Public Safety Canada | Sécurité publique Canada

ARCHIVED - Archiving Content

ARCHIVÉE - Contenu archivé

Archived Content

Information identified as archived is provided for reference, research or recordkeeping purposes. It is not subject to the Government of Canada Web Standards and has not been altered or updated since it was archived. Please contact us to request a format other than those available.

Contenu archivé

L'information dont il est indiqué qu'elle est archivée est fournie à des fins de référence, de recherche ou de tenue de documents. Elle n'est pas assujettie aux normes Web du gouvernement du Canada et elle n'a pas été modifiée ou mise à jour depuis son archivage. Pour obtenir cette information dans un autre format, veuillez communiquer avec nous.

This document is archival in nature and is intended for those who wish to consult archival documents made available from the collection of Public Safety Canada.

Some of these documents are available in only one official language. Translation, to be provided by Public Safety Canada, is available upon request.

Le présent document a une valeur archivistique et fait partie des documents d'archives rendus disponibles par Sécurité publique Canada à ceux qui souhaitent consulter ces documents issus de sa collection.

Certains de ces documents ne sont disponibles que dans une langue officielle. Sécurité publique Canada fournira une traduction sur demande.

Canada

International Conference
of
Law and Mental Health

Paris

July 2005

A Study of Fatal Interactions
between
Canadian Police and Mentally Ill Persons

1992-2002

Phase 1

Terry G. Coleman, MOM., MHRM.
Dorothy Cotton PhD., C. Psych.

Table of Contents

Introduction

Fatalities resulting from the interaction of the mentally ill and police officers are truly tragedies. They are tragedies for the mentally ill person and their families and friends as well as tragedies for the police officer(s) involved and their families, colleagues and friends.

Under most circumstances in Canada, when a person dies while in the custody of a police officer, a Coroner's Inquest or a Fatality Inquiry is held to examine the reasons the death occurred and to make recommendations to avoid similar situations in the future. While the inquiries/inquests are diligent and probing in determining the cause, the juries[1] are comprised of laypersons with limited knowledge and understanding of how police officers, and police organizations, as well as health care services including mental health services, operate. Consequently, the recommendations of juries, while generally useful, are sometimes difficult to implement or may make little difference to a future similar incident even if they are implemented.

The purpose of this study was to examine the circumstances and resulting recommendations in situations where the direct actions of a police officer in a "confrontation" with a mentally-ill person resulted in the death of that person. Although not a common occurrence in Canada, it is in the interests of all parties to examine the circumstances to enable learning so that such incidents may be prevented in the future. To the best of the authors' knowledge, the type of study, comparison and analysis subject of this report has not previously been conducted in Canada.

The initial impetus for this study was the perception by police officers that inquests/inquiries, such as those subject of this study, focused most of their recommendations on police agencies and that many of these recommendations were concerned with the relatively simplistic notion that more training for police officers was an essential solution for future problems. The study, therefore, sought to explore this perception.

The study has been conducted in two phases. Phase 1, subject of this report, identified the situations and analyzed the recommendations of the relevant inquests/inquiries to determine commonalities between each inquest/inquiry. Phase II, which is still underway, followed up with the respective police agency to determine if police agencies have implemented those recommendations affecting them and to determine whether there are commonalities between circumstances such as the experience and training of police officers as well as police procedures.

Methodology:

The criteria for this project was to identify and analyze those interactions with police where the person had a mental illness that played a role in the interaction and where death of that person directly resulted from the actions of police.

Because the jurisdiction of a coroner's inquest/inquiry is provincial/territorial there is no central national repository for records such as those sought for this project. Therefore, in 2002, the

[1] In some provinces, a jury is not required.

researchers asked the chief coroner or chief medical examiner[2] of each Canadian province and territory[3] for the recommendations resulting from inquest/inquiries held from 1992-2002 into the circumstances surrounding persons who died in interactions/confrontations with police officers.

The exceptional cooperation and assistance from the respective chief coroners/chief medical examiners enabled this project to move forward. From across Canada, fifty-two responses were provided ranging from British Columbia to Newfoundland. Subsequent to a preliminary sorting and analysis of the recommendations listed in the responses for the purpose of completing Phase I, follow up questionnaires were sent to the chief officers of the respective police agency to obtain additional information about the total circumstance, the deceased and the police officers involved in order to prepare for Phase II.

Summary of Incidents:

While some of the fifty-two responses provided by the coroners/chief medical examiners were comprehensive, others were lacking details of the incident such that the circumstances precipitating the incident were not always clear and thus follow-up with the respective police agency was sometimes necessary. Although this follow-up information has been slow to materialize, in the absence of additional information, the following eleven[4] met the criteria of this study:

1.

Name:	Reid
Age:	43 years
Police Agency:	RCMP – Little Catalina, NF
Date Occurred:	26 August 2000
Location:	outside his house
Duration of incident:	3.52PM – 4.05PM: "12-13 minutes"
Type of Weapon:	axe
SWAT/ERT:[5]	not present or called
Mental Illness:	schizophrenia
Mental Health Worker:	none in attendance
Summary of Incident:	Reid was acting irrationally and threatening those around him. When police attended, Reid appeared with a hatchet. He refused to put the axe down and police used OC spray to no effect. When he ran at a police officer with the axe, he was shot by the police officer.
Less than lethal force used?	Yes. OC spray was used to no effect
Comments:	Reid had a history of mental illness that was known to police

2 For the purpose of this study, the position of chief coroner and chief medical examiner are equivalent notwithstanding each province/territory has slightly different legislation and uses different terminology.

3 Canada has 10 provinces and 3 territories.

4 One more incident (Fondrouge) may be included when additional information is received.

5 Different police services use different terminology for their special response team trained and equipped to handle weapons incidents. They include Special Weapons and Tactics (SWAT); Emergency Response Team (ERT) and Tactical Unit (TU)

2.

Name: Power
Age: 23 years
Police Agency: Royal Newfoundland Constabulary, Cornerbrook
Date Occurred: 16 October 2000
Location: outside his house
Duration of incident: 5.17AM - 5.24AM: 7 minutes
Type of Weapon: knife
SWAT/ERT: not present or called
Mental Illness: depression-suicide ideation
Mental Health Worker: none in attendance
Summary of Incident: Power, who was home with his mother, was acting irrationally with a knife and had also eaten glass. His mother called police. After police arrived, Power left the house armed with a knife and moved-in on a police officer. The officer shot Power.
Less than lethal force used? No.
Comments: Power had a history of mental illness that was known to police. The Reid and Power incidents both occurred in Newfoundland within a few months of each other. Consequently, one inquiry was held to consider both events

****

3.

