, conditions or requirements for different

persons or classes of persons, and exempting persons or classes of persons from specified qualifications, conditions or requirements;

26.4 governing procedures, conditions or requirements for the investigation of complaints under Part V;

26.5 providing for the payment of fees and expenses to witnesses at hearings conducted under Part V;

27. prescribing the method of accounting for money to which section 133 applies;

28. prescribing forms and providing for their use;

29. prescribing any matter that this Act requires to be prescribed or refers to as being prescribed;

30. respecting any matter that is necessary or advisable to implement this Act effectively. R.S.O. 1990, c. P.15, s. 135 (1); 1995, c. 4, s. 4 (11); 1997, c. 8, s. 40; 1997, c. 17, s. 10; 2006, c. 33, Sched. Z.3, s. 27; 2007, c. 5, s. 12 (1, 2).

Conflict

(1.1) In the event of a conflict between a rule established by a regulation made under paragraph 24 of subsection (1) and a rule established by the Independent Police Review Director under clause 56 (1) (a), the rule established by regulation prevails. 2007, c. 5, s. 12 (3).

Same

(1.2) In the event of a conflict between a procedure, condition or requirement made under paragraph 26.4 of subsection (1) and a procedural rule or guideline established by the Independent Police Review Director under clause 56 (1) (b), the procedure, condition or requirement made by regulation prevails. 2007, c. 5, s. 12 (3).

Regulations

Adequacy and Effectiveness of Police Services, O. Reg. 3/99, ss. 3, 10, 13(1), 29.

CRIME PREVENTION

3. Every chief of police shall establish procedures and processes on problem-oriented policing and crime prevention initiatives, whether the police force provides community-based crime prevention initiatives or whether crime prevention initiatives are provided by another police force or on a combined or regional or co-operative basis or by another organization. O. Reg. 3/99, s. 3.

LAW ENFORCEMENT

10. Every chief of police shall,

(a) ensure that there is supervision available to members of the police force 24 hours a day;

(b) establish procedures and processes on supervision, including setting out circumstances where a supervisor must be contacted and when a supervisor must be present at an incident; and

(c) ensure that the police force's supervisors have the knowledge, skills and abilities to supervise. O. Reg. 3/99, s. 10.

13.(1) Every chief of police shall establish procedures and processes in respect of,

(a) internal task forces;
(b) joint forces operations;
(c) criminal intelligence;
(d) crime, call and public disorder analysis;
(e) informants and agents;
(f) witness protection and security;
(g) police response to persons who are emotionally disturbed or have a mental illness or a developmental disability;
(h) search of the person;
(i) search of premises;
(j) arrest;
(k) bail and violent crime;
(l) prisoner care and control;
(m) prisoner transportation; and
(n) property and evidence control. O. Reg. 3/99, s. 13 (1).

ADMINISTRATION AND INFRASTRUCTURE

29. Every board shall establish policies with respect to the matters referred to in section 3, subsections 4 (3) and 6 (3), section 8, subsection 9 (4), sections 10 to 17, 19, 20, 22, subsection 24 (2) and sections 25 to 28. O. Reg. 3/99, s. 29.

Police Services Act
ONTARIO REGULATION 268/10
GENERAL
CONTENTS

PART I- OATHS AND AFFIRMATIONS
1. Member of the board
2. Police officer, etc.
3. Auxiliary member of a police force
4. Secrecy

PART II -REMUNERATION OF POLICE SERVICES BOARDS MEMBERS
5. Remuneration

PART III - MUNICIPAL POLICE FORCES
APPLICATION
6. Application
UNIFORM AND RANKS
7. Providing uniform and equipment
8. Ranks
9. Insignias
10. Service badges
POLITICAL ACTIVITY
11. Political rights
12. Activities while not on duty
13. Authorized activities
14. Appointments, etc.
15. Application
16. Candidacy for election
17. Resignation upon election
18. Effect of absence on length of service
FORFEITURE OF PAY
19. Forfeiture of pay

PART IV- ONTARIO PROVINCIAL POLICE
20. Definition
21. Application
22. Providing uniform and equipment
23. Political activity
24. No contracting debts
25. Forfeiture of pay
26. Notice of resignation

PART V - DUTIES OF POLICE OFFICERS
27. Preparing informations

PART VI - UNSATISFACTORY WORK PERFORMANCE
28. Application
29. Assessment of performance

PART VII - CODE OF CONDUCT
30. Code of conduct
Schedule
Code of conduct

PART I
OATHS AND AFFIRMATIONS

Member of the board

1. The oath or affirmation of office to be taken by a member of the board shall be in one of the following forms set out in the English or French version of this section:

I solemnly swear (affirm) that I will be loyal to Her Majesty the Queen and to Canada, and that I will uphold the Constitution of Canada and that I will, to the best of my ability, discharge my duties as a member of the (*insert name of municipality*) Police Services Board faithfully, impartially and according to the Police Services Act, any other Act, and any regulation, rule or by-law.

So help me God. (*Omit this line in an affirmation.*)

or

I solemnly swear (affirm) that I will be loyal to Canada, and that I will uphold the Constitution of Canada and that I will, to the best of my ability, discharge my duties as a member of the (*insert name of municipality*) Police Services Board faithfully, impartially and according to the *Police Services Act*, any other Act, and any regulation, rule or by-law.

So help me God. (*Omit this line in an affirmation.*)

O. Reg. 268/10, s. 1.

Police officer, etc.

2. The oath or affirmation of office to be taken by a police officer, special constable or First Nations Constable shall be in one of the following forms set out in the English or French version of this section:

I solemnly swear (affirm) that I will be loyal to Her Majesty the Queen and to Canada, and that I will uphold the Constitution of Canada and that I will, to the best of my ability, preserve the peace, prevent offences and discharge my other duties as (*insert name of office*) faithfully, impartially and according to law.

So help me God. (*Omit this line in an affirmation.*)

or

I solemnly swear (affirm) that I will be loyal to Canada, and that I will uphold the Constitution of Canada and that I will, to the best of my ability, preserve the peace, prevent offences and discharge my other duties as (*insert name of office*) faithfully, impartially and according to law.

So help me God. (*Omit this line in an affirmation.*)

O. Reg. 268/10, s. 2.

Auxiliary member of a police force

3. The oath or affirmation of office to be taken by an auxiliary member of a police force shall be in one of the following forms set out in the English or French version of this section:

I solemnly swear (affirm) that I will be loyal to Her Majesty the Queen and to Canada, and that I will uphold the Constitution of Canada and that, when authorized to perform police duties by the chief of police, I will discharge my duties as an auxiliary member of the (insert name of police force) faithfully, impartially and according to law.

So help me God. (*Omit this line in an affirmation.*)

or

I solemnly swear (affirm) that I will be loyal to Canada, and that I will uphold the Constitution of Canada and that, when authorized to perform police duties by the chief of police, I will discharge my duties as an auxiliary member of the (insert name of police force) faithfully, impartially and according to law.

So help me God. (*Omit this line in an affirmation.*)

O. Reg. 268/10, s. 3.

Secrecy

4. The oath or affirmation of secrecy to be taken by a police officer, auxiliary member of a police force, special constable or First Nations Constable shall be in the following form set out in the English or French version of this section:

I solemnly swear (affirm) that I will not disclose any information obtained by me in the course of my duties as (insert name of office), except as I may be authorized or required by law.

So help me God. (Omit this line in an affirmation.)

O. Reg. 268/10, s. 4.

PART II
REMUNERATION OF POLICE SERVICES BOARDS MEMBERS

Remuneration

5. A municipality shall pay to each board member who is appointed by the Lieutenant Governor in Council or the Solicitor General,

(a) in a municipality having a population exceeding 500,000 according to the last revised assessment roll, not less than $1,000 a year;

(b) in a municipality having a population exceeding 100,000 and not exceeding 500,000 according to the last revised assessment roll, not less than $500 a year;

(c) in a municipality having a population exceeding 10,000 and not exceeding 100,000 according to the last revised assessment roll, not less than $300 a year;

(d) in a municipality whose population does not exceed 10,000 according to the last revised assessment roll, not less than $100 a year. O. Reg. 268/10, s. 5.

PART III
MUNICIPAL POLICE FORCES

APPLICATION

Application

6. (1) This Part applies to municipal police forces. O. Reg. 268/10, s. 6 (1).

(2) This Part does not apply to insignias or service badges in use or operation on or before January 1, 1974. O. Reg. 268/10, s. 6 (2).

UNIFORM AND RANKS

Providing uniform and equipment

7. The municipality shall provide all articles of uniform and equipment necessary for the performance of duty but, if a uniform or equipment is damaged or lost through the fault of a member of a police force, the member shall bear the cost of replacement. O. Reg. 268/10, s. 7.

Ranks

8. (1) Subject to subsections (2) and (3), every force may have all or any of the following police ranks, but no others:

Chief of Police
Deputy Chief
Staff Superintendent
Superintendent
Staff Inspector
Inspector
Staff Sergeant
Sergeant
Constable

O. Reg. 268/10, s. 8 (1).

(2) If a force has a detective branch, detective sergeant is equivalent to the rank of staff sergeant and detective is equivalent to sergeant. O. Reg. 268/10, s. 8 (2).

(3) The rank of constable shall have the following gradations in descending seniority:

First-Class Constable
Second-Class Constable

Third-Class Constable
Fourth-Class Constable

O. Reg. 268/10, s. 8 (3).

(4) A fourth-class constable is eligible for reclassification as a third-class constable after serving one year as a fourth-class constable. O. Reg. 268/10, s. 8 (4).

(5) A third-class constable is eligible for reclassification as a second-class constable after serving one year as a third-class constable. O. Reg. 268/10, s. 8 (5).

(6) A second-class constable is eligible for reclassification as a first class constable after serving one year as a second-class constable. O. Reg. 268/10, s. 8 (6).

(7) In the case of outstanding or meritorious service, any of the one-year periods mentioned in subsections (4), (5) and (6) may be abridged. O. Reg. 268/10, s. 8 (7).

Insignias

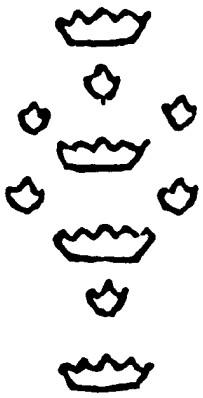
9. (1) The following ranks shall wear on their shoulder straps the insignia described and illustrated opposite the rank:

Chief of Police
— Crown and Three Maple Leaves

Deputy Chief
— Crown and Two Maple Leaves

Staff Superintendent
— Crown and One Maple Leaf

Superintendent
— Crown



Staff Inspector
— Three Maple Leaves

Inspector
— Two Maple Leaves

O. Reg. 268/10, s. 9 (1).

(2) The following ranks shall wear on their shoulder straps or on the upper part of each sleeve in the discretion of the chief of police the insignia described and illustrated opposite the rank:

Staff Sergeant
— Crown and Three Chevrons

Sergeant
— Three Chevrons

O. Reg. 268/10, s. 9 (2).

(3) The following ranks shall wear on their headgear the insignia described opposite the rank:

Chief of Police	—	A double row of embroidered oakleaf pattern gold braid affixed to the peak; black simulated patent leather strap.
Deputy Chief	—	A single row of embroidered oakleaf pattern gold braid affixed to the peak; black simulated patent leather strap.
Staff Superintendent	—	5/8 inch gold embroidered braid of field officer pattern affixed to the peak; black simulated patent leather strap.
Superintendent	—	5/8 inch gold embroidered braid of field officer pattern affixed to the peak; black simulated patent leather strap.
Staff Inspector	—	5/8 inch black embroidered braid of field officer pattern trimmed all round with gold cord affixed to the peak; black simulated patent leather strap.
Inspector	—	5/8 inch black embroidered braid of field officer pattern trimmed all round with gold cord affixed to the peak; black simulated patent leather strap.

O. Reg. 268/10, s. 9 (3).

(4) If shoulder flashes or other insignia are worn, they shall be silver in colour from the rank of staff sergeant and below and gold in colour from the rank of inspector and higher. O. Reg. 268/10, s. 9 (4).

Service badges

10. If a service badge is awarded, it shall be in the shape of a maple leaf one-half of one inch by one-half of one inch and shall be worn on the left sleeve of the tunic three and one-half inches up from the bottom. O. Reg. 268/10, s. 10.

POLITICAL ACTIVITY

Political rights

11. A municipal police officer may,

(a) vote in an election;

(b) be a member of or hold office in a political party or other organization engaged in political activity;

(c) make contributions of money or goods to,

(i) a political party or other organization engaged in political activity, or

(ii) a candidate in an election. O. Reg. 268/10, s. 11.

Activities while not on duty

12. (1) A municipal police officer who is not on duty and who is not in uniform may engage in the following political activities:

1. Expressing views on any issue not directly related to the police officer's responsibilities as a police officer, as long as the police officer does not,

i. associate his or her position as a police officer with the views, or

ii. represent the views as those of a police force.

2. Attending and participating in a public meeting, including,

i. a meeting with elected representatives or government officials, or

ii. a meeting with candidates in an election.

3. Attending and participating in a meeting or convention of a political party or other organization engaged in political activity.

4. Canvassing on behalf of a political party or other organization engaged in political activity, or on behalf of a candidate in an election, as long as the police officer does not solicit or receive funds on behalf of the party, organization or candidate.

5. Acting as a scrutineer for a candidate in an election.

6. On the polling day of an election, transporting electors to a polling place on behalf of a candidate.

7. Engaging in any other political activity, other than,

i. soliciting or receiving funds, or

ii. political activity that places or is likely to place the police officer in a position of conflict of interest. O. Reg. 268/10, s. 12 (1).

(2) The expression of views in the course of an activity mentioned in paragraphs 2 to 7 of subsection (1) is subject to paragraph 1 of that subsection. O. Reg. 268/10, s. 12 (2).

Authorized activities

13. If authorized to do so by the police services board or chief of police, a municipal police officer may, on behalf of the police force,

(a) express views on any issue, as long as the police officer does not, during an election campaign, express views supporting or opposing,

(i) a candidate in the election or a political party that has nominated a candidate in the election, or

(ii) a position taken by a candidate in the election or by a political party that has nominated a candidate in the election; and

(b) subject to clause (a), attend and participate in a public meeting. O. Reg. 268/10, s. 13.

Appointments, etc.

14. (1) Subject to subsection (2), a municipal police officer may,

(a) be appointed to or be a candidate for election to a local board as defined in the *Municipal Affairs Act*, other than a police services board;

(b) serve on a local board as defined in the *Municipal Affairs Act*, other than a police services board; and

(c) engage in political activity related to the appointment, candidacy or service mentioned in clause (a) or (b). O. Reg. 268/10, s. 14 (1).

(2) Subsection (1) does not apply if the appointment, candidacy or service,

(a) interferes with the police officer's duties as a police officer; or

(b) places or is likely to place the police officer in a position of conflict of interest. O. Reg. 268/10, s. 14 (2).

Application

15. Sections 16, 17 and 18 apply to a municipal police officer other than a chief of police or a deputy chief of police. O. Reg. 268/10, s. 15.

Candidacy for election

16. (1) A municipal police officer may be a candidate, or may seek to become a candidate, in a federal or provincial election or in an election for municipal council only while on a leave of absence granted under subsection (2). O. Reg. 268/10, s. 16 (1).

(2) A municipal police officer who seeks to become a candidate in a federal or provincial election or in an election for municipal council shall apply to the board of the municipality in which he or she is employed for a leave of absence without pay and the board shall grant the leave of absence. O. Reg. 268/10, s. 16 (2).

(3) Despite subsections (1) and (2), a municipal police officer may seek to become a candidate or may be a candidate in an election for municipal council without taking a leave of absence if,

(a) the election is in a municipality that does not receive police services from the municipality in which the police officer is employed; and

(b) seeking to become or being a candidate does not interfere with the police officer's duties as a police officer and does not place, or is not likely to place, the police officer in a position of conflict of interest. O. Reg. 268/10, s. 16 (3).

(4) Regardless of whether a leave of absence is required under this section, a board shall grant any leave of absence that a municipal police officer requests if the leave is to enable the police officer to seek to become a candidate or to be a candidate in an election for municipal council. O. Reg. 268/10, s. 16 (4).

(5) The following rules apply to a leave of absence granted to a municipal police officer under subsection (2) or (4):

1. A leave of absence shall begin and end on the dates specified in the police officer's application, subject to paragraphs 2, 3, and 4.

2. A leave of absence granted to enable a police officer to be a candidate in an election for municipal council shall not begin earlier than 60 days before polling day or continue after polling day.

3. A leave of absence granted to enable a police officer to be a candidate in a federal or provincial election shall not begin earlier than the day on which the writ for the election is issued or later than the last day for nominating candidates under the applicable provincial or federal statute and shall not continue after polling day.

4. A leave of absence granted to enable a police officer to seek to become a candidate in a federal or provincial election or in an election for municipal council shall not continue after the day the police officer withdraws from or loses the nomination campaign or, if the police officer wins the nomination, after polling day. O. Reg. 268/10, s. 16 (5).

Resignation upon election

17. (1) A municipal police officer who is elected in a federal or provincial election or in an election for municipal council shall immediately resign as a police officer. O. Reg. 268/10, s. 17 (1).

(2) Despite subsection (1), a municipal police officer need not resign as a municipal police officer upon being elected in an election for municipal council if,

(a) the police officer is elected a member of the municipal council of a municipality that does not receive police services from the municipality in which the police officer is employed; and

(b) being a member of the municipal council does not interfere with the police officer's duties as a police officer or does not place, or is not likely to place, the police officer in a position of conflict of interest. O. Reg. 268/10, s. 17 (2).

(3) A municipal police officer who is elected in an election for municipal council and who, as permitted by subsection (2), does not resign as a police officer,

(a) shall not take part at any meeting of the municipal council in the discussion of, or vote on, any question relating to the budget for a police services board under section 39 of the Act; and

(b) shall not attempt in any way, whether before, during or after a meeting of the municipal council, to influence the voting on any such question. O. Reg. 268/10, s. 17 (3).

