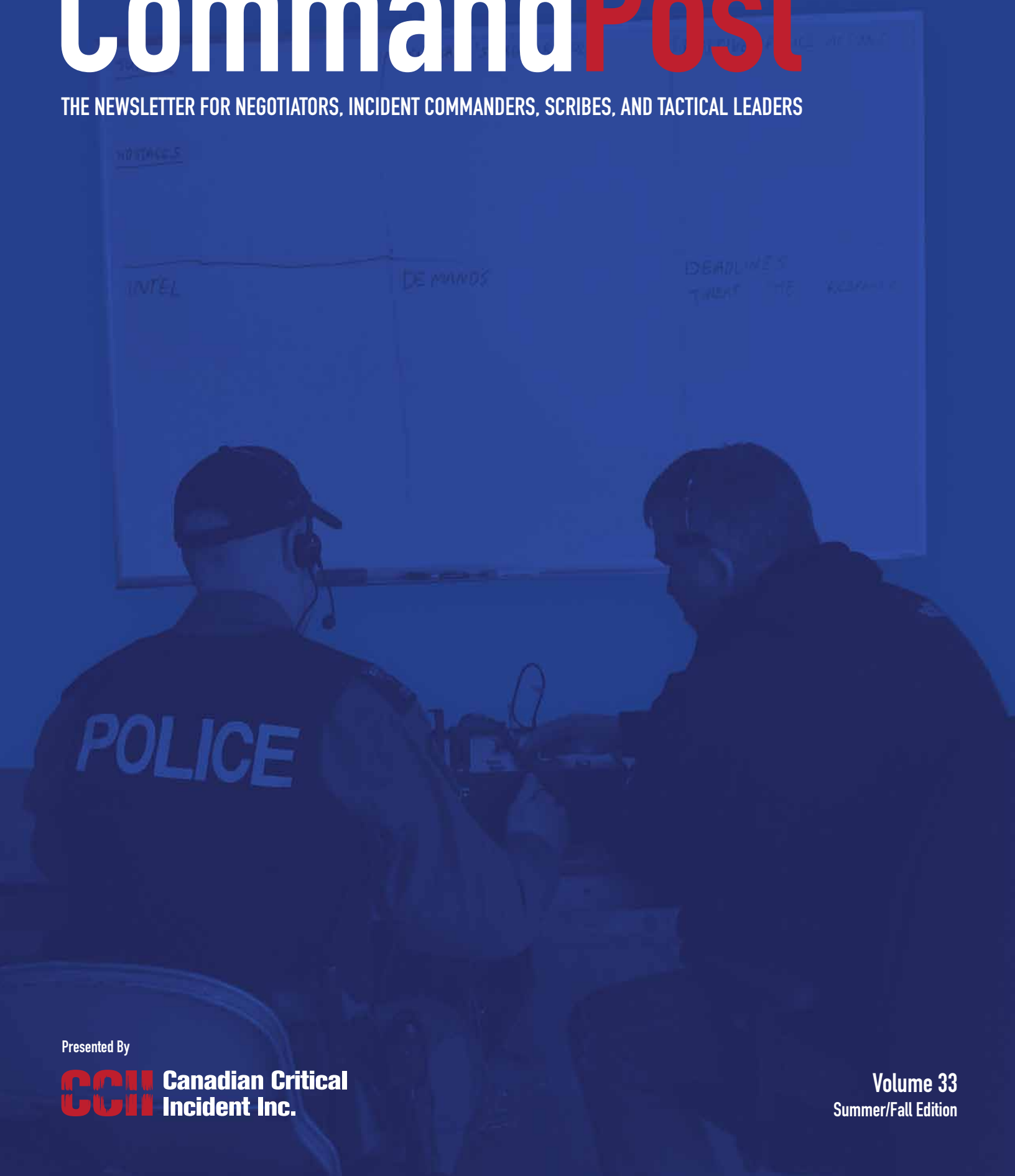
The Command Post

THE NEWSLETTER FOR NEGOTIATORS, INCIDENT COMMANDERS, SCRIBES, AND TACTICAL LEADERS



Presented By

CCII Canadian Critical Incident Inc.

Volume 33
Summer/Fall Edition

THE PRESIDENTS MESSAGE

I hope everyone had a safe and fun summer. There is no place like Ontario in the summer!

I have received many positive comments on the new magazine style format of the Command Post newsletter and the improvements to the CCII website. Thanks to the talented and creative people at Interphased.

The Command Post will continue featuring Incident Command and Crisis Negotiation Training exercises from our membership. Presenting the diverse training scenarios or incident command call outs and sharing the experiences and lessons learned benefits everyone. And it is the primary role of CCII. The Timmins Police Service, Emergency Response Team will be featured in this issue of the Command Post thanks to Sgt. Marty Delich.

"This year's theme is the influence social media has on incident command teams"

CCII will be co-hosting with the Ottawa Police Service, Fall Conference on October 28,29 and 30th 2013. It will be held at the beautiful National Hotel in down town Ottawa. Reserve your room by Sept 27th to receive a special rate.

S/Sgt. Lynne Turnbull with her experienced team and I have been working hard to build on last year's successful conference and deliver an informative, interesting and exciting conference. This year's theme is the influence social media has on incident command teams and the unique challenges it presents to Incident Commanders, Tactical members, Negotiators and the Media Relations Officer. We are thrilled with a list of dynamic guest speakers.

Det. Warren Bulmer of the Toronto Police Service will be discussing the role social media had during the Boston Bombing Investigation. Det. Bulmer recently qualified in the Ottawa Superior Court as an expert on Facebook specifically on the aspect of the social network and the impact it has on police investigations.

It is my pleasure to announce that FBI Supervisor Special Agent Michael Yansick of the Critical Incident Response Group, Crisis Negotiation Unit will be providing interesting case studies at this years fall conference.

In this issue of the Command Post Dr. Mamak and Dr. Hy Bloom have prepared an article regarding Not Criminally Responsible. It is an excellent overview of the complicated process that will surely offer some insight to the Richard Kachkar case.

Also in the Command Post Professor Frank Travoto writes an interesting and valuable article relating to leadership and incident command.

I am pleased to have Stephanie Conn presenting an interesting article on secondary traumatic stress disorder (STSD). It is a very good read with some surprising facts.

CCII will be delivering the Critical Incident Commanders Course and Refresher to Chatham-Kent Police Service, October 7 to 11, 2013. Please contact S/Sgt. Rose Kucharuk or Sgt. Jon Mudler for more details.

"This workshop will significantly strengthen their ability to resolve a crisis situation with minimal use of force"

The Crisis Intervention Techniques for the First Responder continues to get interest from both the public and private sectors. I presented a workshop for the Blue Line Expo and recently to the City of Toronto Security Staff. The workshop helps first responders to recognize and understand common mental illnesses. Furthermore it also develops higher situational awareness, subject assessment, expands defusing techniques, enhances active listen skills and tactical communications. This workshop will significantly strengthen their ability to resolve a crisis situation with minimal use of force, and will help reduce officer's injury and promote public safety and police accountability when dealing with people in a state of crisis.

I want to thank the Executive Members and the Advisory Board. I want to personally thank the Advisory Board members who continue to support CCII over the years, they are; Dr. Peter Collins Forensic Psychiatrist, Dr. Mini Mamak Forensic Psychologist, Dr. Jim Cairns Deputy Regional Coroner (Ret),Inspector Greg Lamport Waterloo Regional Police, Staff Sergeant Dean Streefkerk London Police Service Emergency Support Section and Staff Sergeant Krista Miller of the OPP Crisis Negotiation Program Co-ordinator.

Looking forward to seeing you at the Fall Conference in Ottawa!

Thank you, take care and be safe.

Tom Hart

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CCII Canadian Critical Incident Inc.

"Make the Call Count"

IN THIS ISSUE

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TRAINING DAY

CCII PROFILES THE TIMMINS EMERGENCY RESPONSE TEAM

The City of Timmins is located in North Eastern Ontario. The City is 3,210 km2 (1,240 square miles) comprised of 29 townships, within its jurisdiction

The 45,000 person community is policed by the Timmins Police Service, which celebrated its 100th anniversary in 2012.