Name: Williams
Age: 24 years
Police Agency: Toronto Police, ON
Date Occurred: 11 June 1996
Location: public street in a residential area
Duration of incident: approx 5.40AM – 6.25AM: approx 45 minutes
Type of Weapon: knives
SWAT/ERT: not present or called
Mental Illness: schizophrenia
Mental Health Worker: none in attendance
Summary of Incident: Williams was seen by the public to be damaging car windows in a residential area. When police arrived he pulled out two knives. He advanced towards the officer and despite warnings to drop the knives failed to do so and was shot by the police officer.
Less than lethal force used? No
Comments: given this was a situation encountered after a call by a concerned member of the public, the police officer did not have the benefit of a family member or friend to provide any personal history of the subject.

4.

Name: Wai
Age: 61 years
Police Agency: Vancouver Police, B.C
Date Occurred: 14 December 1999
Location: hotel room/hallway
Duration of incident: approx 3.25PM – 3.45PM: "19 minutes"
Type of Weapon: meat cleaver
SWAT/ERT: one member of ERT attended to assist
Mental Illness: paranoid schizophrenia
Mental Health Worker: none in attendance
Summary of Incident: Wai emerged from his hotel room with a meat cleaver in his hand. Police were called by which time Wai was in his room. After police called for him to come out he did so with his arm raised and the meat cleaver in his hand. Police shot Wai with the *Arwen*[6] to incapacitate him but he continued to advance. He was then shot and killed by a second police officer.
Less than lethal force used? yes. The Arwen was used but to no effect
Comments:

5.

Name: Romanelli
Age: 23 years
Police Agency: Montreal Police, PQ
Date Occurred: 9 March 1995
Location: hotel room/hallway
Duration of incident: 3.30PM – 5.30PM: approx 2 hours
Type of Weapon: **????**
SWAT/ERT: Yes. Involved in the conclusion of the incident
Mental Illness: not clear from the report other than he was mentally ill
Mental Health Worker: none in attendance
Summary of Incident:
Less than lethal force used?
Comments:

---

[6] Arwen is a firearm that provides a less-than-lethal use of force option

6.

Name: Carruthers
Age: 19 years
Police Agency: Chatham Police, ON
Date Occurred: 7 November 1992
Location: in a house he had broken into
Duration of incident: 2.00AM – 2.14AM: a few minutes
SWAT/ERT not in attendance
Type of Weapon: knife
Mental Illness: not clear from reports. However, just prior to this incident he had gone AWOL from the hospital as a voluntary patient under psychiatric care
Mental Health Worker: none in attendance
Summary of Incident: after Carruthers went AWOL from the hospital he broke into a house to steal a knife to kill himself. By the time police arrived, he had already cut and stabbed himself "severely". As police tried to calm him down and stop the self harm, he attacked the police officers who then shot him.
Less than lethal force used? no.
Comments: police were aware that the subject had a background of mental illness. The jury made only three recommendations. One of which was to compliment police on their actions during the incident.

7.

Name: Ell
Age: 45 years
Police Agency: Lethbridge Police, AB
Date Occurred: 2 June 1999
Location: in an apartment
Duration of incident: 10.00AM – 10.15AM: 15 minutes
SWAT/ERT: not in attendance
Type of Weapon: machete
Mental Illness: not apparent from the report except categorized as "deranged" in the report of the Fatality Inquiry.
Mental Health Worker: none in attendance
Summary of Incident: police responded to a "domestic disturbance. Ell was shot by a police officer at a distance of 7ft when he advanced on the police officer and ignored warnings to drop the machete.
Less than lethal force used? no
Comments: no recommendations

8.

Name: Engdahl
Age: approx 19 years
Police Agency: Regina Police, SK
Date Occurred: 10 September 1998
Location: street/schoolyard
Duration of incident: to be obtained
SWAT/ERT: not in attendance
Type of Weapon: knife
Mental Illness: specifics are not clear from the Coroners Report; although it was clear Engdahl was mentally ill
Mental Health Worker: none in attendance
Summary of Incident: shot and killed by police after he had pulled a knife on a police officer
Less than lethal force used? no
Comments: police at the scene were not aware of the subject's mental illness.

9.

Name: Mayer
Age: 46 years
Police Agency: RCMP Langley, BC
Date Occurred: 17 December 2000
Location: inside a hospital
Duration of incident: approx 9.00PM – 9.10PM: "a few minutes"
SWAT/ERT: not in attendance
Type of Weapon: scissors
Mental Illness: depression
Mental Health Worker: none in attendance
Summary of Incident: Mayer was at a hospital to see a physician re being depressed and suicidal. He grabbed an oxygen tank and scissors and threatened to stab staff. When police arrived he lunged at the police officer with the scissors. He was sprayed with OC but again lunged at the police officer and was shot by the police officer
Less than lethal force used? yes. OC spray was used but to no effect
Comments: police at the scene were aware when they attended that the subject's was likely mentally ill

---

10.

Name:	Yu
Age:	35 years
Police Agency:	Toronto Police, ON
Date Occurred:	20 February 1997
Location:	transit bus
Duration of incident:	approx 5.00PM – 5.25PM: "a few minutes"
SWAT/ERT:	not in attendance
Type of Weapon:	hammer
Mental Illness:	schizophrenia
Mental Health Worker:	none in attendance
Summary of Incident:	Yu assaulted a woman waiting for a bus. When police arrived he was sitting on the bus at the rear. After a few minutes of conversation between the police officers and Yu, he pulled out a hammer in a manner threatening to the police officers. One officer then shot Yu.
Less than lethal force used?	no
Comments:	when police attended, they had no knowledge of the subject's history of mental illness

---

11.

Name:	Barnett
Age:	22 years
Police Agency:	Toronto Police, ON
Date Occurred:	10 January 1996
Location:	public street
Duration of incident:	approx. 10.00 pm: time taken to be obtained but it was brief
SWAT/ERT:	not in attendance or called
Type of Weapon:	samurai sword
Mental Illness:	specifics are not clear from the report. But the report did acknowledge Barnett had a mental illness
Mental Health Worker:	none in attendance
Summary of Incident:	a police officer had seen the subject acting in a strange manner walking on the center line of the street. The police officer walked up to the subject from behind at which time he charged at the police officer with a three foot long samurai sword,
Less than lethal force used?	no
Comments:	given this was a situation encountered "on view" by the police officer, he had no knowledge of the mental health history of the subject. The jury made no recommendations

Findings/Discussion:

1. **Gender:** In each of the eleven incidents, the subject was male. While this may be coincidental, more research is necessary to determine if this is of importance.

2. **Age:** The ages of the subjects were varied ranging from 19 years to 61 years. The mean age was 32.5. However, 6 of the eleven subjects were young men aged from 19 years to 24 years.[7] Three were in their 40s and one was in his 60s. Whether the predominance of the 19-24 year age group in this admittedly small sample is of consequence requires further research and analysis. However, of note is that the crime prone years of males is generally accepted to be from about 14 years to the late 20s.

3. **Nature of Mental Illness:** In several cases, it was difficult to determine from the coroners'/medical examiners' reports the nature of the mental illness of the subject, even though based on the incident summaries and recommendations it was apparent that mental illness was a factor.

