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In crisis: Can Mobile Crisis Intervention Teams end police killings?

Critics question whether Toronto's Mobile Crisis Intervention Teams, under current procedure, will do anything to stop lethal outcomes.

TORONTO STAR / LAURA KANE

Mental health nurse Sharon Lawlor and Const. Peter Sidlauskas have been working together for a year on the Toronto Police Mobile Crisis Intervention Team in 54 and 55 divisions.

By: Laura Kane Staff Reporter, Published on Mon Jun 02 2014

An elderly man stands outside on a blustery April morning, shaking and alone on an empty residential street. Wearing only a light windbreaker and jogging pants, he doesn't know who he is or how he got there.

"Do you know your name, sir?" asks Sharon Lawlor, a mental health nurse with the Toronto Police Mobile Crisis Intervention Team, as she gently wraps him in a blanket.

During a ride-along with the Star, Lawlor and her partner, Const. Peter Sidlauskas, soothe people gripped by paranoia and dementia. What they don't do is talk down people with knives, or thwart suicide attempts.

Mobile Crisis Intervention Teams, consisting of a mental health nurse and a police officer, are one way the Toronto Police is trying to stem the tide of rising mental health-related calls. But the teams are secondary responders, do not operate after 11 p.m. and generally do not engage with people holding weapons — unlike in other cities such as Hamilton.

Toronto Police say the teams are meant to prevent future, potentially deadly, encounters, but critics say they will do nothing to stop police killings. In recent high-profile shootings such as Sammy Yatim, the 18-year-old wielding a knife on an empty streetcar, the team would likely not have intervened even if it had been available.

During the Star's ride-along in 54 and 55 divisions, a call comes in about a furious-looking man slamming a large piece of wood against a storefront, terrifying the customers inside. While the MCIT cruiser heads for the scene, frontline officers arrive and are able to get the man's name.

Sidlauskas enters the name into the computerized police database in the car. “SCHIZOPHRENIA,” the screen reads. “NOTE: SUICIDAL TENDENCIES. WANTS TO BE KILLED BY POLICE.”

Lawlor, a registered nurse with 25 years of mental health experience, says she has engaged with people holding weapons during her year on the MCIT. But she says she will only do so once officers have deemed the situation safe enough — for example, if the person is contained, behind a door or conversing in a lucid way with police.

“If the person’s holding the weapon and they’re talking, and if I see an officer’s not doing so well, I don’t do anything to hurt their ego, I will just try to say, ‘I’m a nurse. So talk to me. I know you’re agitated and you’re upset,’” she says.

There ends up being no need: while the MCIT is on its way to the call, frontline officers de-escalate the situation and release the man. The mobile team drives around looking for him for several minutes before giving up.

“It’s rare that we’re de-escalating somebody who is very violent,” says Sidlauskas. “One reason is quite often the situation is already done by the time we get there. We may be close, we may be involved initially, but quite often it’s done by the time we get there.”

It’s not the only call the MCIT — the lone team serving two divisions — narrowly misses on this particular shift. While the team is busy on another call, a man threatens to “drink himself to death.” Frontline officers attend and call an ambulance to take him to hospital.

These scenarios, among thousands resolved peacefully by frontline officers every year, bear some resemblance to those that have ended in tragedy: Edmond Yu, a schizophrenic man shot by police while wielding a hammer on a bus in 1997; Michael Eligon, killed by police in 2012 after escaping from hospital and holding two pairs of scissors.

In fact, the first Mobile Crisis Intervention Team was created in 2000 in response to a recommendation made in an inquest into Yu’s death. Fourteen years later, an inquest jury examining Eligon’s death and the deaths of two other mentally ill people recommended expanding the teams city-wide and making them available 24 hours a day.

But under current MCIT procedure, had the teams existed in either Yu or Eligon’s case, they would likely not have intervened as those crises were unfolding.

Deputy chief Michael Federico told the Star in a sit-down interview that the goal of the teams is to introduce people to the mental health system as early as possible to prevent future — potentially violent — encounters with police.

But he expressed doubts about the overall impact of the teams, given that the prevalence of mental illness in society appears to be growing.

“The reality, of course, is . . . there are increasing numbers of people in distress,” he said. “I don’t think it’s realistic to anticipate significant reductions in the number of people who experience crisis in their lives, so regrettably, I think, police are going to continue to be responding.”