The Timmins Police Service Emergency Response Team is comprised of twelve members and lead by Sgt. Marty Delich and Team Leader Cst. Bruce Turner.

The Critical Incident Commanders are: S/Sgt Rick Blanchette, S/Sgt Henry Dacosta, and S/Sgt Danny Charest.

The Timmins Police Service has partnered with Canadian Critical Incident Inc. for over a decade and received Crisis Negotiator training and refresher courses from our organization.

On May 22, 2013, the Timmins Police Service conducted a practical Crisis Negotiator / Incident Command training exercise to continue to develop and improve the capabilities of the Critical Incident Team. The training was attended by Timmins Police Crisis Negotiators, Emergency Response Team members, Incident Commanders and members of our partnered medical support unit, Cochrane District Special Operations Medics (CDEMS SOM).

Timmins Police were also fortunate to have in attendance, Dr. Jean Guy Gagnon. Dr. Gagnon is a Sudbury Psychiatrist who has consulted with several police forces across Canada (RCMP, OPP, Greater Sudbury Regional Police, Thunder Bay Police, Toronto Police Services (ETF) on Hostage-Takings and Barricaded Standoffs, both domestic and foreign.

The training exercises were divided into two scenarios. The first scenario was a suicidal male that had barricaded himself in his car. The desponded male had poured gasoline over himself and throughout the interior of the car. Uniform members arrive to secure the scene and establish an inner perimeter. The Timmins Emergency Response Team and Critical Response Team arrive and establish a line of communication with the male. Following a lengthy crisis intervention and negotiations with the subject, he surrendered to police without incident.

The second scenario was an armed and barricaded male. A citizen reported hearing shots being fired from a cabin located in a rural area. Uniform members while approaching the scene observed an elderly male subject with a shotgun run into a cabin.

The responding members locate a male lying outside of the cabin. And he was bleeding profusely with an obvious gunshot wound to the abdomen. While trying to render first aid to the victim, the suspect orders them off his property at gun point and threatens to shoot them.

The Emergency Response Team and the Incident Command teams arrive at the designated staging area and a line of communication was established with the suspect.

"The training exercise proved to be a valuable and meaningful experience"

The Crisis Negotiators were able to convince the suspect to allow EMS Special Operation Medics to treat and remove the victim from the scene and in the "fatal funnel". Following lengthy and challenging negotiations of demands and deadlines the suspect surrendered to the police, with minimal tactical resolution.

The training exercise proved to be a valuable and meaningful experience for the EMS Special Operations Medics, uniform members, communications, crisis negotiators, scribes, incident commanders and tactical team members to work cohesively as a team under the stressful demands of a critical incident. It also served as an excellent opportunity to test the equipment and familiarize themselves with the operations.

Training exercises test the skills and abilities of the members involved and an opportunity to identify areas for improvement. Some lessons learned were the need for the incident commanders to limit their influence on the crisis negotiators and tactical team members. This is a common problem among all incident command teams. This training exercise reminded us that commander's command and negotiators negotiate.

Dr. Gagnon was able to participate in the training exercises and his expertise was valuable asset to the team and feedback to the members of the Critical Response Team. Dr. Gagnon has provided his contact number as a resource to other agencies. He can be contacted at 705 626 5828.

Sgt. Marty Delich
Training, ERT

KAWARTHA LAKES DETACHMENT

CENTRAL REGION CRISIS NEGOTIATION TEAM CALL OUT

Inspector Gail Webster, D/Cst. Kris Size, ERT, TRU and other members of the OPP attended this violent and challenging critical incident call, which will be presented in detail at the fall conference.

On Sept 4, 2012 the OPP received a call at 11:13am about a domestic at a residence in Emily Twp just outside Lindsay Ontario. A female party had failed to show up at work that morning and her friends had driven by her residence and observed a truck in the garage which they knew was owned by the female's ex-boyfriend. The friends were very concerned for the female's safety and called police.

When police arrived they heard screaming from inside the residence and as a result entered the house and set up in the kitchen and living room. The male and female were barricaded in the back bedroom and he indicated he had a knife, handgun and shotgun. Officers observed the word " SORRY" written in blood on the wall in the hall outside the bedroom.

Two TRU team, Negotiators, K9, crime and an Incident Commander were dispatched and at 14:58 all units arrived on scene. A church, a short distance from the residence, became the command post and staging area. Directly across the street from the command post was a school and the children were sent home to ensure their safety.

Once everyone was briefed, TRU moved into the residence relieving the front line officers inside the house. Two negotiators also entered the residence and set up in the kitchen.

At 14:56 TRU advised they were ready to breach and they requested approval to use an explosive window charge if required.

Negotiation begins at 15:07 hrs. It was very difficult as negotiation was done by yelling down the hall. The secondary negotiator was using text to keep the CP updated because if he used the phone his voice would affect the primary's ability to hear subject.

The female kept calling to the officers says "guys, guys" and the sound of glass breaking could be heard. The male party had threatened to cut off the female's feet and kill her parents in front of her.

At 15:55 the male opened the door to the bedroom which was barricaded with furniture and spoke to the TRU members down the hall. As he went to shut the door two TRU members rapidly approached the door and struck it twice opening it enough for them to enter the room and taser the subject. The suspect is taken into custody and the female was located tied to the bed but uninjured.

The suspect had stabbed himself in the stomach and as a result the Crisis Negotiator was made the subject officer by the SIU.

The suspect recently was found guilty and sentenced to 17 months in jail however on the way out of the courtroom threatened the judge and the investigating officer so he now faces further charges.

Insp. Gail Webster
OPP Kawartha Lakes Detachment

This incident will be presented in detail at the fall conference as a case study.

CCII AND THE OTTAWA POLICE SERVICE ARE PLEASED TO PRESENT

2013 FALL CONFERENCE

OCTOBER 28-30

CCII and the Ottawa Police Service are actively preparing an excellent Fall Conference. We are excited to bring you a list of dynamic, well-informed speakers to present interesting case studies and share their experiences to make this year's conference an enjoyable learning experience. This year's conference will be focusing on social media and the influence it has on crisis negotiations and critical incident command. An expert in the application of social media sites such as Facebook and Twitter to name a few will explain the benefits and detriments relating to incident command and crisis negotiations. We will also be presenting case studies relating to Mental Health issues.

The National Hotel located at 361 Queen Street Ottawa is offering a special blocked rate of $159.00 per night. Attendees are responsible for making their own individual reservations, by calling the reservation department at 1.855.238.6001 or email reservation@nationalhotelottawa.com. Callers must identify themselves as being with the CCII/Ottawa Police Fall Conference and quote reservation I.D code: GSOPS27A. Guest must call prior to September 27, 2013 to qualify for this special offer.

POLICE Ottawa

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2013 Annual Fall Conference Registration Form

Prefer to register online? Visit http://canadiancriticalincident.com/register.php

Registration Rate - $400.00 (Includes HST)

First Name _____

Last Name _____

Email Address _____

Rank _____

Badge/ID Number _____

Agency _____

Agency Address _____

City/Province _____

Postal Code _____

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Mail Cheques Payable to:
Canadian Critical Incident Inc.
946 Lawrence Ave East
P.O. Box 47679
Toronto, ON M3C 3S7

Reservations:
National Hotel & Suites
361 Queen Street
1-855-238-6001
Quote Reservation ID Code:
GSOPS27A – (prior to Sept 27)

HST No. 860377886

WATERLOO REGIONAL POLICE SERVICE BUS INCIDENT

January 5, 2013

On a cold January afternoon, Kevin Holden boarded a Grand River Transit bus refusing to pay his fare, stating this was the day he was "going to die". He was allowed to remain on the bus and took a seat beside his soon to be victim, Susan Wiebe, whispering to her he "was sorry". A short time later, Kevin quietly prevented Susan from leaving the bus at her scheduled stop causing her to text her husband who notified police.