4. **Duration of Incident:** The time of day ranged from early morning to late evening and consequently there does not appear to be any common denominators with respect to the time of day. Most of the incidents were over in a very short time. The only exception was when SWAT was deployed (Romanelli). The review of incident summaries suggests these incidents accelerated quickly after the arrival and intervention of police and left little time or opportunity for specialized resources to attend. However, although not applicable to, or practical in, all the situations reviewed, the question does arise about whether containment rather than immediate confrontation would have been a preferred strategy until other resources could attend.

   It could be argued that the presence of uniform police officers (it appears all incidents were attended by uniform police officers) may have aggravated the situation. While this is in large part supposition it is worthy of consideration when considering the correct response to a situation involving a person known to have a mental illness. In several of the situations studied it was known by the person calling police and/or by the police organization, if not the attending police officers, that the subject was mentally ill.

5. **Location of Incident:** The incidents occurred in a wide variety of circumstances ranging from a dwelling house, to a hospital to a public street and, in one case (Yu), a transit bus.

6. **How police became involved:** In most cases police were present after being called by a concerned person(s) who was often a neighbor or a family member. In only one case, (Barnett) did the police officer observe unusual behavior of a subject without a prior call from the public or family.

[7] The median age was 24 years

7. **Less-than-lethal use of force:** It is apparent that less-than-lethal use of force, other than engaging the subject in conversation, was not used in most cases. Only three of the eleven tried a less-than-lethal use of force option. In each of these three cases, the use of OC and the Arwen was not effective in incapacitating the subject sufficiently to prevent continuance of the situation. It is not clear without follow up enquiries with the respective police agency whether a less-than-lethal option was not used because it was not available, or in the police officers judgment not appropriate, or there was insufficient time to use it. Of interest is that the incidents studied all occurred before the advent of Tasers[8] in Canadian police organizations. Whether Tasers would have made a difference to the outcomes of these incidents is impossible to determine.

   While not strictly speaking a less-than-lethal use of force option, the use of trained crisis negotiators have the capability to diffuse a situation without having to resort to any use of force. Their use was not apparent in most of the incidents studied. In at least one instance a trained negotiator was many hours away (Reid). A negotiator was called in the Power incident, but the incident concluded before he could attend. In the other situations, with the exception of the Romanelli incident attended by SWAT, it is not clear that crisis negotiators were considered and/or viable once police had attended and confronted the subject.

8. **Suicide-by-Cop:** While the researchers for this study are not authorities on "suicide-by-cop", several of the incidents would seem to fall into that category notwithstanding that in at least one case it was argued that the subject, due to his mental illness, could not formulate that intent.

9. **Presence of Mental Health Professionals:** In all the eleven cases reviewed, a mental health worker was not involved or present. This is of interest as in many of the situations subject of this review the police officers attending and/or the person who called the police to attend knew the person had a history of mental illness. Although, several of the situations were in public areas and developed sufficiently rapidly that the timely attendance/presence of a mental health worker may have been difficult even if one were available, if the police agency involved had access to a joint mental health/police crisis unit/team or to a crisis response by mental health workers,[9] one can surmise the outcome(s) might have been different.

   Of some note is that none of these incidents were attended by a joint police/mental health such as these found in Hamilton (COAST) and Car 87 (Vancouver). Some of these incidents occurred before these types of units were established and were, thus, unavailable. However, another study such as this one should be conducted in the next few years to determine if there has been a decrease in these types of incidents in communities with such work units.

10. **Recommendations:** While two of the inquiries/inquests did not make any recommendations and a third only made three relatively inconsequential

8 Although they were recommended in three of the inquests/.inquiries
9 This was the recommendation in more than one instance.

recommendations, the recommendations of the inquest/inquiries conducted with respect to the other eight selected incidents are detailed in **Appendix A.** As can be seen in **Appendix A,** most of the incidents resulted in numerous and comprehensive recommendations. For example, Reid/Power; Wai; Williams and Yu.

Although some recommendations are idiosyncratic to the specific incident, the summary of recommendations will address re-occurring themes that arose in the incidents studied. To assist in understanding the recommendations, they have been broken down into the following categories to identify, in part, the potential impact on each human service agency:

1) **Education of Stakeholders**
2) **Establishment of Relationships/Liaison**
3) **Structures/Procedures of Police Organizations**
4) **Structures/Procedures of Justice System**
5) **Structures/Procedures Health Services**
6) **Funding/Resource Requirements**

1) Education of Stakeholders

i) Education of the Public: Recommendations placed an onus on government/health to inform the public about mental illness so that the public is better informed about mental illness and the mental health services that are available.

ii) Education of Health Care Providers: Recommendations focused on improved and additional training for mental health "workers." One of the recommendations suggested education about ethno-specific issues in psychiatry.

iii) Education of Consumers/Consumer Families: Recommendations placed an onus on government to ensure consumers/consumers' families are aware of the services available and of their rights pursuant with respect to mental health legislation. One recommendation suggested that police be responsible for educating "consumers" about how to access mental health services. At first instance, this is curious except that police due to their 24/7 availability are frequently the first to interface with mentally ill persons who are in crisis.

iv) Education of Police Officers: The recommendations with respect to training/education of police officers can be grouped as:

(a) increasing the knowledge and skills of crisis resolution by the use of de-escalation communication techniques; e.g., through the training of all police officers in "crisis resolution"; and
(b) training/education of police officers in understanding mental illness and the behavior of persons with mental illness.

2) Establishment of Relationships/Liaisons

i) Several recommendations were that health services and police should form a closer, with respect to the sharing of information, working relationship to assist in not only training and education of police officers, but also and to responding to situations involving mentally ill persons; in particular.

3) Structures/Procedures of Police Organizations

The issue of effective incident command arose in several of these incidents in particular with respect to control, command and containment and the use of alternatives to lethal force. For example, the use of crisis negotiators. The importance of sharing information with other agencies in particular health was stressed and the institution of joint police/mental health units recommended. One interesting recommendation was that police should enter the names of those who have been found to be unresponsive to OC spray onto CPIC so that all Canadian police agencies could quickly obtain this information. While this may at first glance have some merit, the danger is that a false sense of security is possible if the name of person does not appear on CPIC.

4) Structures/Procedures of Justice System

Only one inquiry/inquest recommended the establishment of a mental health court (Reid/Power). The deceased in one instance (Engdahl) had connections to youth detention facilities hence recommendations were made about the exchange of information and the circumstances with respect to youth facilities. However, while this was a unique situation the recommendations are of value in that persons in this age group are likely to interact with the police.

5) Structures/Procedures Health Services

While the recommendations were various (Refer to Appendix A), a theme was that of expediting the attention given to mentally ill persons in hospital emergency rooms and the sharing of information with police to the extent of establishing joint crisis units.

6) Funding/Resource Requirements

Funding recommendations not surprisingly focused on increased services to those with a mental illness and the funding of police mental health models where police and mental health share information and/or work together in crisis response units such as Car 87 in Vancouver. Less than lethal uses of force were recommended for funding in particular the Taser. It is of interest to note that the Taser is one of the most recent developments in the use of force options having been preceded by many other options such as OC spray. In several cases subject of this study OC spray was found to be ineffective.

