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Human Behaviour II for Public Safety Communicators

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Answering the Call

HUMAN BEHAVIOUR II

FOR PUBLIC SAFETY COMMUNICATORS





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TABLE OF CONTENTS

HUMAN BEHAVIOUR FOR PUBLIC SAFETY COMMUNICATORS

HUMAN BEHAVIOUR FOR PUBLIC SAFETY COMMUNICATORS	I
SECTION 1: VIOLENCE AND ABUSE	1
CHAPTER 1 – PERSONAL SAFETY AND SELF-DEFENSE	1
<i>Personal Safety.....</i>	<i>1</i>
<i>Self-defense Strategies.....</i>	<i>1</i>
<i>Who Attacks? Where?</i>	<i>2</i>
<i>What Causes Attack?.....</i>	<i>2</i>
<i>Canadian Criminal Code: Defence of Person.....</i>	<i>2</i>
<i>Personal Response</i>	<i>4</i>
CHAPTER 2 – ROBBERY.....	7
<i>Criminal Code Definition of Robbery</i>	<i>7</i>
<i>Police Response.....</i>	<i>7</i>
<i>Cycle of Personal Response to Robbery.....</i>	<i>8</i>
<i>Support</i>	<i>9</i>
<i>Cognitive Maps and Schema</i>	<i>9</i>
<i>Personal Control Orientation</i>	<i>10</i>
CHAPTER 3 – HOME INVASIONS.....	11
<i>Home Invasions</i>	<i>11</i>
<i>Elements of Invasion Style Robberies.....</i>	<i>11</i>
<i>Business Invasions.....</i>	<i>12</i>
<i>Escape Plans</i>	<i>13</i>
<i>Carjacking.....</i>	<i>14</i>
<i>Common Issues and Reactions of Major Crime Victims</i>	<i>14</i>
CHAPTER 4 – CHILD ABUSE	17
<i>Child Abuse</i>	<i>17</i>
<i>Emotional Abuse</i>	<i>17</i>
<i>Neglect of Basic Needs.....</i>	<i>18</i>
<i>Child Physical Abuse</i>	<i>18</i>
<i>Definition of Child Sexual Abuse</i>	<i>19</i>
<i>Child Abuse and Incest.....</i>	<i>19</i>

<i>Myths about Child Sexual Abuse</i>	20
<i>Possible Indicators of Child Sexual Abuse</i>	21
<i>Disclosure.....</i>	23
<i>Reporting Child Abuse</i>	24
<i>Victim's Concerns During Legal Process</i>	24
<i>Allegations of Abuse</i>	25
CHAPTER 5 – ADULT SEXUAL VIOLENCE.....	27
<i>Legal Definition of Sexual Assault</i>	27
<i>Removal of the Term 'Rape' from the Criminal Code.....</i>	29
<i>Rights of the Victim and Changes in the Rules of Evidence</i>	29
<i>The 1991 Constitutional Challenge to the Rape Shield Laws.....</i>	30
<i>Common Elements of Sexual Assault.....</i>	31
<i>Sexual Assault Myths.....</i>	31
<i>Types of Sexual Assault Calls.....</i>	34
<i>Crisis Intervention Checklist</i>	35
<i>Reasons for Not Reporting</i>	36
<i>Impact Stage Emotions and Reactions</i>	36
<i>Recoil Stage Emotions and Reactions</i>	37
<i>Support.....</i>	38
<i>Common Questions about Criminal Justice System Procedures.....</i>	40
<i>The Issue of Repressed Memory vs. False Memory.....</i>	40
CHAPTER 6 – ELDER ABUSE.....	42
<i>Elder Abuse</i>	42
<i>Types of Elder Abuse</i>	42
<i>Possible Criminal Code Offences.....</i>	42
<i>Common Elements of Elder Abuse</i>	43
<i>Characteristics of Offenders.....</i>	43
<i>Theories in Elder Abuse</i>	44
<i>Elder Abuse Does Not Include.....</i>	45
<i>Elder Abuse Victims Need</i>	46
<i>Laws Protecting the Elderly.....</i>	47
<i>Aging Population.....</i>	48
<i>Responses to Victim's Needs</i>	51
SECTION 2: DIFFERING ABILITIES.....	53
CHAPTER 1 – PUBLIC SAFETY AND THE DISABLED COMMUNITY	53
<i>The Disabled Community</i>	53

CHAPTER 2 – ASSISTING PEOPLE WITH DIFFERING ABILITIES	55
<i>Communication Devices</i>	55
<i>Generating Speech Difficulties</i>	56
<i>Hearing Impairments and the Message Relay Center</i>	56
<i>Limited Comprehension</i>	57
SECTION 3: MENTAL DISORDERS	59
CHAPTER 1 – MENTAL ILLNESS	59
<i>Psychological Labels</i>	59
<i>Classification System – Axis Definitions</i>	59
<i>Caution about Psychological Labels</i>	60
CHAPTER 2 – PSYCHOLOGICAL DISORDERS – AXIS I	63
<i>Clinical Disorders</i>	63
<i>Psychiatric Emergencies</i>	69
<i>Communication Strategies for Psychiatric Emergencies</i>	70
CHAPTER 3 – PERSONALITY DISORDERS – AXIS II	71
<i>Personality</i>	71
<i>Personality Disorder</i>	71
<i>Hospitalization vs Medication</i>	75
CHAPTER 4 – RELATED MEDICAL CONCERNS – AXIS III.....	77
<i>Dementia</i>	77
<i>Alzheimer’s Disease</i>	77
<i>Communication Strategies</i>	78
CHAPTER 5 – ENVIRONMENTAL STRESSORS AND LEVEL OF FUNCTIONING.....	81
<i>Environmental Stressors – Axis IV</i>	81
<i>Level of Functioning – Axis V</i>	81
SECTION 4: CRITICAL INCIDENT STRESS.....	83
CHAPTER 1 – SUDDEN OR ACCIDENTAL DEATH.....	83
<i>Sudden Death Calls to 9-1-1</i>	83
<i>Accidental Death Calls to 9-1-1</i>	83
<i>Death Notification</i>	84
<i>Dealing with Sudden Death</i>	85
<i>The Bereavement Process</i>	87
<i>Issues Impairing Emotional Recovery</i>	88
CHAPTER 2 – SUICIDE INTERVENTION.....	91
<i>Why?</i>	91
<i>Suicide Profiles</i>	94

<i>Suicide Calls</i>	95
<i>Survivors of a Suicide Victim</i>	97
CHAPTER 3 – CRITICAL INCIDENT STRESS	99
<i>Critical Incidents</i>	99
<i>Critical Incident Stress (CIS)</i>	99
<i>Causes of Critical Incident Stress</i>	99
<i>Reaction Severity</i>	100
<i>Immediate Reactions to Critical Incident Stress</i>	101
<i>Delayed Stress Response Syndrome</i>	102
<i>Reactions to CIS</i>	102
<i>Recovery Process</i>	103
CHAPTER 4 – CRITICAL INCIDENT STRESS DEBRIEFINGS	104
<i>Critical Incident Stress Debriefing</i>	104
<i>Who Conducts the Debriefing?</i>	104
<i>CISD Process</i>	105
<i>Working through CIS</i>	107
<i>Cumulative Stress</i>	109
SECTION 5: POLICY AND LEGAL CHANGE	112
CHAPTER 1 – IMPACT OF PUBLIC GROUPS FOR SOCIAL CHANGE.....	112
<i>Generation of New Laws</i>	112
<i>Media Influence on Public Opinion</i>	113
<i>Effects of Opinions</i>	113
<i>Vicarious Traumatization</i>	114
<i>Public Lobby Groups</i>	115
CHAPTER 2 – POLICY CHANGES AS A RESULT OF INQUESTS	118
<i>Coroner’s Inquests</i>	118
<i>Role of Inquests on Legal and Policy Change</i>	118
<i>Coroner’s Court of British Columbia</i>	119

SECTION 1: VIOLENCE AND ABUSE

Chapter 1 – Personal Safety and Self-defense

Personal Safety

There are many theories and suggestions about personal safety. There is a tendency to think that if a person is attacked, they must have done something wrong. Actually most people behave in a very safe way in most parts of their lives. The *usual precautions* are extensive and well integrated in our daily routines. There are many publications devoted to identifying safe personal strategies. One such publication, *Reduce the Risk by Women Educating in Self-defense Training of B.C.*, is used as a companion to this workbook. It looks at the positive ways we can and do make our environment safer.

Self-defense Strategies

The best strategy is always to get away as soon as possible. It is very difficult to hurt someone if you are not there. Defending yourself starts with the same determination that most mothers feel in protecting their children. If someone told you that you should not defend your three-year-old child, what would you think? If we are willing to try to protect our children, we can try to protect ourselves. Determination to succeed is a key factor in the decision to resist an attack. Thousands of women and men have defended themselves successfully, most without ever taking a self-defense class.

Should you be attacked, only you can make the decision to fight back or not. Even the choice of remaining passive is personally yours. You will decide what is best for you at the time. A little knowledge about self-defense is only dangerous when you think it is a lot. Anything you learn can expand your horizons and increase your survival potential.

Studying self-defense gives you more options for avoiding or escaping an attack. You can maximize the possible strategies that you could choose to use. Self-defense training is available through many sources. Various self-defense and martial arts classes are readily available, and

training courses ranging from an evening to a life-long commitment are part of the mix. In twelve hours of training, you will not become an expert; however, you can discover your strengths, how to use them, and how to make informed decisions when you are threatened. The mental aspects of self-defense are as important as the physical ones. In addition to learning physical techniques, each person builds a feeling of self-determination and a belief in his or her own abilities to defend themselves.

Who Attacks? Where?

The majority of attackers are larger and stronger than the attackee. Your attacker will probably be male, but there is a small possibility she may be female. In more than three-quarters of all attacks on women, the attacker is known to her. The most common place for an attack to happen is in a home – yours, his, or someone else's. The next most common place is in a motor vehicle. Lights and people inhibit the attacker, but attacks still happen in well-lit areas and/or with people around.

What Causes Attack?

The attacker's thoughts and emotions are the largest factor in an attack. He has a need to dominate and control. The majority of assaults on women and children are planned well in advance.

Despite the mistaken idea that some people "ask" to be attacked, you cannot make someone attack you unless THEY decide to become aggressive or abusive. What you wear, say, do, or where you are located has little to do with the attack, although it may offer an opportunity at the time or may be used as an excuse later.

Attackers attack because they want to, and think they will get away with it.

Canadian Criminal Code: Defence of Person

Section 34 Self-Defence Against Unprovoked Assault – Extent of Justification.

1. Everyone who is unlawfully assaulted without having provoked the assault is justified in repelling force by force if the force he uses is

- not intended to cause death or grievous bodily harm and is no more than is necessary to enable him to defend himself.
2. Every one who is unlawfully assaulted and who causes death or grievous bodily harm in repelling the assault is justified if
 - a) he causes it under reasonable apprehension of death or grievous bodily harm from the violence with which the assault was originally made or with which the assailant pursues his purposes: and
 - b) he believes on reasonable grounds, that he cannot otherwise preserve himself from death or grievous bodily harm.

Section 35 Self-Defence in Case of Aggression

Everyone who has without justification assaulted another but did not commence the assault with intent to cause death or grievous bodily harm, or has without justification provoked an assault on himself by another, may justify the use of force subsequent to the assault if

- a) he uses the force
 - i) under reasonable apprehension of death or grievous bodily harm from the violence of the person whom he has assaulted or provoked, and
 - ii) in the belief, on reasonable grounds, that it is necessary in order to preserve himself from death or grievous bodily harm;
- b) he did not, at any time before the necessity of preserving himself from death or grievous bodily harm arose, endeavour to cause death or grievous bodily harm; and
- c) he declined further conflict and quitted or retreated from it as far as it was feasible to do so before the necessity of preserving himself from death or grievous bodily harm arose.

Section 36 Provocation

Provocation includes, for the purposes of sections 34 and 35, provocation by blows, words or gestures.

Section 37 Preventing Assault – Extent of Justification

1. Every one is justified in using force to defend himself or any one under his protection from assault, if he uses no more force than is necessary to prevent the assault or the repetition of it.
2. Nothing in this section shall be deemed to justify the wilful infliction of any hurt or mischief that is excessive, having regard to the nature of the assault that the force used was intended to prevent.

The Canadian Criminal Code also deals with various types of assault in sections 265 – 270.

Personal Response

When you are uncomfortable in some situations or with some people, you are normal! In fact, the odds are that if you are nervous, there is an external reason for it even if you cannot identify it immediately.

We all read news items, see reports on TV and watch movies about terrible incidents involving women and children. Your awareness of them may trigger nervousness in similar situations.

While some attacks are sudden and straightforward, many begin with gestures or behaviors that are calculated to test you, to put you off guard, or to coerce you. The attacker may be saying one thing and doing another. Pay attention to his or her behavior as well as his words. His previous good behavior is not a guarantee that he will not attack you.

Your intuition or hunches are triggered by a heightened awareness of body language from the person with whom you are uncomfortable. The safest thing you can do is act on those hunches when they occur and extract yourself from that situation. It is easier to analyze a problem when you are not in the middle of it.

Surprise!

You can be surprised, but that does not mean you have lost. Most attacks go on for more than half an hour. If you are prepared to change with the situation, you may turn the tables and surprise the assaulter.

No matter how much he may know about attacking, he does not know what you can or will do. Your attacker cannot read your mind. He does not expect you to fight back effectively. He may expect you to cry,

cringe, plead, or to scream and struggle. Attackers tend to pick on smaller and weaker people and believe that no woman is a match for them. In a fair fight, he may be right, but an assault is not fair. When you use self-defense effectively, by kicking him in the knee to dislocate the joint or by using some other physical technique, he will be the one who is surprised and incapacitated. Then, you escape.

Chapter 2 – Robbery

Criminal Code Definition of Robbery

343. [302] Every one commits robbery who

- (a) steals, and for the purpose of extorting whatever is stolen or to prevent or overcome resistance to the stealing, uses violence or threats of violence to a person or property;
- (b) steals from any person and, at the time he steals or immediately before or immediately thereafter, wounds, beats, strikes or uses any personal violence to that person;
- (c) assaults any person with the intent to steal from him; or
- (d) steals from any person while armed with an offensive weapon or imitation thereof.

R.S., c C-34, s. 302

Police Response

When the police respond to an armed robbery, something similar to the following events occur:

1. A tone is sounded on the radio for the police officers.
2. Quadrants are established in the event that roadblocks need to be established. Police cars refrain from rushing to the scene because the safety of the victims could be compromised by the suspects panicking when they see a police car.
3. Detectives in plain clothes enter the robbed premises first to ascertain if the suspects have left the scene of the crime. Plain clothes police officers ensure the safety of the victims by lessening the chance that a hostage taking will be triggered due to the suspects seeing the police uniforms.
4. Communicators may be requested to contact the local cab companies and public transit to alert them to the prospect of the suspects utilizing cabs, buses, or other forms of public transit. Taxicabs usually have radios, and bus drivers carry cellular phones, enabling them to call relevant information in to the police very quickly.

Cycle of Personal Response to Robbery

The victim's reactions to a robbery are uniquely personal and may include:

- feeling alone and frightened
- retelling the experience over and over
- not wanting to talk about it
- fearing for their and their family's safety at home
- loss of appetite
- loss of interest in family
- inability to return to work
- not wanting to listen to others
- restlessness
- nightmares

A number of factors influence a person's reactions. Their reactions to a robbery may depend upon:

- the suddenness
- extent to which safety was threatened
- the environment provided by the employer (video cameras, security features etc.)
- number of times a person may have been robbed before
- a person's stress level
- a person's physical and mental health

Immediate Reactions

- After the robber(s) leaves, the most immediate reaction is usually one of relief that the crisis is over, and that the victim survived it unhurt. This may be followed by feelings of anger, helplessness, guilt, and frustration.