(4) A former municipal police officer who resigns in accordance with subsection (1) and later ceases to be an elected political representative is entitled, on application, to be appointed to any vacant position on the police force for which he or she is qualified under section 43 of the Act. O. Reg. 268/10, s. 17 (4).

(5) Subsection (4) applies only if the former police officer,

(a) ceases to be an elected political representative within,

(i) in the case of a former police officer who was elected in a federal or provincial election, five years after resigning as a police officer,

(ii) in the case of a former police officer who was elected in an election for municipal council, three years after resigning as a police officer; and

(b) makes an application to be reappointed to the police force within 12 months after ceasing to be an elected political representative. O. Reg. 268/10, s. 17 (5).

(6) Another person's right to be appointed or assigned to a position on the police force by virtue of a collective agreement prevails over the right conferred by subsection (4). O. Reg. 268/10, s. 17 (6).

Effect of absence on length of service

18. (1) The period of a leave of absence granted under subsection 16 (2) or (4) shall not be counted in determining the length of the police officer's service, but the service before and after the period of leave shall be deemed to be continuous for all purposes. O. Reg. 268/10, s. 18 (1).

(2) Subsection (1) applies, with necessary modifications, to a police officer who has resigned and subsequently been reappointed to the police force in accordance with subsection 17 (4). O. Reg. 268/10, s. 18 (2).

FORFEITURE OF PAY

Forfeiture of pay

19. (1) If a penalty of more than one day's forfeiture of pay is imposed under Part V of the Act, not more than one day's pay shall be deducted in each pay period until the full penalty has been paid, unless otherwise agreed to by the police officer against whom the penalty is imposed or otherwise ordered by the chief of police or board imposing the penalty. O. Reg. 268/10, s. 19 (1).

(2) If the police officer against whom a penalty described in subsection (1) is imposed ceases to be a member of the police force, the whole amount of the forfeiture of pay then remaining may be deducted from any pay then due. O. Reg. 268/10, s. 19 (2).

PART IV
ONTARIO PROVINCIAL POLICE

Definition

20. In this Part,

"Force" means the Ontario Provincial Police. O. Reg. 268/10, s. 20.

Application

21. This Part applies to the Force. O. Reg. 268/10, s. 21.

Providing uniform and equipment

22. The Force shall provide all articles of uniform and equipment necessary for the performance of duty but, if a uniform or equipment is damaged or lost through the fault of a member of the Force, the member shall bear the cost of replacement. O. Reg. 268/10, s. 22.

Political activity

23. No member of the Force shall contravene or fail to comply with any provision in Part V (Political Activity) of the *Public Service of Ontario Act, 2006*. O. Reg. 268/10, s. 23.

No contracting debts

24. No member of the Force shall contract debts that the member is unwilling or unable to discharge and that may interfere with the performance of his or her duties as a member of the Force. O. Reg. 268/10, s. 24.

Forfeiture of pay

25. (1) If a penalty of more than one day's forfeiture of pay is imposed under Part V of the Act, not more than one day's pay shall be deducted in each pay period until the full penalty has been paid, unless otherwise agreed to by the police officer against whom the penalty is imposed or otherwise ordered by the Commissioner. O. Reg. 268/10, s. 25 (1).

(2) If the police officer against whom a penalty described in subsection (1) is imposed ceases to be a member of the Force, the whole amount of the forfeiture of pay then remaining may be deducted from any pay then due. O. Reg. 268/10, s. 25 (2).

Notice of resignation

26. Without the consent of the Commissioner, no member of the Force shall resign unless the member has given two weeks notice in writing to the Commissioner. O. Reg. 268/10, s. 26.

PART V
DUTIES OF POLICE OFFICERS

Preparing informations

27. (1) Every information sworn by a member of a police force that alleges the commission of an offence under an Act of the Parliament of Canada or of the Legislature of Ontario shall be prepared by a member of a police force. O. Reg. 268/10, s. 27 (1).

(2) Every information mentioned in subsection (1) shall be prepared in a manner suitable for laying before a justice of the peace, on a prescribed form where it is required. O. Reg. 268/10, s. 27 (2).

(3) Subsection (1) does not apply to a member of a police force who is police officer appointed under the *Interprovincial Policing Act, 2009*. O. Reg. 268/10, s. 27 (3).

PART VI
UNSATISFACTORY WORK PERFORMANCE

Application

28. This Part applies to municipal police forces and the Ontario Provincial Police. O. Reg. 268/10, s. 28.

Assessment of performance

29. (1) Every chief of police shall establish policies for the assessment of police officers' work performance. O. Reg. 268/10, s. 29 (1).

(2) The chief of police shall make the policies available to the police officers. O. Reg. 268/10, s. 29 (2).

(3) Before the chief of police may make a complaint against a police officer of unsatisfactory work performance,

(a) the police officer's work performance shall have been assessed in accordance with the established procedures;

(b) the chief of police shall advise the police officer of how he or she may improve his or her work performance;

(c) the chief of police shall accommodate the police officer's needs in accordance with the *Human Rights Code* if the police officer has a disability, within the meaning of the *Human Rights Code*, that requires accommodation;

(d) the chief of police shall recommend that the police officer seek remedial assistance, such as counselling or training or participation in a program or activity, if the chief of police is of the opinion that it would improve the police officer's work performance; and

(e) the chief of police shall give the police officer a reasonable opportunity to improve his or her work performance. O. Reg. 268/10, s. 29 (3).

PART VII
CODE OF CONDUCT

Code of conduct

30. (1) Any conduct described in the code of conduct, set out in the Schedule, constitutes misconduct for the purpose of section 80 of the Act. O. Reg. 268/10, s. 30 (1).

(2) The code of conduct applies to all police officers, except that subclauses 2 (1) (c) (iii), (ix) and (x) of the code do not apply to a police officer appointed under the *Interprovincial Policing Act, 2009*. O. Reg. 268/10, s. 30 (2).

PART VIII (OMITTED)

31. OMITTED (REVOKES OTHER REGULATIONS). O. Reg. 268/10, s. 31.

32. OMITTED (PROVIDES FOR COMING INTO FORCE OF PROVISIONS OF THIS REGULATION). O. Reg. 268/10, s. 32.

SCHEDULE
CODE OF CONDUCT

1. In this code of conduct,

"marital status" means the status of being married, single, widowed, divorced or separated and includes the status of living with a person in a conjugal relationship outside marriage; ("état matrimonial")

"record" means any record of information, however recorded, whether in printed form, on film, by electronic means or otherwise, and includes correspondence, a memorandum, a book, a plan, a map, a drawing, a diagram, a pictorial or graphic work, a photograph, a film, a microfilm, a sound recording, a videotape, a machine readable record, any other documentary material, regardless of physical form or characteristics, and any copy of the record. ("document")

2. (1) Any chief of police or other police officer commits misconduct if he or she engages in,

(a) DISCREDITABLE CONDUCT, in that he or she,

(i) fails to treat or protect persons equally without discrimination with respect to police services because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status or disability,

(ii) uses profane, abusive or insulting language that relates to a person's race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status or disability,

(iii) is guilty of oppressive or tyrannical conduct towards an inferior in rank,

(iv) uses profane, abusive or insulting language to any other member of a police force,

(v) uses profane, abusive or insulting language or is otherwise uncivil to a member of the public,

(vi) wilfully or negligently makes any false complaint or statement against any member of a police force,

(vii) assaults any other member of a police force,

(viii) withholds or suppresses a complaint or report against a member of a police force or about the policies of or services provided by the police force of which the officer is a member,

(ix) is guilty of a criminal offence that is an indictable offence or an offence punishable upon summary conviction,

(x) contravenes any provision of the Act or the regulations, or

(xi) acts in a disorderly manner or in a manner prejudicial to discipline or likely to bring discredit upon the reputation of the police force of which the officer is a member;

(b) INSUBORDINATION, in that he or she,

(i) is insubordinate by word, act or demeanour, or

(ii) without lawful excuse, disobeys, omits or neglects to carry out any lawful order;

(c) NEGLECT OF DUTY, in that he or she,

(i) without lawful excuse, neglects or omits promptly and diligently to perform a duty as,

(A) a member of the police force of which the officer is a member, if the officer is a member of an Ontario police force as defined in the *Interprovincial Policing Act, 2009*, or

(B) a police officer appointed under the *Interprovincial Policing Act, 2009*,

(ii) fails to comply with any provision of Ontario Regulation 267/10 (Conduct and Duties of Police Officers Respecting Investigations by the Special Investigations Unit) made under the Act,

(iii) fails to work in accordance with orders, or leaves an area, detachment, detail or other place of duty, without due permission or sufficient cause,

(iv) by carelessness or neglect permits a prisoner to escape,

(v) fails, when knowing where an offender is to be found, to report him or her or to make due exertions for bringing the offender to justice,

(vi) fails to report a matter that it is his or her duty to report,

(vii) fails to report anything that he or she knows concerning a criminal or other charge, or fails to disclose any evidence that he or she, or any person within his or her knowledge, can give for or against any prisoner or defendant,

(viii) omits to make any necessary entry in a record,

(ix) feigns or exaggerates sickness or injury to evade duty,

(x) is absent without leave from or late for any duty, without reasonable excuse, or

(xi) is improperly dressed, dirty or untidy in person, clothing or equipment while on duty;

(d) DECEIT, in that he or she,

(i) knowingly makes or signs a false statement in a record,

(ii) wilfully or negligently makes a false, misleading or inaccurate statement pertaining to official duties, or

(iii) without lawful excuse, destroys or mutilates a record or alters or erases an entry in a record;

(e) BREACH OF CONFIDENCE, in that he or she,

(i) divulges any matter which it is his or her duty to keep secret,

(ii) gives notice, directly or indirectly, to any person against whom any warrant or summons has been or is about to be issued, except in the lawful execution of the warrant or service of the summons,

(iii) without proper authority, communicates to the media or to any unauthorized person any matter connected with,

(A) the police force of which the officer is a member, if the officer is a member of an Ontario police force as defined in the *Interprovincial Policing Act, 2009*, or

(B) the police force with which the officer is working on a joint forces operation or investigation, if the officer is appointed as a police officer under the Interprovincial Policing Act, 2009, or

(iv) without proper authority, shows to any person not a member of the police force described in sub-subclause (iii) (A) or (B), as the case may be, or to any unauthorized member of that police force any record that is the property of that police force;

(f) CORRUPT PRACTICE, in that he or she,

(i) offers or takes a bribe,

(ii) fails to account for or to make a prompt, true return of money or property received in an official capacity,

(iii) directly or indirectly solicits or receives a gratuity or present without the consent of,

(A) the chief of police, if the officer is a member of an Ontario police force as defined in the *Interprovincial Policing Act, 2009*, or

(B) the person who appointed the police officer under Part II or III of the *Interprovincial Policing Act, 2009*,

(iv) places himself or herself under a pecuniary or other obligation to a licensee if a member of the following police force may have to report or give evidence concerning the granting or refusing of a licence to the licensee:

(A) the police force of which the officer is a member, if the officer is a member of an Ontario police force as defined in the Interprovincial Policing Act, 2009, or

(B) the police force with which the officer is working on a joint forces operation or investigation, if the officer is appointed as a police officer under the *Interprovincial Policing Act, 2009*, or

(v) improperly uses his or her character and position as a member of a police force for private advantage;

(g) UNLAWFUL OR UNNECESSARY EXERCISE OF AUTHORITY, in that he or she,

(i) without good and sufficient cause makes an unlawful or unnecessary arrest, or

(ii) uses any unnecessary force against a prisoner or other person contacted in the execution of duty;

(h) DAMAGE TO CLOTHING OR EQUIPMENT, in that he or she,

(i) wilfully or carelessly causes loss or damage to any article of clothing or equipment, or to any record or other property of,

(A) the police force of which the officer is a member, if the officer is a member of an Ontario police force as defined in the *Interprovincial Policing Act, 2009*, or

(B) the police force with which the officer is working on a joint forces operation or investigation, if the officer is appointed as a police officer under the *Interprovincial Policing Act, 2009*, or

(ii) fails to report loss or damage, however caused, as soon as practicable; or

(i) CONSUMING DRUGS OR ALCOHOL IN A MANNER PREJUDICIAL TO DUTY, in that he or she,

(i) is unfit for duty, while on duty, through consumption of drugs or alcohol,

(ii) is unfit for duty when he or she reports for duty, through consumption of drugs or alcohol,

(iii) except with the consent of a superior officer or in the discharge of duty, consumes or receives alcohol from any other person while on duty, or

(iv) except in the discharge of duty, demands, persuades or attempts to persuade another person to give or purchase or obtain for a member of a police force any alcohol or illegal drugs while on duty.

(2) A police officer does not commit misconduct under subclause (1) (e) (iii) if he or she engages in the described activity in his or her capacity as an authorized representative of an association, as defined in section 2 of the Act.

(3) A police officer does not commit misconduct under subclause (1) (f) (iii) if he or she engages in the described activity in his or her capacity as an authorized representative of an association, as defined in section 2 of the Act, or of a work-related professional organization.

3. Any chief of police or other police officer also commits misconduct if he or she conspires in, abets or is knowingly an accessory to any misconduct described in section 2.

O. Reg. 268/10, Sched.

Conduct and Duties of Police Officers Respecting Investigations by the Special Investigations Unit, O. Reg. 267/10, s. 11

Investigation caused by chief of police

11.(1) The chief of police shall also cause an investigation to be conducted forthwith into any incident with respect to which the SIU has been notified, subject to the SIU's lead role in investigating the incident. O. Reg. 267/10, s. 11 (1).

(2) The purpose of the chief of police's investigation is to review the policies of or services provided by the police force and the conduct of its police officers. O. Reg. 267/10, s. 11 (2).

(3) All members of the police force shall co-operate fully with the chief of police's investigation. O. Reg. 267/10, s. 11 (3).

(4) The chief of police of a municipal police force shall report his or her findings and any action taken or recommended to be taken to the board within 30 days after the SIU director advises the chief of police that he or she has reported the results of the SIU's investigation to the Attorney General, and the board may make the chief of police's report available to the public. O. Reg. 267/10, s. 11 (4).

(5) The Commissioner of the Ontario Provincial Police shall prepare a report of his or her findings and any action taken within 30 days after the SIU director advises the Commissioner that he or she has reported the results of the SIU's investigation to the Attorney General, and the Commissioner may make the report available to the public. O. Reg. 267/10, s. 11 (5).

Courses of Training for Members of Police Forces, O. Reg. 36/02, s. 1

Initial training

1. (1) Every municipal police officer shall, within six months of his or her appointment, successfully complete the Basic Constable Training Program at the Ontario Police College as his or her initial training. O. Reg. 36/02, s. 1 (1).

(2) In the case of a police officer who previously completed a program of recruit police training in another province or territory and who successfully completed a probationary period in the other province or territory equivalent to the probationary period under section 44 of the Act, the Director of the Ontario Police College may, within six months of the police officer's appointment to an Ontario municipal police force, exempt the police officer from the requirement in subsection (1) if, in the Director's opinion, the police officer's qualifications and skills are substantially equivalent to those that would be obtained in the Basic Constable Training Program. O. Reg. 36/02, s. 1 (2).

(3) In exempting a police officer under subsection (2), the Director may require the police officer to complete other specified courses or examinations, or both, to ensure that the police officer's qualifications and skills will be equivalent to those that would be obtained in the Basic Constable Training Program. O. Reg. 36/02, s. 1 (3).

Equipment and Use of Force, R.R.O. 1990, Reg. 926, ss. 4, 9, 10(a), 14.5

4. Before a firearm is issued to a member of a police force, the Commissioner or chief of police, as the case may be, shall satisfy himself or herself that the member has successfully completed the training required by section 14.2 and is competent in the use of the firearm. O. Reg. 552/92, s. 3.

9. A member of a police force shall not draw a handgun, point a firearm at a person or discharge a firearm unless he or she believes, on reasonable grounds, that to do so is necessary to protect against loss of life or serious bodily harm. O. Reg. 283/08, s. 3.

10. Despite section 9, a member of a police force may discharge a handgun or other firearm,

(a) to call for assistance in a critical situation, if there is no reasonable alternative;

REPORTS ON THE USE OF FORCE

14.5(1) A member of a police force shall submit a report whenever the member,

(a) draws a handgun in the presence of a member of the public, excluding a member of the police force who is on duty, points a firearm at a person or discharges a firearm;

(b) uses a weapon other than a firearm on another person; or

(c) uses physical force on another person that results in an injury requiring medical attention. O. Reg. 552/92, s. 9; O. Reg. 283/08, s. 4 (1); O. Reg. 264/10, s. 9 (1).

(1.1) The member shall submit the report to,

(a) the chief of police or Commissioner if the member is an Ontario police officer as defined in the Interprovincial Policing Act, 2009; or

(b) the following persons if the member is a police officer appointed under the Interprovincial Policing Act, 2009:

(i) the appointing official or local commander who appointed the member under that Act, as the case may be,

(ii) the extra-provincial commander of the officer. O. Reg. 264/10, s. 9 (2).

(2) The report shall be in Form 1. O. Reg. 751/92, s. 1 (1).

(3) Subsection (1) does not apply when,

(a) a handgun is drawn or a firearm is pointed at a person or is discharged in the course of a training exercise, target practice or ordinary firearm maintenance in accordance with the rules of the police force;

(b) a weapon other than a firearm is used on another member of a police force in the course of a training exercise in accordance with the rules of the police force; or

(c) physical force is used on another member of a police force in the course of a training exercise in accordance with the rules of the police force. O. Reg. 552/92, s. 9; O. Reg. 283/08, s. 4 (2).

(3.1) If the report is submitted to the chief of police or Commissioner, the chief of police or the Commissioner, as the case may be, shall ensure that Part B of the report is destroyed not later than 30 days after the report is submitted. O. Reg. 264/10, s. 9 (3).

(3.2) Despite subsection (3.1), Part B of the reports submitted under clause (1.1) (a) may be retained for an additional period specified by the board or the Commissioner, as the case may be, if the board or the Commissioner is of the opinion that the additional period is necessary for the purpose of determining whether members of the police force should receive additional training. O. Reg. 751/92, s. 1 (2); O. Reg. 264/10, s. 9 (4).