While the recommendations were numerous and they did include training and education of police officers as suggested solutions, they also included numerous recommendations for the

improvement of mental health services and the encouragement to share information between police and mental health services as well as with the public. That is, contrary to the perception held by many police officers, the recommendations were not primarily addressed to the police.

Conclusion:

The fatal encounters reviewed in this study are symptomatic of larger societal problems such as the lack of resources for mental illness, the lack of knowledge and understanding about mental illness by the public and the police and even the stigma associated with mental illness. Police are regularly called to deal with symptoms of greater social or health issues. This is due in large part to the 24/7 availability of police but also often due to the absence of an available alternative human service provider. Consequently, police frequently find themselves not well equipped or trained to deal with situations they are expected to resolve and with no immediate or easy access to alternative resources. This is particularly true with respect to situations involving substance abuse and/or mental illness which account for the consumption of a substantial amount of police resources.

This study has examined incidents, and the resulting recommendations, where a mentally person has died as a result of an intervention by a police officer(s). While these recommendations are varied, there is a substantial focus on police organizations and health authorities, through their respective levels of governance, to not only be better trained and educated with respect to mental illness and dealing with crises involving the mentally ill but also to provide additional and improved access to mental health services and information to the public so that to such incidents can possibly be prevented in the first place. This is, of course, preferable to dealing with the crises as evidenced by the eleven situations subject of this report.

While the number of incidents studied are fortunately small, when all the recommendations are considered together they provide a comprehensive overview of the state of affairs with respect to police dealing with persons who are mentally ill. The incidents point out the obvious need for training/education on a variety of fronts, the basic problems of stigma and alienation in society, the idiosyncratic nature of these calls-for-service to police, the disconnect between systems, and the conflicts with mental health legislation that prevents some of these changes from happening.

This study, and the recommendations, demonstrates that policing is far more than “law enforcement” but is about the need to be prepared and proactive to make order out of disorder, to be sensitive to the less fortunate and to work with others to resolve crises.

There is no doubt there are additional questions raised by this review that require answers and, therefore, more research is necessary. Phase II of this study will explore the extent to which recommendations have been implemented by police agencies and the characteristics of the incidents such as the training and experience of police officers.

Appendix A

The Recommendations of Eleven Coroner's Inquests/Fatality Inquiries

These recommendations have been broadly categorized as:

- Education of Stakeholders
- Establishment of Relationships/Liaison
- Structures/Procedures of Police Organizations
- Structures/Procedures Health Services
- Funding/Resource Requirements

1.0. Education of Stakeholders:

1.1. Health Services:

1.1.1. Education of the Public (in General) by Health Services:

- Williams #1: ensure a range of mental health crisis services are available throughout the GTA and that information regarding these services be available to the public via Ministry of Health and Long-Term Care.

- Yu #3: the Ministry of Health should provide a long-term funding commitment, and appoint a long-term position to the Mental Health Law Education Project. Its mandate should be extended to provide education to **members of the public** in addition to mental health care professionals. It should include a public relations campaign to inform people about the operations of the Mental Health Act and other mental health legislation, with particular attention on consent and capacity legislation and leave of absence provisions.

- Engdahl #16: more information be made available to the public concerning mental health issues.

- Reid/Power #20: develop comprehensive strategy for eliminating stigma.

1.1.2. Education of Health Care Providers:

- Williams #2 (a): Ministry of Health and Long-Term Care should develop protocols to ensure staff (including doctors) are aware of all available mental health services available.

- Williams #3: Ministry of Health and Long-Term Care should continue to support initiatives to educate consumer/survivors, affected family members, the police, and **health care providers** about relevant mental health law and the roles and responsibilities of various players in the mental health system. (referring to Mental Health Law Education Project – they want it restarted because existing legislation is complex).

- Yu #5: ensure that all psychiatrists and psychiatric residents receive training and/or further education on the Mental Health Law of Ontario.

- Yu #3: the Ministry of Health should provide a long-term funding commitment, and appoint a long-term position to the Mental Health Law Education Project. Its mandate should be extended to provide education to members of the public in addition to **mental health care professionals.** It should include a public relations campaign to inform people about the operations of the Mental Health Act and other mental health legislation, with particular attention on consent and capacity legislation and leave of absence provisions.

- Yu #6: all psychiatrists and psychiatric residents be educated that there are ethno-specific issues in psychiatry.

- Wai #10 (b): (Vancouver Mental Patients' Association) we recommend additional training to mental health workers be provided on an ongoing annual basis to keep workers updated on mental health patient management.

- Wai #10 (a): (Vancouver Mental Patients' Association) we recommend written policy be developed for minimum training requirements of mental health workers.

- Wai #10 (c): (Vancouver Mental Patients' Association) we recommend any mental health workers who are currently employed and do not meet minimum training standards be provided with the training required to meet the standard.

- Mayer #5: implement training in preventing violence in health care for staff.

1.1.3. Education of Patients (Consumers) by Health Services:

- Williams #2 (b): Ministry of Health and Long-Term Care should develop protocols to ensure staff (incl. Doctors) fully inform **patients** and families of patients of available mental health services.

- Williams #2 (d): Ministry of Health and Long-Term Care should Discharge instructions should be signed by the **patient** or caregiver, and the person who gave the instructions.

- Williams #3: Ministry of Health and Long-Term Care should continue to support initiatives to educate **consumer/survivors**, affected family members, the police, and health care providers about relevant mental health law and the roles and responsibilities of various players in the mental health system. (referring to Mental Health Law Education Project – they want it restarted because existing legislation is complex).

- Williams #5: a case manager/primary health care provider be required to specifically advise a consumer/survivor suffering from a major mental illness characterized by periodic psychotic episodes as to the existence of powers of the attorney for personal care.

- Williams #6: persons receiving their medication through injections receive within information concerning the medication and potential side effects and risks associated with the medication.

1.1.4. Education of Families of Patients (Consumers) by Health Services

- Williams #2 (b): Ministry of Health and Long-Term Care should develop protocols to ensure staff (incl. Doctors) fully inform patients and **families of patients** of available mental health services.

- Williams #2 (e): Ministry of Health and Long-Term Care should develop protocols to ensure If an individual discharges against medical advice, that person or *caregiver*, is offered all information respecting available resources and offered assistance in accessing them.

- Williams #3: Ministry of Health and Long-Term Care should continue to support initiatives to educate consumer/survivors, **affected family members**, the police, and health care providers about relevant mental health law and the roles and responsibilities of various players in the mental health system. (referring to Mental Health Law Education Project – they want it restarted because existing legislation is complex).

1.1.5. Education of Police by Health Services:

- Williams #3: Ministry of Health and Long-Term Care should continue to support initiatives to educate consumer/survivors, affected family members, **the police**, and health care providers about relevant mental health law and the roles and responsibilities of various players in the mental health system. (referring to Mental Health Law Education Project – they want it restarted because existing legislation is complex).