Delayed Reactions

Delayed reactions may happen over the next week to a month. It is common for victims to continue to dream about the event, not to sleep through the night, to be depressed, to keep to themselves, to startle easily, or to get angry at things that never bothered them before.

Professional help should be sought if these reactions to the robbery continue to affect a person's family or work life.

Support

The victim of a robbery who is a friend, member of your family, or who has called in or arrived at an agency, needs some support. You may be able to help by:

- listening to what they have to say
- encouraging them to eat a proper diet and to exercise
- encouraging them to refrain from excessive use of alcohol or sleeping pills
- encouraging them to get adequate rest

Cognitive Maps and Schema

A cognitive map is a hypothetical structure in memory that preserves and organizes information about the various events that occur in a learning situation. It is a mental picture of the learning situation. E.C. Tolman, an early learning psychologist, first used the concept in 1932 with lab experiments of rats learning the spatial relationships between places and objects in a maze. More recently, cognitive maps have been used in causal beliefs and decision making processes.

Cognitive schema is a knowledge structure which preserves and organizes information stored in our memory about some event or concept. It contains the attributes of events or concepts as well as our perception of relationships among the different events or concepts. Schemas help us organize our past experiences and provide us with a framework for understanding future experience. With an emotional situation such as a robbery, a schema is developed to process the experience in a way that allows the person to cope with the trauma.

Personal Control Orientation

Control orientation is our ability to predict and influence events in our lives. Robbery is an event in which a person's control orientation will most likely be lost. Our sense of control helps us make order of the world in which we live. One way we do this is to attempt to identify the internal or external causes of the behavior of others. For instance, robbery victims frequently ask, "Why did he do this?"

The victim may attribute the robbery to an internal cause such as the robber having a mental illness. On the other hand, the victim may attribute the robbery to an external cause such as the robber owing debts to drug dealers. Either explanation gives the robbery victim a sense of order and reason to the event they have just experienced.

We may also assume outcomes of what might happen to us based on our past experiences. For example, a store clerk in a convenience store may identify all young persons with ball caps turned backwards as potential robbers. As a result, the clerk may take safety precautions such as locking the time safe when a person who fits that description enters the store. This may not always be appropriate behavior, but at least the clerk is prepared if a robbery is attempted.

Recently, in cases of home or business invasions, victims have been restrained, attacked, and in some cases sexually assaulted. In such cases, the call taker may be speaking to a person with multiple traumas. Understanding this will help the call taker to be patient and helpful.

Chapter 3 – Home Invasions

Home Invasions

The phenomenon of home invasions, in which people are deliberately targeted in their homes, is of increasing concern. When one is confronted by a person with a weapon, the expectation is that they want money or property and will then leave. In the situation of a home invasion, criminals may also assault the residents, restrain children and/or sexually assault the women, despite having possession of whatever they initially came for. This is a fundamental part of controlling the victims through terror. It reduces resistance and can increase the time it takes to have the crime reported, making it more difficult to catch and convict the criminals. Invasion style robberies appear to be well planned in advance, with the perpetrators being familiar with the household routine. In order to ensure victim compliance and eliminate resistance, criminals will sometimes target a business person's home when the whole family is present.

Contributing Factors for Home Invasion

Traditional business targets are becoming more difficult to rob with the increased use of sophisticated alarms, surveillance cameras, etc. Home invasion, like car-jacking, is a way for the robber or robbers to overcome technological barriers. With the wide-spread use of house alarm systems and upgraded security, the robbers choose to wait until the owner is home and the security system is disabled. Intimidating victims reduces the home-invaders' risk of being caught if the victims are too fearful to report the robbery immediately, or at all. Gangs and organized groups may be part of the problem, with groups planning and executing group activities to maximize their chances for success.

Elements of Invasion Style Robberies

1. The invasion style robbery is usually well planned in advance, with the suspects being familiar with the household routine.
2. Victims are isolated from helping resources such as neighbors, phone, and police during an invasion.
3. Robberies of family-owned restaurants tend to occur at the end of the day when the staff are busy closing up and counting the money.

4. Industrial park robberies have occurred early in the morning when arriving staff are taken by surprise. With this type of robbery, escape routes are usually carefully chosen to ensure easy get-away during the early morning rush-hour traffic. Heavy traffic gives the criminals more time by ensuring a poor police response time.
5. The invasion style robbers may use violence. For example:
 - Victims have been restrained with duct tape applied to their eyes and mouths
 - Gunshots have been fired into roofs to intimidate victims
 - Employees have been intentionally shot in order to frighten off other employees
 - Large bayonet style knives have been used to poke and stab victims

Business Invasions

When we think of an armed robbery, we think of a suspect with a gun or knife holding up a bank, a gas station, or a convenience store. These places of business expect to be robbed, and through the years have accordingly improved their security by having time-locked safes on the premises, video surveillance cameras, and staff training on robbery prevention safety measures.

Businesses in industrial parks also assume they may have their products stolen. However, their expectations are that thefts will occur at night when no staff are in the building. Sophisticated monitored alarm systems and private police patrols are effectively employed to discourage such activity. This results in the shift of criminal focus to more vulnerable time periods.

Such companies are vulnerable to theft when staff are at work. Unfortunately, with staff present, it is no longer a theft of insured property. It has become a crime against people whereby violence is used to obtain goods and intimidate staff.

Generally speaking, staff of industrial park businesses do not expect to be robbed and rarely are prepared for an invasion. They are therefore ill

equipped to handle the occurrence and are at risk of being traumatized as a result of the event.

Types of Businesses Targeted

Generally speaking, staff of industrial park businesses do not expect to be robbed and rarely are prepared for an invasion. They are therefore ill equipped to handle the occurrence and are at risk of being traumatized as a result of the event.

1. Businesses located in industrial parks with excellent access to major roadways are at risk because it provides the robbers with an easy escape route.
2. Businesses located at a distance from the nearest police station are at risk because it creates a longer response time by the local police. Most police stations are located in more central and populated areas which are usually a considerable distance from a city's industrial area.
3. Businesses with offices in the front of the building give robbers an easy entrance via a loading dock in the back of the business.

Escape Plans

People need an escape plan. The simplest escape plan is to use a fire evacuation plan. Parents need to talk with their children about the possibility of a home invasion, and prepare them with an action plan. If an escape plan is presented to children in a sensitive and mature fashion, they will understand it plan without being unnecessarily panicked. Businesses, regardless of location or type of product, need to be prepared with robbery prevention education and an escape plan. There should be escape routes in addition to main ground floor entrances. This could include windows and basement or other doors.

Everyone in a place of business or home need to react immediately to a pre-arranged signal like someone screaming, "Get Out – Intruder!", according to escape plan procedures. Much like a fire drill, the escape plan needs to be practised routinely.

- In an escape plan, a person is designated to call the police.
- A gathering spot in a safe place is prearranged.

The front office staff of a business need to be made aware that they may be the most vulnerable to attack during an invasion style robbery. If there are children on the premises, safety and protection for them must also be a consideration.

Carjacking

If you believe you are being targeted while you are in your vehicle and have a cellular phone, call the police and tell them where you are. Maintain contact. Keep the car moving as long as possible. Try to stay with the vehicle as long as possible.

If you are forced out by the threat of a weapon, cooperate! Hopefully the carjacker only wants the car. Try to take your purse with you. If they demand it, give it up. Be aware that they now have your identification and keys.

Note what they looked like, which direction they went, and licence plate numbers of other vehicle(s) used while stealing your car. When you get home, have your residence locks changed, inform others who need to know about the loss of keys, and cancel any credit cards that may have been taken.

Common Issues and Reactions of Major Crime Victims

Complex issues face each major crime victim. A person's perception of an event is unique due to his/her individual life experience. A public safety communicator's response needs to fit the victim and the situation.

A person's sense of control may be lost during a robbery occurring at work or in a public place, but people tend to cope because they can return to the safety of their homes. In a home invasion, this home comfort zone is lost because the house was the scene of the crime. Victims often state, "I cannot stay here! Where can I go to be safe and get a good night's sleep?"

Some people focus on the could haves, would haves, and should haves. They may deny that they were scared and attempt to hide their emotions. In some cases they may be concerned with saving face and may try to deny that they were even involved. They may fear retaliation against them and their family for getting the police involved.

Other victims may be more emotional, focusing on the danger and fear of the event. When these people show their emotions at the crime scene, police, emergency personnel, and victim services workers may be more attentive to them because of their obvious distress. It is important for responders to be aware that those not displaying emotion may be traumatized as well.

If young children are in the house at the time of the attack, they may be withdrawn and clinging to their parents. They may also become hyperactive. If asked a question, they may or may not answer. If it is late at night, it may be difficult to get them to go to bed. They wish to stay with their parents. Children react to the emotions of their parents. For example, if a mother starts to cry, her children may start to cry as well.

Sudden movements and noises may elicit startle reactions from victims, and they may have a shortened attention span due to the trauma. They may be unsettled and uncomfortable while they are being questioned, examined, or debriefed.

Victims may express their feelings and thoughts using foul or violent language. They may also make racist comments. They may reflect upon the effectiveness of totalitarian measures of crime control such as execution and castration.

There is usually much chaos at the scene of the crime as the investigators try to take statements and forensic personnel look for physical evidence like fingerprints, shell casings, etc.

If the news media become aware of the event and consider it newsworthy, they will want the story. The victims may not wish to see the media. If the media pursues the story persistently with the victims, it can lead to further frustration and victimization.

Chapter 4 – Child Abuse

Child Abuse

Calls to public safety communicators involving or apparently involving child abuse are a recurring theme. In some call centers, there is little chance a week can go by without a report of an incident in which a child has been abused, or policy or procedures are being debated. Child abuse can be broken into four general types:

- emotional abuse
- neglect of necessities based on the standards set by our society
- physical abuse
- sexual abuse

While this method of categorizing abuse may be useful, it is important to be aware that specific incidents will likely overlap these categories.

Public safety communicators must to be aware that not all abuse is necessarily criminal in nature, but provincial law may require that all complaints of child abuse be reported to the appropriate ministry.

Emotional Abuse

Emotional abuse or neglect does not constitute a criminal code offence, but its long-term effects may be much worse than physical abuse. Teachers often note that emotionally abused children tend to be withdrawn, are unable to concentrate, and may act out in the schoolyard. These children tend to be sick more often and have more sleeping problems than their peers. There also seems to be a general lack of parental involvement in their lives.

In British Columbia, recent child protection legislation recognizes children suffering from emotional abuse. When police officers investigate allegations of spousal assaults, the police officers and/or the police victim services unit need to consider if the children are involved. If the parents are embroiled in some form of conflict, the Ministry for Children and Families is notified to check the wellbeing of the children. Children suffering any kind of abuse will be traumatized.

Neglect of Basic Needs

In all communities, a considerable number of children are undernourished. Similarly, housing for many families is below what our society considers acceptable. These situations are problematic for the children affected and have a long-term impact on the continuation of the cycle of poverty. The children may not perform well in school academically and may develop socially inappropriate behaviors. Statistically, children in such circumstances tend to have parents who have come from similar backgrounds, and are at risk of parenting families who will suffer from similar stressors.

Child Physical Abuse

Child physical abuse describes assault on a child. The difference between acceptable hitting to discipline a child and abuse is largely a function of the form, severity and frequency of the hitting.

An adult who constantly slaps, hits, and threatens a child may be considered an abuser; however, an adult who gives a child a smack on the behind for misbehaving in the mall is not at this time considered an abuser. Regardless, if someone calls the police to report an incident, you need to respond according to the child protection legislation.

Beliefs About Physical Abuse

There was a time when use of the strap was the final line of discipline in our public schools. If a teacher were unable to handle a student, he or she would send the student to the school principal for discipline. It was more common in the past for children to be disciplined at home by the use of a belt. Today, however, a parent using a belt on his child may be regarded as an abuser, and a schoolteacher using the strap could be charged with assault with a weapon causing bodily harm.

Today, a teenager who is punished with a belt by his/her parent might go to a social services office and complain of physical abuse by the parent. The teenager could be placed into care in a foster home, and the parent may be arrested for assault.

Parent Complaints

Disputes between parents sometimes result in complaints leveled by one spouse against the other, alleging child abuse. One parent may phone the police to make allegations of abuse, possibly in a bid to

discredit the other parent. Such complaints may represent honest concerns about the child's welfare, or they may be motivated by a desire to get back at or get even with a former partner.

Other Information Sources

Child abuse may be reported by persons outside the child's immediate or extended family. School teachers and school counsellors see children five days in most weeks and are often the first to notice changes in behavior, or may notice physical indications of abuse. Family physicians are legally required to report any physical signs or symptoms that could be linked to abuse. Neighbors who see or hear abuse may also call in.

Definition of Child Sexual Abuse

Child sexual abuse is defined as any sexual activity with a child under the age of 14, usually by someone who is in a position of trust or authority over the child. Sexual abuse may also be committed by someone who is a stranger to the child. The definition of sexual abuse ranges from exhibitionism to fondling to intercourse. By current reporting, half of all girls and one in three boys will be victims of unwanted sexual acts before they are 18 years old. Children with special needs are at higher risk of sexual abuse.

Child Abuse and Incest

What children know about their world and themselves is often learned from family members. This makes child abuse a serious social problem. In an abusive household, the nurturing function of the family is replaced with social forces that can be destructive to the child. It is important to everyone in the community for children to have a healthy social environment in which to grow and develop.

Adults have more power because of age, sex and physical size. In incestuous relationships, this is aggravated by the child's dependence on the abuser for basic needs such as shelter, food, affection and security.

The power imbalance between adults and children is similar to the one between men and women. When physical battering happens to children, the batterer could be male or female. The issue is one of power and control over a weaker or more passive person. If a woman is battered,

her children are often also battered. Children may accept this treatment as normal because they have not known anything else. Besides battering, emotional and sexual abuse of children by family members may include being physically exposed to others, fondling, sexual penetration of infants as well as older children, forced oral sex, child prostitution and child pornography.

There is an apparent incest taboo in our society. In fact, the taboo is about discussing it. When children try to speak up, they are often not taken seriously or believed. Sometimes they have no words to describe their distress. Adults may not want to know. For example, parents may be unwilling to believe that their spouse would behave in such a manner. It is estimated that up to sixty per cent of children have been subjected to incestuous attacks. Often, the attacks continue over a period of years. Coercion and threats are often used to keep the child silent. The child's self-esteem will be undermined. They may be told that no will believe them. "I'll kill you," or "If you co-operate, I won't do this to your sisters," or "Your mother would be so upset" are common lines. The child may be told that it is normal for little children to do this.

Myths about Child Sexual Abuse

There are a number of myths about child sexual abuse. They have a negative impact on the reporting of the abuse and on the degree to which abusers are pursued, charged and convicted of their offenses. Worst of all, the myths increase the likelihood the victims will assume that they are the problem, having done something to cause the abuse. These myths may have contributed to the slowness of the legal/political system to develop adequate ways of dealing with the problem.

Myths about child sexual abuse include:

- Children lie about sexual abuse.
- Only girls are victims of sexual abuse.
- Only homosexual men abuse children.
- Children are responsible for their own sexual abuse.
- Children are sexually abused most often by strangers.
- Offenders are crazy or sick.

- Women sexually abuse children as frequently as men.
- Mothers are responsible for incestuous relationships, even when they are not the offender.
- Children always hate the offender.