(3.3) The additional period specified under subsection (3.2) shall not extend past the second anniversary of the date the report is submitted. O. Reg. 751/92, s. 1 (2).

(3.4) A report submitted under subsection (1) shall not be admitted in evidence at any hearing under Part V of the Act, other than a hearing to determine whether a police officer has contravened this section. O. Reg. 751/92, s. 1 (2); O. Reg. 283/08, s. 4 (3).

(4) The Solicitor General may require a chief of police or the Commissioner to deliver or make available to the Solicitor General a copy of a report submitted under subsection (1). O. Reg. 552/92, s. 9.

(5) Every police force shall review on a regular basis its policies on the use of force and on the training courses provided under section 14.3, having regard to the reports submitted under subsection (1). O. Reg. 552/92, s. 9.

(6) SPENT: R.R.O. 1990, Reg. 926, s. 14.5 (6). See: O. Reg. 552/92, s.

Public Complaints – Local Complaints, Ont. Reg. 263/09, s. 4

Resolution

4. (1) In this section,

"alternative dispute resolution process" includes mediation, conciliation, negotiation or any other means of facilitating the resolution of issues in dispute. O. Reg. 263/09, s. 4 (1).

(2) Every chief of police shall attempt to resolve a local complaint accepted by him or her under section 3 in accordance with this section. O. Reg. 263/09, s. 4 (2).

(3) In order to attempt to resolve a local complaint, the chief of police may discuss the matter with the complainant or otherwise communicate with the complainant in a mutually agreed upon manner respecting the matter. O. Reg. 263/09, s. 4 (3).

(4) If the local complaint is in respect of the conduct of a police officer, the chief of police may do one or more of the following:

1. Discuss the matter with the police officer or otherwise communicate with the police officer respecting the matter and inform the complainant of the results of the discussion or communication.

2. Facilitate discussion or other communication between the complainant and the police officer and, if appropriate, any other member or employee of the police force.

3. Facilitate the making of an apology by the police officer to the complainant.

4. With the consent of the complainant, the police officer and the Independent Police Review Director, refer the complainant and the police officer to an alternative dispute resolution process. O. Reg. 263/09, s. 4 (4).

(5) The following rules apply if the chief of police refers the complainant and the police officer to an alternative dispute resolution process:

1. The person selected or appointed to facilitate the alternative dispute resolution process shall not be a member or employee of any police force.

2. All communications at an alternative dispute resolution process and the facilitator's notes and records shall remain confidential and are deemed to have been made without prejudice to the complainant and the police officer in the process. O. Reg. 263/09, s. 4 (5).

(6) If the local complaint is in respect of a policy or service, the following rules apply:

1. If the complaint is in respect of a policy or service provided by a municipal police force, the chief of police shall notify the board about the matter.

2. If the complaint is dealt with by a delegate, the delegate may notify the chief of police about the matter and inform the complainant of the results of the notification.

3. If the complaint affects or relates to a policy of or service provided by another police force, the chief of police of that police force may be notified about the matter and the complainant informed of the results of the notification. O. Reg. 263/09, s. 4 (6).

(7) If at any time while attempting to resolve a local complaint in accordance with this section the chief of police determines that the complainant has made a Part V complaint in respect of the matter that is the subject of the local complaint, the chief of police shall cease dealing with the complaint. O. Reg. 263/09, s. 4 (7).

(8) If at any time while attempting to resolve a local complaint in accordance with this section the chief of police determines that the complaint meets any of the criteria set out in subsection 3 (4), the chief of police shall,

(a) cease dealing with the complaint; and

(b) request that the complainant make a Part V complaint respecting the matter. O. Reg. 263/09, s. 4 (8).

(9) The chief of police may consult the Independent Police Review Director before making a determination under subsection (7) or (8). O. Reg. 263/09, s. 4 (9).

(10) If a chief of police ceases to deal with a complaint under subsection (7) or (8), he or she shall provide written notice of the fact, with reasons, to the complainant, to the Independent Police Review Director and, in the case of a complaint respecting the conduct of a police officer, to the police officer. O. Reg. 263/09, s. 4 (10).

(11) In the case of a local complaint respecting the conduct of a police officer other than the chief of police or deputy chief of police of the police force, if the complainant refuses a request under clause (8) (b) to make a Part V complaint respecting the matter, the chief of police shall make an internal complaint respecting the matter under subsection 76 (1) of the Act. O. Reg. 263/09, s. 4 (11).

Regulation under the Mental Health Act: R.R.O. 1990, Reg. 741

TAKING INTO CUSTODY BY FACILITY

7.2 (1) Where a person is taken to a psychiatric facility under section 33 of the Act, the officer in charge or his or her delegate shall ensure that a decision is made as soon as is reasonably possible as to whether or not the facility will take custody of the person. O. Reg. 616/00, s. 6.

(2) The staff member or members of the psychiatric facility responsible for making the decision shall consult with the police officer or other person who has taken the person in custody to the facility. O. Reg. 616/00, s. 6.

(3) A staff member designated for this purpose shall communicate with the police officer or other person about any delays in the making of the decision. O. Reg. 616/00, s. 6.

(4) Where a decision is made to take the person into custody, the designated staff member shall promptly inform the police officer or other person of the decision. O. Reg. 616/00, s. 6.

APPENDIX E

Selected Toronto Police Service Procedures

Appendix E
Selected Toronto Police Service Procedures

1. Procedure 06 - 04 - Emotionally Disturbed Persons - Provincial Investigations
2. Procedure 06 - 04 - Appendix A - Quick Reference Guide for Police Officers - Emotionally Disturbed Persons
3. Procedure 06 - 04 - Appendix B - Designated Psychiatric Facilities
4. Procedure 08 - 05 - Health and Safety - Substance Abuse
5. Procedure 10 - 01 - Emergency Incident Response - Emergencies & Hazardous Incidents
6. Procedure 15 - 01 - Use of Force - Use of Force and Equipment
7. Procedure 15 - 01 - Appendix A - Provincial Use of Force Model
8. Procedure 15 - 01 - Appendix B - Provincial Use of Force Model - Background Information - New Ontario Use of Force Model (2004)
9. Procedure 15 - 09 - Conducted Energy Weapon - Use of Force & Equipment

PROVINCIAL INVESTIGATIONS

06 – 04 Emotionally Disturbed Persons

New [ ] **Amended** [ ] **Reviewed – No Amendments** [X]

Issued: R.O. 2014.05.09–0599

Replaces: R.O. 2013.10.30–1216

Rationale

The *Mental Health Act* (MHA) provides for the control, apprehension, detention and treatment of emotionally disturbed persons. This Procedure addresses situations where officers observe verbal cues, behavioural cues or other behaviours that provide them with reasonable cause to believe a person is apparently suffering a mental disorder. The following process governs police interaction with and apprehension of emotionally disturbed persons and their subsequent admission to psychiatric facilities.

Supervision

Attendance	Mandatory Notification
N/A	• Supervisory Officer – if detained at a psychiatric facility for more than one (1) hour • Officer in Charge – for MCIT notification

Governing Authorities

Provincial Child and Family Services Act
Mental Health Act
Police Services Act, O.Reg. 03/99, Adequacy and Effectiveness of Police Services

Associated Service Governance

Number	Name
TPSB LE-013	Police Response to Persons who are Emotionally Disturbed or have a Mental Illness or a Developmental Disability
02–12	Ontario Review Board Warrants and Dispositions
04–14	Field Information Report
04–41	Youth Crime Investigations
Chapter 5, Appendix A	Excerpt from Guideline LE– – Preventing or Responding to Occurrences Involving Firearms
05–21	Firearms
06–05	Elopees/Community Treatment Orders

08–07	Communicable Diseases
09–01	Property – General
09–03	Property – Firearms
13–17	Memorandum Books and Reports
17–08	Use of Special Address System

Forms

Number	Name	Authorization Level
	eReports	GO Review
TPS 228	Special Address System Report	Officer in Charge
TPS 405	Property Receipt	Officer in Charge
TPS 649	Internal Correspondence	Police Officer
TPS 710	Emotionally Disturbed Person (EDP) Information Form	Officer in Charge

NOTE: *The TPS 710 is available as a text template.*

Definitions

Child in Need of Protection means a child that can be apprehended as being in need of protection as defined in ss. 37(2) of the *Child and Family Services Act*.

Disorderly means behaviour that appears to the police to be "to some extent irrational although not unruly". [*R v. O'Brien (1983), 9W.C.B. 270* (Ontario County Court)]

Divisional Mental Health Liaison Officer means the police officer responsible for coordinating all *Mental Health Act* (MHA) issues within the division, usually the Community Relations Officer.

Emotionally Disturbed Person (EDP) includes any person who appears to be in a state of crisis or any person who is mentally disordered.

Form 1 MHA means an 'Application by Physician for Psychiatric Assessment' signed by a doctor within seven (7) days of examining the person, giving **any** person authority to take the person named on the application to a psychiatric facility.

A Form 1 is valid for seven (7) days from and including the day it was signed.

Form 2 MHA means a Justice of the Peace 'Order for Examination' directing **police officers** to take the person in custody to an appropriate psychiatric facility where a physician may order the person detained for examination.

A Form 2 is valid for seven (7) days from and including the day it was signed.

Form 9 MHA means an 'Order for Return' of an elopee issued by a psychiatric facility which authorizes a **police officer** to return the person without their consent to the psychiatric facility.

A Form 9 is valid for a period of one (1) month after the person is absent without leave.

Form 47 MHA means an 'Order for Examination' issued by the physician who issued the person a Community Treatment Order (CTO) and
(a) has reasonable cause to believe the person has failed to comply with the conditions under the CTO
(b) the CTO subject or substitute decision–maker has withdrawn consent to the CTO and the subject fails to permit the physician to review their condition within 72 hours and the physician believes the subject may cause harm or suffer deterioration.

A Form 47 authorizes a **police officer** to take that person into custody and return them to the physician promptly and is valid for a period of 30 days.

Mental Disorder means any disease or disability of the mind. A person suffering from a mental disorder may have to live with a long–term breakdown of coping skills including perception, decision making and problem solving abilities.

Person in Crisis means a person who suffers a temporary breakdown of coping skills but often reaches out for help, demonstrating that they are in touch with reality. Once a person in crisis receives the needed help, there is often a rapid return to normalcy.

Physician means a legally qualified medical practitioner.

Psychiatric Facility means a facility for the observation, care and treatment of persons suffering from a mental disorder and designated as such by the regulation contained in the MHA. See Appendix B for a list of designated psychiatric facilities.

Procedure

An eReport must be completed for
- all MHA apprehensions; and
- circumstances where the location of the person named on the Form – MHA is unknown and every effort to locate the individual has been made.

Section 17 MHA – Action by Police Officer

Section 17 of the MHA states that

Where a police officer has reasonable and probable grounds to believe that a person is acting or has acted in a disorderly manner and has reasonable cause to believe that the person,

(a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;
(b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or
(c) has shown or is showing a lack of competence to care for himself or herself,

and in addition the police officer is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

(d) serious bodily harm to the person;
(e) serious bodily harm to another person; or
(f) serious physical impairment of the person,

and that it would be dangerous to proceed under section 16 [Justice of the Peace Order for Examination, Form 2], the police officer may take the person in custody to an appropriate place for examination by a physician.

NOTE: *There is no longer a requirement for a police officer to actually observe the person's behaviour and may use information obtained from a third party in order to form reasonable and probable grounds for apprehension. Police officers should obtain and record as much information as possible in situations involving third party reports and request that the complainant sign the officer's memorandum book.*

Section 33 MHA – Duty to Remain and Retain Custody

Section 33 of the MHA directs

A police officer or other person who takes a person in custody to a psychiatric facility shall remain at the facility and retain custody of the person until the facility takes custody of him or her in the prescribed manner.

Community Referral Police Access Line

A community based Mental Health & Justice Services police only access line is available to provide police officers with assistance when dealing with

- any individual aged 16 or older who is believed to be emotionally disturbed and at a significant risk of involvement with the criminal justice system, and
- who has not been apprehended under the MHA

The Community Referral Access Line, [redacted] is available 24 hours a day, 7 days a week and is for Police Officers ONLY.

The Public can also access the Referral Access Line by calling (416) 248–4174.

When contacting this referral line, police officers will have access to

- short–term residential beds
- referral to the Mental Health and Justice Prevention Program
- information and referral to other Community Mental Health Services

NOTE: *Mental Health & Justice Services will accept individuals who can be safely supported in the community, which means that the individual does not pose a threat to the safety of the public or is not at serious risk of harming themselves or others. Prior to providing support, the suspected emotionally disturbed person must voluntarily agree to the services being provided.*

Police Officer

1. Where a police officer investigating an Emotionally Disturbed Person (EDP) observes verbal or behavioural cues (e.g. mute, passive, suicidal, yelling, hearing voices) OR receives information that would lead the officer to believe that a person is apparently suffering from a mental disorder, they shall be guided by s. 17 and s. 33 of the MHA.

2. When responding to a complaint of a suspected EDP shall

- conduct a Person Query, including a CPIC and CFRO check
- determine if the suspected EDP owns, possesses or has access to a weapons, firearms, ammunition, explosives or the related authorizations, licences, certificates or permits and comply with Procedure 05–21
- obtain the type of information contained in Chapter 5, Appendix A to help determine whether reasonable grounds exist to believe there is a threat to safety
- if background checks indicate that the person has a history of violence or use of weapons, notify the Specialized Emergency Response – Emergency Task Force (ETF)

  NOTE: *It will be at the discretion of the Supervisory Officer – ETF as to whether they will attend.*

- consider using the search and seizure provisions contained in ss. 117.04(2) CC to minimize any subsequent risk to the victim
- comply with Procedure 09–03, if applicable
- obtain sufficient backup officers

3. When encountering a suspected EDP shall
   - take all necessary steps to ensure the situation is safe
   - determine the need to immediately apprehend under the MHA or arrest under the applicable statute
   - consult with the Mobile Crisis Intervention Team (MCIT), if available
4. When a suspected EDP has committed a criminal offence shall
   - assess the surrounding circumstances
   - consider charging the person under the applicable statute
   - if the person is not being charged, complete the applicable eReport outlining the details of the offence
   - complete the applicable MO Detail page
5. When attending a scene where the risk of contact with blood or body fluids exists shall
   - take the necessary precautions to minimize the risk of exposure to communicable diseases
   - comply with Procedure 08–07
6. If the person appears on CPIC in the Special Interest to Police (SIP) category as being the subject of an Ontario Review Board Warrant shall comply with Procedure 02–12.
7. When receiving a complaint or coming into contact with an elopee, including a person wanted for a terminated Community Treatment Order (Form 47) shall comply with Procedure 06–05.
8. When not apprehending or arresting a suspected EDP shall contact the MCIT, where available.

9. If the MCIT is not available, and the suspected EDP is aged 16 or older and has not been apprehended under the MHA shall

- contact the Community Referral Police Access Line for support
- complete a Community Safety Note on the Street Check screen

10. If the MCIT is not available and the suspected EDP is under 16 years of age shall

- determine if this is a child in need of protection under the *Child and Family Services Act*
- comply with Procedure 04–41, as appropriate
- complete a Community Safety Note on the Street Check screen

11. When there are sufficient grounds to apprehend a suspected EDP under s. 17 MHA shall

- comply with item 2, if applicable
- apprehend the person
- ensure the dwelling and any valuables are secured for safekeeping in compliance with Procedure 09–01, if applicable
- transport the person to the nearest psychiatric facility listed in Appendix B
- take any medications currently prescribed to the person and turn over to the nursing supervisor upon arrival at the psychiatric facility
- notify the next of kin or public trustee, if necessary
- comply with Procedure 09–03, if applicable
- complete the applicable eReports
- complete the applicable MO Detail page

12. If the person is an outpatient of, or has recent history with a more distant psychiatric facility, may use discretion and transport the person to that psychiatric facility where practicable.

13. When detailed to apprehend a suspected EDP on the basis of a Form – MHA shall

- obtain the original Form – MHA
- ensure the Form – MHA is still in effect
- obtain background details from the complainant
- comply with item 2
- attend the address of the suspected EDP
- comply with items 11 and 16

- give the original Form – MHA and any medications currently prescribed to the person to the nursing supervisor at the psychiatric facility

14. Where the location of the person named on the Form – MHA is unknown and every reasonable effort to locate the individual has been made shall

- complete the applicable eReports, including the applicable MO Detail page
- complete the Missing Person Details page, selecting Yes for the BOLO option

NOTE: *Records Management Services – Operations (RMS – Ops) will enter the person on CPIC, and create and post a BOLO.*

- scan and attach the Form – MHA and relevant memorandum notes to the original eReport
- submit the original Form – MHA and eReport number to the officer in charge

15. If the suspected EDP has been apprehended under a Form – MHA after an entry has been made in CPIC shall

- add supplementary information to the original eReport, detailing the circumstances of the apprehension
- complete the Located/Found section of the Missing Persons details page

NOTE: *Upon receiving and transcribing the person located/found update, RMS – Ops will cancel the BOLO, and the missing person from CPIC.*

- comply with items 11 and 16

16. Upon arriving at the psychiatric facility shall

- complete a TPS 710 and provide the report to the nursing supervisor
- remain with the patient until the psychiatric facility accepts custody
- advise a supervisory officer if detained or expect to be detained at the psychiatric facility for more than one (1) hour

NOTE: *Custody occurs when the hospital arranges for their staff to take charge of the individual, or when the person is taken for an assessment. With a supervisor's approval, a police officer may remain at the psychiatric facility if it is in the public interest, requested by hospital staff or charges against the person are being considered, and a decision on whether or not to admit the person has yet to be made.*

- if items 14 and 15 do not apply, complete the applicable eReport, outlining the details of the apprehension and include the information contained in the TPS 710
- complete the applicable MO Detail page
- notify or arrange for notification of the next of kin

17. If difficulty is experienced when having a person examined/admitted to a hospital

- may request a second opinion from another physician or psychiatrist on call
- may attend another hospital, if necessary
- shall submit a TPS 649 to the unit commander detailing the problem

NOTE: *Within reason, an officer may transport the person to more than one psychiatric facility if the officer feels it is in the public interest to do so. Officers must be prepared to articulate their reasons for taking this course of action.*

18. Where there are safety concerns for officers attending an address in the future shall complete a TPS 228 to activate the Special Address System in compliance with Procedure 17–08.