1.2. Police Organizations:

1.2.1. Education/Training of Police Officers:

- Williams #7: Toronto Police Service and Chief of Police made Crisis Resolution Course mandatory for all officers since March 1999 and officers have been trained since that time. Suggest they continue delivering the course and making it a high priority until all officers have been trained. Also recommend implementing a mandatory refresher course.

- Yu #11: the Solicitor General should amend the Police Services Act to require annual Crisis Resolution Training, of at least one day, in addition to annual use of force training. Priority should be given to front line officers; however this training should be delivered to command officers and senior managers as well.

- Yu #13: that the five-day Crisis Resolution course be offered as a training course at the C.O. Bick College[10] until all existing officers are trained.

[10] The police training academy of the Toronto Police.

- Yu #15: that officers who work in divisions with higher concentrations of persons suffering from mental illness be given priority on the list of officers entering the Crisis Resolution Course.

- Yu #16: that the C.O. Bick College evaluates the Crisis Resolution training to determine its effectiveness. The evaluation should include survey research, detailed interviews and/or performance appraisals of a proportion of graduate officers.

- Yu #17: continue decentralized training, using Live-Link or other approved methods at those divisions that are determined to have a proportionately high concentration of emotionally disturbed persons.

- Yu #19: that the Toronto Police Service and the Ontario Police College establish a closer working relationship to facilitate the sharing of information, training expertise, and professional exchanges to avoid unnecessary duplication or delivery of conflicting training.

- Engdahl #1: police services receive on-going and periodic education regarding various aspects of mental health.

- Reid/Power #24: have RCMP provide a day of training to all members in the province within a year.

- Reid/Power #32: that the RNC training program for police dealing with the mentally ill should be fully developed and implemented.

- Reid/Power #3: within a year of this report RNC should have a one day seminar for members about this report, current Mental Health Act issues, status of training initiatives, Taser, Memorandums of Agreement, etc.

- Mayer #12: police receive specific training in dealing with mentally-ill persons.

- Wai #11: (Vancouver City Police, Attn. Gen. Graeme Bowbrick) we recommend funding for ongoing training of police officers in dealing with mental health clients.

- Yu #12 (d): the Crisis Resolution Course should have input of mental health professionals, consumer survivor and multicultural groups, and should include that the "first contact" and the "time talk and tactics" approach used by police whenever possible and that "active listening" be stressed as a skill that officers must develop.

- Mayer #12: that police be given specific training with respect to dealing with mentally ill patients.

- Yu #18: that the Toronto Police Service follows the lead of the 57 other police forces in Ontario who have joined the Video Training Alliance in order to provide better decentralized training to its officers.

1.2.2. Police Education of "consumers" [mentally ill persons]

- Yu #21: that representatives of consumer survivor groups, in consultation with the Community Policing Support Unit, should develop a pamphlet for police to give to persons in crisis on how to access services. The pamphlet should be prepared in several different languages to serve our diverse community.

2.0. Establishment of Relationships/Liaisons:

2.2. Health Services

2.2.1. Between Health Services and Patients:

- Williams #2 (c): Ministry of Health and Long-Term Care should develop protocols to ensure mentally ill **patients** are given the option to be linked up with case managers.

- Yu #9: the Ministry of Health should create a long-term case management system whereby caseworkers will follow **consumers** of mental health services on a long-term or permanent basis.

2.2.2. Between Health Services and Police:

- Williams #4: Ministry of Health and Long-Term Care should appoint a coordinator to facilitate integrating responses of various mobile crisis intervention services within the crisis response of the Toronto Police Service.

- Mayer #13: that steps be taken to create a liaison between all police detachments and the local hospital with regards to calls for assistance from the hospital

- Yu #12: the Crisis Resolution Course should have input of mental health professionals, consumer survivor and multicultural groups, and should include, but not be limited to, the following: (list of A-G).

- Reid/Power #25: have RCMP enter into agreements and Memorandums of Agreement with health agencies re apprehension of mentally ill persons.

- Wai #7: (Vancouver/Richmond Health Board; Chief Constable) we recommend written policies be developed jointly by the Vancouver City Police and the Vancouver Richmond Health Board for sharing of information specific to Section 28 of the Mental Health Act apprehensions.

- Wai #9 (a): (Vancouver Mental Patients' Association) we recommend written guidelines/practices be developed for mental health workers regarding communicating client/history/backgrounds to key officers in charge of police interventions.

- Wai #9 (b): (Vancouver Mental Patients' Association) we recommend the development of standardized fact sheets regarding mental health clients to facilitate accurate exchange of information between police and health care workers.

2.3. Police Organizations

2.3.1. Between Police and Police College

- Yu #19: that the Toronto Police Service and the Ontario Police College establish a close working relationship to facilitate the sharing of information, training expertise, and professional exchanges to avoid unnecessary duplication or delivery of conflicting training programs.

2.3.2. Between Police and Schools

- Engdahl #5: that there be a system in place between police and educational institutions where educational institutions are made aware of youth with a history of violence.

3.0. Structures/Procedures of Police Organizations:

3.1. Pre-Incident

- Williams #8: when a police officer involved in an SIU[11] incident is excused from doing memo book notes before the end of a shift, there should be a written record made by the person who excuses the officer from making the notes, setting out the reason for the delay.

- Engdahl #3: police services continue to investigate new methods of the use of force in order to deal with individuals and situations most effectively

- Yu #12 (a): the crisis resolution course should have input of mental health professionals, consumer survivor and multicultural groups, and should ensure that every opportunity should be taken to convert an unplanned operation into a planned operation.

- Yu #12 (b): the crisis resolution course should adopt a cordon and containment approach unless impractical to do so.

- Yu #12 (c): that the aim of crisis resolution should be de-escalation and the resolution of situations without physical force.

[11] Special Investigation Unit – established by the provincial government to investigate all situations of death or serious injury in which a police officer is involved. It is intended to be an independent investigative agency so that police do not investigate circumstances where police are involved and death or serious injury results.

- Yu #12 (d): that the "first contact" and the "time talk and tactics" approach used by police whenever possible and that "active listening" be stressed as a skill that officers must develop.

- Yu #13 (e): the crisis resolution course should have input of mental health professionals, consumer survivor and multicultural groups, and should include the fear and apprehension experienced by officers as a result of previous experiences, stereotyping, or lack of knowledge, whenever about mental illness, race, culture, or other factors.

- Yu #13 (f): the crisis resolution course should have input of mental health professionals, consumer survivor and multicultural groups, and should include the fear and apprehension which persons involved with the police my feel as a result of previous experiences, stereotyping or lack of knowledge, particularly due to a mental illness, racial, or cultural background.

- Yu #20: the Toronto Police Service Board should direct the Chief of Police to ensure that the Toronto Police Service assembles a list of available crisis teams with telephone numbers according to police division in the Toronto area. Such information should be available to front line officers through their dispatchers.

- Reid/Power #26: have the RCMP use another police service such as the OPP[12] to investigate whenever there is a death.