Possible Indicators of Child Sexual Abuse

The personal responses of the abused cover a wide range. All children who are abused are affected, some to devastating proportions. The following are some of the effects of child sexual abuse:

- Fear of intimacy
- Sexual acting out or using sexually explicit language not usually known by their age group
- Extreme reluctance to trust others
- Withdrawal into silence, moodiness or any very different unexplained mood changes
- Guilt, self-hatred, lowered self-esteem
- Using drugs or physical pain to block the emotional pain
- Suicidal behavior

Children usually develop changes in behavior after being sexually assaulted. Often, this is what is focused on rather than the behavior of the attacker. Many women in psychiatric hospitals have been abused as children.

Sometimes, if the abuse is discovered, the child is removed. This may cause the child to suffer from the idea that they are being punished and responsible for the break-up of the family.

Pre-school Children Indicators

It is important to consider the following indicators within the context of behaviors of pre-school children that are part of normal sexual development. The curiosity about the differences between boys and girls may result in exposure of genitalia and a period of preoccupation with the details of urination and elimination. Some indicators should result in further investigation into the safety of a child. These include:

- Comments that make sense only in a sexual context
- Aggression against other children
- Insertion of objects into the vagina or rectum
- Fear of certain areas in the house or of certain people
- Sudden changes in behavior (shrinking away from physical contact)
- Infantile behavior (thumb sucking or baby talk)

Elementary School Aged Children Indicators

- Appear overly mature
- Do drawings with sexual themes
- Afraid to go to school
- Unwillingness to change before others
- Reluctant to be with certain adults

Normal activity at this age includes the following:

- Mutual exploration among peers
- Interest in sexual jokes and swearing
- Seeking sex information from friends or books

Indicators of Abuse in Teens

It is difficult to establish clear indicators of sexual abuse for adolescents due to the stress most of them are working through as they approach adulthood. Some clues are listed below. No individual behavior should be considered a clear indication of abuse in and of itself.

- Prostitution
- Deliberately hurting themselves
- Extreme hatred or fear of an individual
- Low self esteem
- Drug and/or alcohol abuse

- Compulsive need to excel

Disclosure

When a child who has been abused tells someone about the abuse, she or he may be facing a time of great emotional fragility.

Victim's Concerns

A number of factors reduce the victim's willingness to disclose or to cooperate in the investigation of sexual abuse. Some of them follow:

- Fear of not being believed
- Reluctance and embarrassment to talk about the incident
- Difficulty in telling the story
- Self-guilt or sense of culpability for inviting or provoking the assault
- Uncertainty whether actions were right or wrong
- Fear of telling on the offender
- Love of offender
- Fear of repercussions
- Fear of notoriety
- Fear of shocking/hurting loved ones with the disclosure

Support During Disclosure

The support for an abuse victim who is disclosing the abuse includes supporting the actual behavior of disclosing and supporting the victim emotionally. Themes for response to a victim include the following.

- I believe you
- I'm sorry this happened
- It's not your fault
- I'm glad you told me
- Together we're going to try to get some help

Reporting Child Abuse

Current laws in British Columbia require all complaints of behavior of abuse (what a reasonable person would consider abuse) to be reported, to the Ministry for Children and Families.

Courts are seriously considering the role of professionals regarding suspected child abuse, as indicated in a recent case in Alberta, in which a physician was sued for \$600,000 for not reporting indications of abuse discovered in a medical examination of a child.¹

Victim's Concerns During Legal Process

While sexual abuse and incest is illegal, prosecution is difficult. The child's testimony is rarely valid for court standards or acceptable to the court system, and there are usually no witnesses. The court system is trying to make it easier for children. When adult survivors of child sexual abuse decide to prosecute, the length of time between the crime and the charges may lead to further legal. During the process of the investigation of an abuse case, a number of factors reduce the effectiveness of the abused child's contribution.

Investigative Stage

- Dislike of repeated interviews
- Feeling of being disbelieved because of the nature of questioning or repeated questioning
- Fear of family break-up or disruption
- Threats or actual harm from offender or non-offending parent
- Poorly conducted interviews that can lead children to believe they are to blame

Retraction of Disclosure

- Consequences are more serious than expected
- Threats from the offender (directly or indirectly)
- Low self esteem

¹ D. vs. University of Alberta Hospital

- Too many people involved
- Court process too frightening

Common Questions about Going to Court

- Will the offender be in the courtroom?
- Will people yell at me?
- Will they believe me?
- Will the offender go to jail?
- How long will it take?
- What will they ask me in court?

Allegations of Abuse

Reports of children being abused can come from a variety of sources.

- School teachers and school counsellors
- Family physicians
- Neighbors
- Members of the extended family
- Parents
- Children who have experienced or witnessed the abuse

All reports must be taken seriously and followed up.

Chapter 5 – Adult Sexual Violence

Sexual assault is committed in various ways. While popular movies and literature features examples of women exercising power over men through sex, it is important to be aware that the vast majority of sexual assaults are committed by men toward women.

Legal Definition of Sexual Assault

A victim has been sexually assaulted if she has been forced to kiss, fondle or have anal, oral, or vaginal intercourse with someone, or if she has been touched in a sexual way without giving consent.

Changes to Canadian laws in January, 1983, reflect a shift in cultural attitudes about sexual offences. The word rape (defined as forced sexual intercourse) was dropped from the Criminal Code and replaced with three levels of sexual assault which, like physical assault, are defined according to the degree of personal injury inflicted on the survivor.

Sexual assault laws now acknowledge the sense of personal violation experienced by the survivor, regardless of the nature of specific sexual acts. These laws emphasize the violent, rather than sexual, nature of the crime.

Canadian Sexual Assault Law

This is covered in the Canadian Criminal Code – Sections 271-278

Level 1 – Sexual Assault

It is a crime (Level 1 – Sexual Assault) if someone forces any form of sexual activity on someone else (e.g., kissing, fondling, touching, sexual intercourse, etc.) without that person's consent.

Level 2 – Sexual Assault with a Weapon

It is a crime (Level 2 – Sexual Assault With A Weapon) if, during a sexual assault:

- someone uses a weapon or threatens to use a weapon, imitation or real
- someone threatens to cause bodily harm to a third person, i.e. a child or friend
- someone causes bodily harm to another person

- more than one person assaults someone in the same incident

Level 3 – Aggravated Sexual Assault

It is a crime (Level 3 – Aggravated Sexual Assault) if while being sexually assaulted someone is:

- wounded, maimed, disfigured, or brutally beaten up
- in danger of losing their life

Sexual Interference

It is a crime (Sexual Interference) if someone for a sexual purpose, touches any parts of the body of a child under the age of fourteen.

It is a crime if someone, for a sexual purpose, encourages a child to touch them with any part of the child's body or with an object.

It is also a crime if someone, for a sexual purpose, encourages a child to touch his or her own body or the body of someone else.

Sexual Exploitation

It is a crime (Sexual Exploitation) if someone, who is in a position of trust or authority towards a young person or is a person with whom the young person is in a relationship of dependency, commits the offences of sexual interference or invitation to touching described above.

Incest

It is a crime (Incest) if a blood relation has sexual intercourse with another blood relation (e.g., parent, brother, sister, half-brother, grandparent).

Exposure

It is a crime (Exposure) if someone for a sexual purpose exposes his or her genital organs to a person who is under the age of 14. If this happens to someone over the age of 14, this is still against the law if it happens in a public place.

Note: If the victim of any other of the above offences is under the age of 14, the accused may be found guilty whether the victim consented to sexual activity or not, unless:

- the accused is between the ages of 12 to 16; and
- the accused is less than 2 years older than the victim; and

- the accused is not in a position of trust or authority or in a relationship of dependence with the victim.

Removal of the Term ‘Rape’ from the Criminal Code

Communicators for police or ambulance services may receive calls from distraught individuals who have been sexually assaulted. The word “rape” has disappeared from the Criminal Code of Canada in 1983.

Some of the reasons include:

1. Rape relates to sexual intercourse whereby the burden is placed upon the female to prove that she did not agree. It does not take into account sexual acts of other types.
2. Rape was found to be violence with or towards the sexual organs. It is not always penetration of a vagina by a penis.
3. Historically, a guilty verdict for rape carried dire consequences for the accused. On the anniversary date of the conviction, the rapist was whipped while serving a jail term. Consequently, there was a low conviction rate.
4. Historically, victim rights were not recognized, making it difficult for a woman who did disclose. Her sense of dignity and her privacy could be compromised. For example, bans on publication of the victim’s name did not exist.
5. There was a high degree of shame attached to being raped as it was assumed that the woman “asked for it.”

Rights of the Victim and Changes in the Rules of Evidence

In addition to the changes to the criminal code regarding the three levels of sexual assault, victims were afforded some rights during the trial process, which made disclosures somewhat easier. These included:

- Bans on publication of the victim’s name
- Photographic evidence can be admitted showing injuries and disfigurement

- The victim in some circumstances can request that the court be closed
- Children can be videotaped and the tape admitted as evidence

In 1983, the law was also changed to include the Rape Shield Law. Specifically, this meant that the sexual history of the victim could not be brought up in court. For example, a woman who had worked as a prostitute could in fact charge someone with sexual assault if she had said “No,” yet the male had continued to act.

The 1991 Constitutional Challenge to the Rape Shield Laws

In 1991, the Rape Shield laws were overturned by a Supreme Court decision. The court found that section CC 276 had the potential of excluding relevant evidence that might provide proof related to the charge.

The case in question (*R vs. Seaboyer*) argued that the defendants were not allowed to defend themselves. They argued that the sexual history of the victim was their only defence. The case involved a gang rape situation in which the female alleged sexual assault by many members of a sports team. The males were found guilty. However, their appeal was heard and upheld because the sexual history of the alleged victim was in fact relevant. On numerous previous occasions, she had consented freely to the activity. A reasonable expectation had been created that she would be a willing party in the disputed circumstance and the defendants could not be held criminally accountable.

The consequence of the decision to overturn the Rape Shield laws has probably deterred a number of women from coming forward, because they do not wish to have their integrity questioned in the courts. It is impossible to speculate on the numbers of individuals affected by this decision.

This controversial piece of legislation has had amendments, has been reinstated, and is again being challenged as this document is being written.

Common Elements of Sexual Assault

- One in four girls and one in ten boys are sexually assaulted before the age of 18. (United Way Study, Vancouver, 1984)
- 1 woman in 10 has experienced violence in the past twelve months. 27% of these women are under the age of 25. (Statistics Canada, 1993)
- 78 per cent of sexual assaults on women are by a male who is known to her. (Statistics Canada, 1993)
- Victims of sexual assault are physically hurt in at least 60 per cent of cases. (Ministry of the Solicitor General of Canada, 1985)
- 25% of all women have experienced violence at the hands of a current or past marital partner. (Statistics Canada, 1993)
- Children who see abuse in the home have a level of adjustment problems comparable to that of children who are physically abused themselves. (D. Wolfe et al, Journal of Clinical & Consulting Psychology, 1985)

Sexual Assault Myths

Even though the law has changed over the years, some of the old, negative and false attitudes persist. The concept of rape and sexual assault is viewed as violence with or against the sexual organs. Rape is one of the three most frequent violent crimes in our society along with murder and aggravated assault. A number of myths surround rape and sexual assault.

Myth #1: Rape is a sex crime committed by men with uncontrollable sexual drives.

REALITY: Rape is a crime of aggression committed by men who want to dominate, degrade and compel physical intimacy on unwilling women. Most rapes are not spontaneous, but planned ahead of time.

Myth #2: Rapists are usually mentally sick, perverted and/or sexually unfulfilled.

REALITY: Rapists are no different from the average person physically, sexually or psychologically, except that they commit the

crime of sexual assault. In fact, the majority of offenders look very average. Most have a greater tendency to express violence and rage more openly. Many are married and/or have “normal” sexual relationships.

Myth #3: Rape happens outside in dark isolated places.

REALITY The majority of rapes happen in a home, the victim’s, a friend’s, or the rapist’s. The next most common location is the rapist’s car.

Myth #4: Rapist and victim are strangers to each other.

REALITY: In over more than three quarters of the reported cases, the rapist is known to the victim in varying degrees of familiarity, from a trusting initial meeting to a close family friend or relative.

Myth #5: Nice women don’t get raped.

REALITY: All females, from children to grandmothers are potential attackees. Following the correct standards for a virtuous woman does not provide protection from possible rape. The most common characteristic among people who have been attacked is vulnerability. Reasons for vulnerability include the inability to defend oneself, physical limitations, fear or environmental circumstances, such as getting off work at 2 am.

Myth #6: Women enjoy being raped, or if inevitable, “lie back and enjoy it”.

REALITY: The idea that women could enjoy forced sexual intercourse is a fantasy that confuses rape with sex, instead of recognizing it as violence. Comparing rape to sex between consenting people is like suggesting that food is enjoyed whether rammed violently down one’s throat or eaten normally at dinner. As rape is a crime of violence rather than passion, frequently the rapist elicits crying or pleading from the victim. If the victim does not respond according to the attacker’s expectations, he may use more violence to obtain the desired response. After the rape, he may also beat or threaten to kill the victim to prevent identification to the police or others. In 65% of assaults, there is threat of violence. There is no apparent relationship between violence during an assault and whether or not victims fight back. Sexual assault victims who report their

attacks to the authorities will be asked, “Did you fight back?” When victims have fought back, it is taken as evidence that there was no consent, and that an assault did occur.

Myth #7: Women ask for it.

REALITY: Using a gesture or way of dressing to measure provocation on the part of the attacked woman, the Federal Commission on Crimes of Violence found that only 4% of reported rapes involved any *precipitative* behavior by the woman. Our society expects women to appear sexually attractive, but women who are raped are condemned as deserving it.

Myth #8: When a woman says “no” she means “yes”, and is just being coy.

REALITY: In the courts, if the accused believes and can present a case for the woman having consented, then there is no rape. Society’s attitude is that women do not say what they mean or do not know their own minds. If a woman says “no”, she should be prepared to back it up physically if necessary. One constable of the Vancouver Police department has stated that the average male does not hear a woman say “no” until she has said it three times!

Myth #9: If the woman is not of previously chaste character, then consent is implied, since she has shared her sexual favours in the past.

REALITY: The law has taken different positions on this issue, but all too often a victim’s past conduct has been considered admissible evidence when she is cross-examined on the stand. Raising a woman’s past sexual history is like taking a mugger to court for stealing your purse and having his lawyer raise the point that since you have given to charities in the past, the implications are that there was no crime in taking your money. The Rape Shield law currently in place to prevent this has been struck down before.

Myth #10: No healthy women can be raped because she can prevent it.

REALITY: Fear is the rapist’s primary weapon. Most rapes carry an implicit, if not explicit, threat of death or severe harm. In nearly 90 per cent of all reported rapes, a knife, gun, or violent physical force was used. The fear of injury or death terrorizes many women into

cooperation or immobilization. Over 50 per cent of rapes involve more than one attacker.

Myth #11: A woman cannot be raped by her husband.

REALITY: Women are forced by their husbands into physical intimacy at times. This is not legal, although many people believe it is.

Myth #12: Marital rape isn't offensive. After all, a wife has had sex with her husband before, what is one more time?

REALITY: A woman raped by a stranger has to live with the memory of that experience. A woman raped by her husband has to live with her rapist. Many wife-survivors trapped in a husband's reign of terror experience repeated sexual assaults over a number of years.

Myth #13: The Legal system will protect you.

REALITY: In Canada and the USA, judgments within the legal system have been dismal. Women are faced with the reality that courts believe "No may mean yes, or wait awhile," and that a three-year-old female can be sexually provocative. The adult assaulter is innocent until proven guilty, and in a contest between the word of a female against the word of a male, the male is usually considered to be honest (e.g., the Anita Hill case).