Divisional Mental Health Liaison Officer

19. The Divisional Mental Health Liaison officer shall

- co–ordinate any divisional community mental health needs through community service providers
- liaise with mental health professionals in the community and ensure divisional officers are aware of their services
- liaise with Divisional Policing Support Unit (DPSU) – Vulnerable Persons
- ensure that hospitals within the division have a sufficient supply of blank TPS 710 forms

Officer in Charge

20. When in receipt of a TPS 228, or when notified of
    - an MHA apprehension
    - the location of the person named on the Form – MHA is unknown and every reasonable effort to locate the individual has been made

    shall

- ensure all required reports are accurately completed and submitted
- approve and sign completed forms, as necessary
- ensure every effort has been made to locate a next of kin
- ensure appropriate entries are made in the Unit Commander's Morning Report (UCMR)

21. When requested by the Toronto Emergency Medical Services to transport a violent EDP from a residence or hospital to a psychiatric facility shall ensure

- an Application for Admission (Form 1 – MHA) has been signed by a physician
- sufficient police escort
- the ETF is notified prior to the officers attending the address

NOTE: *It will be at the discretion of the Supervisory Officer – ETF as to whether they will attend.*

22. Upon receipt of an original Form – MHA*, which has not been executed* shall ensure

- compliance with item 14
- every effort is made to apprehend the suspected EDP named in the Form – MHA
- the original Form – MHA is maintained at the front desk until the suspected EDP is apprehended or until the Form – MHA has expired

Unit Commander

23. Upon receiving a TPS 649 from an officer who has experienced difficulties at a psychiatric facility shall forward the correspondence to the Unit Commander – DPSU.

24. When in command of a division shall

- designate the divisional Community Relations Officer as the Divisional Mental Health Liaison Officer
- ensure a file is maintained at the front desk with the original Form – MHA until the form expires or the suspected EDP is apprehended

Mental Health Co–ordinator – Divisional Policing Support Unit – Vulnerable Persons

25. In the role of Mental Health Co–ordinator shall

- maintain liaison with Divisional Mental Health Liaison Officers, MCIT and external agencies on mental health issues
- liaise with external psychiatric facilities in order to maintain the list in Appendix B

Associated Documents (LINKS)

Appendix A – Quick Reference Guide for Police Officers – Emotionally Disturbed Persons
Appendix B – Designated Psychiatric Facilities

Procedure 06–04 – Appendix A

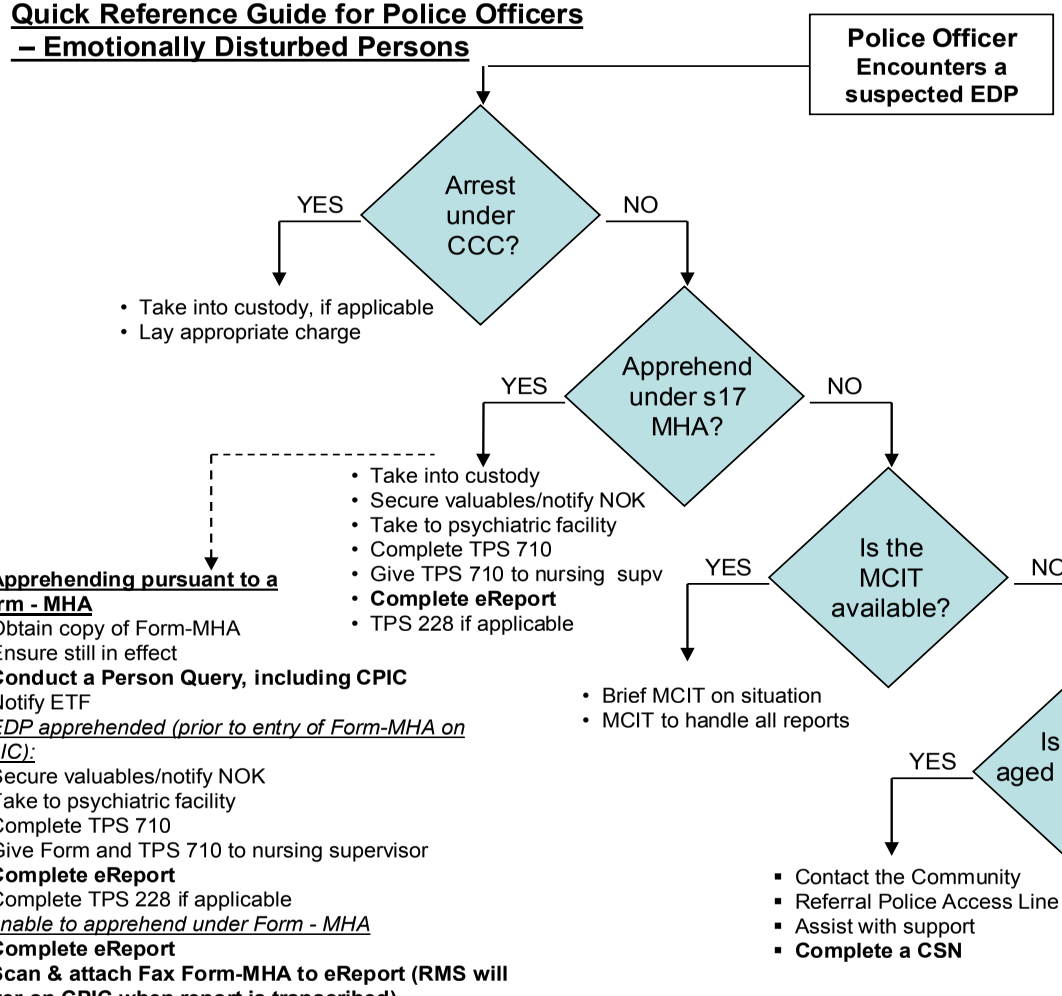
Quick Reference Guide for Police Officers – Emotionally Disturbed Persons

New		Amended	X	Reviewed – No Amendments	

Issued: R.O. 2013.10.30–1216

Replaces: R.O. 2007.12.28–1788

Quick Reference Guide for Police Officers – Emotionally Disturbed Persons



Section 17 MHA – Action by Police Officer

Where a police officer has reasonable and probable grounds to believe that a person is acting or has acted in a disorderly manner and has reasonable cause to believe that the person,

(a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;
(b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or
(c) has shown or is showing a lack of competence to care for himself or herself,

and in addition the police officer is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

(d) serious bodily harm to the person;
(e) serious bodily harm to another person; or
(f) serious physical impairment of the person,

and that it would be dangerous to proceed under section 16 [Justice of the Peace Order for Examination, Form 2], the police officer may take the person in custody to an appropriate place for examination by a physician.

Note: There is no longer a requirement for a police officer to actually observe the person's behaviour and may use information obtained from a third party in order to form reasonable and probable grounds for apprehension. Police officers should obtain and record as much information as possible in situations involving third party reports and request that the complainant sign the officer's memorandum book.

If Apprehending pursuant to a Form - MHA

- Obtain copy of Form-MHA
- Ensure still in effect
- **Conduct a Person Query, including CPIC**
- Notify ETF

If EDP apprehended (prior to entry of Form-MHA on CPIC):

- Secure valuables/notify NOK
- Take to psychiatric facility
- Complete TPS 710
- Give Form and TPS 710 to nursing supervisor
- **Complete eReport**
- Complete TPS 228 if applicable

If unable to apprehend under Form - MHA

- **Complete eReport**
- **Scan & attach Fax Form-MHA to eReport (RMS will enter on CPIC when report is transcribed)**

If EDP apprehended on Form-MHA after CPIC entry made

- **Add supplementary information to original eReport with details of apprehension (RMS will remove from CPIC when report is transcribed)**

COMMUNITY REFERRAL POLICE ACCESS LINE:
POLICE ONLY: [redacted] (24/7)
PUBLIC: (416) 248-4174

Procedure 06–04 – Appendix B

Designated Psychiatric Facilities

New [ ] **Amended** [X] **Reviewed – No Amendments** [ ]

Issued: R.O. 2013.10.30–1216

Replaces: R.O. 2007.12.28–1788

	DIV	HOSPITAL	ADDRESS	REMARKS
1.	11	St. Joseph's Health Centre	30 The Queensway M6R 1B5	Emergency – 24/7
2.	12	Humber River Hospital Church St. Site	200 Church St M9N 1N8	Emergency – 24/7
3.	14	Centre for Addiction & Mental Health (CAMH) Queen St Site	1001 Queen St W M6J 1H4	Non–emergency – 24/7 (only accept MHA Form 9: Order for Return) Officers SHALL attend CAMH – College St Site directly with *MHA* apprehensions
4.	14	University Health Network Toronto Western Hospital	399 Bathurst St M5T 2S8	Emergency – 24/7 Adults (16 yrs +)
5.	23	William Osler Health System Etobicoke General Hospital	101 Humber College Blvd M9V 1R8	Emergency – 24/7 Adults (18 yrs +)
6.	33	North York General Hospital General Site	4001 Leslie St M2K 1E1	Emergency – 24/7 Prefer 32 & 33 Divisions only
7.	41	The Scarborough Hospital General Campus	3050 Lawrence Ave E M1P 2V5	Emergency – 24/7 Regional Crisis Centre – Adults (18 yrs +) Between 0000 – 0800 hrs will accept adult MHA apprehensions from other Scarborough Hospitals 41, 42, 43 Divisions only
8.	42	The Scarborough Hospital Birchmount Campus	3030 Birchmount Rd M1W 3W3	Emergency – 24/7 Adults (18 yrs +)
9.	43	Rouge Valley Health System Rouge Valley Centenary	2867 Ellesmere Rd M1E 4B9	Emergency – 24/7 Regional Crisis Centre – Children & Adolescents (up to 18 yrs)
10.	52	Centre for Addiction & Mental Health (CAMH) College St Site	250 College St M5T 1R8	Emergency – 24/7
11.	52	SickKids	555 University Ave M5G 1X8	Emergency – 24/7 Youth up to 16 yrs (No MHA Form 1s)
12.	52	St. Michael's Hospital	30 Bond St M5B 1W8	Emergency – 24/7 Adults (16 yrs +)

	DIV	HOSPITAL	ADDRESS	REMARKS
13.	53	Sunnybrook Health Sciences Centre Bayview Campus	2075 Bayview Ave M4N 3M5	Emergency – 24/7
14.	54	Toronto East General Hospital	825 Coxwell Ave M4C 3E7	Emergency – 24/7
15.	Peel	Trillium Health Partners Mississauga Hospital	100 Queensway W Mississauga L5B 1B8	Emergency – 24/7 Adults (17 yrs +)
16.	York	MacKenzie Richmond Hill Hospital	10 Trench St Richmond Hill L4C 4Z3	Emergency – 24/7 (No MHA Form 1s)

08 – 05 Substance Abuse

Amendment Pending [X]

IMPORTANT NOTICE: R.O. 2012.07.23-0859

A Routine Order has been issued to change a portion of the procedure that has yet to be incorporated into this version. In addition to the contents contained herein, members shall ensure they follow the direction(s)/amendment(s) contained in the above Routine Order.

New [ ] **Amended** [X] **Reviewed – No Amendments** [ ]

Issued: R.O. 2011.06.30–0728

Replaces: R.O. 2009.01.07–0012

Rationale

The Toronto Police Service (Service) would like to prevent the occurrence of substance abuse, however, it is recognized that substance abuse problems do occur and need to be addressed responsibly by management and members.

Supervision

Attendance

N/A

Mandatory Notification

- Supervisor
  - upon becoming aware of another member's possible substance abuse problem and whenever that member's behaviour creates a safety hazard to anyone

Governing Authorities

Federal
Canadian Charter of Rights and Freedoms
Controlled Drugs and Substances Act

Provincial
Health Protection and Promotion Act
Occupational Health and Safety Act
Human Rights Code
Police Services Act
Regulated Health Professions Act
Workplace Safety and Insurance Act

Other
Relevant Collective Agreements

Associated Service Governance

Number	Name
08–01	Employee and Family Assistance Program (EFAP)
08–02	Sickness Reporting
08-03	Injured On Duty Reporting
08-04	Members Involved in a Critical Incident
09-03	Property – Firearms
Chapter 13	Conduct
15-01	Use of Force
15-16	Uniform, Equipment and Appearance Standards

Forms

Number	Name	Authorization Level
TPS 757	Medical and Health Sick Report	Unit Commander
TPS 765	Injured on Duty Report	Unit Commander
TPS 776	Plainclothes Exemption Consent	Unit Commander
MED 1	Restricted Duties	Medical Advisor – Occupational Health & Safety
MED 2	Release of Member Medical Information to Medical Advisory Services	Member

Definitions

Accommodation means modifying the workplace environment or the functions of a job to enable a member needing medically supported accommodation to perform the essential duties of his or her position or the essential duties of an alternative available position for which the member is qualified.

Health Care Professional means a member of a College regulated under the *Regulated Health Professions Act*.

Medical Advisor means a physician engaged by the Service.

Restricted Duties for the purposes of this Procedure, means work that is modified to permit a member with a disability to work in accordance with limitations imposed by the Medical Advisor – Occupational Health & Safety – Medical Advisory Services (OHS - MAS).

Sick Benefits means sick leave accrued in accordance with the relevant Collective Agreement.

Sickness means an illness/injury that is not work related but which prevents a member from working or completing a tour of duty.

Procedure

For the purposes of this Procedure, substance abuse refers to the use of alcohol, prescription, non-prescription or illegal drugs or other substance in a manner that could have adverse effects on members' health, safety, productivity, quality of family life or the morale and effectiveness of the Service.

Members shall not engage in

i) the illegal use or possession of any of the substances listed in Schedules I, II, III and IV of the *Controlled Drugs and Substances Act*
ii) the use of any other substance, not named in the schedules of the *Controlled Drugs and Substances Act*, to the extent that the said substance may have an adverse effect on the performance of their duties as a member of the Service
iii) the consumption of any alcoholic beverage contrary to Service Governance

A unit commander or supervisor shall not become involved in diagnosing a member's problem but will provide ongoing encouragement to help the member identify and resolve the problem.

Member

1. When voluntarily seeking help for a substance abuse problem shall

   - seek assistance from one or more of, but not limited to OHS - MAS, peers, referral agents, supervisors, the Employee and Family Assistance Program (EFAP), or community–based services
   - make every effort to resolve the problem

2. When treatment requires restricted duties or utilization of Service income replacement benefits shall

   - comply with Procedures 08–02 or 08–03, if applicable
   - notify OHS – MAS
   - comply with the instructions given by the Medical Advisor or designate

3. When directed to attend OHS – MAS for a fitness for duty assessment shall

   - attend as directed
   - comply with the recommendation(s) of the Medical Advisor or designate

4. When a member has been absent for a period longer than ninety (90) consecutive days under any of the following conditions;
   - when deemed not fit for duty,
   - when absent from work due to a non-work related illness/injury,
   - when absent from work due to an work related illness/injury,
   - when absent from work for any reason

   shall return to their unit commander all of their Service issued uniform & equipment including all use of force options, identification card wallet and cap badges, eToken and memorandum book, unless otherwise directed by the Chief of Police.

NOTE: *The surrender of Service issued uniform & equipment is an administrative function. Members shall continue to comply with the PSA, and all Service Governance. A member is an employee of the Service until resignation, retirement, termination or death.*

5. Upon becoming aware of another member's possible substance abuse problem shall

   - encourage the member to seek assistance voluntarily before work performance or safety is affected
   - give immediate assistance, if required, and intervene by notifying a supervisor whenever a member's behaviour creates a safety hazard to anyone
   - follow up, if required, to provide the member with proper support and encouragement to resolve the problem

Supervisor

6. When approached by a member who voluntarily seeks help for a substance abuse problem, where work performance or safety is not affected shall

   - advise the member of options available for assistance including OHS–MAS and EFAP
   - follow up, if required, to provide the member with appropriate support and encouragement to resolve the problem

7. Upon becoming aware of a member who exhibits work performance concerns that may be related to substance abuse, shall

   - determine if there are any immediate fitness for duty or safety concerns
   - discuss performance concerns and expectations with the member
   - encourage the member to seek assistance, where appropriate
   - advise the member of options available for assistance including OHS–MAS and EFAP
   - follow up, if required, to provide the member with proper support and encouragement to resolve the problem
   - provide heightened performance monitoring and management

8. Upon receipt of a TPS 649 and/or a MED 1 containing recommendations from OHS - MAS shall

   - ensure compliance with the restrictions
   - ensure the duties assigned to the member comply with the direction contained in the MED 1
   - report any deviation by the member to their OIC and their unit commander on a TPS 649

Officer In Charge (OIC) or Designate

9. When approached by a member who voluntarily seeks help for a substance abuse problem, where work performance or safety is not affected shall comply with Item 6 of this Procedure.

10. Upon becoming aware of a member who exhibits work performance concerns that may be related to substance abuse, shall comply with Item 7 of this Procedure.

11. When it is determined that there are fitness for duty or safety concerns shall

- ensure the member is given immediate medical treatment, if required
- immediately notify the unit commander of the circumstances on a TPS 649

12. Upon observing that a member is unfit for duty shall

- ensure the member is given immediate medical treatment, if required
- commence an immediate investigation
- initiate the appropriate action depending on the circumstances (e.g. documentation, charges, suspension, etc.)
- comply with Procedures 08-02, 08-03, or 08-04, if applicable
- comply with the applicable Chapter 13 Procedures

13. Upon receipt of a TPS 649 and/or a MED 1 containing recommendations from OHS - MAS shall

- follow up with the member to ensure compliance
- give a copy to the member's immediate supervisor

14. When directed to retrieve Service issued uniform & equipment which has been surrendered and/or returned shall

- place the property in a box and seal with police seals (TPS 214), and submit into the Divisional Locker Management System (DLMS) for storage at the Property & Evidence Management Unit (PEMU)
- comply with Procedure 09-01
- when the member is suspended, forward the eToken to Professional Standards (PRS) - Information Security
- when the member is NOT suspended, forward the eToken to Information Technology Services (ITS) – eToken Administration
- ensure the member's firearm and ammunition, conducted energy weapon (CEW) and air cartridges, and oleoresin capsicum (OC) spray are hand delivered to the Toronto Police College - Armament Section

Unit Commander

15. Upon becoming aware that a member may have a substance abuse problem shall confer with the member's supervisor to determine whether there is any fitness for duty or work performance concerns.