- Reid/Power #28: have RCMP develop a policy so that people who do not respond to OC[13] spray are noted on CPIC.[14]

- Reid/Power #35: RNC[15] to amend policies and procedures around incident management.

- Reid/Power #36: RNC to develop a comprehensive data base with information about mentally ill persons so information is available to all officers.

- Wai #12 (a): (Vancouver City Police, Vancouver/Richmond Health Board, Attn. Gen. Graeme Bowbrick) we recommend funding be provided for Car 87[16] Services to be available on a 24 hour basis.

- Wai #12 (b): (Vancouver Police, Vancouver/Richmond Health Board, Attn. Gen. Graeme Bowbrick) we recommend that Car 87 be included whenever possible in situations dealing with mental health clients, to assist in the preparation phase prior to police intervention.

---

[12] The Ontario Provincial Police.
[13] Oleoresin Capsicum Spray.
[14] The Canadian Police Information Centre: A national database that includes, but is not limited to, criminal records.
[15] Royal Newfoundland Constabulary.
[16] Car 87 is a joint police and mental health worker response to police calls for service where a mentally ill person is involved.

3.2. Incident Command

- Romanelli #1 (a):[17] le chargé de relève appelé sur les lieux pour prendre charge d'une operation où un policier, sous ses orders, a été préalablement blessé ou tué, soit remplacé dans sa fonction par le chargé de relève d'un poste limitrophe. *The supervisor of the police officer who was involved in a shooting where someone was wounded or killed should not be the incident commander but should be replaced by another officer from a another area.*

- Romanelli #1 (b): un poste de commandement ne devrait pas inclure un policier témoin de lattentat d'un confrere comme cela a été vécu. *The personnel in an incident command post should never include a police officer who was a witness/participant in the original incident in which another police officer was attacked*

- Romanelli #2: a partir du moment que l'équipe technique (SWAT) est demandée, le poste de commandement en foction devrait obligatoirement attendre leur arrivée. A moins dévénement nouveau majeur qui l'obligerait à intervenir rapidement. *When SWAT is called to assist, the incident commander must take no further action until they arrive unless there is an escalation that requires immediate action.*

- Romanelli #3 (a): dans les cas d'un homme barricade, la SPCUM devrait réquisitionner un local près du poste de commandement et y diriger les membres de la famille et les voisins immédiats. On devrait nalors leur fournir un certain confort physique, de même qu'un support psychologique. *In the cases of barricaded person, the SPCUM should requisition a room close to the command post and direct the members of the family and the neighbors to it. The SPCUM should provide them with physical comfort and psychological support.*

- Romanelli #3 (b): ils [la famille et les voisins immédiats] seraient accompagnés en tout temps d'un policier responsible, relié au poste de commandement. *The family and immediate neighbors should be accompanied at all times by an assigned police officer who is able to communicate with the command post.*

- Romanelli #3 (c): ils [la famille et les voisins immédiats] pourraient éventuellement donner de l'information aux policiers ou même aider dans d'éventuelles négociations. On ne peut les forcer à demeurer dans un local désigné, mais s'ils y retrouvent une certaine sécurité, il n'y a aucune raison pour lesquelles ils quitteraient les lieux, étant désemparés dans telles situations. *They [the family and immediate neighbors] may be able to give information to the police officers or possibly help in negotiations. One cannot force them to remain in a designated room but, because they are likely to be distraught in such situations, if they find a safety there, there is no reason they should have to leave.*

[17] Romanelli was a situation that occurred in Montréal. The original recommendations in French are therefore included with a paraphrased English translation.

3.3. Post Incident

- Romanelli #4: dans ce dossier, l'agent Lafreniere s'est retrouvé au Centre hospitalier Santa Cabrini, de même que M. Romanelli. Ce dernier étant décédé, il n'y a pas eu d'éventuelles situations embarassantes au center hospitalier. Toutefois, il serait sage que l'on puisse diriger agresseur et agressé vers des hôpitaux différents. Ceci afin d'éviter des situations stressantes pour les victims et leurs familles. *In this file, agent Lafreniere and Mr. Romanelli [the deceased] were sent to the same hospital complex: Santa Cabrini. Although possibly embarrassing situations were avoided at the hospital center, it would be wise that the police officer who shot the subject and the subject are taken to different hospitals. This in order to avoid stressful situations for the victims and their families.*

3.4. Use of Force

- Yu #13 (g): that police officers, whenever possible, should maintain a sufficient reactionary gap to give them the time to disengage, tactically reposition themselves, and/or react in such a way which prevents a situation from escalating from the verbal to the violent.

- Yu #22: the jury endorses the Use of Force report and recommends that the Toronto Police Service implement the recommendations contained in this report.

4.0. Structures/Procedures of Justice System

4.1. Courts:

- Reid/Power #8: establish a mental health court in St John's, Newfoundland.

4.2. Youth Detention Facilities:

- Engdahl #4: youth detention services contact relevant area educational facilities to inquire whether a missing person happens to be registered as a student.

- Engdahl #12: youth detention services maintain close contact with parents and/or guardians on a regular basis.

- Engdahl #11: more funding be provided to all aspects of youth services.

- Engdahl #13: youth detention services provide written reports to parents and mental health personnel on a monthly basis based upon daily log entries regarding all aspects of a youth's behavior as observed by facility staff.

- Engdahl #14: group meetings involving parents or guardians of youth at youth detention centers and facility staff be held on a regular basis to discuss concerns and possible improvements to ensure greater parental involvement.

- Engdahl #6: that youth in a youth detention center with a history of violence or that have been diagnosed as being a threat to society be more closely monitored in a more structured, secure environment.

- Engdahl #7: youth detention services have a permanent, independent psychologist(s) and/or psychiatrist(s) visit youth on a frequent, regular basis in order to sufficiently diagnose and monitory progress and/or change.

- Engdahl #9: copies of a youth's complete and cumulative file be forwarded to the next facility or placement to be accessed by appropriate personnel complete with a follow-up by the last placement to ensure they were received.

- Engdahl #15: family counseling and therapy be made available to youth in detention centers and their parents or guardians.

- Engdahl #10: more gradual re-introduction into society from a more structured environment to a less structured environment.

- Reid/Power #23: have the Minister of Health, etc., report to the House of Assembly annually about progress in responding to these recommendations.

- Reid/Power #40: have government review the policy of police transport of the mentally ill people to hospital such that other agencies be used for transport to reduce stigma and demand on police resources.

5.0. Structures/Procedures of Health Services:

- Yu #24: it would be remiss of this jury not to comment on the issue of forced medication for those mentally ill persons who have a history of demonstrated dangerousness to the public. We feel strongly that the public must be protected. Failure to take corrective medication may require the law to be changed to state that the alternative would be involuntary hospitalization in a mental health facility. The Ministry of Health should address this problem and attempt to reach a solution.

- Reid/Power #13: use nurse practitioners in areas where there are no psychiatrists (e.g. rural areas).