Types of Sexual Assault Calls

Public safety communicators can expect three different types of sexual assault calls:

Survivor of a Past Sexual Assault

An individual may call and report an assault in the past. They may have been an adult when it occurred or may remember the traumatic event from childhood.

Such victims are probably not in a state of crisis, but need sensitive treatment. It may have taken all of their courage to call the police. They are in no immediate danger, so you could arrange for them to talk to an officer of a morality (sex crimes) unit. It is better for detectives to handle these cases because the statements cannot be rushed. Convictions may be difficult to obtain in these circumstances as there is no forensic evidence and offenders from long ago can be difficult to find or may even be dead.

Sexual Assault has just Occurred

A caller phones 9-1-1 and reports they have just been sexually assaulted and that the suspect has left the scene. The first question to ask the caller is, “When did this happen?” If the suspect just fled the scene, there are the issues of:

- Officer safety – the suspect may be armed with a knife or a gun
- Suspect description – a search of the area may be necessary
- Preserving evidence – encourage the victim not to bathe and to keep all sheets or clothing worn during the assault for the police to test for forensic samples
- Ask if the caller is hurt or needs an ambulance
- The caller will be in crisis – keep him/her on the line and ensure them that help will be right there

Possible Sexual Assault in Progress

A caller reports, “I am in fear of being attacked. He is breaking in!” A sexual assault could occur in the next few moments.

This is a crime-in-progress call. Respond according to your SOPs. The victim will probably be afraid, emotional, breathing heavily, hard to understand, and may not respond to long questions. Ensure the location identification and send help immediately!

Keep them calm, if possible. Suggest to them possible escape routes from the house, e.g., the back door or through a window. Survival is the issue.

Crisis Intervention Checklist

- Remain calm
- Ascertain whether you are the first person the caller has spoken to
- Give emotional support
- Reassure victim by telling them help is on the way
- Ask if the victim is safe
- Provide medical attention

Reasons for Not Reporting

The victim of a sexual assault may not report this assault to anyone, including, family, friends or police. There are many complex reasons for this, some of which include:

- Fear of blame for the incident
- Concern about the attitude of police or the courts
- Fear of revenge
- Embarrassment
- Belief that the police will not be able to do anything
- Belief that the courts will not find the accused guilty
- Belief that the best way to cope is to try to forget it

Impact Stage Emotions and Reactions

ShockI feel numb. Why am I so calm? Why can't I cry?

Disbelief.....Did it really happen? Why me?

Embarrassment What will people think? No, I can't tell my family.

ShameI feel so dirty, like there is something wrong with me now. I want to wash my hands all day long.

Guilt.....I feel as if I did something to make this happen to me. If only I had...

Depression.....How am I going to go on? I feel so tired and hopeless.

Powerlessness. Will I ever feel in control again?

Disorientation I can't sit still. I'm having trouble getting through the day. I'm just overwhelmed!

Re-triggering .I keep having flashbacks. I wish they would stop.

Denial Wasn't it just a rape?

Fear.....I'm afraid of so many things. Will I get pregnant or get VD? Can people tell what's happened to me? Will I ever want to be intimate again? Will I ever get over this? I'm afraid I'm going crazy. I have nightmares that terrify me.

AnxietyI'm a nervous wreck! I have trouble breathing.

(Anxiety is often expressed in physical symptoms like difficulty breathing or muscle tension, sleep disturbances, change in eating habits, nausea, stomach problems, nightmares and bedwetting.)

AngerI want to kill him!

Recoil Stage Emotions and Reactions

Emotional

- Feelings of grief and loss
- Feeling lost and alone
- Terror of being alone
- Unwillingness to trust anyone
- Inability to trust others

Mental

- Thinking that no one understands
- Confusion or inability to think clearly
- Inability to get your mind off the assault
- Serious erosion of self-confidence
- Disconnection and distance from day-to-day reality
- Lack of trust in self
- Paranoia
- A feeling of being suspended in time, and a sense of disconnection from the world

Physical

- Feeling unclean and *soiled*
- Change in eating patterns or nausea
- Fatigue and trouble sleeping
- Sleep disturbances

- Headaches and muscle tension
- Sexual dysfunction
- Not wanting to be touched by anyone

Support

It is important for public safety communicators talking with a sexual assault victim to be supportive in whatever ways are possible. In the short time the communicator has with the victim, reassurance that help will come is probably the best support to offer.

Emotional and Mental Support

Listen without judgment. Be sensitive, respectful, and acknowledge whatever feelings they have. Help them to reverse feelings of guilt or self-blame, and discourage any tendency to minimize what has happened by placing the responsibility for the sexual assault on the offender.

Reinforce the fact that they have survived. Whatever they did or did not do was the right thing for them to do because they survived the sexual assault. Avoid looking for what caused the assault to occur. For example, do not ask why questions, as they imply doubt. Disbelieving what happened to them will contribute to their trauma.

Allow them to experience their emotions and feelings however and whenever they wish. Accept how they do feel (angry, sad, guilty or whatever). Avoid telling them how they should feel (angry, sad, guilty or whatever).

Recognize that the changes they will undergo may affect any of their relationships, including their closest ones. The victim may often feel that they are talking too much or being too emotional. Reinforce the fact that expressing themselves is a valuable part of the healing process. Conversely, repressing the experience or negating their feelings could be damaging to them in the long run.

Support them in exploring their choices. Help them gather the information they need to make decisions. A number of immediate decisions need to be made by the survivor regarding safety, emotional well-being, and medical and legal issues. A communicator's first reaction may be to try to take charge for them. Instead, allow them to

determine what they need. Letting them make decisions in response to the sexual assault acknowledges their need and ability to regain as much control over their life as possible. The communicator may need to be patient.

Encourage them to build a support network of friends and family members so they are not entirely dependent on one person. Most sexual assault centers have 24-hour crisis lines that they can call for support at any time. Emphasize their strengths and point out that they survived the assault. Encourage them to have the strength to continue coping.

Physical Needs

To feel safe, they may need to change the locks on their home and have outside lights installed, or even move residences, if need be. Offer to help them with any changes they wish to make in order to feel safe.

Some of the possible physical needs of a sexual assault victim include:

1. Immediate safety/security
2. Transportation
3. Medical Attention
4. Assistance in reporting the assault
5. Emotional/personal support
6. Counseling (at times)
7. Referral to appropriate agencies
8. Information about
 - a) what will happen next
 - b) the investigation
 - c) charges
 - d) prosecution
9. Court preparation
10. Accompaniment to court

Common Questions about Criminal Justice System Procedures

1. Will I be involved in any further investigation?
2. What will happen to the person who assaulted me?
3. Will the assailant be charged?
4. Will the assailant be kept in jail?
5. What if the police do not charge the assailant?
6. Will my name be in the newspaper?

The Issue of Repressed Memory vs. False Memory

This issue of repressed memory versus false memory may not directly affect call takers during the course of their duties, but it is important for them to understand the current controversy around this issue.

Repressed memories are defined as something that haunts a person. When something awful happens, people utilize the ultimate ego-defense mechanism of total denial such that they lose conscious memory of the event. However, it may come back at them in the night, or be triggered by a song or a smell. Sometimes they remember part of the event, or all of it, and then they feel compelled to tell someone.

False memory syndrome is a term that implies that details of incidents a person remembers, but which are not corroborated by forensic evidence, are not true. There are allegations that some counselors probe and suggest that perhaps the reason a person is having problems in their life is that they could have been sexually abused as a young person. Because there is such a power imbalance between a therapist and a client, the person is highly suggestible, and as a consequence could start building a story around this engendered memory.

The bottom line: If someone remembers an assault on his or her own, there is a far greater chance of a conviction. If someone reports because their therapist helped them remember an event which occurred 22 years ago, the system will still respond, but chances of a suspect being found guilty is less likely.

Chapter 6 – Elder Abuse

Elder Abuse

Definition: Any harm to an older person that is caused by a family member, friend, or by someone on whom the victim relies for basic needs, and occurs in situations in which the victim is under the control or influence of the offender.

Types of Elder Abuse

Physical Assault

- Locking the older person in a room
- Tying the victim to a chair
- Slapping, pushing, or beating
- Assaulting the person sexually

Financial

- Forging the victim's signature on pension cheques
- Stealing money or personal possessions
- Fraudulently disposing of property by a holder of power of attorney
- Forcing the victim to sell property

Neglect

- Denying a dependent older person food or health services
- Abandoning a dependent older person

Mental Cruelty

- Isolating or ignoring the older person
- Humiliating or insulting the older person
- Frightening, threatening the older person

Possible Criminal Code Offences

1. **Physical** – assault, sexual assault, forcible confinement, murder or manslaughter

2. **Financial** – theft, theft by a person holding power of attorney, fraud, extortion forgery, stopping mail with intent.
3. **Neglect** – criminal negligence causing bodily harm or death – failure to provide necessities
4. **Mental Cruelty** – intimidation, uttering threats

Common Elements of Elder Abuse

Elder abuse typically occurs within the privacy of the elder's residence, be it their own home, the home of a relative, a boarding house or a continuing care facility.

The following are some of the elements linked to elder abuse:

- The abused person may be male or female and is mentally competent
- They do not depend on the offender for constant physical care
- They have some degree of physical frailty or disability that makes them appear vulnerable
- They are under the control or influence of the offender and in a socially isolated situation

Characteristics of Offenders

The adult child, spouse or family caregiver who abuses an elderly relative may exhibit some of the following characteristics:

- Is alcohol or drug dependent
- Is financially dependent on the victim, e.g., lives in the victim's home and uses the victim's money
- Is chronically unemployed or subject to other external stressors
- Has psychological problems, e.g., mental instability or an immature personality (the child who never left home)
- Is socially isolated
- Is in declining health
- Is over-stressed by being caregiver for dependent elderly relative in addition to meeting the demands of his or her spouse and children.

- Is an institutional caregiver who is ill-equipped to work with the elderly because of lack of education, training, or commitment, or because of a chronically understaffed work environment.

NOTE: Researchers no longer believe that elder abuse results primarily from the stress on a caregiver saddled with an infirm, incompetent, older relative. Rather, a picture is emerging of a relatively well-functioning older person in a relationship with a relative who is dependent financially and/or emotionally on the victim.

Theories in Elder Abuse

There are a number of theories about elder abuse. They include:

Psychological State of the Abuser

Researchers point to a strong association between elder abuse and the abuser's alcohol or drug dependency, and a significant percentage of cases point to an abuser who has a history of anti-social behavior or mental instability.

Exchange Theory and Dependency Relationships

This theory states that humans in healthy relationships have a balance of benefits between the parties. While the give and take at any particular time is not equal, there is an overall satisfactory balance of benefits between those involved. If this balance is no longer achieved, the relationship deteriorates. In families, the relationship may continue with the parties feeling anger and resentment. Caregivers of dependent older persons may experience anger, guilt, frustration, and life dissatisfaction. Readiness to support an elderly or infirm relative can be lost when energy and personal freedom for an independent life are lost. This condition is alleviated to some degree with respite services or programs, which allow the caregiver a break from the responsibility of caring for their relative, and give the elder opportunities for a variety of interactions and experiences.

Stress

Some research indicates that families prone to violence are more likely to have experienced a series of stressful events than non-violent families. Families supporting the elderly often have to deal with stress caused by failing health, reduced income, loss of meaningful roles, or

death of loved ones while supporting the elder and maintaining themselves. While it is obvious that violence contributes to stress, it cannot be established that stress necessarily causes violence.

It is clear that the quality of life of the elderly is adversely affected by stress to care givers, no matter what the setting. This is true for caregivers in residential care settings as well as for relatives. Staff in nursing homes and other long-term care facilities may be under stress from working in chronically understaffed institutions, receiving low levels of pay and/or having low levels of training or expertise. Abuse of residents may result.

Social Isolation

Isolation of both the victim and the abuser appears to be an important causal factor in elder abuse. The older person may be cut off from the community, from social services, and from other family members who live some distance away or have been denied access. In cases where there the older person is isolated, the abuse may continue indefinitely without detection until the victim is hospitalized for emergency treatment, or otherwise comes into contact with someone who identifies the situation as problematic.

Intergenerational Transmission of Abuse (Cycle of violence)

This theory states that children who are victims of physical punishment at home or who observe their father hitting their mother have a higher rates as abusers toward their own spouse and/or children. To date, research on elder abuse has not shown that the abuser of an elderly parent was once abused by him or her, nor has it revealed an element of retaliation against the elderly parent for past wrongs. However, for individuals having grown up within a violent setting, the likelihood that they will use violence as a means of dealing with their own emotions increases.

adapted from: Wolf, R. Spouse Abuse And Neglect In Aging Family, Worcester, Ma: University Center On Aging, University of Massachusetts. Medical Center, 1987.

Elder Abuse Does Not Include

1. Victimization of the elderly by strangers, e.g., fraud artists or burglars. The fraudulent sale of lottery tickets and house renovations is illegal and may be prosecutable under the law, but does not constitute elder abuse simply because of the victim's age.

2. Self-neglect by an older person, e.g., the reclusive individual in need of medical attention who refuses offers of assistance.
3. Situations in which the individual is legally competent and makes decisions contrary to what friends and family believe to be in their best interests.
4. The extortion of money for normal care or service by employees in a group home may be considered elder abuse, due to the existing relationship and the dependence of the elder on the care giver.

Example: A female calls the police to report that her mother is wasting all of her money on a younger man who has moved in with her. She thinks he is a male prostitute. Her mother is spending money on new clothes, a “hot” car, and trips. She says she fears the family won’t have any money left over when she passes away and asks you what the police are going to do about it.

This situation is NOT a case of elder abuse. It does, however, play on a number of biases about the elderly.

Personal Attitudes and Beliefs

In regards to the elderly and elder abuse, older people are often seen as:

- Unproductive members of society, with their wisdom and experience counting little
- Physically unattractive in comparison to the media portrayal of beauty
- Not belonging in a society that worships youth
- Senile, just because they are old and childlike, with only frivolous interests
- Lacking in credibility when they complain of mistreatment
- An inconvenience to those who take care of them

Elder Abuse Victims Need

1. To have the violence, exploitation, or negligence ended
2. Safety, shelter, and financial resources to continue their life
3. Support services that are independent of the abusive caregiver

4. Emotional support, and increased links to the community
5. Information on the criminal justice system, in particular what is likely to happen to the child or spouse abusing them

Possible Impairments of an Elder Abuse Victim

A number of potential impairments limit our ability to assist elder abuse victims. These include difficulty in communicating due to the elder's personal or physical limitations. Personal limitations include speech or hearing impairments and mental incompetency. Physical limitations include inability to access a phone or to have private contact with others because of a caregiver's restrictions on the elder's activities.

Laws Protecting the Elderly

Nursing Homes Legislation (Under authority included in Municipal Act)

Recent amendments to this act make it mandatory for anyone, other than another resident, to report any harm to a resident to the Ministry of Health, which will immediately investigate the allegations. No one who reports abuse of a resident may be reprimanded or dismissed from his or her employment.

Powers of Attorney Act (RS Chapt. 370, 1996 BC)

Anyone who is mentally capable of understanding the nature and consequences of giving power of attorney may give power of attorney to a trusted relative, friend, or if there is no one else, the public trustee. This enables the attorney to manage the person's financial and property matters, but does not allow the attorney to make personal decisions for the donor.

Competent older persons whose relatives are taking financial advantage of them may consider giving power of attorney to the Public Trustee if they are unable to handle or maintain control over their assets.

Mental Health Act (RS Chapt. 288, 1996 BC)

The *Mental Health Act* oversees the provision of mental health services for British Columbia. The act contains a provision for the holding of people involuntarily under certain conditions.