The bus travelled several blocks away before it was finally stopped by the driver on a side street of a busy subdivision. Patrol officers responded within a minute and immediately boarded the bus, unaware of the entire situation. Five passengers, including the driver, were evacuated leaving only Kevin and Susan on the bus.

The patrol sergeant was first on scene and maintained face-to-face communications with Kevin from the front door, while a second officer acted as back-up, responsible for communicating the negotiations back to dispatch until relieved by Emergency Response officers. Kevin told police Susan would die if they did not get off the bus. He also confessed to using a large quantity of crystal methamphetamine that morning and not sleeping for several days.

Fortunately in this situation the patrol supervisor had 35 years of policing experience and was a previous negotiator. He managed to keep Kevin talking until replaced by ERU officers, who also continued to negotiate face-to-face from a safe distance. No weapon was ever observed by any of the officers.

Over the course of the next three hours, Kevin made demands to police including food, starting the bus to drive him to a gravesite, and bringing paramedics on board to ease his pain. He also made repeated threats to kill himself and Susan, stating at times that he had a gun and a syringe filled with infected blood. Susan remained incredibly calm throughout the entire incident.

O.P.P. psychiatrist Peter Collins was contacted by the negotiators and provided some pivotal advice. He advised negotiators to remain patient while buying as much time as possible to allow Kevin to come down from his high so he would become more rational to deal with. Detectives also played a crucial role in this incident by providing detailed background information about Kevin to negotiators in a timely manner, giving them an opportunity to make quick connections with him.

ERU officers delivered McDonald's to Kevin while Crisis Negotiators and ERU officers worked together to negotiate with him, both with a throw phone and face-to-face until he agreed to release Susan. However, officers were bewildered when Susan would not exit the bus, even though Kevin agreed to release her. At one point negotiators spoke to Susan from the throw phone and she told them she was afraid to leave because she was worried he would kill her as soon as she turned her back to him, even though her demeanour was extremely composed. Crisis Negotiators had Kevin tell her to leave and even spoke to her directly from the throw phone telling her to leave but she chose to remain on the bus and eat. Eventually, police ordered Susan to leave the bus and she complied.

WATERLOO REGIONAL POLICE SERVICE BUS INCIDENT

Both negotiators and ERU continued to talk Kevin through his demands until he finally surrendered and exited the bus himself shortly after 6pm. No injuries were sustained by anyone and no weapon was located on Kevin, except for a pair of nail clippers that were used to push into Susan's side throughout the incident.

A debrief was held and several learning points emerged from this incident:

1 Designate a back-Up Officer: Utilizing a second officer as a back-up to the patrol negotiator was paramount to allowing the first officer on scene to focus solely on the conversation with the subject while maintaining officer safety and continuity of the conversation. It also provided the Incident Commander and Tactical Commander, who were both enroute, with immediate information to make appropriate and timely decisions.

2 Designate an interim Incident Commander: If the patrol supervisor becomes directly involved in negotiating in similar type of incident, a second supervisor should be designated as the interim Incident Commander until a Duty Officer arrives onscene and assumes control. This will reduce confusion for directing containment points, setting up a CP location, directing responding units, and developing action plans. In this situation, the patrol supervisor had developed a strong rapport with the subject and was not in a position to take care of these tasks.

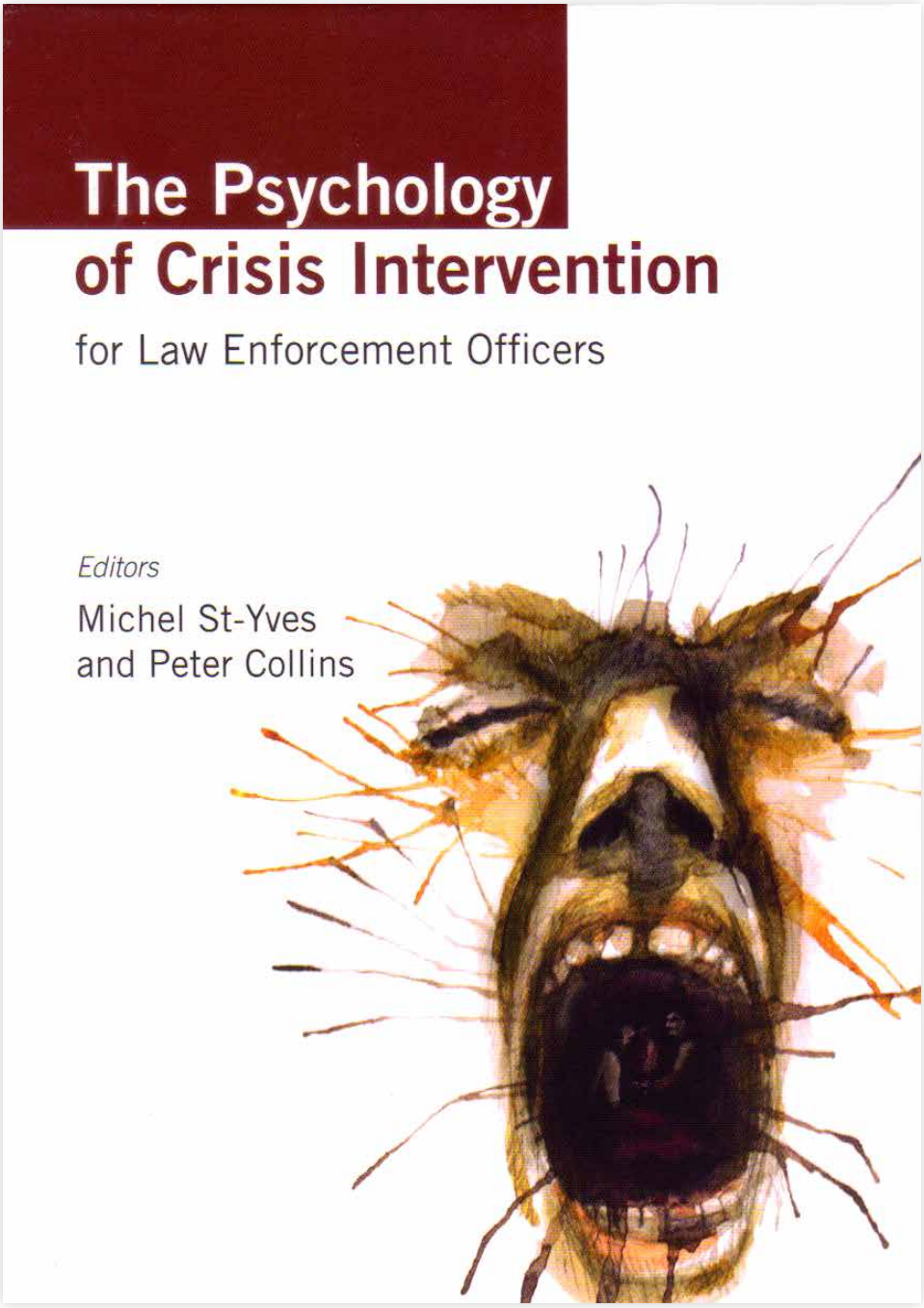
3 Victim Response Should Not Dictate Police Response: Police response should not be dictated by the behaviour or reactions of the victim, nor should police expect a certain set of behaviours from a victim in any situation. In this incident, the victim remained calm and quiet and ate a hamburger while sitting beside her hostage taker. She had to be asked several times to leave the bus, by both the hostage taker and police. Her behaviour could have easily caused officers to become complacent and take the situation less seriously. However, regular training in both tactics and crisis negotiation kept responding officers at an appropriate state of urgency throughout the incident.

4 Maximize Police Resources: Deploying Investigators immediately to gather all relevant background information on the subject was crucial in allowing negotiators the opportunity to develop themes and establishing rapport from the onset of negotiations. It also allowed the Tactical Commander and Incident Commander to make quick, intelligent decisions.