16. After determining that there are no work performance or fitness for duty concerns shall

- confer with the member
- advise the member of options available for assistance including OHS–MAS and EFAP
- follow up, if required, to provide the member with proper support and encouragement to resolve the problem

17. When determining that there are work performance concerns shall

- confer with the member's supervisor and refer the supervisor to the duties described under Item 7 of this Procedure
- confer with the member
- advise the member of options available for assistance including OHS–MAS and EFAP
- follow up, if required, to provide the member with proper support and encouragement to resolve the problem
- ensure that heightened performance monitoring and management is provided

18. When determining that there are fitness for duty concerns shall

- confer with the member
- advise the member of options available for assistance including OHS-MAS and EFAP
- ensure TPS 649 to the Unit Commander – OHS is forwarded requesting a fitness for duty assessment including all relevant facts and history regarding the member (e.g. sick record, performance records, etc.)
- ensure that a mandatory fitness for duty evaluation is arranged, if applicable
- ensure that the member attends for an assessment as determined by the Medical Advisor or designate
- follow up to ensure that the member complies with ongoing recommendations by the Medical Advisor or designate
- follow up, if required, to ensure the member receives proper support and encouragement to resolve the problem
- ensure that heightened performance monitoring and management is provided

19. Upon learning that a member refuses to cooperate with a mandatory fitness for duty evaluation shall take the appropriate disciplinary action.

20. Upon receipt of a TPS 649 and/or a MED 1 containing recommendations from OHS - MAS shall ensure

- the member's OIC is provided with a copy
- the appropriate action is taken
- the duties assigned to the member comply with the directions contained in the MED 1 and/or TPS 649
- the process outlined in this Procedure is reinitiated if work performance or safety concerns reoccur
- when a follow-up is requested by OHS–MAS, a TPS 649 is completed and forwarded to OHS - MAS

21. When a member has been absent for a period longer than ninety (90) consecutive days under any of the following conditions;
   - when deemed not fit for duty,
   - when absent from work due to a non-work related illness/injury,
   - when absent from work due to a work related illness/injury,
   - when absent from work for any reason

shall ensure that the member has returned all of their Service issued uniform & equipment including all use of force options, identification card, wallet and cap badges, eToken and memorandum book, unless otherwise directed by the Chief of Police.

22. When a member has surrendered or has been relieved of their Service issued uniform & equipment, shall ensure Item 14 of this Procedure has been complied with.

NOTE: *Fleet & Materials Management has a master list for uniform & equipment. The Toronto Police College – Armament Section keeps an inventory of weapons (Firearms/CEWs) on Asset Inventory Management System (AIMS). Specialized Operations Command maintains a listing of all approved uniform & equipment for specialized units. These lists should be consulted when a member has surrendered or has been relieved of their Service issued uniform & equipment, as applicable.*

NOTE: *A Senior Officer in consultation with the Staff Superintendent/Director may, at any time, relieve the member of their Service issued uniform & equipment including all use of force options, identification card, wallet & cap badge, eToken and memorandum book or appropriate items as deemed necessary.*

Medical Advisor – Occupational Health & Safety – Medical Advisory Services

23. Upon receipt of TPS 649 requesting a fitness for duty assessment shall

- request reports from the member's unit commander
- make arrangements through the affected member's unit commander
- ensure a determination is made regarding the member's fitness for duty

24. Upon conclusion of the member's evaluation and/or treatment, shall

- assess fitness for duty
- if the member is fit for duty, determine recommendations, if applicable
- notify the member's unit commander on a TPS 649 and/or MED 1
- monitor compliance
- make further recommendations, if required

EMERGENCIES & HAZARDOUS INCIDENTS

10 – 01 Emergency Incident Response

New ☐ **Amended** ☒ **Reviewed – No Amendments** ☐

Issued: R.O. 2014.05.05–0599

Replaces: R.O. 2013.10.30–1216

Rationale

This Procedure provides direction to ensure a standard approach when responding to any emergency incident including those involving hazardous materials, infrastructure disruptions that may involve utility and power failures, natural hazards such as severe weather or a disease or other health risk.

Supervision

Attendance

- Supervisory Officer
  - when determined by the first member on scene or by Communications Services
  - when responding to a Level 2 or 3 Incident

Mandatory Notification

- Supervisory Officer
  - when responding to any emergency incident

Governing Authorities

Federal
Criminal Code
Emergencies Act

Provincial
City of Toronto Act
Emergency Management and Civil Protection Act
Occupational Health and Safety Act, and its Regulations
Police Services Act, O.Reg. 3/99, Adequacy and Effectiveness of Police Services

Municipal
Toronto Municipal Code, Chapter 59 – Emergency Management

Other
City of Toronto Emergency Plan
Emergency Response Guidebook – A Guide for First Responders During the Initial Phase of a Dangerous Goods/Hazardous Materials Incident
Ministry of Community Safety and Correctional Services Emergency Response Plan

Associated Service Governance

Number	Name
TPSB ER-001	Preliminary Perimeter Control & Containment

TPSB ER-004	Major Incident Command
TPSB ER-008	Emergency Plan
04–02	Death Investigations
04–16	Death in Police Custody
04–21	Gathering/Preserving Evidence
05–07	Fire Investigations
05–09	Tampering or Sabotage of Food, Drugs, Cosmetics or Medical Devices
07–04	Railway Collisions
08–03	Injury Reporting
08–06	Hazardous Materials, Decontamination and De–infestation
08–07	Communicable Diseases
Chapter 10	Emergencies & Hazardous Incidents
Chapter 11	Crowd Control
17–01	News Media
17–02	Major News Reports
20–15	Special Events

Forms

Number	Name	Authorization Level
	eReports	GO Review
TPS 648	Situation Report	as appropriate
TPS 698	After Action Report Summary	Staff Superintendent

Definitions

- **Access**
- **Command Post**
- **Egress**
- **Emergency**
- **Emergency Operations Centre (EOC)**
- **Emergency Preparedness Committee (EPC)**
- **Hold and Secure**
- **Incident Commander**
- **Incident Commander Cadre (ICC)**
- **Incident Management System (IMS)**
- **Incident Management System Team (IMS Team)**
- **Level 1 – Emergency Response**
- **Level 2 – Major Incident**
- **Level 3 – Disaster Incident**
- **Lockdown**
- **Materiel**
- **Police Command Centre (PCC)**
- **Senior Management Team (SMT)**
- **Shelter in Place**
- **Staging**
- **Toronto Emergency Management Program Committee (TEMPC)**
- **Unified Command**

Procedure

This Procedure has been divided in three levels of operation: Level 1 – Emergency Response, Level 2 – Major Incident and Level 3 – Disaster Incident. Whether an incident is a Level 1, 2 or 3 will be determined by proper assessment and the application of identified criteria.

Depending upon the circumstances, the emergency response can begin at any one of the three levels, and includes the steps in the previous levels.

Emergency Planning

The Service has enhanced its emergency planning ability by the creation of the Emergency Preparedness Committee (EPC). The EPC is mandated to increase the emergency preparedness; planning, mitigating, responding to and recovering from emergency incidents.

To achieve this mandate, the EPC has established sub-committees reflective of the Incident Management System (IMS): Public Information, Health and Safety, Investigative, Operations, Planning, Logistics, and Administration and Finance. Emergency Management & Public Order (EM&PO) plays an integral role in the EPC as their members are active in each of the sub–committees.

The EPC also works closely with external stakeholders promoting emergency preparedness and positively contributing to a cohesive emergency response as required.

Incident Management System (IMS)

The IMS is based on a doctrine enacted by the Ministry of Correctional Services and Community Safety that recommends IMS as the emergency preparedness model in Ontario. The Ontario Association of Chiefs of Police (OACP) has adopted the IMS as the recommended emergency preparedness system for Ontario police services. The IMS can be used in any size or type of emergency to manage response personnel, facilities and equipment.

The basic modules of the IMS can be expanded or contracted to meet the requirements of the incident as it progresses. Implementation of the IMS is recommended for all emergency responders in Ontario thereby ensuring an effective and co-ordinated emergency response to large-scale and complex emergency incidents. Chapter 10 – Appendix A provides a detailed chart of the IMS model.

Although the first member on scene assumes the role of Incident Commander, the Service has established a cadre of trained Incident Commanders, capable of assuming incident command whenever called upon do so.

As well, Emergency Management, a sub–unit of EM&PO, is staffed by members who respond to and assist in the management of Level 2 – Major Incidents and Level 3 – Disaster Incidents.

Undertaking the strategic role, the PCC may be activated for Level 2 – Major Incident or Level 3 – Disaster Incident emergencies and should be staffed according to the nature and scope of the event. Such staffing will include an officer of sufficient training, rank and authority to access and redirect personnel and materiel support as required, as well as liaise with other policing partners and external agencies. It is recommended that once activated, staffing for command and control should follow the IMS in compliance with Chapter 10 – Appendix A.

Although the IMS may be adopted in response to planned events, the directions in this Procedure are intended for response to unplanned emergencies.

Communication Strategy

In order to ensure the safety of the public, emergency responders and Service members, an effective communication strategy is vital to impart crucial information to all involved at the beginning, during and at the completion of an emergency. When developing a communication strategy, the Incident Commander shall ensure Corporate Communications is consulted, and that the following are considered

- the target audience (general public, other agencies, Service members)
- the information to include in the communication
- the form of communication (public address, radio/television, telephone, news releases)
- will the communication be accessible to the target audience?

LEVEL 1 – EMERGENCY RESPONSE

All Members

1. In addition to the provisions of this Procedure, shall also comply with the procedure addressing the specific incident, if applicable.

First Member

2. When responding to an emergency incident shall

- exercise caution when approaching the site, particularly when hazardous materials are indicated or suspected

- designate a line of approach to the scene that allows for the least risk possible and notify the Communications Operator – Communications Services (Communications Operator) of this route

- assess the situation and notify the Communications Operator of
  - the type of incident
  - the location and extent of damage
  - potential hazards
  - the need for additional members and specialized response
  - the need for a supervisory officer to attend
  - whether immediate traffic diversion is required
  - whether Emergency Medical Services (EMS) or Toronto Fire Services (TFS) response and equipment are required
  - the location of the command post, if necessary

- take charge of the scene, assuming the role of the initial Incident Commander and implement IMS as required until relieved of these duties (refer to Chapter 10 – Appendix A for IMS chart and position profiles)

- if not a police officer, take charge of the scene until relieved by the first attending police officer

- assign members to complete necessary functions such as
  - securing inner and outer perimeter in compliance with Chapter 10 – Appendix A, if necessary
  - clearing access and egress routes for responding emergency vehicles

- ensuring access to scene is restricted to authorized personnel
- establishing a staging area for additional responding units/agencies
- establishing a command post at a safe distance and near other emergency services command posts, when safe to do so

- liaise with other responding emergency services supervisors
- maintain radio communication
- ensure persons are assisted to safety
- comply with Procedure 10–09 if an evacuation is required
- when necessary and if qualified to do so, perform the required standard first aid treatment and/or cardio–pulmonary resuscitation (CPR), using universal precautions at all times
- notify a supervisor

3. Upon arrival of EMS or TFS personnel shall continue to render assistance until relieved by such persons.

4. After the at–scene portion of the incident has been concluded shall complete the applicable eReports prior to the completion of the tour of duty.

Additional Members

5. When responding to an emergency incident shall

- exercise caution when approaching the site, particularly if hazardous materials are indicated or suspected
- in the absence of a supervisory officer or the Incident Commander, take direction from the first police officer
- take direction from the Incident Commander
- report to the command post or staging area when relieved

First Supervisory Officer

6. When responding to an emergency incident shall exercise caution when approaching the site, particularly if hazardous materials are indicated or suspected.

7. After being briefed by the first member or first officer on scene shall

- assess the need to assume the role of Incident Commander and assume the role until relieved of this function, if necessary
- reassess the situation
- advise the Communications Operator of the status of Incident Commander and the new assessment of the incident and any new information

- notify the divisional officer in charge

- consider expanding the IMS as necessary by assigning members to complete necessary functions

- ensure the following are established, co–ordinated and supervised
  - secure inner and outer perimeters in compliance with Chapter 10 – Appendix B, if necessary
  - clear access and egress routes for responding emergency vehicles
  - access to scene is restricted to authorized personnel
  - staging area for additional responding units
  - a command post located at a safe distance and near other emergency services command posts, when safe to do so

- assign one police officer at the scene to maintain radio communication with the Communications Operator and command post support staff, as required

- ensure all members are directed to complete and submit the applicable eReports prior to the completion of their tour of duty

Officer in Charge

8. When notified of an emergency incident shall advise the unit commander, if appropriate.

Incident Commander

9. If assessing that the situation has escalated and is becoming a Level 2 – Major Incident shall

   - take appropriate immediate action, consider expanding the IMS as necessary by assigning members to complete necessary functions

   - notify the Operations Supervisor – Communications Services (Operations Supervisor) and request that the divisional officer in charge, Duty Desk and the EM&PO unit be notified to monitor and attend as required

10. When responding to an incident

    - shall ensure a communication strategy is developed and communicated in compliance with the Communication Strategy section of this Procedure

    - may assign responsibility for the communication strategy to a Member – Corporate Communications

11. Upon conclusion of an emergency incident shall complete an After Action Report, as required.

Unit Commander – Corporate Communications

12. In consultation with the Incident Commander shall ensure the appropriate Member – Corporate Communications assists and/or develops and communicates a communication strategy in compliance with the Communication Strategy section of this Procedure.

LEVEL 2 – MAJOR INCIDENT

First Supervisory Officer

13. When responding to a Level 2 – Major Incident shall

- notify the officer in charge and the Duty Desk
- request the Communications Operator to notify the on–call member of EM&PO
- consider obtaining the assistance of additional members from neighbouring divisions
- request assistance, as required, from such specialized units/services as
  - EM&PO
  - EM&PO – Mounted
  - Specialized Emergency Response – Emergency Task Force
  - Specialized Emergency Response – Marine
  - Specialized Emergency Response – Police Dog Services
  - Intelligence Services
  - Corporate Communications
  - Occupational Health & Safety
  - Divisional Policing Support Unit – Volunteer Resources
  - other police services
  - Regional Police Air Support Units (when authorized by the Duty Inspector or other senior officer)
- when in the role of Incident Commander, continue in the role until relieved
- expand the IMS as necessary by assigning members to complete necessary functions (refer to Chapter 10 – Appendix A)
- ensure the following are established and supervised
  - secure inner and outer perimeters in compliance with Chapter 10 – Appendix B, if necessary
  - clear access and egress routes for responding emergency vehicles
  - access to scene is restricted to authorized personnel
  - staging area for additional responding units/agencies
  - a command post located at a safe distance and near other emergency services command posts and relocate if necessary
- if not already on scene, ensure the attendance of EMS and/or TFS, as required
- ensure persons are assisted to safety when safe to do so
- assess and determine whether it is appropriate to recommend Shelter in Place, to commence evacuation, or in the case of a school, Hold and Secure, or a Lockdown
- comply and ensure compliance with
  - Procedure 10–09 if an evacuation is required
  - Procedure 10–13 if a school is involved

Officer in Charge of Responding Units

14. When notified of a Level 2 – Major Incident shall update the unit commander.

Incident Commander

15. When responding to a Level 2 – Major Incident shall

- ensure that the duties listed for the First Supervisory Officer are completed
- co–ordinate and manage the police response to the incident, ensuring
  - the necessary functions of the IMS are being addressed
  - sufficient police, emergency and support agency personnel attend
  - conduct regular briefings with members of the IMS Team
  - conduct unified command briefings with other responding agencies

16. If assessing the situation to be a Level 3 – Disaster Incident shall contact the Operations Supervisor to request the attendance of a Duty Inspector.

On–Call Member – Emergency Management & Public Order

17. When notified of a Level 2 – Major Incident shall

- notify the Inspector – EM&PO
- monitor the developing situation and attend the scene as directed by the Inspector – EM&PO
- if assigned to attend the scene, reassess the situation upon arrival

Inspector – Emergency Management & Public Order

18. When notified of a Level 2 – Major Incident shall

- monitor the developing situation
- attend the scene in the first instance, or the PCC when necessary
- reassess the situation upon arrival
- update the Unit Commander – EM&PO

Unit Commander – Emergency Management & Public Order

19. When notified of a Level 2 – Major Incident shall notify the
  - Staff Superintendent – Public Safety Operations
  - Staff Superintendent – Detective Operations
  - Staff Superintendents – Area/Central Field.

Staff Superintendent – Public Safety Operations

20. When notified of a Level 2 – Major Incident shall

- contact the Inspector – EM&PO and/or the Incident Commander at the incident to receive a full briefing

- in consultation with the Inspector – EM&PO assess the nature of the incident and designate an appropriate Incident Commander if required or, assess the appropriateness of the current Incident Commander determining whether relief is required from the ICC

- contact the Deputy Chief – Specialized Operations Command and fully brief

- if required, activate and attend the PCC in accordance with IMS to provide strategic support to the Incident Commander at the disaster sites by managing all response efforts outside the inner perimeter including requests for additional human resources, materiel support, heavy equipment, information, safety instructions for emergency responders and media relations

- in consultation with the Incident Commander manage the flow of information, verifying its integrity before dissemination to command officers, elected officials and Service members and provide the public with safety instructions through regular news and Public Service announcements by Corporate Communications

- in consultation with the Deputy Chief – Specialized Operations Command co–ordinate all response activities with the EOC, when activated, and other affiliated municipal, provincial and federal agencies, boards, commissions and departments, as required

- ensure essential police services continue to be provided to areas unaffected by the incident

- ensure long term strategic planning options and recovery issues are continuously reviewed

- ensure the PCC remains capable of operating on a continuous basis (24/7) as long as is required to support the incident and that such relief staffing includes an officer of sufficient training, rank and authority to access and redirect personnel and material support as well as liaise with other policing partners and external agencies

- ensure the incident is being properly documented and records kept of all personnel involved, equipment appropriated, materiel allocated and costs expended

- ensure any other strategic support is provided as required

Staff Superintendent – Detective/Area/Field Services

21. When notified of a Level 2 – Major Incident shall

    - contact the respective Deputy Chief and fully brief

    - ensure essential police services continue to be provided to areas unaffected by the incident

LEVEL 3 – DISASTER INCIDENT

Police Officer Assigned to Maintain Radio Communication

22. When notified of a Level 3 – Disaster Incident or impending disaster shall request the Communications Operator to notify
    - the Duty Desk

- the on–call EM&PO member
- the unit commander/officer in charge of the affected divisions, when appropriate.