A police officer or medical doctor can have persons taken to and held in a psychiatric facility for 72 hours if there is reasonable cause to believe they are dangerous to themselves, to others, or cannot take proper care of themselves due to a mental disorder.

Note: The Mental Health Act is not an appropriate tool for dealing with victims of elder abuse who themselves are not suffering from a mental disorder. Since most victims of elder abuse are mentally competent, this law would be relevant in only a minority of cases.

Aging Population

In 1981, the elderly represented only 9.7 per cent of the Canadian population. Within 30 years, 21 per cent of the population will be over the age of 65.

The current life expectancy for a Canadian female is 79 years, and for a male, 71 years. In the year 1900, a family typically included three generations, whereas today the family often includes five generations, from great-grandparent to great-grandchild. Historically, the three generations often lived in the same home or at least in reasonable proximity to each other. Now, the generations are more geographically separated, making intergenerational support more complex. Where family caregivers are available, their support from other relatives may be made difficult by geographical distance between relatives.

Statistics on Elder Abuse

Complete empirical information on elder abuse in Canada is not available; however, completed studies identify significant levels of abuse in the areas studied. Some researchers have predicted that elder abuse is as prevalent as child abuse.

The 1982 **Manitoba Study**² by Donna Shell questioned nurses, police, social workers, home care providers, and physicians about elder abuse. Her data revealed 402 cases of abuse, representing 2.2 per cent of the Manitoba population over the age of 65. Because of the limitations in the research and the inadequacies of reporting, she concludes that the numbers represent only the tip of the iceberg.

² Shell D.J., "Protection of the Elderly: a Study of Elder Abuse" Manitoba Council On Aging, Winnipeg, Manitoba, 1982)

The Manitoba Study on Elder Abuse

1. Financial abuse was most common (40.3%), followed by mental cruelty (37.5%), and physical abuse (22.5%).
2. The most prevalent characteristics of the abuser that contributed to the abuse were alcoholism (44.8%), financial stress (15.2%), a negative attitude toward aging (10.5%), and poor coping ability (8.6%).
3. The largest group of victims by age was 80 to 84 years (26.1%), and the majority of victims were female (67.7%).
4. A full 75% of the abuse was at the hands of relatives, broken down as follows: sons (and in-laws) accounted for 23.6%; daughters (and in-laws), 21.2%; husbands, 16.4%; wives, 4.5%; and all other family members, 9.8%. Unrelated caregivers accounted for 24.4% of the abusers.

Findings of the Manitoba Study

1. Types of abuse:

Financial	40.3%
Mental cruelty	37.5%
Physical	22.5%

2. Characteristics of abuser:

Alcoholism	44.8%
Financial stress	15.2%
Poor attitude to aging	10.5%
Poor coping ability	8.6%

3. Age and sex of victims:

Largest group by age were 80-84 years old	(26.1%)
Majority of victims were female	(67.7%)

4. Abuser's relationship to the victim:

Unrelated	24.4%
Sons (and in-laws)	23.6%
Daughters (and in-laws)	21.2%
Husbands	16.4%

Wives	4.5%
All other family	9.8%

A 1986 **Boston Study**³ by Dr. Karl Pillemer represents the first large-scale random survey of elder abuse in North America. Interviews with 2,020 elderly persons in Boston resulted in the reporting of 63 cases of abuse (3%). **Note:** This study did not include financial abuse in its definition of abuse.

The Boston Study on Elder Abuse

1. The rates of abuse were no higher for the elderly over 75 than for younger elders, and there was no significant difference in the rate of victimization on the basis of color, religion, economic circumstances, or educational background.
2. 58 per cent of the abusers were spouses, compared to 24 per cent who were children of the victims, reflecting in part the fact that more elderly live with spouses than with children. Had financial abuse been included in the study, it is possible that the number of abusers by children would have been higher.
3. The most important indicator that correlated with abuse was some pattern of deviant behavior on the part of the abuser. The dominant deviances were alcohol or drug dependence/abuse. Other abusers suffered from emotional maladjustment, a high level of stress, and/or financial dependence on the victim. Abusers of elderly spouses were likely to have medical complaints themselves.
4. The majority of victims were mentally competent, not requiring heavy care. Increased physical disability increased the risk of abuse.

Findings of the Boston Study

1. The rate of abuse did not change given:
 - a) Age
 - b) Color

³ Pillemer, K., and Finkelhor, D. The Prevalence of Elder Abuse: A Random Sample Survey and Correlates of Elder Abuse: A Case-Control Study, Family Violence Research Program, University of New Hampshire, Durham, N.H.. November, 1986 and May 1987 respectively

- c) Religion
 - d) Economic circumstances, or
 - e) Educational background of abusers or victims.
2. Abuser's relationship with the victim:
- a) Spouses 58%
 - b) Children 24%
3. Characteristics of abuser:
- a) Alcohol or drug abuse
 - b) Emotional maladjustment
 - c) Stress
 - d) Financial dependence on victim
4. Characteristics of victims:
- a) Majority of victims are mentally competent, not requiring heavy care
 - b) Physical disabilities increased vulnerability to abuse

Responses to Victim's Needs

A number of agencies, starting with the police, are brought into play when there is criminal abuse. There will be investigation and the laying of charges initially. Local community service groups, such as Victim's Services, may become involved in helping to assure safety, shelter and financial resources, home support, emotional support, and to supply information on the criminal system to the victim and family members.

SECTION 2: DIFFERING ABILITIES

Chapter 1 – Public Safety and the Disabled Community

The Disabled Community

It has been said that the biggest hurdle faced by the disabled in a community is the errant behavior of others based on their pre-judgment of what they see or hear. These pre-judgments are not necessarily malicious, nor the acts of those who are ignorant. More likely, such acts are based on incorrect assumptions about the ability of the person.

Public safety communicators typically have only voice communication with the caller. This may be an advantage in that they do not *see* the caller, which might bias their perceptions of what is happening. On the other hand, it may be a disadvantage in that there are fewer stimuli to base an analysis on.

Issues for the professional communicator around dealing with mute, deaf, children, elderly and those with a mental illness are dealt with elsewhere. This short section deals with other physical abilities and issues related to communication with public safety agencies.

The call taker must ascertain the needs of the disabled caller, and identify situations where the person's condition affects his/her ability to communicate clearly. The communicator needs to clarify what abilities are possible when talking to the person. Most people are capable of identifying what they can or cannot do if asked and given a chance to respond.

Differing Abilities

Some who are challenged because of a physical impairment may be constrained to a wheel chair and restricted to what can be reached from a sitting position if they are paraplegic. Most public telephones are mounted out of reach unless heroic – and potentially dangerous – exertions are made. Quadriplegics have more difficulty and may need personal assistance for the most basic tasks. Any impairment of the

ability to move freely may mean that a person is less able to remove her/himself from a dangerous incident or to help another person who is injured. Blindness, deafness, injury, amputation, and various congenital conditions are only a few of the possible physical impairments.

Chronic Illness

Chronic illness is another condition that affects an individual's ability to cope in a society that is primarily set up for fully functioning individuals. Arthritis, multiple sclerosis, Alzheimer's, fibromyalgia, and other diseases and syndromes can have severe effects.

Diabetics

Diabetics live with the constant challenge of regulating their blood sugar levels by balancing activity, food intake and insulin levels in order to maintain the normal chemical functioning of the body. Problems arise if the ratio of sugar/insulin is too high or too low. Severe imbalances can result in insulin shock or diabetic coma, either of which can result in death if not treated appropriately and quickly. Unfortunately, a person who is slipping into one of these conditions may sound like they are drunk, and assumptions about their condition can affect how the call is handled.

Medical Apparatus

A variety of medical conditions may affect callers and the call response. For example, an emergency situation may be adversely affected when a person who is able to move him- or herself is hampered by having to move a medical device such as an oxygen bottle. If callers need assistance, ensure that the information is part of the report that will be dispatched to the field unit, so that assistance will be sent.

Chapter 2 – Assisting People with Differing Abilities

Communication Devices

Life Line Communication System is a program available to people with certain disabilities through the medical community, based primarily in the hospitals. An individual who uses the system is required to wear a *beeper* device around his/her neck, with a button to push in the case of an emergency. The person's phone is programmed to dial the monitoring centre automatically. The phone is a highly sensitive speakerphone, which is capable of picking up breathing or groaning if the person cannot generate speech.

If it sounds serious, an ambulance is dispatched immediately. While the ambulance is en route, the monitoring center tries to reach one of three contacts previously designated, who may meet the ambulance at the house or at the hospital. If the matter is not perceived as life or death, the contact person may be required to check on the patient before an ambulance is dispatched.

The program is reserved for persons with chronic health problems requiring immediate medical attention. This could include persons prone to heart failure and kidney failure. Other individuals having difficulty moving around, such that if they fell down they would need assistance to get up, are also eligible.

Persons with severe spinal cord injuries and serious cerebral palsy are also included in such programs on a limited basis. It is recommended that these persons have a personal care attendant with them 24 hours a day rather than relying on monitors. Disability pensions and social services usually fund this type of care so the patient can maintain an independent life, rather than being confined to an institution.

In some areas where services of this type do not exist, disabled persons will have to rely on others from their family or community to check on them periodically. If someone, such as a home care worker, reports that when they attended the residence, the door was locked and no one came to the door or answered back, it would be appropriate to dispatch someone to check on the person's well being.

Generating Speech Difficulties

Due to stuttering and conditions like Cerebral Palsy or advanced Parkinson's disease, some persons have problems speaking clearly over the phone. They may have a problem holding the phone steady and do not have the luxury of a speakerphone. Being upset may aggravate the situation.

Appropriate Response

- If the caller's speech is slurred, do not assume you are dealing with a drunk individual. Ask them if they have a medical condition.
- Be patient. If you do not understand them, ask them to repeat what they just said. Most will readily tell you their problem.
- Do not be sympathetic, be empathetic.
- Speak slowly and clearly. Calm them down. Give them questions that can be answered with simple "yes" and "no" responses if their speech is labored. For example: "Are you hurt?" "Are you in any danger right now?" "Are you alone?" "Do you need an ambulance?" "It says on my screen that you live at 555 Elm Street, is this true?"

Hearing Impairments and the Message Relay Center

The message relay system has been developed to serve the deaf and hearing-impaired communities. It is available to most persons with hearing difficulties. The system is quite simple. The person with the hearing problem has a keyboard and monitor linked to their telephone. When they dial a number, they are automatically patched into the Message Relay Centre before the number they have dialed is reached.

An operator acknowledges contact with the user by typing back to them that their call is being placed. The operator then speaks to the person the deaf caller is trying to contact, and then types the response back to the deaf person.

If you are taking calls for the police, fire, or ambulance and are contacted by the Message Relay Centre, be aware that the relay operator has to type your responses to the caller. They also need time to process what the caller is sending back to them. Talk slowly and

deliberately. Be patient. Ask simple questions, perhaps those types requiring “yes” and “no”. It may not sound empathetic, but you need to focus on being efficient.

Limited Comprehension

Some persons who contact 9-1-1 may have a diminished IQ or ability to comprehend. Their condition could be genetic. For example, they could have Down’s Syndrome due to having an extra chromosome. Or they could have a condition called phenylketonuria, which produces a physical appearance similar to Down’s, yet it is due to the lack of a gene which produces an enzyme essential to normal metabolism.

The severity of their impairments varies from individual to individual. Some are able to hold various kinds of jobs. For example, the Edmonton Oilers Hockey Team has employed a Down’s person as their equipment manager for nearly 20 years.

Assume that if they have called 9-1-1, they are high functioning and able to understand you. Obviously, they have a problem and need help. If they are excited and panicked, their speech may be hard to understand. Speak politely and choose jargon-free language and ask questions that require simple responses.

Confused Callers

- Be calm. Be patient. Ask simple questions.
- If the caller’s speech is poor, ask them politely to repeat what they have said or to use other words.
- If information is still unclear, send help ASAP.
- If you can ascertain their name, check for similar calls under their name.
- If there are previous calls, check to see whether or not calls were founded.
- If there are previous call files, check to see if there are any family members or next of kin indexed on the file. If so, give them a call because they may be able to verify the potential seriousness of the call. They may also wish to attend the scene.

- Ask if they have a Medic Alert bracelet. If so, obtain their name from the bracelet and run the name. If there is a reference, connect with the contact person and inform them of the situation.

SECTION 3: MENTAL DISORDERS

Chapter 1 – Mental Illness

Psychological Labels

Mental illness is characterized by the inability to function in a normal situation. Confusion, distorted perception and altered memory are usual mental patterns of a person with a mental illness. A person who is experiencing difficulty coping temporarily is not considered to have a mental illness.

Abnormal behaviors are those actions taken by a person that are outside the expected range for a particular situation. In an emergency, normal people may behave abnormally.

Behavior Continuum

There is a behavior continuum between mental illness and abnormal behavior. There is no clear line drawn as to where one becomes the other.

Public safety communicators are required to deal with callers on the basis of the callers' behavior, with a focus on eliciting descriptions of what callers are doing or seeing, and *without* attempting to diagnose or attaching psychological labels to any caller. However, there is value in understanding the process for diagnosing those with mental illnesses. It provides a basis for communicators' awareness of potential reasons for behavior perceived as abnormal.

Classification System – Axis Definitions

Diagnosing mental illness is unlike the process of diagnosing physical afflictions, in that it must rely on secondary indicators of the illness. Often, change induced by a treatment is the only proof of the illness. Over the years a methodology has been developed to classify mental disorders. The current version of the system is contained in *Diagnostic and Statistical Manual of Mental Disorders 4ed (DSM IV)*.

Under the DSM IV methodology, the clinician collects information along five dimensions (Axis I to IV). On the basis of this total approach, a diagnosis is made. Cataloguing this information can provide others who may come in contact with the person/patient a clear understanding of the person's psychological condition and allow notations about changes in their condition to be made by using this data as a reference.

Axis I – Clinical Psychological Disorders: Behaviors that are not always in evidence. They occur periodically as episodes that disrupt the individual's regular pattern of behavior.

Axis II – Personality Disorders: Describes permanent characteristics of an individual distinct from any periodic problem they may be suffering with.

Axis III – General Medical Conditions: Describes any ongoing or incidental medical conditions.

Axis IV – Psychosocial and Environmental Stressors: Describes problems in the person's life that may have precipitated their problems

Axis V – Level of Functioning: Describes how well the person is functioning at work, in their family and in their relationships now, and over the previous year.

Caution about Psychological Labels

As indicated above, an elaborate and detailed process of assessment is required by a mental health professional to diagnose a person with a mental illness. The use of psychiatric terminology by lay people is not only inappropriate, but can be additionally problematic when used by emergency communicators. Labeling callers is likely to be inaccurate and can mislead those relying on accurate and complete information.

Public safety communicators come across – or receive reports about – persons who are behaving abnormally. Because their behavior might be described in a way that is associated with a psychopathology, it is tempting to use a psychiatric label as a form of shorthand.

Communicators must resist this tendency to diagnose or label individuals. Dealing with the incident on the basis of *behavior* provides a better chance to handle the situation successfully and reduces the problems that result from labeling individuals by either professional or

amateur diagnosis. In no case should records contain labels indicating diagnosis. Behavioral descriptions are more useful and reduce the chance of legal problems.

Chapter 2 – Psychological Disorders – Axis I

Clinical Disorders

Psychological disorders (Axis I) are relatively acute specific patterns of behavior that are not part of the sufferer's normal personality.