Federico said the teams must be secondary responders — meaning they arrive after police constables — in order to protect the safety of the mental health nurse, an unarmed “civilian.”

In at least one other Ontario city, a similar team is the first response to 911 calls involving mental health crises.

The Hamilton Police Service and St. Joseph’s Healthcare Hamilton introduced a Mobile Crisis Rapid Response Team to serve its downtown area last year, a new addition to its already successful Crisis Outreach and Support

Team (COAST) initiative. The team pairs a uniformed officer with a mental health nurse and is a first responder when geographically closest to the call.

Jodi Younger, director of mental health and addiction services at St. Joseph's Healthcare, said there were no concerns about making the team a first responder, because the nurses are well-trained and other officers will also attend the scene if there is a weapon.

"The role of police is community safety, so they're going to be taking the lead in a situation like that, but the mental health care worker is right there with them, working around de-escalation as part of the approach," she said.

In the 14 divisions in Toronto where MCITs were available in 2013, there were some 11,056 calls regarding what police call "emotionally disturbed people." Mobile crisis teams responded to about 15 per cent of those calls, and only after frontline officers had already attended the scene.

(The teams also respond to calls that are not classified as "EDP." During the Star's ride-along, for example, the team responds to a call classified as "theft" — an elderly woman, likely suffering from dementia, is gripped by the belief her neighbours are stealing from her.)

In a submission to the Iacobucci Review — the ongoing review of Toronto Police use-of-force practices led by retired Supreme Court Justice Frank Iacobucci — the Criminal Lawyers' Association questioned whether expanding MCITs would reduce the number of police killings.

"This is not to say that it may not be worthwhile indeed to increase hours of operation, geographical availability, of MCIT — albeit that alternatives to the particular model adopted in Toronto also merit exploring," the submission reads.

"The reality is simply that by the very terms of their existing mandate, they will do nothing to head off lethal outcomes in violent scenarios and/or those involving weapons."

Former mayor John Sewell, head of the Toronto Police Accountability Coalition, has been pushing for MCITs to be made first responders. He said that expanding the teams city-wide may help to "change attitudes" among police towards people with mental illness.

"Police are trained to command and control," he said. "The teams in fact don't approach things that way. Their approach is: 'How do you get this person to relax, calm down, so we can start resolving it.' "

On the Star's ride-along, the team's dedication to calming people gripped by distressing beliefs is undeniable. Inside an elderly woman's cramped apartment, Lawlor listens intently as the distraught woman complains of her belongings, like a cane, going missing.

The woman has called police before, and it is not the first time Lawlor and Sidlauskas have visited her. Every time, she tells the same story of how another officer allegedly treated her.

"He said, 'You are old woman, your brain don't work anymore and you are cuckoo,'" she says, deeply distressed, in a thick Eastern European accent.

Later, Sidlauskas says he doubts any officer trained today would say something like that. It may have been a comment made to her decades ago, he suggests, or the way she interpreted an officer's comments.

The 86-year-old is likely suffering from dementia, but the team does not tell her that her delusions aren't real or that

she has an illness. Instead, they carefully check her apartment, and find her cane.

The team talks to her for about 45 minutes, extra time that frontline officers are unable to spend. After ensuring the woman has enough food and can care for herself, Lawlor makes a plan to call the woman's doctor and case worker. They leave the MCIT's number and say if she wants to call police again, to call them directly.

At least two calls to which they respond during the ride-along are repeat callers.

Lawlor also points out that the vast majority of calls involving mentally ill people are not violent scenarios. It is a stereotype that people with mental illness are violent or unpredictable, she says.

"Sometimes they're just loud and they want to be validated and heard. That comes across scary, to a lot of people, but it's just their presentation so we're not scared of it," she says.

The pair have been working together since April 2013, when the team in 54 and 55 divisions launched. After hundreds of calls together, they have seen success stories — running into those they've successfully connected with services — and heartbreakers — a teenage boy in and out of shelters.

"Sometimes police go on calls and they're pleasant. They're finding a lost child, or they're doing something where they walk away and they feel good," says Lawlor.

"I worked with officers who have done this job who have said, 'I have to get out of this, because every call we go to is misery. Every call we go to, somebody's in pain, somebody's hurting, somebody's life is messed up.' Nobody calls us for a rewarding moment. We have to find those ourselves."