Incident Commander

23. When responding to a Level 3 – Disaster Incident shall

- establish communication with the PCC at local 8–8880 and request personnel and logistical support
- update the PCC, as required

On–Call Member – Emergency Management & Public Order – Emergency Management

24. When notified of a Level 3 – Disaster Incident shall

- notify the Inspector – EM&PO and take direction, as required
- contact the Incident Commander to receive a situation report on the incident
- determine the needs of the Incident Commander and provide support as necessary

Inspector – Emergency Management & Public Order

25. When notified of a Level 3 – Disaster Incident shall

- attend the scene, if required
- if not required at the scene, attend the PCC, when necessary
- reassess the situation upon arrival

Unit Commander – Emergency Management & Public Order

26. When notified of a Level 3 – Major Incident shall notify the
    - Staff Superintendent – Public Safety Operations
    - Staff Superintendent – Detective Operations
    - Staff Superintendents – Area/Central Field.

Staff Superintendent – Public Safety Operations

27. After the at–scene portion of the incident has been concluded shall in consultation with the Inspector – EM&PO, the Incident Commander, Deputy Chief – Specialized Operations Command and/or the Chief of Police

- identify the appropriate support to be given victims and responding emergency personnel
- assist in co–ordinating the demobilization of police resources at the scene

- assist in identifying the appropriate measures to be undertaken to further enhance recovery and restoration of services at the community level

- ensure the operation has been properly documented, including all costs associated with the police response, with all necessary reports completed and post event investigations conducted

USE OF FORCE AND EQUIPMENT

15 – 01 Use of Force

New [ ] **Amended** [X] **Reviewed – No Amendments** [ ]

Issued: R.O. 2014.06.16–0738

Replaces: R.O. 2014.05.09–0599

Rationale

The Toronto Police Service (Service) places the highest value on the protection of life and the safety of its members and the public, with a greater regard for human life than the protection of property. Members of the Service have a responsibility to only use that force which is reasonably necessary to bring an incident under control effectively and safely.

The Ontario Use of Force Model (Model) is an aid to promote continuous critical assessment and evaluation of every situation, and can assist members to understand and make use of a variety of force options to respond to potentially violent situations. It is not intended to serve as a justification for a member's use of force, nor does it prescribe specific response options appropriate to any given situation. However, the Model does provide a valuable framework for understanding and articulating the events associated with an incident involving a member's use of force.

Supervision

Attendance

- Firearm Discharge Investigator or Supervisory Officer

Mandatory Notification

- Supervisory Officer
  - firearm discharge
  - when a conducted energy weapon has been used
- Officer in Charge (OIC) of Division of occurrence
  - firearm discharge

Governing Authorities

Federal Criminal Code

Provincial Police Services Act
Police Services Act, O.Reg. 3/99, Adequacy & Effectiveness of Police Services
Police Services Act, O.Reg. 926/90, Equipment and Use of Force
Ontario Use Of Force Model (2004)

Other Policing Standards Manual

Associated Service Governance

Number	Name
TPSB Policy	Use of Force
04–02	Death Investigations
04–21	Gathering/Preserving Evidence
08–04	Members Involved in a Traumatic Critical Incident
10–06	Medical Emergencies
13–16	Special Investigations Unit
13–17	Memorandum Books and Reports
14–20	Auxiliary Members
15–02	Injury/Illness Reporting
15–04	Service Firearms
15–05	Shotguns
15–09	Conducted Energy Weapon
15–10	Suspect Apprehension Pursuits
15–16	Uniform, Equipment and Appearance Standards
17–03	Municipal Freedom of Information and Protection of Privacy Act

Forms

Number	Name	Authorization Level
TPS 105	Injury/Illness Report	Unit Commander
TPS 584	Conducted Energy Weapon Use Report	Unit Commander
TPS 586	Firearm Discharged Report	Unit Commander
TPS 649	Internal Correspondence	Member
UFR Form 1	Use of Force Report	Officer in Charge

Definitions

- **Authorized Range**
- **Conducted Energy Weapon (CEW)**
- **Dispatching of an Animal**
- **Firearm**
- **Firearm Discharge**
- **Firearm Discharge Investigator (FDI)**
- **Firearm Discharge Investigator – Professional Standards (FDI – PRS)**
- **Handgun**
- **Rifle or Long Gun**
- **Use of Force Review Committee (UFRC)**

Procedure

The *Criminal Code* (CC) empowers every person who is required or authorized to do anything in the administration or enforcement of the law, when acting on reasonable grounds, to use as much force as necessary for that purpose. Every person is liable, both criminally and civilly, for any unjustified or excessive force used.

Training

Ontario Regulation 926/90 (*O.Reg. 926/90*) made under the *Police Services Act* (PSA) prohibits a member of a police service from using force on another person, unless the member has successfully completed the prescribed training course on the use of force, and that at least once every twelve (12) months, members who may be required to use force on other persons receive a training course on the use of force. When a use of force option is employed, its application shall be in keeping with the training received.

Approved Use of Force Options

Ontario Regulation 3/99 provides that, at minimum, police officers are

- issued a handgun
- issued oleoresin capsicum (OC) aerosol spray
- issued a baton and
- trained in officer safety, communication and physical control techniques.

Members shall not use a weapon other than a firearm unless

- that type of weapon has been approved for use by the Solicitor General
- the weapon conforms to technical standards established by the Solicitor General
- the weapon is used in accordance with standards established by the Solicitor General
- the weapon, in the course of a training exercise, is used on another member in compliance with Service Governance.

Intermediate Force Options

Members may use an intermediate weapon such as their issued baton, OC spray or conducted energy weapon (CEW) as a force option

- to prevent themselves from being overpowered when violently attacked
- to prevent a prisoner being taken from police custody
- to disarm an apparently dangerous person armed with an offensive weapon
- to control a potentially violent situation when other force options are not viable
- for any other lawful and justifiable purpose

Weapons of Opportunity

Despite the foregoing, nothing in *O.Reg. 926/90* or this Procedure prohibits a member from the reasonable use of weapons of opportunity when none of the approved options are available or appropriate to defend themselves or members of the public.

Authorized Restraining Devices

Handcuffs, leg irons and other restraints authorized by the Chief of Police (e.g. plastic flexi–cuffs) may be used

- to control the violent activities of a person in custody
- when prisoners are being transferred from one place to another
- to prevent a prisoner from escaping

Fleeing Suspect

A peace officer, and every person lawfully assisting the peace officer, is justified in using force that is intended or is likely to cause death or grievous bodily harm to a person to be arrested, if

a) the peace officer is proceeding lawfully to arrest, with or without warrant, the person to be arrested;
b) the offence for which the person is to be arrested is one for which that person may be arrested without warrant;
c) the person to be arrested takes flight to avoid arrest;
d) the peace officer or other person using the force believes on reasonable grounds that the force is necessary for the purpose of protecting the peace officer, the person lawfully assisting the peace officer or any other person from imminent or future death or grievous bodily harm; and
e) the flight cannot be prevented by reasonable means in a less violent manner.

[Authority: *CC,* s. 25(4)]

Motor Vehicles

Discharging a firearm at a motor vehicle is an ineffective method of disabling the vehicle. Discharging a firearm at a motor vehicle may present a hazard to both the officer and to the public. Members are prohibited from discharging a firearm at a motor vehicle for the sole purpose of disabling the vehicle.

Members shall not discharge a firearm at the operator or occupants of a motor vehicle unless there exists an immediate threat of death or grievous bodily harm to officers and/or members of the public by a means other than the vehicle.

Members shall be cognizant that disabling the operator of the motor vehicle thereby disabling the control over the motor vehicle may also present a hazard to both the officer and the public.

Except while in a motor vehicle, members shall not place themselves in the path of an occupied motor vehicle with the intention of preventing its escape. Additionally, members should not attempt to disable an occupied vehicle by reaching into it.

Pursuant to Procedure 13–03 and 13–05, any apparent breach of this Procedure will be carefully considered on its merits having regard to all the circumstances before discipline is commenced.

Excessive Force

Everyone who is authorized by law to use force is criminally responsible for any excess thereof according to the nature and quality of the act that constitutes the excess. (Authority: CC, s. 26)

Reporting Use of Force

Ontario Regulation 926/90 compels members to submit a UFR Form 1 to the Chief of Police when a member

- uses physical force on another person that results in an injury that requires medical attention
- draws a handgun in the presence of a member of the public, excluding a member of the police force while on duty
- discharges a firearm
- points a firearm regardless if the firearm is a handgun or a long gun,
- uses a weapon other than a firearm on another person

NOTE: *For the purpose of reporting a use of force incident, the definition of a weapon includes a police dog or police horse that comes into direct physical contact with a person.*

Additionally, members are required to submit a UFR Form 1 and a TPS 584 to the Chief of Police when the member uses a CEW

- as a "demonstrated force presence"
- in drive stun mode or full deployment, whether intentionally or otherwise

Use of force reports are collected and used to identify individual and group training requirements, or Service use of force governance requirements.

Team Reports

Specialized Emergency Response – Emergency Task Force (ETF) and Emergency Management & Public Order – Public Safety (Public Safety), when operating/responding as a team, shall submit a Team Report UFR Form 1 in situations where force, meeting the reporting requirements, is merely displayed. An incident in which force was actually used, including the Demonstrated Force Presence of a CEW, requires a separate UFR Form 1 from each individual member involved.

Exemptions to the Reporting Criteria

A UFR Form 1 is not required when

- a firearm, other than an issued handgun, is merely carried or displayed by a member
- a handgun is drawn or a firearm pointed at a person or is discharged in the course of a training exercise, target practice or ordinary firearm maintenance in accordance with Service Governance
- a weapon other than a firearm is used on another member of the Service in the course of a training exercise
- physical force is used on another member of the Service in the course of a training exercise

Use of Force Reports – Prohibited Uses

Under no circumstances shall the UFR Form 1, or the personal identifiers associated with Part B be retained beyond the limitations dictated by *O.Reg. 926/90*, and in accordance with Board Policy.

The UFR Form 1 shall not be admitted in evidence at any hearing under Part V of the *PSA*, other than a hearing to determine whether the police officer has contravened s. 14.5 of *O.Reg. 926/90* and Service Governance on use of force reporting.

The information from the UFR Form 1 shall not be contained in an officer's personnel file.

The UFR Form 1 shall not be introduced, quoted from, or in any way referred to, during considerations of promotion or job assignment without the consent of the reporting officer.

Duplication/Disclosure/Retention

Members shall not make or retain a copy of the UFR Form 1 for any purpose, except as required to conduct a proper analysis for training purposes and Service Governance review.

Where a court order, subpoena, or prosecutor's request for disclosure of the UFR Form 1 is received, such request shall be directed to Legal Services. Where the request is made under the *Municipal Freedom of Information & Protection of Privacy Act* and not by a court order, subpoena, or prosecutor's request for disclosure, such request shall be directed to the Co–ordinator – Records Management Services – Access and Privacy Section.

Additional Training

The unit commander of a member who has been identified with a training issue shall submit a TPS 649 to the Unit Commander – Toronto Police College (TPC) detailing the issue. TPC shall be responsible for liaising with a unit commander recommending individual training for a member, and shall schedule the required training in accordance with unit specific guidelines. Final determination on individual training will be made by the Unit Commander – TPC.

Additional Investigative Requirements – Firearm Discharge

When a member of the Service discharges a firearm, the Duty Inspector shall be notified forthwith.

The Firearm Discharge Investigator from Professional Standards (FDI–PRS) shall be responsible for all administrative investigations pertaining to firearm discharges. The discharging officer's supervisor is required to complete a Firearm Discharge Report. Based on the type of firearm discharge a supervisor from the involved member's unit may be assigned to support and assist the FDI–PRS in the investigation.

Exemption to the Additional Investigative Requirements

A FDI is not required when investigating the discharge of an impact projectile launcher or a tear gas launching device, where the projectile expelled by the firearm is designed or intended as a less–lethal mechanism.

The investigation and report on the incident shall be the responsibility of the unit commander, in conjunction with the training staff, of the unit responsible for the discharge.

Auxiliary Members

Auxiliary members are not issued firearms except with the consent of the Chief of Police.

With the exception of firearms, the provisions of this Procedure regarding training, use of force options and the reporting of force used shall also govern auxiliary members.

Member

1. Members shall not use force on another person unless they have successfully completed the prescribed training course on the use of force.

2. Members who may be required to use force on other persons shall complete a training course on the use of force at least once every twelve (12) months.

3. Members

   - unless otherwise authorized, shall only use the use of force options identified in the Approved Use of Force Options and Intermediate Force Options sections in this Procedure

   - may use weapons of opportunity when none of the approved options are available or appropriate to defend themselves or members of the public

4. Unless otherwise authorized, members shall

   - only use their Service issued baton

   - not use impact devices commonly known as 'saps' or 'blackjacks'

NOTE: *Batons are the only impact weapon permitted for use when dealing directly with the public.*

5. When authorized to use OC aerosol spray shall

   - only use it when other options reasonably present a risk of injury to a subject or themselves

   - make all reasonable efforts to decontaminate sprayed individuals at the earliest safe or practicable opportunity, including the consideration of aerosol water mist decontamination devices

6. When issued with and/or authorized to carry firearms or ammunition shall

   - not draw a handgun, point a firearm at a person, or discharge a firearm unless
     - there are reasonable grounds to believe that to do so is necessary to protect against loss of life or serious bodily harm (Authority: *O.Reg. 926/90*, s.9)
     - engaged in a training exercise, target practice or ordinary weapon maintenance (Authority: *O.Reg. 926/90*, s.9.1)
     - the discharge of a handgun or other firearm is to call for assistance in a critical situation, if there is no reasonable alternative [Authority: *O.Reg. 926/90*, s.10(a)]
     - the discharge of a handgun or other firearm is to destroy an animal that is potentially dangerous or is so badly injured that humanity dictates that its suffering be ended [Authority: *O.Reg. 926/90*, s.10(b)]

   - not discharge a firearm
     - at a motor vehicle for the sole purpose of disabling the vehicle
     - at the operator or occupants of a motor vehicle unless there exists an immediate threat of death or grievous bodily harm to the officers and/or members of the public by a means other than the vehicle
     - as a warning shot

   NOTE: *Warning shots present an unacceptable hazard to both the public and the police.*

7. When it is necessary to discharge a Service issued firearm for the purpose of dispatching an animal shall comply with Procedure 15–04.

8. In critical situations shall, when tactically appropriate

   - avoid confrontation by disengaging to a place of safety

   - take all reasonable measures to contain the scene

   - notify the communications operator and request the attendance of
     - a supervisory officer
     - Emergency Medical Services (EMS), if required

9. When the use of force results in an injury to a person shall

   - comply with Procedure 10–06

   - ensure the person receives proper medical attention, making all reasonable efforts to relieve their discomfort

   - notify the communications operator and request the attendance of

- a supervisory officer
- EMS, if required

10. Members unless engaged in an approved training exercise shall submit a UFR Form 1 to their supervisor prior to the completion of the tour of duty when they
    - use physical force on another person that results in an injury that requires medical attention
    - draw a handgun in the presence of a member of the public, excluding a member of the police force while on duty
    - discharge a firearm
    - point a firearm regardless if the firearm is a handgun or a long gun,
    - use a weapon other than a firearm on another person
    - use a CEW as Demonstrated Force Presence, Drive Stun Mode, Full Deployment or when an unintentional discharge occurs

11. When a CEW is used as a Demonstrated Force Presence, in Full Deployment, Drive Stun Mode, or when an unintentional discharge occurs shall comply with Procedure 15–09.

12. When discharging any firearm other than at an authorized range or under the exemption provisions shall immediately notify
    - their supervisor
    - the OIC of the division in which the discharge occurred.

    NOTE: *As per the Firearm Discharge definition, this includes discharges that occur at an authorized range or under the exemption provisions* ***that result in injury or death****.*

13. After the at–scene portion of the event has concluded shall

    - complete a
        - UFR Form 1 when force has been used
        - TPS 105 when injury or illness has occurred
        - TPS 584 when a CEW is used as Demonstrated Force Presence, Drive Stun Mode, Full Deployment or unintentional discharges

    - attach the TPS 105 and TPS 584 , as applicable, to the UFR Form 1 and submit to their supervisor prior to the completion of the tour of duty

    - where critical incident stress may have occurred, comply with 08–04

14. When additional use of force training has been recommended by the unit commander shall attend as directed.

15. When becoming aware of a firearm discharge by a law enforcement officer other than a member of the TPS shall immediately notify their supervisor.

16. When making recommendations regarding training, equipment or policy issues related to the use of force shall submit details of the recommendations on a TPS 649 to the unit commander.

Supervisor

17. When notified of a firearm discharge incident shall

    - attend the scene immediately

- ensure the scene and all evidence are protected and collected in compliance with Procedure 04–21
- exercise all due caution to ensure the evidence is not contaminated, overlooked or destroyed
- advise the OIC at the first available opportunity and provide regular updates
- ensure the OIC of the division in which the firearm discharge occurred has been notified, if the discharge did not occur in the members home unit
- support and assist the FDI – PRS and investigate as required
- complete and submit a TPS 586 to the OIC prior to the completion of the tour of duty

18. Upon receipt of a UFR Form 1 shall

- where critical incident stress may have occurred, comply with 08–04
- ensure the report is completed in accordance with this Procedure
- ensure the TPS 105, TPS 584 and TPS 586, as applicable, are attached to the UFR Form 1
- submit the completed UFR Form 1 and TPS forms to the OIC prior to the completion of the tour of duty
- where a member is incapable of completing the UFR Form 1, as the immediate supervisor, complete the member's portion
- if recommending additional training, complete the applicable section of the UFR Form 1
- comply with the provisions of Procedure 15–04, if applicable

Divisional Firearm Discharge Investigator

19. When detailed to attend a firearm discharge incident shall support and assist the FDI – PRS and investigate as directed.