- Reid/Power #38: reduce wait time for police in ER by having a designated MH nurse or other triage arrangement.

- Reid/Power #39: have same staff member who receives a call for assistance be the person who actually calls the police.

- Wai #3: (Minister of Finance and Corporate Relations) we recommend a written policy be developed for the use of "extended leave" so that the application of extended leave is applied consistently across health practitioners.

- Wai #4: (Minister of Health) we recommend the ministry should approve and fund computerized information systems as proposed by the Vancouver/Richmond Mental Health Board.

- Wai #5: (Vancouver Richmond Health Board) we recommend the development of policies and procedures to share information on mental health clients with community service providers

- Wai #6: (Federal Health Minister, Provincial Minister of Health) we recommend that the "special authority" required for the prescription of atypical drugs for mental health clients be removed.

- Wai #14: (Vancouver/Richmond Health Board) we recommend standardized criteria for admission of mental health clients to the various community health programs like Strathcona Mental Health and Outreach.

- Wai #15: (Vancouver/Richmond Health Board) we recommend the development of specific guidelines for closing and deactivating mental health clients' files.

- Wai #16: (Vancouver/Richmond Health Board) we recommend written policies be developed for charting practices by mental health team workers.

- Wai #17: (Vancouver/Richmond Health Board, The Vancouver Mental Patients' Association, Ministry of Health and Ministry Responsible for Seniors) we recommend the MPA and the Vancouver Richmond Health Board develop Best Practice staffing models for Mental Health Workers. It is a concern that housing facilities funded by the Vancouver Richmond Health Society are presently understaffed and do not have 24-hour coverage.

- Wai #18: (Vancouver/Richmond Health Board, The Vancouver Mental Patients' Association, Ministry of Health and Ministry Responsible for Seniors) we recommend that following the development of Best Practices standards for staffing, the ministry of health provide additional funding over the next two years to meet these minimum staffing requirements.

- Carruthers #2: the jury further recommends that the Ontario Hospital Association and the Ontario Ministry of Health Act to establish a standard of medical practice that a psychiatric assessment be performed by a medical doctor upon initial admittance to, and upon acceptance of, transfer to any psychiatric facility to ensure that tan assessment of the patient's current condition is determined.

- Mayer #1: immediate notification of next of kin when someone suicidal or homicidal arrives at ER or is triaged.

- Mayer #2: that a psychiatric consultation be available within a half hour or hour at ER.

- Mayer #3: that a "Brief Stay Unit" be established at hospital.

- Mayer #6-7-8: hospital to establish safe/secure rooms in ER and a protocol for use of secure rooms and alarms for staff.

- Mayer #9: psychiatric nurse clinician to be on duty 24 hours a day.

- Wai #12 (c): (Vancouver Police, Vancouver/Richmond **Health Board**, and Attorney General) we recommend the development of criteria for the implementation of more Car 87 units. Funding should be provided to implement the program as required.

- Williams #2 (d): Ministry of Health and Long-Term Care should develop protocols to ensure that discharge instructions should be signed by the patient or caregiver, and the person who gave the instructions.

5.1. Mental Health Legislation:[18]

- Yu #4: the Ministry of Health should include a member of the mental health community in the drafting of amendments to mental health legislation in order to facilitate its comprehension by members of that community.

- Reid/Power #1-7: recommendations about revising and updating the Mental Health Act.

- Reid/Power #27: include RCMP in consultation re new Mental Health Act.

- Reid/Power #37: include RNC in consultation re new Mental Health Act.

- Reid/Power #19: review community treatment order provisions.

- Carruthers #1: the jury recommends that the Ontario Ministry of Health undertake to amend the Mental Health Act Section 15, Part I to include a fourth criteria for involuntary admission as a psychiatric patient to be as follows: "The person is suffering from a serious psychotic mental illness causing a serious impairment of judgment excluding personality disorders."

6.0. Funding/Resource Requirements:

6.1. Police:

- Yu #14: the Toronto City Council provide adequate funding to allow the Toronto Police Service Board and the **Toronto Police Service** to implement the recommendations of this Coroner's jury.

- Wai #12 (c): (**Vancouver City Police**, Vancouver/Richmond **Health Board**, and Attorney General) we recommend the development of criteria for the implementation of more Car 87 units. Funding should be provided to implement the program as required.

[18] The titles of the department of the provincial/territorial governments responsible for mental health vary between provinces and territories. In most cases, the Minister of Health has the responsibility.

6.1.1. Police Equipment

- Wai #8: (Chief Constable, Attorney General, and Police Board Chair) we recommend that if trials of the Taser weapon by the Vancouver City Police are successful, training of all officers be provided and sufficient Tasers be purchased to meet the needs of the Vancouver Police Department.

- Williams #9: Toronto Police Service should continue research and testing of non-lethal weapons and report developments annually to the Police Services Board. The Solicitor General should authorize the Toronto Police Service, in addition to the Ottawa Police Service, to conduct a pilot project regarding operational capabilities and effectiveness of the M26 Taser.

- Reid/Power #33: RNC should get Tasers.[19]

- Reid/Power #30: RNC should have a digital cell phone in each car.

- Reid/Power #31: RNC should replace long batons with foldable batons.

- Engdahl #2: police services continue to upgrade technological information systems to better equip officers in the field.

6.2. Health Services:

- Williams #10: Health Canada should appoint a coordinator to monitor the amount of dollars dedicated annually to research in to the causation and treatment of schizophrenia, it being recognized that significant research funding flows from federal funding sources.

- Yu #1: the Ministry of Health should provide continued funding for research into the cause and treatment of schizophrenia, including research into non-medical and non-drug alternatives.

- Yu #2: as part of the "Making it Happen" draft, the Ministry of Health should proceed with these initiatives and be encouraged to ensure that ethno-specific psychiatric services and community-based non-medical outreach programs are funded. We would encourage these communities to present their needs to the Ministry of Health.

- Yu #3: the Ministry of Health should provide a long-term **funding** commitment, and appoint a long-term position to the mental Health Law Education Project. Its mandate should be extended to provide education to members of the public in addition to mental health care professionals. It should include a public relations campaign to inform people about the operations of the Mental Health Act and other mental health legislation, with particular attention on consent and capacity legislation and leave of absence provisions.

[19] Taser is a non-lethal use of force option that incapacitates the subject.

- Wai #1: (Minister of Finance and Corporate Relations) additional funding be provided to deal with the backlog of mental health patents awaiting appropriate housing, as previously recommended by the Vancouver/Richmond Health Board. Currently, 2000 mental health patients are waiting for appropriate housing, as reported by the Vancouver Richmond Health Board. We would suggest accommodation for 3000 units per year over the next five years be provided. Funding should include capital and annual operating expenses.

- Yu #8: the Ministries of Health and Community and Social Services should continue funding for the purchase and construction of new housing for consumer survivors in Toronto. Such housing should include short-term "safe-house" facilities like the Gerstein Centre.

- Yu #10: we recommend that the Ministry of Health consider reducing the number of A.C.T. teams and redirecting this share of the funds for non-medical "safe-houses" such as the Gerstein Centre.