5 Exercise Patience with Drug-Induced Subjects: The subject in this situation had consumed a large quantity of drugs and had not slept for several days. He was irrational and paranoid. The advice provided by the consulting psychiatrist was for negotiators to be patient with the subject with the expectation that as time progressed he would become more rational to deal with as he came down from his high. This may extend the duration of the incident and tax police resources but in the end it provided the opportunity for this incident to be resolved peacefully with minimal impact on the community.

Immediately following his surrender, Kevin was arrested and moved to the hospital for medical treatment. He was convicted of Hostage Taking and sentenced to five years in custody.

S/Sgt. Shaena Morris
Special Response Branch,
Waterloo Regional Police Service



Responding to emergency situations, protecting society and saving lives are the tasks of all police officers. To accomplish this mission, they must adapt to the evolution of our society and intervene among groups that are increasingly diverse and in situations that are increasingly complex and risky. Mentally disturbed or suicidal individuals, random shooters, hostage-takers, religious or political fanatics are all part of the situations in which police officers must intervene. These present a high risk of harm to others as well as to the responding officers. A remarkably efficient and safe weapon, utilized in these incidents, is called communication. A police officer's work relies on the use of psychology, especially when it comes to resolving conflictual or crisis situations.

This book provides a better understanding of human crises and the methods used to intervene, whether it be in relation to those "responsible" for the crisis or the victims of these events. This book is for all those who are called upon to intervene in crisis situations, especially police officers, crisis intervention teams and mental health professionals.

Dr. Peter Collins
Forensic Psychiatrist

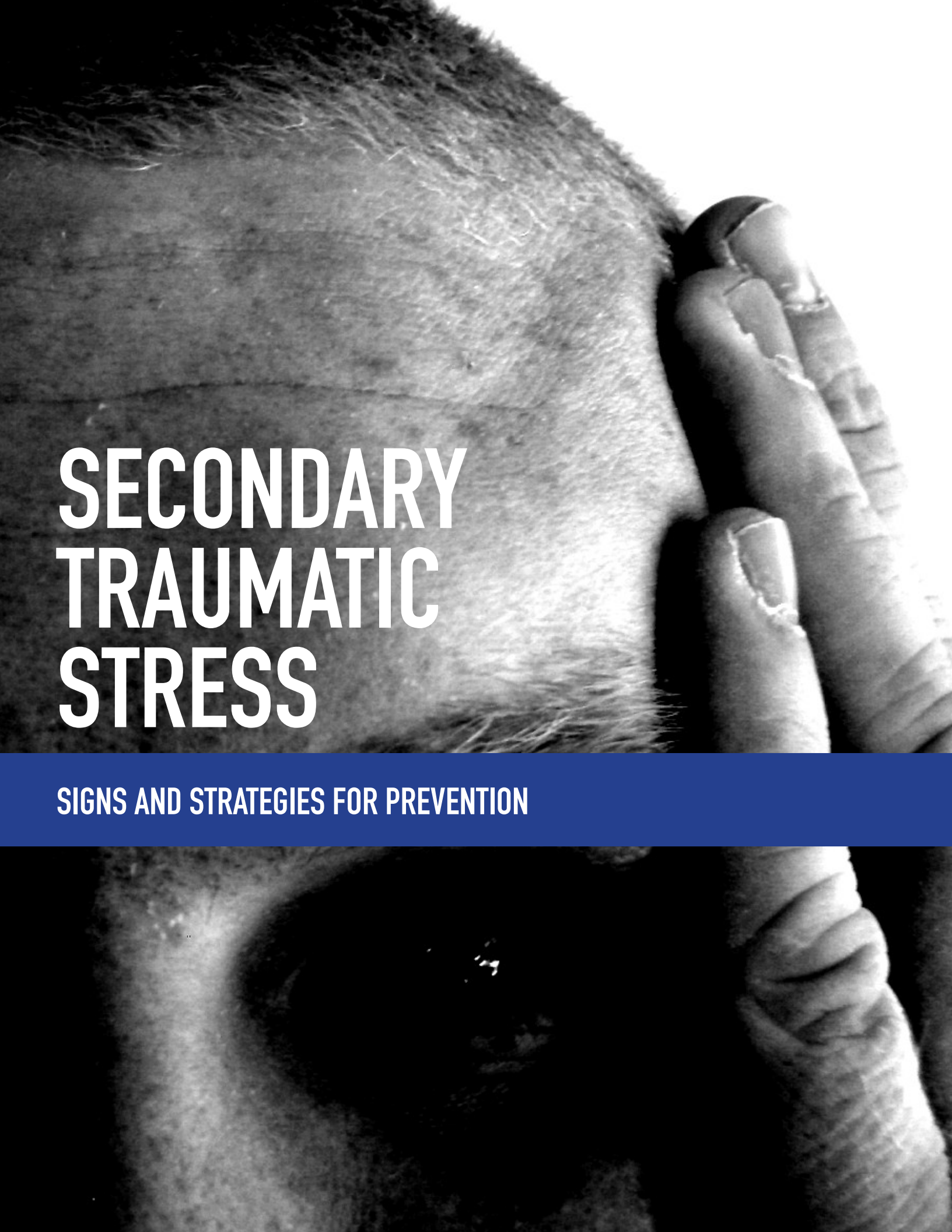
About the Authors

Michel St-Yves is a forensic psychologist with the Division de l'analyse du comportement (behavioural analysis service) of the Sûreté du Québec. He works as a critical-incident specialist and is actively involved in criminal investigations, both in profiling suspects and preparing police interrogations. He trains police officers in crisis negotiation techniques and is a member of the Sûreté du Québec's specialised intervention team. He also teaches at the École nationale de police du Québec (Quebec Police Academy) and at the Université de Montréal.

Peter Collins is the forensic psychiatrist with the Criminal Behaviour Analysis Unit of the Behavioural Sciences and Analysis Section – Ontario Provincial Police and has been a member of the Toronto Police Service Emergency Task Force negotiation team since 1992. His clinical appointment is with the Complex Mental Illness Program at the Centre for Addiction and Mental Health. He is an Associate Professor with the Division of Forensic Psychiatry at the University of Toronto and an Associate Clinical Professor with the Department of Psychiatry and Behavioural Neurosciences at McMaster University.

See more at:

http://www.carswell.com/product-detail/the-psychology-of-crisis-intervention-for-law-enforcement-officers/#sthash.T6roO4ri.dpuf



SECONDARY TRAUMATIC STRESS

SIGNS AND STRATEGIES FOR PREVENTION

Most police officers are familiar with the concept of post-traumatic stress disorder (PTSD). PTSD is often associated with significant events such as officer-involved shootings or exceptionally heinous crime scenes. Supportive measures such as critical incident stress debriefings and defusings help officers overcomeadverse reactions stemming from the incident. The average rate of PTSD in police officers is 7-10%, which is very close to and sometimes even below the general population rate of 9%. Clearly, the majority of officers demonstrate resilience despite their exposure to critical incidents. This statistic might be surprising to read in light of the Ontario Ombudsmen's Report released last year that indicated officers are more likely to die by suicide than be killed in the line of duty. So what accounts for this sobering occurrence when we consider the low prevalence rate for PTSD in police? I believe secondary traumatic stress disorder (STSD) is to blame.

Officers do not have to experience a full-blown critical incident in order to be affected psychologically by their exposure to trauma. STSD occurs when officers are continuously exposed to the traumatization and suffering of others. In fact, research indicates that a larger percentage of officers are affected by their routine exposure to the suffering and traumatization of others. According to one study, the incidence rate for STSD is 30-40%. STSD results in symptoms that are indistinguishable from PTSD. In a large-scale study of STSDpolice officers reported high levels of disturbance from their exposure to trauma on the job.