Officer in Charge

20. Upon being notified of a firearm discharge by a member shall

- ensure a FDI or applicable supervisor is assigned to support and assist the FDI – PRS during the course of the firearm discharge investigation in accordance with the 'Additional Investigative Requirements – Firearm Discharge' section of this Procedure
- where the firearm discharge results in injury or death to a person, notify the unit commander and comply with the provisions contained in Procedures 04–02 and 13–16, as applicable
- notify the Officer in Charge – Duty Desk forthwith

- ensure a description of the event is detailed in the Unit Commander Morning Report (UCMR)

21. Upon receipt of a UFR Form 1 shall

- where critical incident stress may have occurred, comply with 08–04
- ensure the TPS 105, TPS 584 and TPS 586, as applicable, are attached to the UFR Form 1
- ensure the reports are accurate and complete
- if recommending additional training, complete the applicable section of the UFR Form 1
- forward the completed reports to the unit commander, prior to the completion of the tour of duty
- comply with the provisions of Procedure 15–04, if applicable

Unit Commander

22. When in command of members who, in the course of their duties, may be required to use force on other persons shall ensure

- the members have successfully completed a training course on the use of force
- at least once every 12 months, the members receive a training course on the use of force

23. When notified that a firearm discharge has occurred shall ensure the incident is investigated in accordance with this Procedure.

24. Upon being notified of a firearm discharge shall ensure a FDI or applicable supervisor is assigned to support and assist the PRS – FDI, as requested.

25. Upon receipt of a UFR Form 1 and the TPS 105, TPS 584 and TPS 586, as applicable, shall

- where critical incident stress may have occurred, ensure compliance with Procedure 08–04
- ensure the forms are accurate and complete
- if recommending additional training, complete the applicable section of the UFR Form 1
- ensure the completed forms are distributed appropriately

NOTE: *The original TPS 586 shall be forwarded to PRS by the next business day.*

The applicable forms shall be forwarded to the Training Analyst – TPC within four (4) days of receipt.

- comply with the provisions of Procedure 15–04, if applicable
- except for information pertaining to additional training, as outlined in item 27, ensure the information from a UFR Form 1 is not contained in a member's personnel file

26. In addition to the duties described above, where a use of force results in serious injury or death, shall comply with Procedure 13–16.

27. When additional training is recommended for a member shall

- forward a TPS 649 to the Unit Commander – TPC, with a copy to the appropriate Staff Superintendent or Director
- ensure the member attends training as directed
- ensure all information pertaining to additional training is included in the member's personnel file, except the UFR Form 1

28. When receiving or making recommendations regarding training, equipment or policy issues about the use of force shall forward a TPS 649 to the Training Analyst – TPC.

Officer in Charge – Duty Desk

29. Upon being notified of a firearm discharge by a member or another law enforcement officer shall notify the Duty Inspector and on-call FDI – PRS forthwith.

Duty Inspector

30. Upon being notified of a firearm discharge shall ensure the

- incident is investigated in accordance with this Procedure
- on-call FDI-PRS has been notified

31. In addition to the duties described above, where a use of force results in serious injury or death, shall comply with Procedure 13–16.

32. When becoming aware of a firearm discharge within the City of Toronto by a law enforcement officer other than a member of the TPS shall liaise with the agency and ensure all appropriate action is taken.

Firearm Discharge Investigator – Professional Standards

33. When advised that a firearm discharge incident has occurred shall

- take charge of the investigation
- direct all required resources to ensure compliance with the additional investigative requirements
- conduct a thorough investigation and submit the appropriate report

Unit Commander – Toronto Police College

34. In addition to unit specific guidelines, shall ensure a member is designated as the Training Analyst to

- schedule and co–ordinate additional use of force training
- review all UFR Form 1, TPS 105, TPS 584 and TPS 586 reports, as applicable, to identify individual and group training requirements
- if individual training requirements are identified, conduct a further review of the use of force incident and direct appropriate remedial training through the applicable unit commander
- if group training requirements are identified, conduct a further review of required training and make changes as appropriate
- conduct ongoing review and evaluation of all use of force procedures, training and reporting
- submit an annual CEW report

Unit Commander – Professional Standards Support

35. Unit Commander – Professional Standards Support shall ensure

- a database of use of force data from Part A of all UFR Form 1 reports is maintained
- at least once every calendar year, a study, including an analysis of use of force trends for the entire Service, which does not contain data that identifies reporting police officers, is produced

Staff Superintendent – Corporate Risk Management

36. Upon receipt of an administrative report for a firearm discharge, in addition to unit specific guidelines, shall

- ensure a thorough investigation has been conducted and appropriate reports submitted
- ensure recommendations concerning policy or training are forwarded to the UFRC
- have final sign–off authority on the conduct portion of the investigation

Associated Documents (LINKS)

Appendix A – Provincial Use of Force Model
Appendix B – Provincial Use of Force Model Background Information

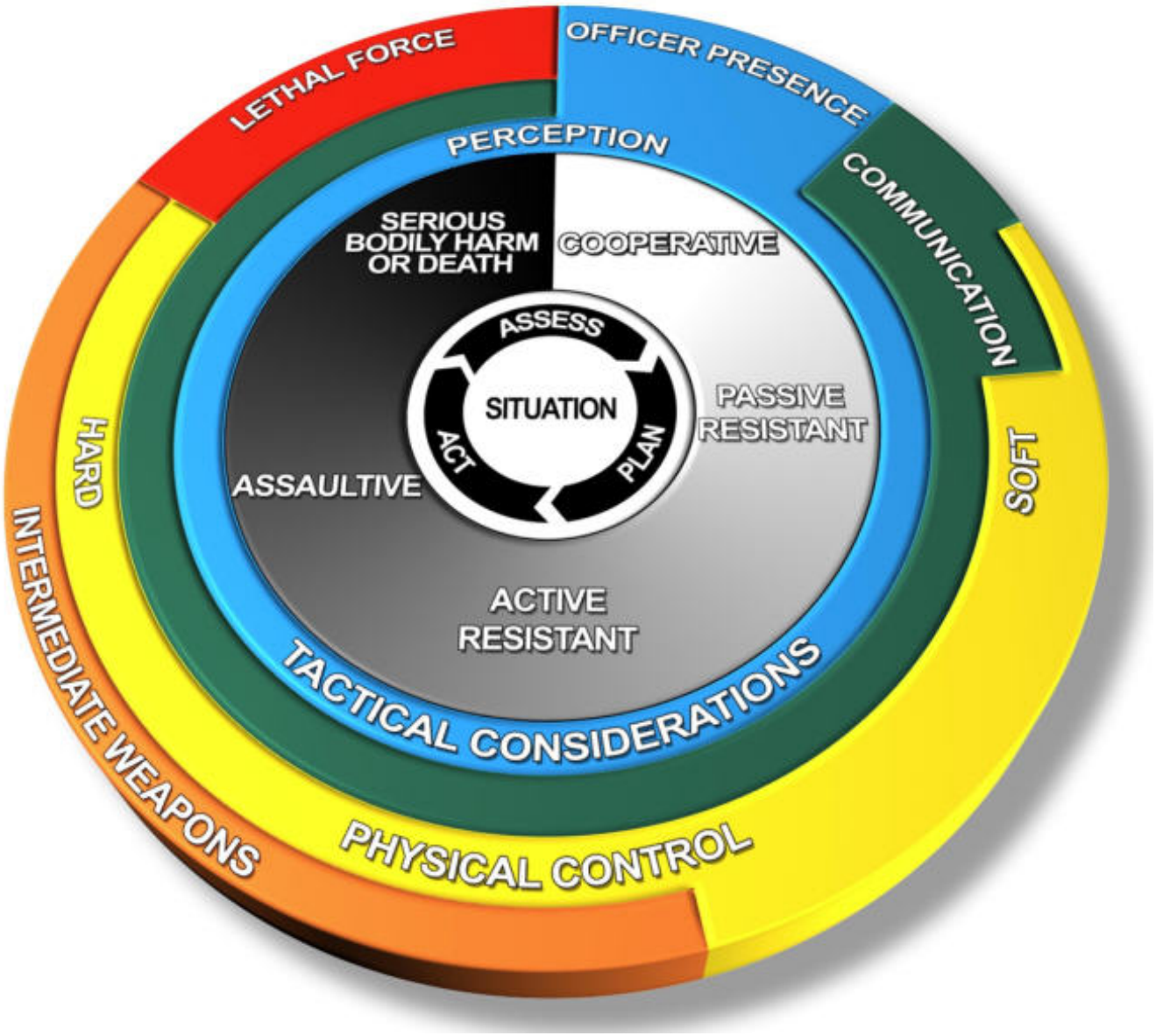
Procedure 15–01 – Appendix A

Provincial Use of Force Model

New	[X]	**Amended**	[ ]	**Reviewed – No Amendments**	[ ]

Issued: R.O. 2009.02.18–0180

Provincial Use of Force Model



Procedure 15–01 – Appendix B

Provincial Use of Force Model

New	X	Amended		Reviewed – No Amendments	

Issued: R.O. 2009.02.18–0180

Provincial Use of Force Model

BACKGROUND INFORMATION

New Ontario Use of Force Model (2004)

Introduction

The new Ontario Use of Force Model – 2004 (based on the National Use of Force Framework) is a graphical representation of the various elements involved in the process by which a police officer assesses a situation and acts in a reasonable manner to ensure officer and public safety. The Model assists officers and the public to understand why and in what manner an officer may respond with force.

As an aid to training, the Model promotes continuous critical assessment and evaluation of each situation and assists officers to understand and make use of a variety of force options to respond to potentially violent situations.

The Ontario Use of Force Model (2004) is not intended to serve as a justification for officer use of force nor does it prescribe specific response option(s) appropriate to a situation. The Model does provide a valuable framework for understanding and articulating the events associated with an incident involving officer use of force.

History

Graphical models describing use of force by officers first began to appear in the 1970s in the United States. These early models depicted a rather rigid, linear-progressive process, giving the impression that the officer must exhaust all efforts at one level prior to being allowed to consider alternative options. A frequent complaint lodged against these early models was that they did not accurately reflect the dynamic nature of potentially violent situations, in which the entire range of officer, subject and force options must be constantly assessed throughout the course of the interaction.

In Canada, use of force models first began appearing in the 1980's, one of the first being the provincial model of Nova Scotia, followed by Quebec in the early 1990's. In 1994, as part of a comprehensive use of force strategy, Ontario developed a provincial use of force model, and a number of other provinces and the Royal Canadian Mounted Police have since followed suit.

In 1999, the Canadian Association of Chiefs of Police (CACP) endorsed an initiative involving a proposal to develop a National Use of Force Framework. In April of the same year, use of force experts and trainers from across Canada met at the Ontario Police College to undertake to draft a National Use of

Force Framework. As conceived by the CACP and the use of force experts and trainers, the National Use of Force Framework would bring together into one model all of the best theory, research and practice about officer use of force. The model would be dynamic, support officer training, and facilitate professional and public understanding of officer use of force.

In Ontario, the National Framework, along with updated Provincial Use of Force Guidelines, were vetted through the Policing Standards Advisory Committee (PSAC) The new Ontario Use of Force Model-2004 (based on the National Framework) was endorsed by PSAC and has subsequently been approved by the Minister for release.

The Principles

Six basic principles underlie the Ontario Use of Force Model (2004).

1. The primary responsibility of a peace officer is to preserve and protect life.

2. The primary objective of any use of force is to ensure public safety.

3. Police officer safety is essential to public safety.

4. The Ontario Use of Force Model (2004) does not replace or augment the law; the law speaks for itself.

5. The Ontario Use of Force Model (2004) was constructed in consideration of (federal) statute law and current case law.

6. The Ontario Use of Force Model (2004) is not intended to dictate policy to any agency.

The Model - Description

The Ontario Use of Force Model (2004) was developed to assist in the training of officers and as a reference when making decisions and explaining their actions with respect to a use of force. The model does not justify an officer's actions.

The inner-most circle of the model, labelled "SITUATION", contains the "*assess-plan-act"* component which should be visualized as dynamic as an officer's "assessment" of a situation is never-ending. The process of continuous assessment also helps to explain how a behaviour (and response option) can change from co-operative to assaultive (or from communication to lethal force) in a split second without passing through any other behaviour or force options.

The area adjacent to the "SITUATION" contains the various subject behaviour categories including cooperative, resistant, assaultive and serious bodily harm or death.

Perception and Tactical Considerations are interrelated and are therefore contained in the same area, or ring on the model. Factors that the officer brings to the situation, that are unique to the individual officer *interact* with both situational and behavioural factors to determine how an officer may perceive or assess the situation. Further, the officer's perception of a situation may affect his/her assessment and, in turn his/her tactical considerations.

The outer area of the model represents the officer's use of force options. These options range from officer presence to communication skills, physical control techniques, intermediate weapons and lethal force.

Though officer presence and communication skills are not *physical* use of force options, they have been included to illustrate the full range of factors that have an impact on the behaviour of the subject.

THE ASSESSMENT PROCESS:

The process of assessing a situation is threefold involving:

1. **The Situation,**
2. **Subject Behaviours,** *and*
3. **Officer's Perception / Tactical Considerations**

Careful consideration of all possible factors within each of the above categories, assists the officer in understanding, and responding to situations, and in explaining to others how a particular situation was perceived, assessed, and responded to.

The examples provided throughout this document are presented for the purpose of illustration, and are by no means exhaustive.

1. THE SITUATION:

When an officer responds to an incident, he or she must assess various aspects of the immediate situation. There are at least six different conditions that can characterize a situation. Each of these may become part of the officer's assessment.

It should be noted that some of these factors may fall under more than one category (i.e. situation, subject behaviour, or perception/tactical considerations). Additionally the following lists are not exhaustive. They are simply common factors that an officer can expect to consider when making their decisions.

a) Environment
There will be times when environmental conditions may affect the officer's assessment of the situation.

- weather conditions: rain, snow, wind, heat, etc.
- moment of the day: daylight or darkness
- location: residential, rural, urban, indoor, outdoors
- physical position: roof top, roadside, stairwell, cell area
- other factors: cover, concealment

b) Number of Subjects
The number of officers versus the number of subjects will affect the officer's assessment of the situation:

- one subject facing one officer
- one subject facing two or more officers
- multiple subjects facing one officer
- multiple subjects facing multiple officers

c) Perceived Subjects' Abilities
The officer's perception of a subject's various characteristics will affect his or her assessment of the situation:

- under the influence of drugs or alcohol

- intoxicated vs. under the influence
- subject's physical size, strength, skills
- emotional state
- proximity to weapons

d) Knowledge of Subject
Prior knowledge may affect the officer's assessment of the situation. He or she may be aware of the subject's criminal history, reputation, or the officer may have had prior contacts with the subject.

- Canadian Police Information Centre (CPIC) information
- previous history, reputation
- demonstrated ability

e) Time and Distance
The concept of time and distance refers to those conditions that determine whether an officer must respond immediately or whether a delayed response may be employed. For example, in situations where there is a pressing threat to public safety, an immediate response may be unavoidable. In other situations, conditions may allow the officer to delay his or her response. For example, the availability of cover, the imminent arrival of backup, or simply being able to increase the distance between the officer and the subject may allow the officer to reduce the threat and delay responding until conditions are more favourable. The officer must address the following time and distance factors as part of the *Assess-Plan-Act* process.

- seriousness of situation
- must you act immediately
- can you create more time and distance
- escape routes

f) Potential Attack Signs
A subject may give clues to his or her intentions. The following list includes physical behaviours displayed by a subject that have been known to precede an attack on a police officer.

- ignoring the officer
- repetitious questioning
- aggressive verbalization
- emotional venting
- refusing to comply with lawful request
- ceasing all movement
- invasion of personal space
- adopting an aggressive stance
- hiding

2. SUBJECT BEHAVIOURS:

Central to the *Assess-Plan-Act* process is the behaviour of the subject. The model records five different categories of subject behaviour in the circle adjacent to the *SITUATION*. The gradual blending of colours in this circle reflects the fact that the boundaries between categories are difficult to distinguish. It is often difficult to differentiate between categories of behaviour. Where a subject falls in these categories is in part dependent upon the officer's perception. The following describes each of the five categories of subject behaviour.

Co-operative

The subject responds appropriately to the officer's presence, direction and control.

Resistant (Passive)
The subject refuses, with little or no physical action, to cooperate with the officer's lawful direction. This can assume the form of a verbal refusal or consciously contrived physical inactivity.

Resistant (Active)
The subject uses non-assaultive physical action to resist, or while resisting an officer's lawful direction. Examples would include pulling away to prevent or escape control, or overt movements such as walking toward, or away from an officer. Running away is another example of active resistance.

Assaultive
The subject attempts to apply, or applies force to any person; attempts or threatens by an act or gesture, to apply force to another person, if he/she has, or causes that other person to believe upon reasonable grounds that he/she has, present ability to effect his/her purpose. Examples include kicking and punching, but may also include aggressive body language that signals the intent to assault**.**

Serious Bodily Harm or Death
The subject exhibits actions that the officer reasonably believes are intended to, or likely to cause serious bodily harm or death to any person. Examples include assaults with a knife stick or firearm, or actions that would result in serious injury to an officer or member of the public.

3. PERCEPTION AND TACTICAL CONSIDERATIONS:

Perception and Tactical Considerations are two separate factors that may affect the officer's overall assessment. Because they are viewed as interrelated, they are graphically represented in the same area on the model. They should be thought of as a group of conditions that mediate between the inner two circles and the responses available to the officer.

