Stop Killing Us!

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This is a revised version of “Stop the Killing: A Critique of Toronto Police Force Responses to “Mentally Ill Citizens,” the author’s submission to the Toronto Police Services Board at a public meeting on April 19, 2012.

A Critique of Toronto Police Responses to Psychiatric Survivors

By Don Weitz

I am deeply concerned—in fact, alarmed—by what has become a virtual epidemic of police shootings-and- killings of people labelled “mentally ill.” The Toronto police have a disturbing history of targeting-tasering-shooting people labelled “mentally ill,” ”potentially dangerous,” or allegedly violent. Here is a partial list of the ages and dates of death of ten psychiatrized citizens, mostly young men, whom the Toronto police has killed since 1988. Since over half were men of African descent, this fact reflects continuing racism in the Toronto Police Force. With the exceptions of Charles McGillvary, who was labelled “mentally ill” and “mentally disabled,” and Michael Eligon, whose psychiatric diagnosis I don’t know, all were labelled “schizophrenic”—the most damning, stigmatizing and fraudulent label in psychiatry. These men’s deaths were driven by classism, racism, and mentalism. All were preventable.1

reasonable and responsible decisions, unless they ’re incapacitated by heavy doses of psychiatric drugs and/or electroshock.2

The second reason is that the police are trained to use deadly force and issue commands—not to engage in dialogue or emotional support—when faced with people who

are allegedly “mentally ill”and carrying something that might be used as a weapon. Police academy “mental health” courses that include de- escalation techniques are based on a militaristic- hierarchical-command model, which is doomed to fail. That’s because in this model there is virtually no room for dialogue, flexibility, sensitivity, emotional or social support. It’s not surprising that such “mental health” courses and training have had minimal or no major impact on the police force’s order-and-obey approach to people experiencing personal crises—crises that require flexibility, empathetic communication, and non- threatening approaches. Police intervention in these crisis situations have resulted and will continue to result in more tragic and unnecessary deaths. While going through a serious personal crisis, psychiatric survivors such as Michael Eligon and Charles McGillvary are frequently traumatized and may “freak out,” due to fear or panic triggered by seeing uniformed and armed police officers or the unnerving wailing of a police siren. In this tense, highly charged situation, the person in crisis needs someone who can and will understand his or her situation and communicate calmly (“talk down”) in a non-threatening, supportive and empathetic way—not uniformed policemen loudly ordering the person to obey or else.

Community Treatment Orders (CTOs), unfortunately enshrined in Ontario’s Mental Health Act since 2000, have been a total failure. CTOs, signed by psychiatrists, order forced psychiatric treatment (usually forced drugging and/or outpatient electroshock) and lengthier incarceration of psychiatric survivors who try to resist psychiatry-and-police interventions in their lives. For example, people can be forced back into a hospital or mental health centre for a longer time for refusing to “take their meds.”

A critical note regarding mobile response teams (MRT) or

assertive community treatment teams (ACTT) is worth mentioning. Currently, there are 56 MRTs and 79

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So what is triggering these tragic police killings of mainly young men the police label “EDPs” (emotionally disturbed persons)? I believe there are two major reasons: the first is a very common stereotype— the myth of the violent mental patient. This stereotype is also propagated by the media. It is mentalism or sanism—the false and stigmatizing belief that people labelled “mentally ill,” “psychotic,” or “schizophrenic” are basically violent, unpredictable, and incompetent—inferior human beings. Numerous scientific studies have exploded this myth, conclusively proving that there is no significant relationship between “mental illness” and violence: the vast majority (95%) of violence in society is committed by so-called sane or normal people, and people on street drugs—not “the mentally ill.” It is also a fact that allegedly “mentally ill” people can and do make