• 74% of participants reported experiencing recurring memories of an incident

• 62% experienced recurring thoughts or images

• 54% avoided reminders of an incident

• 47% experienced flashbacks of an incident

• 96% of participants reported that their opinions of others had changed

• 92% reported they no longer trusted others

• 82% believed the world was an unsafe place

• 88% experienced prejudices they did not hold prior to being on the job

• 11% experienced suicidal ideation as a result of the occupation

Some of the lesser-known symptoms of STSD make it difficult for the officer and others to understand what is happening. The impacts are cognitive- difficulty concentrating, losing things and accident-proneness; emotional - anger, sadness, numbness, impatience, moodiness and negativity; behavioural- withdrawal and interpersonal difficulties; and physical- aches, pains, and exhaustion. Making matters worse, there appears to be an additive-dose effect. The more traumas the officer is exposed to, the more symptoms he or she will have. In fact, the number of traumas exposed to is deemed more important than the intensity of the trauma. Adding to the confusion, some officers may be asymptomatic until the next event. It is difficult for officers and their family members and co-workers to understand what is happening with the officers because you cannot point to a specific source of the disturbance, as you could with PTSD.

The effects of STSD are not limited to the officer. Studies have shown that spouses and partners of officers experiencing PTSD symptoms experienced STS symptoms that mirrored PTSD symptoms. Higher levels of PTSD symptoms in police officers have indicated higher levels of secondary trauma in police wives. Secondary traumatization has led spouses to avoid the source of the trauma, the officer. Secondary trauma of police wives has been strongly correlated to psychological distress, depression, anxiety and increased levels of alcohol consumption.

Negotiators and tactical team members may be at heightened risk for STSDfor several reasons. I conducted a study in 2011 on what hindered police officers'abilities to cope with STS. Several of the factors that officers identified are commonly experienced by negotiators and tactical team members such as remaining at the scene for a protracted period of time, having unclear or contradictory objectives, learning personal details of the victim(s), a negative outcome in the incident and feeling a heightened sense of responsibility based on the vulnerability of some victims.The prevalence of these risk factors for negotiators and tactical team members calls for both proactive and reactive strategies to prevent STS from becoming STSD.

Personal Strategies to Mitigate STS

There are several ways officers can promote resilience. Talking with family members, friends, and co-workers helps many officers to discharge some of the stress they feel following a difficult call. Many officers have found that exercise also helps them to better manage stress. Officers improve their coping ability by staying active outside of work with hobbies and non-work interests.Resilient people know to not take themselves too seriously and know the value of having a sense of humour.

SECONDARY TRAUMATIC STRESS

The attitude officers take regarding their work also has an impact on their resilience. For instance, officers who recognize and accept their limitations as a person are better able to let go of the outcome of the incident. I realize this is easier said than done. There is a natural tendency to equate your "input" with the outcome, discounting all other factors that contributed to the event itself. It is important to ask yourself how you define success in your job and determine if this is a fair standard, given all the aspects that are out of your control.

Organizational Strategies to Mitigate STS

Police agencies can also take measures to promote the resilience of their officers. Preventing the accumulation of STS is far more productive than trying to help an officer with STSD. Educating officers aboutthe signs of STS helps them to understand what is happening, normalizing their reactions. Police are trained to tactically respond to traumatic events but lack training on how to psychologically respond. Psychological preparedness training reduces uncertainty, increases a sense of control, and teaches automatic responses that are less readily eroded during stressful events.

Supervisors are urged to monitor for signs of distress in their team that indicate the accumulation of traumasso they can encourage adaptive coping such as exercise, mental and physical check-upsand facilitate access to mental health services, including peer support. Everything you do or don't do sends a message toyour team. If you don't ask them how they're doing after a particularly heinous call, what message might that send? Even if you get tight-lipped responses such as "I'm fine", it might invite an officer to come at a later point and say "I'm not fine anymore". Supervisors also promote their team's resilience when they demonstrate grief leadershipby expressing their own grief. This normalizes reactions that arise in these incidents. It could be as simple as saying "Man! That was a tough call. It was hard to hear the kids screaming and know I couldn't do anything about it." Saying something like this encourages others to share what it was like for them and offsets the stigma of being weak. Several officers in my study said they hid their feelings until they knew that someone else felt the same.

Experiencing STS is a normal reaction to the continuous exposure to human suffering. It is when it accumulates and begins to cause distress that it becomes a problem.I hope this article helps you recognize the signs of STS and take a proactive approach to your resilience.

Stephanie Conn

About the Author

Stephanie holds her M.A. in Counselling Psychology and M.Sc.in Criminal Justice, and is a Registered Clinical Counsellor. She is currently completing her Ph.D. in Counselling Psychology at the University of British Columbia. Stephanie is an experienced police officer having served 9 years with Fort Worth Police Department in various roles including patrol, gang, and on the Critical Incident Stress Management Team, where she offered support to police employees and their family members. She was a member of the Texas Association of Hostage Negotiators for several years and researched and published her work on hostage negotiations. Stephanie's research is in the area of police stress and trauma. Stephanie has presented widely to police audiences on critical incident stress, trauma, secondary trauma, resilience, and crisis intervention. Stephanie works with police officers and their family members in her private practice, and writes a monthly column for Blue Line Magazine on police mental health. Comments and questions may be directed to Stephanie at Stephanie@conncounsellingandconsulting.com

LEADERSHIP STYLES AND INCIDENT COMMAND

Is there one best leadership style for managing crisis incidents? The management literature offers an abundance of opinions on this subject. For example in the police literature, the common styles identifiedby a number of police training facilities have included: Authoritarian style-leaders who communicate less with subordinates but approach tasks in a direct manner deemed effective in crisis situations;Participatory style-best characterized as the leader selling his ideas to subordinates to gain acceptance and consensus; the Laize-faire style- best known to promote innovation and motivation in people by providing autonomy to work and grow independent of the leader's influence; and the more recent references to Transformational leaders-characterized as charasmatic and visionary, best known to lead and promote change in their organizations. Other ideas on leadership have been addressed by notables like US Chairman and Former Secretary of State, Colin Powell,who describes ideal leadership as the art of accomplishing more than management science says is possible; or,quoting from an historical and influential scholar, Aristotle, who describes the best leaders as "He who is to be a good ruler must have first been ruled (Aristotle, on Politics)"

"Good leaders are those who have the ability to always learn from others"

Essentially, a sound working definition that encompasses the ideal leadership styles mentioned thus farcan be summaized by stating good leaders are those who have the ability to always learn from others, have achieved skills and abilities through experiences; are skillful in getting along with others; accept responsibility for their actions; and who will always demonstrate a clear mind under duress or crisis situations (Trovato 2013).

During a crisis, good leaders must quickly form a perspective based on an assessment of all potentialrisksthat exist in a developing crisis as well as be able to direct and manage all available technical and human resources to deal with a situation.

The ability of leaders to communicate effectively is considered one of the most important skills used to influence others. Consider how many challenges a leader can face during a crisis such as the scale and nature of a crisis they are confronted with, the often available and incomplete information that is presented during a crisis, the environtmental conditions that existand the need at times to deal with less than clear objectives or conflicting procedures that can hamper how operations are to be conducted (Hart, T. & Trovato, F. 2013).

Acrucial task for good leaders is to decide on a course of action after weighing all the risk factors involved in any given situation. Once the leader weighs all the risk factors involved, he or she must be clear on what needs to be done, re-examine the rationale why something needs to be done, and finally establish consice operating standards/proceudres and measures on what goals need to be accomplished each step of the way.

As part of this analytical process, good leaders will always consult with team memberswho will have a keen sense of situational changes to conditions to ensure the decisions made are void of errors as much as possible.

In conclusion, leadership styles during a crisis is about a leader making quality decisions, communicating clearly, trusting team members under their command and being able to apply human and technical resources in the most effective way possible.

With respect to trusting your team members, another important fact to consider is that in a crisis, feedback or communication normally flows bottom-up. Meaning, once a course of action is set in motion by the leader it is the front line team members who play a critical role in keeping leaders informed on what is unfolding on the ground.This critical fact cannot be underscored as this timely communication is what a leader relies on to modify deicisions as the situation evolves.