The mediating effect of the *Perception and Tactical Considerations* circle explains why two officers may respond differently to the same situation and subject. This is because tactical considerations and perceptions may vary significantly from officer to officer and/or agency to agency. Two officers, both faced with the same tactical considerations may, because they possess different personal traits, or have dissimilar agency policies or guidelines, assess the situation differently and therefore respond differently. Each officer's perception will directly impact on their own assessment and subsequent selection of tactical considerations and/or their own use of force options.

PERCEPTION:

How an officer sees or perceives a situation is, in part, a function of the personal characteristics he or she brings to the situation. These personal characteristics affect the officer's beliefs concerning his or her ability to deal with the situation. For various reasons, one officer may be confident in his or her ability to deal with the situation and the resulting assessment will reflect this fact. In contrast to this, another officer, for equally legitimate reasons, may feel the situation to be more threatening and demanding of a different response. The following list includes factors unique to the individual officer which interact with situational and behavioural factors to affect how the officer perceives and, ultimately assesses and responds to a situation.

Factors that may be unique to the individual officer include but are not limited to:

- strength/overall fitness

- personal experience
- skill/ability/training
- fears
- gender
- fatigue
- injuries
- critical incident stress symptoms
- cultural background
- sight/vision

TACTICAL CONSIDERATIONS:

An officer's assessment of a situation may lead to one of the following tactical considerations. Conversely, these same factors may impact on an officer's assessment of a situation.

- Disengage and consequences**
- Officer appearance
- Uniform and equipment
- Number of officers
- Availability of backup
- Availability of cover
- Geographic considerations
- Practicality of containment, distance, communications
- Agency policies and guidelines
- Availability of special units and equipment: canine, tactical, helicopter, crowd management unit,
- Command post, etc.

** Note: An officer's primary duty is to protect life and preserve the peace. However, when a situation escalates dangerously, or when the consequences of continued police intervention seriously increase danger to anyone, the option to disengage may be considered appropriate. It is also recognized that due to insufficient time and distance or the nature of the situation, the option to disengage may be precluded. If the officer determines the option to disengage to be tactically appropriate, the officer may consider disengagement with the goal being containment and consideration of other options, such as, seeking alternative cover, waiting for back-up, specialty units, etc.

*US*E OF FORCE OPTIONS

The situation, subject's behaviour, the officer's perception and tactical considerations drive the *Assess-Plan-Act* process. Based on the assessment, the officer must develop a plan that involves selecting what he or she feels to be an appropriate response. The following section discusses the categories of response options available to the officer.

In the model's outer ring, there are five use of force options. They range from the simple presence of the officer to lethal force. Unlike the representation of the subject's behaviour there is a great deal of overlap amongst these options. For example, the *Communication* circle overlaps with *Physical Control, Intermediate Weapons* and the *Lethal Force* options. This overlap indicates that the officer may use several of these options at the same time.

There is an approximate correspondence between the model's depiction of a subject's behaviours and the use of force options available to the officer. Because each officer has different personal characteristics that affect his or her perception and because each situation presents different tactical

considerations, the correspondence between the subject's behaviour and that of the officer can never be precise. How reasonable one considers an officer's actions can be judged only after one considers the complex interplay amongst the situation, the subject's behaviour, the officer's perceptions and tactical considerations.

The force options may be used alone or in combination to enable the officer to control the situation. The premise of the model is that an officer's perception and tactical considerations are specific to the situation. The dynamic nature of the situation requires continual assessment, therefore, the force options selected may change at any point.

The following provides a brief discussion of the five use of force options available to an officer.

Officer Presence
While not strictly a use of force option, the simple presence of an officer can affect both the subject and the situation. Visible signs of authority such as uniforms and marked police cars can change a subject's behaviour.

Communication
An officer can use verbal and non-verbal communication to control and/or resolve the situation.

The Police Challenge (*"Police, Don't Move!"*) is to be delivered loudly and clearly, when a handgun is drawn or a firearm is presented in response to a threat to life, or threat of serious bodily harm, recognizing that some circumstances, due to the need for an instantaneous response, may not immediately allow for the use of the challenge.

Physical Control
The model identifies two levels of physical control: soft and hard. In general, physical control means any physical technique used to control the subject that does not involve the use of a weapon.

Soft techniques are control oriented and have a lower probability of causing injury. They may include restraining techniques, joint locks and non-resistant handcuffing. *Hard* techniques are intended to stop a subject's behaviour or to allow application of a control technique and have a higher probability of causing injury. They may include empty hand strikes such as punches and kicks.

Intermediate Weapons
This use of force option involves the use of a less-lethal weapon. Less-lethal weapons are those whose use is not intended to cause serious injury or death. Impact weapons and aerosols fall under this heading.

Lethal Force
This use of force option involves the use of any weapons or techniques that are intended to, or are reasonably likely to cause serious bodily harm or death.

Summary

The Ontario Use of Force Model (2004) represents the process by which an officer assesses, plans and responds to situations that threaten public and officer safety. The assessment process begins in the centre of the model with the SITUATION confronting the officer. From there, the assessment process moves outward and addresses the subject's behaviour and the officers *Perceptions* and *Tactical*

Considerations. Based on the officer's assessment of the conditions represented by these inner circles, the officer selects from the use of force options contained within the model's outer circle. After the officer chooses a response option the officer must continue to *Assess-Plan* and *Act* to determine if his or her actions are appropriate and/or effective or if a new strategy should be selected. The whole process should be seen as dynamic and constantly evolving until the SITUATION is brought under control. Authority to use force separates law enforcement officials from other members of society and the reasonable use of force is central to every officer's duties. The Ontario Use of Force Model (2004) provides a framework that guides the officer in that duty.

15 – 09 Conducted Energy Weapon

New [ ] **Amended** [X] **Reviewed – No Amendments** [ ]

Issued: R.O. 2014.05.09–0599

Replaces: R.O. 2009.10.13–1308

Rationale

In February 2004, the Ministry of Community Safety and Correctional Services approved the use of Conducted Energy Weapons (CEWs) for tactical units, hostage rescue teams, preliminary perimeter control containment teams and qualified front–line supervisors. The CEW is designed as a less–lethal weapon and is a legitimate force option within the Ontario Use of Force Model.

The hand held CEW when applied directly, is specifically designed to gain control of a subject who is assaultive as defined by the *Criminal Code* (CC). This includes threatening behaviour if the officer believes the subject intends and has the ability to carry out the threat, or where the subject presents an imminent threat of serious bodily harm or death, which includes suicide threats or attempts.

When CEW contact is made with a subject in Full Deployment, it delivers a metered and pulsed electrical current, which is designed to result in involuntary muscle spasms and loss of motor control. This may cause a subject to become incapacitated, permitting officers the opportunity to gain control of the subject.

Supervision

Attendance	Mandatory Notification
	• Supervisory Officer – when a CEW has been used

Governing Authorities

Federal
Criminal Code
Firearms Act

Provincial
Police Services Act
Police Services Act, O.Reg. 926/90, Equipment and Use of Force
Police Services Act, O.Reg. 3/99, Adequacy and Effectiveness of Police Services

Other
Ontario Use Of Force Model

Associated Service Governance

Number	Name
TPSB Policy	Use of Force

08–06	Hazardous Materials, Decontamination and De–infestation
13–16	Special Investigations Unit
13–17	Memorandum Books and Reports
15–01	Use of Force
15–02	Injury/Illness Reporting
15–16	Uniform, Equipment and Appearance Standards

Forms

Number	Name	Authorization Level
TPS 105	Injury/Illness Report	Officer in Charge
TPS 584	Conducted Energy Weapon Use Report	Unit Commander
TPS 594	Location of Issued Conducted Energy Weapon	Police Officer
TPS 649	Internal Correspondence	Member
TPS 901	Policy, Service or Conduct Report	Unit Commander
UFR Form 1	Use of Force Report	Officer in Charge

Definitions

Conducted Energy Weapon (CEW) means a weapon that primarily uses propelled wires to conduct energy that affects the sensory and/or motor functions of the central nervous system.

Conducted Energy Weapon Use means Demonstrated Force Presence or Drive Stun Mode or Full Deployment or an unintentional discharge.

Demonstrated Force Presence (DFP) means that the CEW is un-holstered and/or pointed in the presence of a subject and/or a spark is demonstrated and/or the laser sighting system is activated to gain compliance of a subject.

Drive Stun Mode (DSM) means when the device is placed in direct contact with the subject and the current is applied without the probes being propelled.

Full Deployment (FD) means the CEW is used wherein the probes are fired at a subject and the electrical pulse applied. In this mode, the device is designed to override the subject's nervous system and affect both the sensory and motor functions causing incapacitation.

SDTH Regulations means the *Storage, Display, Transportation and Handling of Firearms by Individuals Regulations* (SOR/98-209) pursuant to the *Firearms Act*.

Subject for the purposes of this Procedure, means either a person or an animal.

Procedure

The hand held CEW when applied directly, is designed to gain control of a subject who is assaultive as defined by the CC. This includes threatening behaviour if the officer believes the subject intends and has the ability to carry out the threat, or where the subject presents an imminent threat of serious bodily harm or death, which includes suicide threats or attempts.

The CEW may not be effective under certain circumstances, including encountering heavy clothing, having only one probe in contact with the subject and/or other weapon limitations. Officers should be prepared to adjust their use of force options accordingly.

The device, therefore, when applied directly, is used strictly to gain control of a subject who is at risk of causing harm, not to secure compliance of a subject who is merely resistant. This policy limits the deployment of the device to the more serious of circumstances.

Full Deployment or Drive Stun Mode use should be considered an appropriate force option in relation to the Use of Force Model, beginning at subject behavior considered "assaultive". It should not be used on children, pregnant women or the elderly except under exceptional circumstances wherein the use of other force options would reasonably be expected to cause greater potential injury.

Any time a CEW is activated, the date, time and duration of the firing is recorded in a microchip. This data will be downloaded for analysis and audit purposes. Under no circumstances shall a member remove the digital power magazine (DPM) from the weapon. Only members of Toronto Police College – Armament Office shall conduct modifications or replacement of the DPM.

The CEW has a built–in weapon management system to prevent misuse/abuse and protect officers from unfounded allegations through documentation of usage.

Use of CEW

Police officers may use a CEW as a force option

- to prevent themselves from being overpowered when violently attacked
- to prevent a prisoner being taken from police custody
- to disarm an apparently dangerous person armed with an offensive weapon
- to control a potentially violent situation when other use of force options are not viable
- for any other lawful and justifiable purpose.

Prohibitions on Use of CEW

Police officers shall NOT use a CEW in Drive Stun Mode or Full Deployment on a subject who is

- operating a motor vehicle, bicycle or other conveyance, except as a last measure to protect life
- subdued and under control
- known to have been in contact with flammable liquids, or in a flammable atmosphere (e.g. natural gas leak, drug lab), except as a last measure to protect life, or
- in a precarious position or location where a fall will likely cause serious injury or death.

CEW Use Reporting Responsibilities

Any time a CEW is used as Demonstrated Force Presence, Drive Stun Mode, Full Deployment or unintentional discharges, a UFR Form 1 and a TPS 584 shall be completed and submitted prior to the completion of the tour of duty.

Police Officer

1. When issued with a CEW shall

    - carry it in the approved holster on the support side, in a cross–draw fashion

- conduct a spark test at the beginning of each tour of duty while pointing the CEW into a firearm proving unit and record the spark test in the memorandum book

- comply with other standards as detailed in Procedure 15–16

- submit a TPS 594 to the unit commander through the officer in charge

- whenever there is a subsequent change in the choice of storage election, notify the unit commander of that change

2. When permanently issued with a CEW shall store the CEW with the safety switch on 'safe', with the air cartridges removed, in the assigned firearm storage locker along with all of the air cartridges.

3. When electing to regularly store their CEW at their principal residence while off duty, rather than at their assigned unit shall

   - be subject to the provisions of the *SDTH Regulations*

   - transport the CEW directly to their principal residence

   - immediately upon arrival at their principal residence ensure the CEW is stored with the safety switch on 'safe', and the air cartridges removed

   - ensure that the CEW is unloaded while stored and shall be stored using either one of the two options
     - CEW and issued air cartridges will be stored in a securely locked container, receptacle or room that is secure. If this method is used, the CEW must be rendered inoperable using a secure locking device (i.e. a trigger lock)
     - CEW and issued air cartridges will be stored in a securely locked vault, safe or room that has been specifically constructed or modified for a restricted or prohibited firearm. If this method is used, the CEW does not need to be rendered inoperable

   NOTE: The Service will not provide a CEW storage container for officers who elect to store a CEW at other than a Service facility.

4. Whenever a CEW is cycled for any reason, including the mandatory spark test, shall record the particulars in the memorandum book.

5. When the CEW is used as a Demonstrated Force Presence shall

   - notify a next level supervisor at the first available opportunity

   - complete and submit a UFR Form 1 and a TPS 584 to the officer in charge prior to the completion of the tour of duty

6. When the CEW is used in Drive Stun Mode or Full Deployment shall

   - verbally caution the subject before use, when practicable

   - immediately secure the subject

   - advise the subject that they have been subjected to a CEW and that the effects are short term

- request the attendance of Toronto Emergency Medical Services (EMS) and monitor the subject until their arrival

- unless circumstances make it impossible, restrain the subject in a sitting position to promote easier and more efficient breathing, monitoring them closely

- allow only EMS personnel or medical staff to remove the probes, when the skin has been punctured

  NOTE: *Service personnel are authorized to remove the probes that are only attached to clothing.*

- notify a next level supervisor at the first available opportunity

- complete and submit a UFR Form 1 and a TPS 584 to the officer in charge prior to the completion of the tour of duty

- complete and submit a TPS 105 when injuries result

- attach a copy of the TPS 105 to the TPS 584

  NOTE: *Injuries include, but are not limited to, probe marks when the CEW is used in Full Deployment or burn marks when used in Drive Stun Mode.*

- comply with Procedure 15–01 and 15–02, if applicable

7. When a CEW is unintentional discharge shall

   - notify a next level supervisor at the first available opportunity

   - complete and submit a UFR Form 1 and a TPS 584 to the officer in charge prior to the completion of the tour of duty

   - complete and submit a TPS 105 when injuries result

   - attach a copy of the TPS 105 to the TPS 584

8. Whenever a CEW is used shall present the CEW to the officer in charge to download the stored data as soon as practicable but prior to the completion of the tour of duty.

   NOTE: *All divisions, Traffic Services and the ETF have CEW downloading capability from the officer in charge's workstation. Officers attached to an identified specialty units have been assigned a specific nearby division for this purpose.*

9. When a CEW Full Deployment has occurred, or in the event of an unintentional discharge, shall

   - separate the cartridge from the probes by breaking the attached wires and carefully place fired probes into a sharps container found in the Bio–Hazard Kit which is standard issue in all scout cars

     NOTE: *Probes that have penetrated a body should be considered a bio–hazard and safety precautions should be used.*

   - comply with disposal instructions contained in Procedure 08–06

- package the expended air cartridge in a plastic property bag
- document the particulars on a TPS 649 and submit along with the expended air cartridge package to the officer in charge to obtain a replacement air cartridge

Supervisory Officer

10. In addition to the foregoing shall
    - ensure the officer in charge is notified of the CEW use
    - ensure compliance with Procedure 15–01 and 15–02, as applicable
    - ensure the UFR Form 1, the TPS 584 and, if applicable, the TPS 105 are properly completed and submitted to the officer in charge
    - ensure the officer presents the CEW to the officer in charge to download the stored data as soon as practicable but prior to the completion of the tour of duty.
    - complete the officer's portion of the UFR Form 1 when an officer is incapable of doing so
11. If the CEW use occurs in other than the police officer's home unit shall ensure the officer in charge of the division where the CEW use occurred is notified of the use.

Officer in Charge

12. Upon being notified of CEW use shall
    - ensure a description of the event is detailed in the Unit Commander's Morning Report (UCMR)
    - ensure compliance with Procedure 15–01 and 15–02, as applicable
    - ensure all reports including the UFR Form 1, the TPS 584 and, if applicable, the TPS 105 are properly completed
    - if the discharge is unintentional, submit a TPS 901 to the unit commander prior to the completion of the tour of duty
13. Whenever a CEW is used shall as soon as practicable but prior to the completion of the tour of duty
    - download the stored data

    NOTE: *All divisions, Traffic Services and the ETF have CEW downloading capability from the officer in charge's workstation. Officers attached to an identified specialty units have been assigned a specific nearby division for this purpose.*

    - save the data to the respective officer's folder
    - attach a hard copy of the download to the UFR Form 1, TPS 584 and, if applicable, the TPS 105

- submit all relevant reports to the unit commander

14. When in receipt of the expended air cartridge package and accompanying TPS 649 shall ensure

    - the expended air cartridge package and the TPS 649 are delivered to the unit commander for replacement approval

    - where replacement has been approved, the TPS 649 and the cartridge package are transported to Toronto Police College – Armament Office

15. Upon notification of CEW use within the division by a police officer from another unit shall ensure a description of the event is detailed in the UCMR.

16. When in receipt of a TPS 594 shall review and forward to the unit commander.

Unit Commander

17. When in charge of a unit where CEWs are authorized for use shall

    - review and approve as required any TPS 649 requesting
      - replacement equipment
      - additional training with the CEWs

    - ensure a TPS 594 is completed for each officer who is issued a CEW and the TPS 594 is placed in the officer's personnel file

18. Upon receipt of a TPS 105, TPS 584, UFR Form 1 and hard copy CEW download shall

    - review for accuracy and appropriateness of CEW use

    - forward to the Use of Force Analyst – Toronto Police College as soon as practicable but no later than 72 hours after CEW use

    - if additional training is identified, document the particulars on a TPS 649 and forward to the Unit Commander – Toronto Police College

19. Upon receipt of a TPS 901 shall review and take the appropriate action.

Unit Commander – Toronto Police College

20. The Unit Commander – Toronto Police College shall ensure

    - a summary of CEW use involving Demonstrated Force Presence, Drive Stun Mode, Full Deployment or an unintentional discharge is presented to the Use of Force Review Committee for review

    - software and file storage requirements to retain usage data from the CEWs are maintained

    - the Armament Officer conducts random download of the data from the Service–owned CEWs for audit purposes