- Engdahl #11: more funding be provided to all aspects of youth services.

- Engdahl #8: more funding be given for more psychiatrists to be hired to deal with the overloaded system in order to decrease the waiting period for initial consultations and continuing visits.

- Reid/Power #9: fund case management service for SMI.[20]

- Reid/Power #11: fund assertive case management models

- Reid/Power #16: substantial increase in funding for mental health home care services

- Reid/Power #17-18: fund self help groups and CMHA.[21]

- Wai #1: (Minister of Finance and Corporate Relations) additional funding be provided to deal with the backlog of mental health patents awaiting appropriate housing, as previously recommended by the Vancouver/Richmond Health Board. Currently, 2000 mental health patients are waiting for appropriate housing, as reported by the Vancouver Richmond Health Board. We would suggest accommodation for 3000 units per year over the next five years be provided. Funding should include capital and annual operating expenses.

- Wai #2: (Minister of Finance and Corporate Relations) the funding as promised ($125 million) for the implementation of the 1998 Mental Health Plan be provided.

- Reid/Power #9: fund case management service for SMI.

[20] SMI – Seriously Mental Ill.
[21] CMHA – Canadian Mental Health Association.

- Reid/Power #11: fund assertive case management models.

- Reid/Power #16: substantial increase in funding for Mental Health home care services

- Reid/Power #17-18: fund self help groups and CMHA.

- Reid/Power #14-15: continue funding of crisis services.

- Williams #10: Health Canada should appoint a coordinator to monitor the amount of dollars dedicated annually to research into the causation and treatment of schizophrenia, it being recognized that significant research funding flows from federal funding sources.

- Wai #18: (Vancouver/Richmond Health Board, The Vancouver Mental Patients' Association, Ministry of Health and Ministry Responsible for Seniors) we recommend that following the development of Best Practices standards for staffing, the ministry of health provide additional funding over the next two years to meet these minimum staffing requirements.

- Wai #2: (to Minister of Finance and Corporate Relations) the funding as promised ($125 million) for the implementation of the 1998 Mental Health Plan be provided.

6.2.1. Resources for Mental Health

- Yu #1: the Ministry of Health should provide continued funding for research into the cause and treatment of schizophrenia, including research into non-medical and non-drug alternatives.

- Yu #2: as part of the "Making it Happen" draft, the Ministry of Health should proceed with these initiatives and be encouraged to ensure that ethno-specific psychiatric services and community-based non-medical outreach programs are funded. We would encourage these communities to present their needs to the Ministry of Health.

- Yu #3: the Ministry of Health should provide a long-term funding commitment, and appoint a long-term position to the mental Health Law Education Project. Its mandate should be extended to provide education to members of the public in addition to mental health care professionals. It should include a public relations campaign to inform people about the operations of the Mental Health Act and other mental health legislation, with particular attention on consent and capacity legislation and leave of absence provisions.

- Yu #8: the Ministries of Health and Community and Social Services should continue funding for the purchase and construction of new housing for consumer survivors in Toronto. Such housing should include short-term "Safe-house" facilities like the Gerstein Centre.

- Yu #10: we recommend that the Ministry of Health consider reducing the number of A.C.T. teams and redirecting this share of the funds for non-medical “safe-houses” such as the Gerstein Centre.

Appendix B
Responses received from Coroners/Chief Medical Examiners

Name		Province	Situation	Met Criteria of Study
1	Halcrow	Manitoba	Shot by police	N
2	Henson	Manitoba	Drowned while escaping police	N
3	Hill	Manitoba		N
4	Reid	Newfoundland	Shot by police	**Y**
5	Power	Newfoundland	Shot by police	**Y**
6	Yu	Toronto, ON	Shot by police	**Y**
7	Ranieri	Ottawa, ON	Died in police vehicle after being arrested	N
8	Yeo	Hamilton, ON	Suicide (review)	N
9	Carruthers	Chatham, ON	Shot by police	Y
10	Pukec	Whitby, ON	Positional asphyxia	N
11	Barnett	Toronto, ON	Shot by police	N
12	Brown	Thunder Bay, ON	Suicide (MI)	N
13	Donaldson	Toronto, ON	Suicide (MI)	N
14	Lambert	Sturgeon Falls, ON	Suicide	N
15	Moses	Toronto, ON	Shot (MI ??)	N
16	Williams	Toronto, ON	Shot	**Y**
17	Fondrouge	Montreal, PQ		**Maybe**
18	Romanelli	Montreal, PQ		**Y**
19	Barnabe	Montreal, PQ		N
20	Bedard	Montreal, PQ	MI	N
21	Comeau	Halifax/Dartmouth, NS	Shot (not MI)	N
22	Clarke	Aberdeen, NS	MI (not police)	N
23	Smith	Hinton, AB	Suicide in cells by hanging	N
24	Adams	Edmonton, AB	Shot by police – died 11 months after	N
25	Miller	Drayton Valley, AB	Overdose	N
26	Hamelin	Ft. Vermillion, AB	Heart failure	N
27	Gagner	Leduc, AB	Suicide in cells	N
28	Hadden	Calgary, AB	Suicide jumped from balcony MI	N
29	Cain	Calgary, AB	Jumped from hospital window MI	N
30	Heinrichs	High Prairie, AB	Hanged himself in cells	N
31	Sheppard	Calgary, AB	Excited delirium and MI	N
32	Mercer	Calgary, AB	Suicide by hanging in an	N

			interview room	
Name		**Province**	**Situation**	**Met Criteria of Study**
33	Sparkling eyes	Fort McMurray, AB	Suicide by hanging in cells	N
34	Tremblay	Edmonton, AB	Suicide during Crisis Negotiation	N
35	Grewal	Calgary, AB	Shot by police – alcohol not MI?	N
36	Ell	Lethbridge, AB	Shot by police MI	**Y**
37	Kamel	Calgary, AB	Suicide – MI	N
38	Seath	Ft. Saskatchewan, AB	Suicide during Crisis Negotiation	N
39	Provencal	Calgary, AB	Shot during robbery in progress not MI	N
40	Mayer	Langley, BC	MI shot by police	**Y**
41	Wai	Vancouver, BC	MI shot by police	**Y**
42	Faulkes	Abbotsford, BC	MI – natural causes	N
43	Henry	Burnaby, BC	MI – suicide	N
44	Millar	Victoria, BC	Killed by MI son	N
45	McMillan	Saskatoon, SK	Not MI – shot by police after a pursuit	N
46	Bigsky	Saskatoon, SK	Not MI	N
47	Engdahl	Regina, SK	MI – shot by police	**Y**
48	Cyr	Regina, SK	Shot by police not apparent MI	N
49	Piche	Prince Albert, SK	Shot by police	N
50	Mercredi	Fond du Lac, SK	Shot by police	N
51	Nowlin	North Battleford, SK	Shot by police	N
52	McDonald	Regina, SK	Shot by police – MI	N