Frank Trovato
PHD, Justice Studies

CANADIAN CRITICAL INCIDENT COURSES AND REFRESHER WORKSHOPS

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CRISIS NEGOTIATORS COURSE

The Canadian Critical Incident Inc. (CCII) has revamped the course training standards for the Crisis Negotiators Course. This five day course will provide a current and comprehensive understanding of the role and responsibilities of a Crisis Negotiator. Crisis Negotiating or Crisis Intervention with a hostage / barricaded / suicidal person is among the most stressful and difficult task a police officer will encounter. It will review the Incident Command Triangle, their respective roles and the need for a coordinated effort to resolve the incident with minimal tactical intervention. It will also review the concept and philosophy of crisis negotiations, subject / suspect assessment, mental illnesses and the emotionally disturbed persons. The Crisis Negotiators 5 Day Course will develop the Negotiator's ability to use defusing techniques, enhancing active listen skills and effective communication.

Day One

Understand the roles, responsibilities and limitations of the Tactical Team, Negotiating Team, Scribe and the Commander working collectively towards a common goal; Effectively assessing the situation and profiling the suspect / subject, as expressive, instrumental or high-risk; Understanding common mental illnesses, the emotional disturbed person and the correct terminology; Reviewing communication techniques, active listening skills and defusing / de-escalating methods.

Day Two

Review the Incident Command guidelines, checklists and Operational Planning (S.M.E.A.C.). Discuss third party intermediaries, interpreters and the challenges they represent. Discuss demands, deadlines while dealing with the hostage taker or barricade person. Understanding the theory of the Stockholm Syndrome / Survival Identification Syndrome. Review Crisis Intervention Techniques when dealing with a suicidal person or suicide by cop.

Day Three

Review tactical considerations and the levels of force. Knowing the purpose and meaning of compromise authority, exit and recovery plan. The deliberate, alternative, and immediate action plans; Understanding the purpose and benefits of having a Psychiatrist or Psychologist consulting at the Command Post. A review the Provincial Standards (Ministry Accredited Training Standards) and Sault Ste. Marie Police Service internal directives and procedures; A basic review of critical incident stress and valuable tips on handling that "difficult call". A demonstration by the Police Service Emergency Services Unit.

Day Four

Arrangements can be made for a Forensic Psychiatrist or Forensic Psychologist for this day. They can provide a comprehensive review of the common mental health illnesses and the characteristics of an emotionally disturbed person. A basic review of Post-Traumatic Stress Disorder and Secondary Traumatic Stress Disorder (STSD). And a review in understanding and dealing with a suicidal person and suicide by cop. Suicide is the leading cause of death among people in Ontario between the ages of 17 and 24. Twenty seven percent of the federal prison population has an identified emotional or mental illness.

Day Five

The course candidates shall participate in a scenario based learning opportunity using all of the Police Service Incident Command resources, such as the Emergency Services Unit, Crisis Negotiators, Scribes and Incident Commanders. The course candidates will be given a hypothetical and multifaceted hostage / barricade person scenario. The candidate will demonstrate effective subject assessment, formulate negotiation strategies and work as a team to support the Incident Commander to achieve a successful tactical intervention. Following the scenario there will be a critique, course evaluation and certificate presentation.

CCII Canadian Critical Incident Inc.
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CRISIS INTERVENTION TECHNIQUES FOR FIRST RESPONDERS

The Canadian Critical Incident Inc. (CCII) has recently developed a dynamic and informative one day workshop designed for the first responder, which includes the 911 Communicators; Crisis Intervention Techniques for First Responders. This workshop was created to assist the first responders in dealing with the challenging, demanding and potentially violent interaction with persons suffering from a mental illness or in a state of personal crisis.

The Ontario Coroner's Inquest, SIU investigations and the Mental Health Commission of Canada (March 2012 study) all have emphasized the need for the first responder to continue training in dealing with people suffering from a mental illness and in a state of crisis.

CCII has the unique privilege of an Advisory Board, comprised of Dr. Peter Collins Forensic Psychiatrist, Dr. Mini Mamak Forensic Psychologist and Dr. Jim Cairns Deputy Regional Coroner (Ret) and Professor Frank Trovato all of whom assist in the course development and training standards for CCII.

Developing the first responders ability to recognize and understand common mental illnesses, develop a higher level of subject assessment, expand defusing techniques, enhancing active listen skills and tactical communications will significantly strengthen the first responders ability to resolve a crisis situation with minimal use of force. This workshop will help reduce officer's injury and promote public safety and police accountability when dealing with people in a state of crisis.

This can be achieved by the following learning objectives; A blend of crisis negotiations and crisis intervention techniques

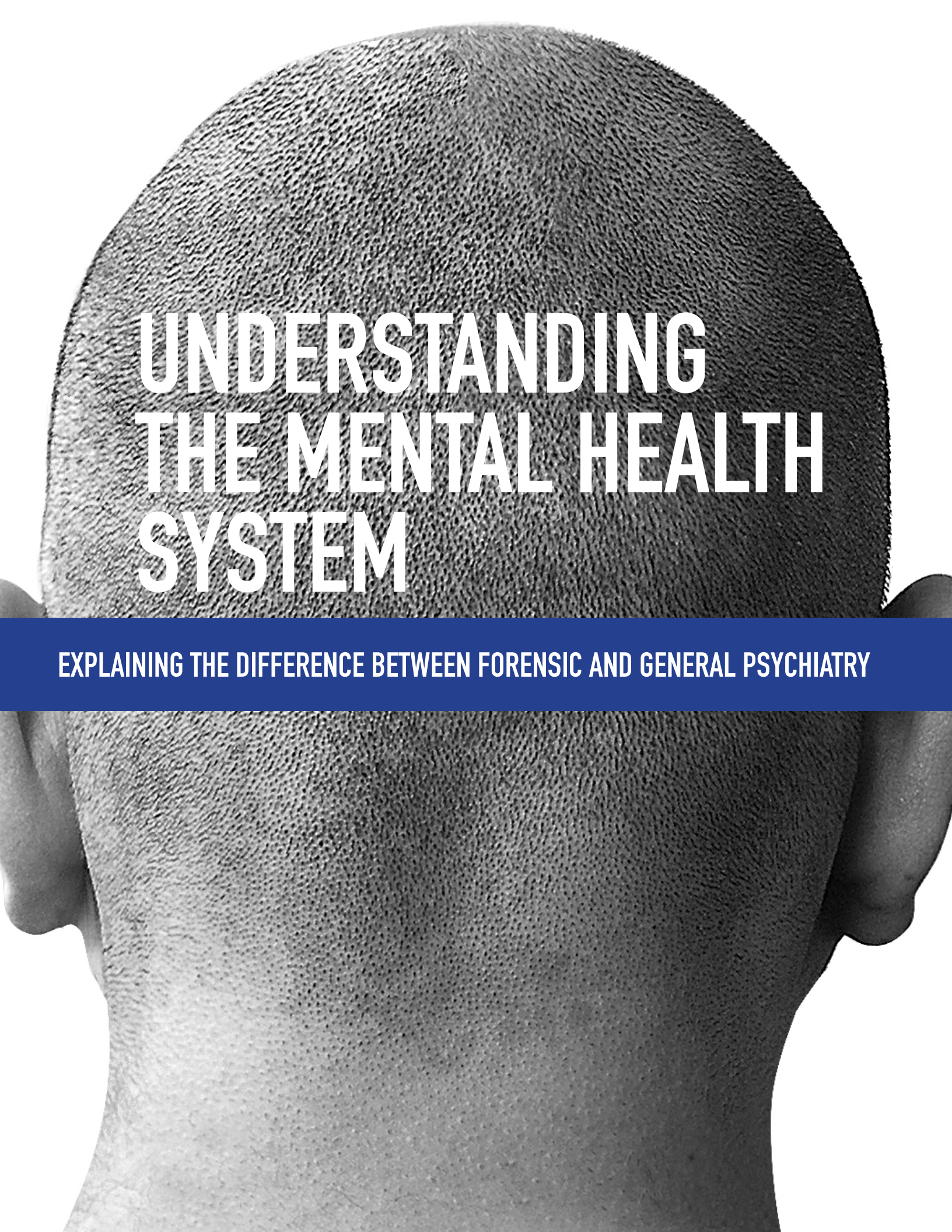
- Basic terminology and understanding common Mental Illnesses
- Subject assessment and situational awareness
- Defusing and de-escalating communication techniques
- Active listening skills
- Creating dialogue techniques
- Basic Crisis Negotiation techniques to communicate with a suspect/subject who are threatening to harm themselves or others
- Basic Crisis Intervention techniques and emergency psychological care to assist a person in a crisis situation

The Crisis Intervention Techniques for First Responders workshop would be a great asset to your front line officers, communicators as well as emergency responders and CAS workers, who are in most cases the first point of contact with a person in a state of crisis. This workshop will include audio and video training aids and is a blend of academic studies and terminology delivered by an instructor with over twenty years of crisis negotiations experience.