1. Psychoactive Substance Use Disorders

Psychoactive substance use disorders are the most common psychological disorders. The most common substance of abuse is alcohol. Approximately 50 per cent of all traffic accidents and domestic disputes in North America involve people who have been using alcohol. The degree of the overuse defines sub-categories of disorders involving substances.

Alcohol /Drug Dependent

Individuals who are dependent need alcohol or drugs to function. If they quit using the substance, they suddenly experience physical symptoms. In the case of alcohol, they may experience delirium tremens (DTs). In the case of heroin dependency, stopping abruptly can cause a shock to the system so traumatic that the person may die. In either case, the body is chemically dependent on the substance. Withdrawal is a painful process, and the individuals may require tremendous emotional and medical support to function without the substances.

Alcohol/Drug Abuse

Alcohol/drug abuse is characterized by periodic overuse of substances. While the behavior is not a function of dependency on the substance, the overuse may lead to associated problems, such as driving under the influence or violent behavior. Individuals may periodically overuse, but are not chemically dependent on the substance in that they are highly functional most of the time.

2. Anxiety Disorders

Anxiety disorder is the fear of nonexistent threats. The individual develops real symptoms (heart rate change, muscular contractions, and sweating, etc.), but the response seems out of proportion to the situation, or there is no apparent threat.

Phobias

Phobias are fears of situations or things. Some of the more common ones are :

- *Acrophobia* – fear of heights
- *Aviophobia* – fear of planes
- *Claustrophobia* – fear of closed places
- *Agoraphobia* – fear of open spaces

Panic Disorders

People with *panic disorders* find that certain places or things elicit a sudden onset of physical symptoms. At a gathering of a large number of people, a person might suddenly feel the need to leave. Individuals suffering from panic disorders can learn to avoid the problem by staying out of situations that might induce their panic reaction.

Obsessive-Compulsive Disorders

Obsessive-compulsive disorders describe the tendency of an individual to have a dominating thoughts and the repetition of behaviors. A person might have different focuses from time to time, but the pattern of dominating thoughts and repeated behaviors will be consistent. Some individuals have learned to cope without acting out the patterns.

A classic reported case is that of the Hollywood tycoon Howard Hughes. He was obsessed with dirt and felt that everything was dirty. Compulsively, he isolated himself in hotels to reduce the anxiety of meeting others and being infected by them.

3. Mood Disorders

Also referred to as the *affective* disorders, these conditions are classified as either *Major Depression* or *Bipolar Disorder*.

Major Depression

Beyond the type of sadness experienced by most people in both severity and duration, major depressions are deep and continual.

It is estimated that 20 per cent of the population at one time or another will have a bout of depression. Classic symptoms include feelings of worthlessness and finding no pleasure in things that previously gave them pleasure. These persons may be at high risk of suicide.

Bipolar Disorder or Manic Depression

Bipolar disorder or manic depression is characterized by radical mood swings.

All people experience emotional highs and lows. Individuals experiencing bipolar disorder, however, can oscillate between the extremes very rapidly and without apparent cause.

Symptoms of Bipolar Disorders

- *Speech Pressure:* The individual will talk all of the time, and shows lack of respect for other persons by constantly interrupting.
- *Lack of Reality Testing:* The individual will have grandiose ideas.
- *Mood Swings:* The individual may at one moment seem to be content and happy, then switch to being upset or angry.

Medications Used to Control Mood Disorders

Many people suffering from mood disorders have been prescribed prescription drugs to assist in the moderation of the disorder's effects. They are diverse, with a range of both positive and negative influences.

Antidepressants

Antidepressants are used to treat depression by elevating mood, increasing physical activity, improving appetite and restoring interest in life. These medications may also be used to treat phobias, obsessive disorders and panic attacks. The two types of antidepressants are called Cyclical Group and MAO Inhibitors.

Note: All antidepressants are toxic when taken in overdose.

Cyclical Group

- Common names include Elavil, Pertofrane, Prozac, Luvox, Surmontil, and Desyrel.
- The most common side effects are dry mouth, constipation, and blurred vision.

Monamine Oxidase Inhibitors (MAOs)

- Common names include Nardil, Parnate, and Manerix.

- These medications have similar side effects to the cyclical group. However, they may also produce ringing in the ears and sexual impotence.
- There are dietary restrictions for people taking MAOs. They need to refrain from red wine, street drugs, and fermented foods such as blue cheese to avoid reactions.
- Serious reactions to MAOs due to the violation of diet restrictions are the cause of a variety of 9-1-1 calls. Symptoms may include convulsions, and the inability to breathe.

Mood stabilizers – Antimanic

- Used for treatment of mania or great excitement and emotional distress.
- The most commonly described medication is lithium. Its negative side effects include weight gain, profound thirst, and acne.
- Other common antimanic drug names include Tegretol, Rivotril, and Tryptan.

Hypnotics/Sedatives and Anxiolytics

- Also referred to as the benzodiazepine group of medications, they are used to help calm the individual and relieve anxiety without causing excessive sedation or motor coordination. These medications are recommended for only short periods of use because they can become addictive.
- Common names are Ativan, Librium, Serax, Valium, Xanax, and Halcion.
- Commonly prescribed as sleeping pills, they may be lethal when taken in overdose. Side effects can include drowsiness, slurred speech, agitation, and chemical dependence.

Common Problems Observed with Mood Disorders

Public safety communicators come into contact with persons who are on medication for depression or a mood disorder. Problems may stem from not using, overusing, or reacting to these medications.

1. Individuals often believe they do not have a mental illness and see no reason why they should take the prescribed medicine.
2. They may be experiencing unpleasant side effects from the medication. This might make the individuals seem unfriendly and uncooperative.
3. The individual may feel well and not realize it is primarily due to the medication. They may decide to go off the medication, claiming they do not need it anymore.
4. Individuals may have a tough time coping with day to day realities without the appropriate support from their families or the community health system.
5. Individuals may be victimized in the inner city. They can be assaulted for their medication, or they may sell it, which could lead them into crisis.

4. Schizophrenia

Schizophrenia is the most severe mental disorder. A person with the condition may express extreme behaviors. Symptoms can range from total withdrawal to the expression of bizarre behavior due to hallucinations. Prior to the discovery of anti psychotic medications, schizophrenic individuals were segregated from society in institutions. These facilities were often dreadfully maintained, and the patients were subjected to neglect or radical physical treatments. The two most radical treatments, which gained much notoriety, were Electro Convulsive Therapy (ECT) and Frontal Lobotomies.

As our society has evolved to be more humanistic, individuals are not being kept in hospital for years. They may be released back into society on medication. Unfortunately, individuals are not necessarily afforded the necessary support in the community to help them maintain a socially acceptable level of functioning. As a consequence, many of them end up back in hospital or in jail following an episode.

The three most common types of schizophrenia are simple or undifferentiated, catatonic, and paranoid.

Simple or Undifferentiated

Simple or undifferentiated, the most common form of schizophrenia, afflicts approximately one per cent of the world's population. These

persons are unable to separate reality from fantasy. For example, the person could adopt the role of a character from a television show. Everything he or she does and says would be in the context of the character.

This condition has the best prognosis for being kept under control by medication because the symptoms are not severe and the person is not typically classified as dangerous.

Catatonic

The classic symptom of this disorder is the apparent disregard for parts of the body. Individuals in this state will sit for hours on end in contorted positions, not moving. They require constant supervision to protect them from abusing themselves. Prognosis for recovery in such cases is poor.

The movie *Awakenings* focused on this condition. In the movie, the patients were given an anti-Parkinson's medication called L-Dopa which caused a short-term remission of the disease. There is no treatment at this time with a proven long-term impact.

Paranoid

Paranoia is characterized by patients feeling they are the victims of elaborate plots against them. The plots usually involve authority figures such as the government or religious figures. They frequently report hearing voices, and hold conversations with the voices they hear. They can be agitated and are very unpredictable.

These individuals can carry on conversations about their perceived situations. Their schemes are so complete that they will be able to provide an answer for every contingency. Trying to rationalize with them is not an effective strategy.

An example is the March 1997 mass suicide in San Diego, USA, where the leader of a cult believed, and convinced his followers, that the world was coming to an end. They believed the only way to escape a grotesque death on earth was to commit suicide and let their spirits soar into the alien spaceship hiding in the vapor trail of a comet, waiting for them.

Psychiatric Emergencies

There is a difference between a *psychiatric emergency* and a *crisis-induced reaction*. A person who is triggered by a crisis situation and who is able to focus on that situation is having a crisis-induced reaction. The person who sees it all as a plot may be having a psychiatric emergency. This distinction may not be clear. You may need to talk for a while with a person before you can ascertain whether or not they need medical intervention, as well as investigating the event.

Psychiatric Emergency Signs and Symptoms

Hallucinations and Delusions

A major symptom of a psychiatric problem requiring treatment is the presence of hallucinations. It is important to know the distinction between a hallucination and a delusion.

A delusion is imagining something that is attainable, but not plausible. For example, having tea with Queen Elizabeth at Buckingham Palace is possible, but not likely for the average person. Delusions of grandeur are quite common in individuals with bipolar disorders.

Hallucinations are far more pervasive, fear generating, and debilitating to the sufferer than delusions. Hallucinations only exist for the individual and cannot be seen or heard by others.

The power of these experiences is that they come as sensory. Two types of hallucinations are *visual*, such as “little green men,” and *auditory*, involving voices or noises.

Word Salad

Some persons in a psychiatric emergency will be able to generate words, and appear to be telling a profound story. However, what they say does not make sense to the listener because their sentences are composed of random words and ideas. For example, “The car was on the road because the rooms in the hotel were full of life’s blood! I mean they were seriously ecstatic because the cat and Hitler were playing guitars in the vestibule but that was a warning that the blue sky was not going to fall on the cedar-shaked roof of my heart!”

Invented Words (Alogia)

Persons with a psychiatric emergency may invent words in an attempt to make a point. For example, “I am really mad at the government. I would like to *syndiasmianism* the whole lot of them!” If you hear a person who has called 9-1-1 talking with invented words, contact the local mental health team personnel immediately.

Communication Strategies for Psychiatric Emergencies

1. Keep the caller on the line. If they are on the phone, it is more difficult for them to hurt themselves.
2. Let the caller direct the conversation, no matter how bizarre they may sound to you. If they are hallucinating, trying to ground them in reality might cause them to hang up or lose control completely.
3. Determine their location and send help as soon as possible. Make sure back up is available. If they are alluding to plots against themselves, they will probably not react favorably to uniforms approaching them. Plain clothes or psychiatric response personnel might be more effective.
4. Check prior files under their name, address, or phone number. Check for any violent history on file.
5. If requested by units at the scene, phone the intake worker from Mental Health Services and check if the individual has ever had an intake into their system.

Chapter 3 – Personality Disorders – Axis II

Personality

Personality can be defined as a person's relatively stable individual characteristics. These characteristics include behaviors, attitudes and feelings that tend to predetermine how they will behave in particular situations. While these characteristics, or traits, appear stable, they are developed over time through the individual's life experience.

Personality Disorder

DSM IV recognizes that a person may not have a problem due to a mental illness, but may have a cluster of personality traits that may lead them into problems in their day-to-day life.

If a person is having problems functioning, they may have a personality disorder. They may be happy with their life, and not realize that their *idiosyncrasies* are causing or contributing to dysfunctionalities in their relationships. The DSM IV defines two types of personality disorders: basic and severe.

Basic Personality Disorders

Dependent Personality

Individuals with *dependent personality* disorders are characterized by being *submissive* to the needs and wants of other people, a philosophy, or a religion. They have a difficult time making decisions for themselves and will frequently seek more aggressive persons to take charge of their life. The potential for such persons being taken advantage of is high.

A classic example would be a young woman who is quite comfortable being married to a male who looks after all of the financial affairs. She also allows him to make all of the decisions regarding where the family will live and what they will do.

Quite often, even when someone with a dependent personality is requested to provide input into solving a problem, they usually will not offer an opinion. In therapy, they often state that they fear rejection and would rather agree than be left alone.

Histrionic Personality

Persons with *histrionic personality* are characterized as being **unsettled**. These persons become bored easily with a situation or event. They can be quite childish, undependable, and make flighty judgments. Their immature stimulus-seeking behavior usually leads them into difficulties.

An example is the young man from a family with an average or above average income, whose materialistic needs are well met, yet he steals cars when he is out with his friends on the weekend. When questioned about why he engaged in this behavior, he may say, “I did it just for the thrill of it!”.

Another example of this disorder is the runaway street kid who, unlike many others, has not experienced any form of physical, sexual, or emotional abuse, yet chooses to live on the streets in the rougher part of town.

Narcissistic Personality

Narcissistic personality is an **egotistic** pattern characterized by inflated self-esteem. A person with this personality disorder commonly exaggerates about his/her achievements and may demonstrate a limited social conscience. Daily small tasks quickly bore this type of person, who is underrepresented in jobs that are repetitive.

Antisocial Personality

Antisocial personality is the **aggressive** pattern of behavior that results in an affinity to self-reliance and a tough life style. These people can be prone to being confrontational, cruel, and danger-seeking. They may appear to be cold and calloused.

Persons with antisocial personality are described as being *manipulative*, and many are of above average intelligence. As the term *antisocial* implies, they do not require much external reward from relationships with other people, and can be very happy being loners.

When discussion focuses on the antisocial person, most of us tend to think of the hardened criminal. In actuality, few end up as criminals. In a competitive goal-oriented society, being self-supporting and aggressive in business and life can be quite functional.

The common use of the term *psychopath* is misleading. The people typically described as psychopaths – such as serial killers – have both an undiagnosed Axis I–Major Mental Disorder in addition to the more obvious Axis II–Antisocial Personality.

Severe Personality Disorders

Borderline Personality

Individuals with borderline personality disorder usually are not aware of having a problem. They usually function productively in society.

Persons with this diagnosis are characterized as being high-functioning on the surface, yet have major deficits in their personal lives and in the way they interact with other persons. They turn up for work each day and do a reasonably good job. However, when faced with criticism, they do not accept it. They will debate anything. If they do not have their way, they will act depressed, making sure others hear heavy sighs and see them dragging their feet.

They may lack affectionate relationships and often bounce from partner to partner. They lack the insight to realize their responsibility for relationship. They need to be in control and would rather be alone than have someone criticize them.

Borderline – Passive Aggressive Mixed Personality

Persons diagnosed with *borderline passive aggressive mixed personality* disorders display all the symptoms of borderline personality disorders, but with more intensity. Such persons are unpredictable, restless, irritable, and seem to complain about everything.

They are trapped by inclinations to *move towards, away from, or against others*. They can lash out and then beg for forgiveness, making short-lived promises to behave differently.

Paranoid Personality

Persons with *paranoid personality* disorder have the following personality characteristics:

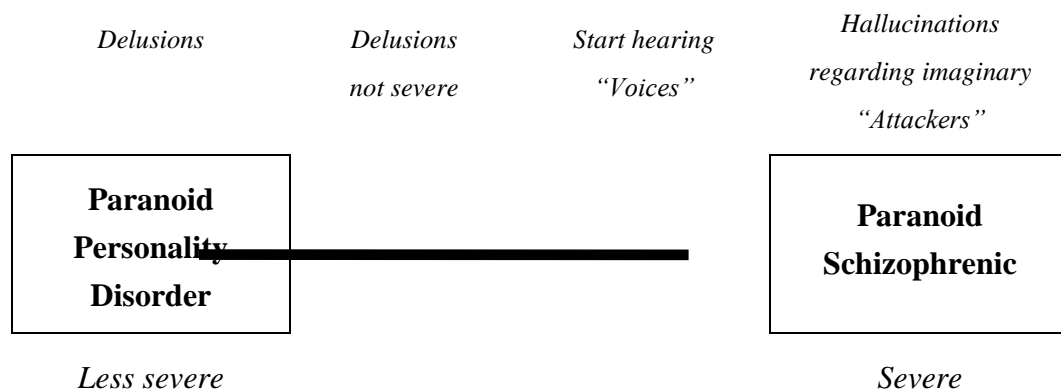
- Pervasive and unwarranted suspiciousness and mistrust
- Hypersensitive – feel that people are talking about them
- Restricted emotion on the positive side – very negative

- Strive tenaciously for autonomy – “No one is going to control me!”
- Hyper-vigilant when it comes to their own personal safety
- Always question the loyalty of others and expect trickery

This is the type of person who says that they will never venture onto the streets after dark, fearing an attack. They will take a lot of coaxing to get out. Should something happen by chance, like a car accident or a robbery, all of their suspicions will be confirmed and they will dwell on the incident forever.