ACT teams spread across Ontario.3 Each team consists of a police officer and nurse riding in a police car, dispatched by the police and based in various hospitals. These teams are allegedly set up to respond to and help people going through emotional crises in the community. In the Greater Toronto Area, there are 11 ACT teams that the Ontario government established to enforce the notoriously coercive CTOs authorized in the Mental Health Act. This CTO law, an amendment to the Mental Health Act, is a draconian law that legitimizes forced psychiatric treatment (e.g., forced drugging) in the community and longer or indefinite involuntary committal—psychiatric imprisonment. As an extension of the police force and psychiatric system, these teams are intrusive and coercive. Further, they perpetuate psychiatry's discredited medical model of "mental illness," and aggravate people's fears of harm from forced drugging/electroshock and longer incarceration. They also violate people's human rights including the right to freedom, forcing people back into psychiatric facilities without a public hearing or trial if they refuse psychiatric drugs or stop seeing

a doctor or therapist ordered under a CTO “agreement.” Many activists and lawyers believe that CTOs violate the Canadian Charter of Rights and Freedoms, should be challenged in court as unconstitutional, and should be abolished.4, 5

A Proposed Pilot Project

Since the police are essentially not trained to deal peacefully and safely with people in emotional or personal crisis, I propose this community -based alternative as a pilot project: establish two Community Crisis Response Teams. Each team would consist of a small number (6-8) of crisis workers including trained psychiatric survivors, street nurses, and community health workers. Each team would be based in and accountable to a community health centre located in downtown Toronto, completely independent of the Toronto Police Force and Ontario’s mental health system. All crisis workers would have special communication and crisis counselling skills, be knowledgeable about a broad spectrum of health crises and community resources, and be trained in using de-escalation methods by experienced street outreach workers and community health professionals. Their mandate would have two major goals: (1) to respond to personal crises such as attempted suicide, depression, loneliness or social isolation; and (2) to offer emotional and social support and referral information to people in crisis, including people experiencing drug “side effects” or withdrawal reactions. Both teams would be educated in and work under an anti-oppression/antipsychiatry/anti-racist model that promotes mutual cooperation and respect,
dialogue, personal empowerment, autonomy and human rights. The crisis worker’s basic approach to a person in crisis would be informal, respectful, non-threatening, and supportive; any threat, pressure or coercion while offering assistance or support would be absolutely forbidden.

Workers who feel their lives might be seriously threatened could immediately call the police— as a last resort. The project could start in spring 2013 and continue for one year. Evaluation of its effectiveness should be carried out by a non-government, community- based research organization; a final report should be accessible online. Local community groups, social justice and advocacy organizations, and interested individual donors could be approached for possible funding.

I believe this community pilot project would be a constructive, empowering, humane, and urgently needed alternative to coercive police intervention in personal crises that frequently end in serious injury or death. Most importantly, the proposed project will save people's lives and respect their rights.

Notes

1 Before Toronto police shot 29-year old Michael Eligon at point-blank range, over ten police officers swarmed him and did not try to talk with him or de-escalate the crisis. Trying to run away from Toronto East General Hospital (probably a psychiatric ward), Michael was wearing a hospital gown, slippers and carrying a pair of scissors, but never lunged at or attacked the police. Nevertheless, the Ontario government's Special Investigations Unit refuses to charge the policeman involved in his tragic death; see, "No blame in Eligon shooting," Toronto Star, March 20th 2012, pp. GT1, 4.

2 J. Monahan and J. Arnold (1996, spring). "Violence by People with Mental Illness: A Consensus Statement," Psychiatric Rehabilitation Journal. "[There is]...sensationalized reporting by the media whenever a violent act is committed by 'a former mental patient... a weak association [exists] between mental disorders and violence... serious violence by people with major mental disorders

appears concentrated in a small fraction... Mental disorders... account for a minuscule portion of the violence that afflicts American society."

3. Personal communication from Tori Gass, Media Relations Coordinator, Ministry of Health and Long-Term Care, Government of Ontario, May 9th 2012.

4. D. Weitz (2000). Fighting Words— Community Treatment Orders and 'Brian's law.' Canadian Dimension, September/October.

5. E. Fabris (2011). Tranquil Prisons: Chemical Incarceration Under Community Treatment Orders. Toronto: University of Toronto Press.

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