CRITICAL INCIDENT REFRESHER WORKSHOP

The Critical Incident refresher workshop will provide their Incident Commanders and Crisis Negotiators a Critical Incident Refresher Workshop. The three day workshop will provide a current and comprehensive review of strategic planning and tactical considerations. Planning and directing multiple aspects which face the Commander can be among the most stressful facing a crime scene manager. The need for a total coordinated effort from arrival at the scene to the successful tactical resolution or intervention and understanding their respective roles, responsibilities and limitations is essential.

This workshop is designed to provide personnel a review of their knowledge, skills, and commonly accepted practices and procedures essential to the effective and efficient planning and direction of operations in hostage and/or barricade person(s) situations. It will review the theory of crisis negotiations, strategies, communication skills, third party intermediaries, demands and deadlines.



UNDERSTANDING THE MENTAL HEALTH SYSTEM

EXPLAINING THE DIFFERENCE BETWEEN FORENSIC AND GENERAL PSYCHIATRY

Forensic Psychiatry/Psychology:

Forensic Psychiatry/Psychology is generally defined as a subspecialty that addresses psychological and mental health issues or questions arising from a subject's involvement in a judicial or quasi-judicial (e.g. professional standards) matter. Forensic psychiatrists and psychologists routinely provide consultation, assessment, and treatment as required, to Crown, defense or to the court, in a criminal matter.

In their work with law enforcement, psychiatrists and psychologists consult about various suspect related matters, for example, profiling, dangerousness, and hostage negotiation. These disciplines may also be involved in assisting law enforcement agencies with fitness for duty evaluations and individual officers with assessment and treatment for work-related difficulties like posttraumatic stress.

These specialized clinicians provide unique and much-needed expertise to the courts concerning medical/psychological aspects of offender behaviour. Unlike lay witnesses, who are only allowed to testify as to what they saw and/or heard, experts in the behavioural science (i.e. psychiatrists and psychologists) are exceptions to the usual rules of evidence in that they can offer courts their inference about facts, i.e. opinions.

The forensic mental health system provides assessment and rehabilitation services to offenders who suffer from serious mental illness. Psychiatrists and psychologists working in federal or provincial corrections can consult about classification, treatment and risk assessment, as well as parole eligibility.

The role of a general psychiatrist or psychologist who conducts assessment and/or treatment, for example, in the course of his or her hospital or clinic duties, or at the behest of a family doctor, is very different from the role of a psychiatrist or psychologist functioning in a medico-legal environment. Patients sent for court-related psychiatric assessments often have a different agenda than a regular patient in that exoneration or a lesser sentence is what they are primarily concerned about. Forensic assessors consequently do not form a doctor-patient relationship with the evaluee. They maintain a high index of suspicion about the evaluee's truthfulness, invariably consider malingering as a possibility, and ensure that scrupulous attention is paid to maintaining impartiality.

Behavioural sciences experts can consult on and/or assess a suspect/accused at multiple junctures on the temporal continuum between arrest and disposition (i.e. sentencing or after an accused has entered the forensic system). Some of these includes assessments concerning the voluntariness of a confession or statement, an accused's candidacy for bail (from a psychiatric perspective), eligibility for Diversion (from the criminal justice system back into the mental health system), fitness to stand trial, criminal responsibility, and sentencing (or ongoing risk for violence and criminal or sexual recidivism, if the person has entered the forensic system).

"Only the court can decide who enters the forensic system and who does not."

We are often asked if forensic psychiatry is the interface between the law and mental health, why are subjects not placed within the forensic system when police bring them to hospital? The simple answer is that only the court can decide who enters the forensic system and who does not.

There are three possible paths to entering the Forensic Mental Health system: Assessment, Treatment, and Warrant of Committal. In terms of assessments, an assessment order is typically issued by a judge when questions are raised regarding an accused's fitness to stand trial, criminal responsibility, or general mental status. Most assessment orders are issued for 30 days and the accused is admitted to a forensic unit, typically located within a psychiatric hospital, pending the completion of the evaluation. Of course, it is always up to either the Crown or defense counsel to pursue an independent consultation and/or assessment. Note that the Crown does not have an automatic right to have an accused assessed by its own psychiatrist, even when a private defense psychiatric evaluation has been conducted. The Crown might, however, invite the judge to make a negative inference based on an accused's refusal to submit to a Crown requested psychiatric evaluation, after a defense psychiatric report has already been tendered.

Once an accused is returned to court and the person is deemed to be either Unfit to Stand Trial or Not Criminally Responsible on account of Mental Disorder (NCR), the judge then issues a Warrant of Committal which brings the accused back to hospital. At this point, the accused falls under the jurisdiction of a provincial or territorial Review Board, the governing body that is required to review any accused's case at least yearly to oversee the accused's progress and make determinations about the person's liberties (e.g. access to the community). If at some point the accused is no longer deemed to be a risk to the safety of the public (in the Criminal Code, a "significant threat"), the RB has an obligation to order an "absolute discharge" which frees the individual from the forensic mental health system.

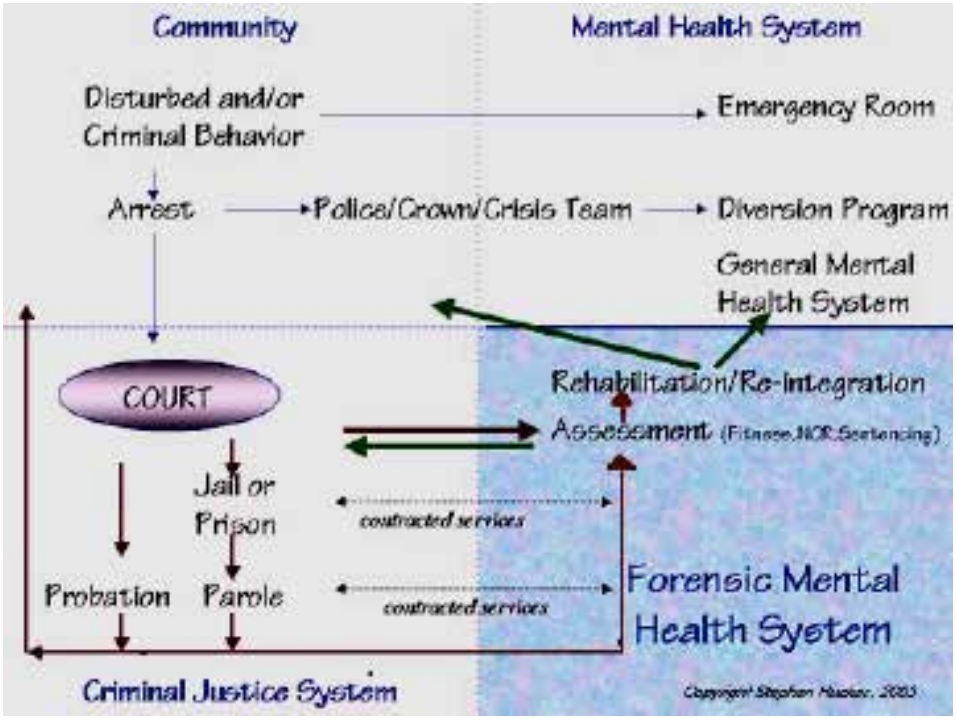
If someone is found by a court to be criminally responsible for his or her offending behaviour, he or she is sentenced accordingly. Mental illness falling short of entitling a person to an NCR defense may still result in a mitigated therapeutically-oriented sentence.