Transition from Paranoid Personality to Paranoid Schizophrenia

Paranoids have delusions of plots against them. If the delusions are replaced by specific auditory or visual hallucinations, their diagnosis could change. The following graphic outlines a transition from Paranoid Personality to Paranoid Schizophrenia:



Schizotypal Personality Disorder – The Eccentric Pattern

Persons with this disorder are characterized as aloof and socially isolated, or bland and apathetic. These persons have minimal social attachments and do not join clubs or groups.

Their peculiar habits are perceived by the general population to be different and extreme. Public safety communicators may receive calls from concerned citizens phoning in about a person who fits this description. They may dress in fashions that are perceived as wild.

Schizotypals may have a history of social deficits. (They have had failures in marriage and failures in school, etc.) They may appear to be distant, daydreaming quite a bit. They may be the person you pass as you are walking down the street, who has a big smile on their face and glassy eyes. At the end of the continuum, they may have *mini*-episodes of psychoses presenting inappropriate moods and short breaks from reality.

Hospitalization vs Medication

Over the past 15 years, there has been a move to de-institutionalize persons with mental illnesses. This has been accomplished primarily by the widespread use of anti-psychotic medications.

However, the success of a patient released into the community depends upon the regular use of their medication and the help of community-based home support systems. Unfortunately, the costs of providing one-on-one support appears to be beyond what society is prepared to pay.

As a consequence, many of these persons appear to be in a rotating door between the hospitals and the community. When they lose control, they may end up coming to the attention of the Emergency Services System and need to be hospitalized to re-stabilize.

As a public safety communicator, you will have to dispatch units or ambulances to transport them to the hospital. It is important to know your own views on the process of de-institutionalization. What are your stereotypes of mental illness?

Consider the following:

- The impact on the community where the hospital is
- The impact on the community receiving the patients
- The impact on organized labor – loss of jobs at the hospital vs. creation of jobs in community
- The individual human rights of the patient – quality of life
- The cost of utilizing emergency services to help patients who lose control
- Public opinion – “Not in my Neighborhood!”
- Government deficits – practical use of public funds

- Public education

Chapter 4 – Related Medical Concerns – Axis III

Related medical concerns include a variety of differing abilities as well as the following states of mental dysfunction.

Dementia

As the Canadian baby-boomer population grows older, public safety agencies may expect more calls from people suffering from some form of memory loss. This might be due to the normal process of aging and reduction in the use of mental processes, or due to a form of dementia.

Dementia is a chronic and progressive decline in mental functioning. It consists of a cluster of symptoms characterized by both short- and long-term memory loss. There may also be resultant personality changes, loss of judgment, loss of abstract thinking abilities, and – importantly for public safety communicators – difficulty in understanding or using language.

Some forms of dementia are reversible, for example, those caused by infections, metabolic problems, drug overdoses, thyroid problems, or depression. Irreversible dementia may occur as a result of Alzheimer's disease, strokes, Huntington's disease, Multiple Sclerosis, Parkinson's disease, or advanced AIDS.

Alzheimer's Disease

Alzheimer's Disease is the most common form of dementia public safety communicators will encounter. There are frequent calls to report (or from) someone having *wandered off*.

As the most widely known disease leading to memory loss, Alzheimer's is currently the focus of much research to attempt to establish its cause and means of preventing it, retarding its progress, or establishing a cure. The following is known:

1. It is a brain disease, whose cause is still unknown. Factors to be considered and researched include genetics, environmental toxins, a virus, or chemical changes in the brain. Part of the problem in establishing cause is that the clinical behaviors named Alzheimer's are the result of multiple factors in various combinations.
2. It is not a part of the normal aging process. Old people do not automatically have clinically poor memory.

3. It is irreversible and grows progressively worse with time. It is not clear what treatments are effective in controlling it.

Symptoms vary in severity depending on the stage of the disease.

Alzheimer patients have problems with the following:

1. Remembering information: They may not remember their address or their date of birth.
2. Remembering friends and family: Men have called the police to report *a strange woman in my house* when they forget their wife of 60 years.
3. Use of language: On the phone it may sound like gibberish.
4. Finding their way around.
5. Losing sense of time, even to the degree they may not know when it is appropriate to eat or sleep.
6. Make poor decisions about safety: There have been robbery victims who have taken large amounts of cash out of the bank and made no attempts to conceal it.

Communication Strategies

It is important for public safety communicator to be aware of problems associated with Alzheimer's. In one instance, a female placed an emergency 9-1-1 call for an ambulance due to someone choking. She was given instructions to put the phone down to try clear the patient's airway with both hands. Every time she put the phone down, she forgot what she was required to do and would then come back on the phone more panicked than before. How you deal with the person affects how they will react.

- Be calm. Be patient.
- Ask simple questions requiring 'Yes' or 'No' or other short responses.
- If the caller's speech is poor, ask them politely to repeat what they have said or to use other words.
- If information is still unclear, send help ASAP.
- If you can ascertain their name, check for similar calls under their name.

- If there are previous calls, check to see whether or not calls were founded.
- If there are previous call files, check for any family members or next of kin indexed on the file. If so, give them a call because they may be able to verify the potential seriousness of the call. They may also wish to attend the scene.

Wandering

Many persons with *Alzheimer's disease* seem to be compelled to wander. Sometimes they roam aimlessly. This wandering can lead them into traffic, bad weather, or unsafe areas.

If the patient is lost and calls 9-1-1, or someone else reports a disoriented older person, send a car. Ask the police officers to check if the person is wearing a Medic Alert bracelet, which could verify that they are an Alzheimer's patient.

The *Alzheimer Wandering Persons Registry* is a joint program between the RCMP and Alzheimer's Society of Canada. The cost to register in the program is \$25 (1998). A person who is registered is given an ID bracelet and card, and their vital information is stored on the police database. It is designed to assist police officers in identifying and returning home those individuals suffering from Alzheimer's disease. If the person is found wandering or is reported missing, their personal information can be accessed by police anywhere in Canada. Alzheimer Canada can be reached at a toll free number: 1-800-616-8816.

Chapter 5 – Environmental Stressors and Level of Functioning

Environmental Stressors – Axis IV

Environmental stressors are the problems in a person's life that may have precipitated or contributed to their presenting problems.

Because prior conditions in any person's life can greatly influence their effectiveness in dealing with stress, part of the DSM IV diagnosis process is the assessment of those factors in a person's life that influence their life beyond normal clinical factors. Those stress factors imposed by their relationships, for example, or by their job and financial situation can reduce the effectiveness of their normal interactions.

Environmental stressors can range from mild to moderate to catastrophic.

- **MILD** stress may refer to the general day-to-day grind of getting up and going to work.
- **MODERATE** stress may be due to a relationship going poorly, or having children with behavior problems at home.
- **CATASTROPHIC** stress may be due to the death of a spouse, moving across the country, or being locked up in prison. For example, if you hate to move, researchers who developed DSM IV liken moving to being put in a concentration camp.

Level of Functioning – Axis V

Level of Functioning describes how the person is functioning at work, in their family, and in their relationships, now and over the last year.

A person's prognosis for recovery from a mental illness is tied closely to their level of functioning. As our work environment and family can have a major impact on our emotional well-being, it is important to know both how the person is doing within their family and their relationships and how they are doing at work, now and over the past year.

SECTION 4: CRITICAL INCIDENT STRESS

Chapter 1 – Sudden or Accidental Death

Sudden Death Calls to 9-1-1

Public safety communicators working for the ambulance service or the police can expect calls for service regarding sudden deaths in a number of situations.

Sudden death calls are often made first thing in the morning when elderly persons, who traditionally rise early, find their partner dead in the bed, the washroom, or on the couch. It is also a time when infants struck by Sudden Infant Death Syndrome (SIDS) may be discovered.

During snowstorms, individuals who are out of shape and attempt to clear away heavy wet snow, may die of heart attacks.

Sudden death calls also originate from the airport or local hotels when elderly people may die on their way home from holidays. For example, it is quite common for people from the Orient or Australia to have a stop-over in Vancouver on their way home from the east coast or Europe.

Accidental Death Calls to 9-1-1

Accidental death is the number one cause of death among people ranging in age from fifteen to thirty-four years old. This type of death is sudden, unexpected, and often also premature. A survivors who calls to report an accidental death may be in a traumatic set of circumstances and may be in shock, completely unprepared, and feel both deprived and vulnerable.

Poor road conditions contribute to car accidents that kill many people every year. Communicators in an area with a narrow or winding highway can expect many fatal head-on collisions. Many examples of such areas are found in mountainous regions of the country.

High school graduation parties may lead to accidental deaths due to reckless drinking and driving. In large cities, more accidental deaths

happen around *Welfare Wednesday* due to drug overdoses and/or acts of violence escalated by substance abuse.

Accidental deaths also happen on job sites in certain occupations. Some high-risk occupations are logging, mining and fishing, but death or injuries happen in other occupations as well.

Death Notification

Police officers and victim services workers are often tasked with the job of notifying the next of kin when a death has occurred.

Communicators should avoid inadvertently giving out such information over the phone. One of the important goals of the death notification is to make the news bearable. It is difficult to deliver such devastating news, but there is protocol to help the survivor receive the information in the least traumatic manner.

Standard Police Protocol During a Death Notification

The officer is involved in the bereavement or impact phase. Their role is to guide the recipient through that stage in a way that fosters full recovery. The officer needs to follow four important steps.

1. Information Gathering

The officer is responsible for obtaining clear, correct, concise information about the deceased and the survivor before attending.

The survivor will have lots of questions that, if answered completely, may provide some comfort. For example some common questions are *Was she conscious? Did he suffer? Did he ask for me? Why couldn't they resuscitate her?*

2. Control/Direction

The officer needs to gain entrance into the home, and should state clearly and deliberately the facts of the death in stages or doses, increasing the severity of statements until the ultimate fact is reached. The officer should take a leadership role at this time, for example, to suggest that other family members be contacted.

3. Assessment

Using verbal and non-verbal clues, the officer assesses the level of impact on the survivor. The officer should stay until the survivor appears in control.

4. Referral

The officer should then answer questions regarding funeral homes, coroner procedures, police investigations and court process.

Dealing with Sudden Death

Another way of looking at the process for dealing with loss is to consider the stages of the process. Note that some behaviors overlap from one phase to another. The value of this way of organizing the process is that it focuses on behaviors as seen by others.

1. Impact or shock and disbelief
2. Recoil or developing awareness
3. Reorganization or resolving the loss, adjustment and adaptation

It is important to note that the stages a survivor goes through are in fact the same as those experienced by the victim in a criminal act. However, the severity of the reactions at each stage sets this situation apart.

Impact Stage

Shock and disbelief are part of the impact stage, which is characterized by some or all of the following:

- Hysteria
- Failure to cope
- Distress
- Shock
- Confusion
- Self-accusation
- Denial of event
- Sense of failure
- Anger
- No emotion

This stage is commonly thought of as the crisis period and may last from several hours to several days.

Recoil Stage

Awareness of the situation is heightened. The recoil stage is characterized by:

- Stress
- Anger
- Disorientation
- Helplessness
- Depression
- Fatigue
- Insomnia
- Guilt
- Shame
- Coping

This stage may last for several months. The duration depends entirely on the individual.

Reorganization Stage

Resolution is evident. This is the recovery stage characterized by:

- Normal eating and sleeping patterns
- A return to the pre-incident state of normality
- Restructuring their life
- Resolution of the guilt
- Acceptance

This stage may persist from several months to years.

It is important to note that there are no clear-cut divisions between stages. The process needs to be considered as an emotional gradient on which people move back and forth until their grief is resolved. For example, between recoil and reorganization a person may be angry and have trouble sleeping one day, and the next allude to getting on with life.

Each individual will have their own path and timetable for getting through the process, which results in the inconsistencies often witnessed among family members dealing with the same loss. Those involved with people in the process of grieving should support them where they are, rather than trying to move them through a rigid sequence. It is important to be aware that often our drive for a “normal” process and timetable is a result of our needs, not theirs.

The Bereavement Process

Each individual coping with death or other major loss will experience the process in a personal and unique way. The stages of the grieving process are identified and described in a number of ways, but what is important for the communicator to realize is that all parts of the various stages are normal. People move through the grieving process in individual ways, though they rarely move smoothly from one stage to the next.

One breakdown of the process focuses on five stages. (Adapted from Kübler-Ross, 1969)

- Denial
- Anger
- Bargaining/Guilt
- Depression
- Acceptance

Denial

At this stage, the reality of the loss is rejected.

Anger

This stage typically includes expressed or repressed anger at the loss.

Bargaining/Guilt

“If I only had...” statements and thoughts typify this stage as the survivor tries to assume responsibility for the loss.

Depression

Sadness and withdrawal are typical behaviors in this mourning phase.

Acceptance

The final stage is when people start to put their lives back together, as they deal with life after their loss. This stage includes a focus on plans for the future.

Issues Impairing Emotional Recovery

Altered Family Structure

The whole family is affected when there is a death. At least five major factors can pose problems and present special burdens. They are:

- An increased level of stress within the family
- A chaotic environment
- The family's changed economic status
- The family's changed social status
- The changed roles within the family

Stress Level

When a family member dies, one of the obvious changes is the increased stress level within the family. This is often the result of one or more family members suppressing their own emotions, reasoning that if they show their anguish, they will evoke a similar response from another member. They are the ones who say, "The family needs to be strong; I have to hold it together!" Even though they have pure motives and truly believe this, they put strain on the weaker members to also hold up when it might be much healthier for the whole group to acknowledge their stress and anguish.

It is not unusual for a family member to feel his/her pain is more extreme than the others'. This may start a silent competition for being the *most bereaved*, which may result in increased tension and resentment in the family.

Chaos

A family that has been affected by various medical, social and substance abuse issues prior to the death may disintegrate into a state of chaos.

Such families are easily identified. Soon after the deaths, particularly if the dead person was the head of the family, the family will probably need to access outsiders for help. Child survivors who have lived through the turmoil report lasting memories of noise and disorganization. One described it as “the glue that held us together was gone and all that remained was commotion.” As an agency outside the family, public safety communicators can make practical suggestions and may link the survivors up with helping agencies, even though the survivors may seem reluctant at first.

Changed Economic and Social Status

If the dead person was a major provider for the family, the loss of their income could change the family’s economic position and the closely connected social status. The things survivors could do or buy before may no longer be attainable. The children may have to quit expensive sports, the mother who stayed home previously may have to go to work, and going out for dinner may become a rare event. The family may have to relocate, and may encounter persons of an economic status they are not used to. Being known as the “new kid” or the “new family” can diminish self esteem.

Role Changes

Sometimes when a family member who had a specific functional role dies, the missing role leaves a void. The survivors then assign the role to another member of the family. For example, the role of the father may be assumed by the eldest son, who may forfeit his own needs in order to help his mother. He may become increasingly stressed by his new inappropriate role, and younger family members may resent him for the added authority he now has.