In terms of a Treatment Order, the judge can issue such an order if the accused has been deemed unfit to stand trial and there are reasonable grounds to believe that if treated with psychiatric medications the accused would become fit to stand trial. Treatment orders are typically issued for 60 days. If at the end of this period, the accused remains unfit to stand trial, a warrant of committal is issued and they fall under the jurisdiction of the RB. If they are deemed fit to stand trial, they return to court to deal with their charges.

"There are no set limits for how long an accused remains within the forensic mental health system."

There are no set limits for how long an accused remains within the forensic mental health system. An NCR forensic patient's progress through the system is entirely based on whether he or she continues to represent a "significant threat" to the safety of the public. Once their risk is adequately managed, most patients are able to access the community in some capacity and eventually many patients are able to live in the community while still subject to a RB under the care of the forensic system. As stated, if they get to the point where they are no longer considered a risk to the safety of the public, they

UNDERSTANDING THE MENTAL HEALTH SYSTEM



The chart is courtesy of Dr. Stephen Hucker's website: www.forensicpsychiatry.ca

are awarded an absolute discharge, and released from the forensic system. Most continue in some form of psychiatric follow-up.

General Psychiatry:

Psychiatrists working within the civil or general psychiatric system manage patients pursuant to rules contained in provincial or territorial mental health and/or capacity legislation, typically a Mental Health Act (as in Ontario). The main purpose of this act is to regulate the involuntary admission of individuals into hospital based on mental illness. All provincial and territorial mental health acts have provisions that allow police to bring an Emotionally Disturbed Person (EDP) to hospital for assessment by a physician.

One method to involuntarily admit someone to hospital is a Form 1. A Form 1 can be issued if the assessing physician believes that the individual presents a risk to cause serious bodily harm to him/herself, to another person, or is unable to care for him or herself. Once a Form 1 is issued, the individual is admitted to hospital for a 72 hour assessment period. At the end of the 72 hours, the individual must either be released, be admitted as a voluntary patient, or continue to be held as an involuntary patient under a certificate of involuntary admission (Form 3).

The second method of initiating an involuntary admission for psychiatric assessment is a Form 2. The Form 2 allows anyone to bring information to a Justice of the Peace who then issues the form if there is sufficient evidence that the person represents a risk to themselves, others, or is unable to care for him or herself. Typically under these circumstances, the person's risk is not immediate or imminent.

An individual has significant rights even when placed on a Form 1 or Form 2. Neither Form allows for an individual to be treated without their consent. If there are reasonable grounds that the individual does not appreciate the nature of the illness and the possible benefits-and side-effects-of medications, the attending psychiatrist must make the individual "incapable to consent to treatment" and must then present evidence to the Consent and Capacity Board (CCB). Only if the CCB agree with the psychiatrist's opinion about the patient being incapable to consent to treatment can treatment be involuntarily administered.

Even within the forensic mental health system, a patient cannot be treated against their will, unless there is a determination that they are incapable of consenting to treatment. The only exception to this is when a 60 day treatment order is issued by a judge to help someone become fit to stand trial.

Summary:

The forensic and general psychiatric systems are two distinct but related fields. While the entry into either system differs, a key mission of both is usually twofold – to assist those with serious mental illness live healthy, productive, and safe lives and to protect the public.

Psychiatrists working within and outside the forensic system generally operate by different rules, as regards the nature and quality of their relationship with an evaluee/patient.

Dr. Mini Mamak
Senior Psychologist

Dr. Hy Bloom
Psychiatrist

About the Authors

Dr. Mamak is the Senior Psychologist on the Forensic Service of St. Joseph's Healthcare Hamilton and Assistant Professor with the Department of Psychiatry and Behavioural Neurosciences at McMaster University. Dr. Mamak is also a member of the Ontario Review Board. Her professional and research interests include criminal recidivism, aggression, and hostage negotiations. Dr. Mamak is routinely called upon to provide psychological services and opinions to both private and public sector organizations both nationally and internationally.

BRONCO INCIDENT

The Bronco Incident a Barricade suspect Kingston Ontario November 2012.

On the evening on November 14th, 2012, the suspect was arrested and charged with Refusal and Impairment by Drug by the CFB Kingston Military Police. The accused admitted to consuming Dilauded tablets. He was described by the Military Police Officers to be “delusional” but was eventually released via Promise to Appear with an Undertaking by an Officer in Charge.

The next day the suspect contacted the local paper, and said that his name was “Bronco.” The suspect stated that he was being “set up for something,” “was going to barricaded himself” and “had a gun.”

After identifying the suspect and his whereabouts, Kingston Police responded to the Siesta Motel located at 830 HWY 2 and containment was established.

Negotiations were being conducted at this time by Sgt Craig MacFarlane in communications while the command post was being set up. This proved to have its limitations as the secondary negotiators could only hear Sgt. MacFarlane’s conversation and not the suspect’s conversation. At one point the suspect stated; “Tell the cops on the corner to move back.” The officer’s at the scene were quickly advised that the suspect could apparently see them.

Following two hours of containment, officers noted what sounded like a “gun shot.” At that time, it was believed that the suspect had discharged the firearm he claimed was in his possession. Given the threat of violence, weapons and suspect assessment, several occupants at that motel were forced to evacuate. The Incident Commander deployed multiple police resources including all members of the Kingston Police Force Emergency Response Team.

The three Crisis Negotiators received the information of the “gun shot” while en route to the command post. There was discussion about the subject test firing his gun or of having harmed himself.

After the lengthy phone lock down procedures were completed on the motel, a phone call was made to the suspect’s room. The suspect answered the phone and Crisis Negotiators were able to determine that he had not harmed himself and continued to assess the suspect and attempt to build a rapport with him.

Throughout the night, the suspect brandished a knife or had weapons in his hands stating that he was going to kill himself, hurt police and “open fire” if anyone entered his room. The suspect further stated several times that he “wanted police to kill him.” As such, the incident was determined to be “high risk” given that the suspect was suggesting suicide or police-assisted suicide.

Following extensive negotiations by the Kingston Police Crisis Negotiators and the suspect it became increasingly apparent that he was extremely intoxicated by either drugs and/or alcohol and was not de-escalating or responsive to negotiations.

Crisis Negotiators learned that the suspect was in possession of a cell phone and had been texting his sister during the incident. This became very problematic to the Incident Command Team.

Throughout the course of the night the suspect destroyed his room, by smashing the front bay window, breaking items and throwing furniture out the window.

The Incident Command Team arranged to deploy a mechanical robot in an effort to bring a telephone to suspect. This was done after the he smashed the hotel phone. The suspect threw

BRONCO INCIDENT

beer bottles out of the window directly at the robot striking and breaking the optical camera lens.

The Incident Commander Team decided that the only available option having considered the suspects assessment and threats to himself and others that the Emergency Response Team should considered a deliberate action plan to use the less lethal option of the Taser to subdued the suspect. This was done successfully, when the suspect exited his room to get the throw phone from the robot.

Following his arrest, the suspect was transported to Kingston General Hospital where he was treated for minor injuries. At the time of his arrest, a replica handgun, two knives and an unspent 22 caliber round was located and seized; however no real firearm was found.

Ironically after his arrest negotiators later found a zippered case with a CCII conference logo on it next to the robot, which the subject had thrown from his room. Perhaps this was some type of commentary on the subject's part re: the ability of the three negotiators?

This violent and potentially dangerous incident will be presented by members of the Kingston Police Force at the fall conference in Ottawa.

Article Provided by

Cst. Ron Leyenhorst
Training Unit,
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