Often in accidental deaths, a family member may unwittingly be made the scapegoat to satisfy the family’s need to blame someone for the situation. For example, a rebellious female teenager may be blamed for the death of her mother in a car crash. The family may blame her bad attitude for preoccupying and distracting the mother, resulting in the fatal car crash. It usually does not stop just with this one incident. The scapegoat may also be blamed for everything else that goes wrong in the family after the death. This person should be reassured that she is

not the reason for the distress in the family, but rather that the family dynamics are in turmoil because a key player is missing.

As child survivors of a parental death proceed through stages of development and gain maturity, they require additional information about the dead person. It is important to remember that children are curious, and that they need to know about the parent even if they are gone. Children do not stop grieving until they have fully developed. For example, a child who lost her mother at age 4 may recall lasting memories of mom being kind and fun to be around; at age 12, she may ask her father about her mother's school career; at age 16, she may ask about her mother's dating years.

The surviving parent in such cases should be encouraged to be open and honest and not to keep secrets as the child's development and grieving progresses.

Chapter 2 – Suicide Intervention

Some of the most difficult situations professional communicators have to deal with involve suicides or attempted suicides. Little can be done to prepare for being present at any death, and suicide calls are more difficult in that there is little warning, and having only the phone to work with does not allow for a great sense of control over the situation.

Suicide intervention is intervening in a life or death situation and by doing so giving hope to a potential suicide victim. A suicidal individual is not in a permanent state, and the thoughts of suicide can be changed.

Public safety communicators with a suicidal person on the phone must prepare for the possible implications of their part in the situation, regardless of whether the agency is police, fire, or ambulance. When intervening with a suicidal individual, communicators must be aware of risk factors, warning signs, questions to ask the caller, how to assess the risk and ways of providing safety. A communicator may not know some of the information about a specific caller, but needs to know that these risk factors exist.

Why?

People attempt or carry out suicide attempts for many reasons. Some of the key factors contributing to suicide include:

- Interpersonal conflict
- Financial problems
- Mental illness
- Inadequate support systems
- Personality variables
- Physical illness
- Loss
- Anger
- Substance abuse

Risk Factors

A variety of situations and times increase the chance of suicides or suicide attempts. These are sometimes based on the time of year or connected to individual or societal events.

- Easter, Thanksgiving, Christmas, New Years Day: the increased pressures of social interaction and on finances can lead some people to respond to their sense of hopelessness or guilt by taking their own life.
- End of the month: The lack of money at the end of a pay period or from welfare cheques can precipitate suicide.
- Anniversary of the death of a significant person such as Kurt Cobain, John Lennon, Martin Luther King, or other notable figures
- Job loss
- Loss of a companion
- Release from mental hospital or other institution
- *A suicide pact* with another person or persons
- Previous suicide attempts
- Recent traumatic loss (for example, a loved one may recently have committed suicide)
- Previous history of physical and/or sexual abuse, which may contribute to feelings of low self esteem and self blame
- Recent car accident or conflict with the law
- Chronic physical illness
- Increased isolation

Warning Signs

Some of the warning signs of a potential suicidal include:

- Talking or writing notes about suicide
- Direct or indirect statement about suicide (Example: Talks about wanting to die or wanting to go away)

- Increased use of alcohol and/or drugs (poor coping skills)
- Giving away personal things or possessions, making a will or saying good-byes
- Depression (Example: cries easily, sleep and appetite disturbances, lack of energy, weight gain, general loss of interest or pleasure in usual activities, difficulty in concentrating)
- Anxiety
- Feelings of hopelessness, helplessness or worthlessness
- Sudden changes in behavior or mood (Example: moodiness, recklessness, changes in sleeping or eating habits or a change from being talkative to being withdrawn)
- Feeling confused and overwhelmed and believing they are in a crisis that can never be resolved

Suicide is much more common than one might expect, with the average annual rate of suicide in Canada being 3500, or about 13 to 14 out of every 100,000 people.

Public safety communicators should be familiar with the warning signs of suicide, and must take all of them seriously.

Adult Victims

For most adult suicides, multiple and complex reasons lead to the final decision to act, when major stressors in the individual's life escalate in severity and/or increase in number. Some examples of escalation:

- Heavy workload: colleague becomes ill and workload increases
- Destructive relationship: child is injured in a car accident

Child Victims

Children have less experience and are more likely to see the world as black and white. Their repertoire of options is smaller. Death, while not totally understood, is seen as an option. Other factors for children include:

- High impulsivity due to lack of understanding of alternative strategies
- Physical abuse
- Emotional abuse, neglect and/or isolation
- Physical illness
- Relationship conflicts
- Personality variables (tendency to internalize or externalize pain)

Adolescent Victims

Teens are very susceptible to stimuli that lower their self-esteem.

- Relationship disappointments and rejection by peers
- Conflicts with parents
- Substance abuse
- Copy-cat suicides
- Inability to see hopeful outcome
- Career hopelessness

Suicide Profiles

Referred Suicide

Potential *referred suicides* regard themselves as failures, are concerned about what others think of them, feel they are not living up to others' expectations, and do not maintain relationships. Persons who fits this profile may still have a spark of hope, particularly if they make a call for help.

Surcease Suicide

A *surcease suicide* victim wishes to be released from pain. For example, an ALS patient may not want to endure long-term pain. There may still be hope in such cases.

Cultural Suicide

Some cultures adhere to the values that it is better to die than be dishonored, or that it is better to die than to tax the scarce resources of

the family. These are examples of cultural perspectives that tend to predispose people to end their lives voluntarily.

Psychotic Suicide

The psychotic profile fits a person who has a weak or unreliable connection to reality and who might see death as an option.

Subintentional Suicide

Some apparently accidental deaths in traffic or due to drug overdoses are in fact suicides. They are rarely recorded as such, but there is general agreement that the occurrences are considerable. Due to the circumstances, it is quite difficult to determine if there was conscious or unconscious intent.

When the Call Comes to 9-1-1

Some of these above profiles are easier to deal with and may result in stopping the suicide attempt. The *surcease* and *referred* suicide calls are most positive because there is still hope. Public safety communicators have the chance to be able to talk such callers out of attempting suicide. Techniques include asking them questions about their life, attempting to build up their sense of self-worth, and so on. There is a chance with such callers.

The most difficult profiles of potential suicides are the *cultural* and the *subintentional* because they rarely call for help. Calls about such suicides typically report slashed wrists or a gun shot to the head (cultural) or a single vehicle fatal MVA (subintentional).

Psychotic persons threatening to kill themselves will test communicators' wits and patience. The most profound aspect of such calls will be the sudden mood swings between happy laughter and periods of crying and put-downs. Communicators have **no** predictive power with psychotic persons. The most useful action is to keep the caller on the phone as long as possible, in the hope that the emergency response people arrive while the caller is still on the phone.

Suicide Calls

Suicide calls take several forms and offer different challenges for the communicator. Calls come from

- someone who is trying to kill themselves or threatening to,

- someone who has found a person dead or nearly dead, or
- someone who has received a call from a friend who is trying to kill themselves.

Establish the caller's motive for calling. Are they doing it to themselves? Or are they reporting it only? Can you fully understand what they are doing? Seek clarification. Before you can stop someone from carrying out a threat of fatal violence against themselves, you must first understand the meaning behind their act.

When a communicator suspects they may be dealing with a suicidal individual, the first step is to establish rapport with the caller. If the caller does not trust the communicator, they probably will not tell him/her anything that will be beneficial in assisting them. It is important to listen to the caller.

- ***The number one priority is to maintain contact with the person until help has arrived at the source of the call.*** It is essential to keep the caller on the phone. If it is necessary to make small talk or promise them things which are unrealistic, do it.

The communicator must stay in control, and not let the caller go on and on, but at the same time must give them a chance to talk. You must be able to ask the caller questions about suicide. You will need information, so be prepared to ask questions. For examples, if a caller says he or she has just taken a whole bottle of Tylenol, you may start with:

- What is your name?
- Where are you?
- Are you alone?
- What strength were the Tylenol?
- One of the first priorities with suicide calls is to help ground the person in reality. The communicator is there to help such callers by trying to talk them out of committing suicide.

Things look hopeless to suicidal persons, but calls from them tells you they are looking for solutions to their problems. Suicidal individuals

may not be totally committed to dying, only part of them wants to die. Someone who is suicidal just wants their pain to go away and suicide seems to them to be the best way to make that happen.

Provide Safety

A major part of a communicator's job is to ensure the caller's safety. When dealing with a suicidal individual, the major concern for call takers is to use their knowledge and training in detecting when a caller may be suicidal, and responding to the call appropriately. The goal is to help the suicidal person get help for themselves and their problems without killing themselves. Establishing rapport and providing support is a good start. All suicidal callers need help, regardless of whether they are in a high, medium, and low risk group.

Listen carefully to the caller, and talk about feelings of suicide openly and frankly with the caller. Be objective to the caller, but also show concern and understanding. Keep reassuring the caller that they are not alone that you want to help. It is important to stay on the line until help arrives.

When taking a call from a potentially suicidal individual,

- suspend judgmental attitudes,
- listen to what the caller is telling you, and
- get help immediately.

Let the caller know they are not alone, and continually tell them there are other options than suicide. Try to help them focus on their strengths rather than on their weaknesses. Think about and plan how to keep the caller on the phone talking to you until help arrives.

Survivors of a Suicide Victim

It is usually a close family member, personal friend or employees who finds the suicide victim and who calls to report the suicide. The victim is often found first thing in the morning or between 1500 and 1800 hrs when people are coming home from work.

A communicator who receives a call from a survivor of a suicide victim will attempt to support the caller emotionally until help arrives, or if the victim is still alive, to help him/her provide emergency first aid to the

victim. Unfortunately, many people who call in suicides or suicide attempts are too shocked to be of much assistance.

The death of someone you care about is a heart-shattering blow, no matter how much preparation is done, but survivors of someone who commits suicide have had no opportunity for preparatory grieving. Everything is left unresolved and unsettled, and questions are left unanswered. Local or regional victim assistance services provide important back-up support for such victims.

Chapter 3 – Critical Incident Stress

Critical Incidents

A *Critical Incident* can be defined as any situation faced by individuals that causes them to experience unusually strong emotional reactions, and that has the potential to interfere with their ability to function either at the time of the incident or at a later time.

Critical Incident Stress (CIS)

Critical Incident Stress (CIS) is defined as the stress that occurs from dealing with these types of unusually distressing events. The emotional, physical, and cognitive reactions to a critical incident can lead to reduced performance, social stress, personality changes, and a variety of other problems. CIS reactions are incident specific, and may be either acute or delayed. An acute reaction would normally begin while the person is still involved with the incident, whereas delayed reactions may begin minutes, hours, days, even weeks or months after the event.

Causes of Critical Incident Stress

Emergency personnel are thought by many people to be unaffected by the traumatic conditions they quite often encounter. This is a myth. No amount or type of training can prepare emergency personnel for some of the situations they encounter during their careers, though they learn to suppress emotional reactions while doing their jobs.

Two factors influence a possible reaction of critical incident stress. The first is the general emotional state of the individual at the time of the incident. This is influenced by the individual's emotional and physical health, previous experience with handling stress, and how they have prepared themselves for the stressor incident prior to its occurrence. The second factor is the nature of the event that precipitates the stress reaction, and the role the individual plays in the crisis.

Events that can precipitate critical stress include, but are not limited to, the following:

- Death or injury of co-worker
- Death of a child, especially under unusual circumstances such as neglect or abuse
- Death of a person, caused by personnel

- Knowing a victim or seeing a resemblance to someone you know
- Unusual sights, sounds, or smells
- A serious incident extending over a long period of time
- Incident with profound emotion
- Incident with significant media attention
- Threatening situation such as shootings, hostage taking, storms, explosives
- Major incidents with multiple casualties and/or where triage is required

Note: The above list relates to professionals who work in emergency services or health care professions. For the general public or others less exposed to traumatic events, any shocking incident could result in critical incident stress.

Reaction Severity

While each person reacts in an individualistic way, some of the factors that affect the severity of the reaction are:

- Severity and nature of the event or incident
- Involvement of individual, and degree to which they are connected emotionally to what happened
- Level of responsibility associated with the incident (The greater the responsibility, the greater the potential for increased stress and guilt feelings)
- Physical and psychological proximity of the event (next door, or involve friends/associates)
- Individual's previous experience with personal crisis: could help through desensitization, or hinder through cumulative stress
- Worker's life situation at the time: e.g., divorce, death, or job pressures all increase the impact of stress and reduce one's coping ability

- Behavior of others at the incident: effective, or ineffective
- Availability of appropriate support services, such as counselors, or peer debriefers
- Degree of support by colleagues, family or general public
- Media involvement
- Management's attitude towards and knowledge about traumatic stress
- Personal involvement or identification with the victim(s)

Immediate Reactions to Critical Incident Stress

The symptoms of CIS exist in various combinations and are observable to various degrees. Their duration depends on the effectiveness of the intrapersonal and interpersonal processes that occur.

Physical

- Appetite increased or decreased
- Agitation and pacing
- Disorientation and loss of coordination
- Disturbed sleep
- Heart rate and blood pressure increase
- Hyperventilation, chest pains, headaches
- Jumpiness and startle reactions
- Muscle soreness and fatigue
- Nausea, upset stomach, sweating and profuse tremors
- Overwhelming sense of fatigue

Cognitive

- Flashbacks, replaying of the event
- Impaired thinking and decision-making
- Memory and concentration problems
- Poor attention span

- Preoccupation with the event
- Time distortion and perception alteration

Emotional

- Anger, resentment and scapegoating
- Anxiety, guilt and fear
- Grief and depression
- Fear of repetition of the event
- Feeling lost, abandoned and helpless
- Feeling numb, shocked and overwhelmed
- Lack of trust or security
- Loss of interest in something previously enjoyed
- Morbid sense of humor
- Withdrawal, irritability or anger

Delayed Stress Response Syndrome

Delayed CIS reactions may not show up until sometime after the incident. These responses may be identified through increased irritability, or feelings of depression and anxiety, and are characteristics of a condition known as *Delayed Stress Response Syndrome*. This condition can cause both physical (health disorders, isolation, inability to work) and emotional responses (hostility, difficulty forming or maintaining relationships, anxiety states and depression).

Reactions to CIS

Reactions to CIS include a variety of symptoms:

- Overwhelming sense of fatigue: The body and mind are using the available energy to deal with the event. This is normal.
- Disturbed sleep or inability to sleep: The mind is using this item for processing the experience.
- Appetite increased or decreased: depends on the role food plays for an individual.

- Flashbacks: replaying the event whenever one experiences any stimulus associated with the event. These stimuli, or triggers, may be conscious or subconscious and may be sights, sounds, smells or touch. The purpose of the replays is to enable one to organize and process the event.
- Preoccupation with the event, as the mind tries to assimilate it. This preoccupation may cause:
 - withdrawal, irritability or anger,
 - loss of ability to focus or concentrate on other things, or
 - loss of confidence in decision-making ability.

Recovery Process

Trauma can cause post-incident symptoms in anyone. Intrusive imagery, numbing, rage, grief, etc. are all normal. It is our way of dealing with *abnormal* stressors. It is normal to fear losing control post-incident and succumbing to rage, fear, etc. Symptoms usually worsen before they get better. It is more effective to work through the emotions than to block them.

Individuals recovering from post-incident stress do well to abstain from alcohol or drugs, to eat nutritionally, and to exercise. They may want to assess their chosen work and vocational path. Most importantly, it takes time to heal.

Early professional help may be needed to recover from *critical incident stress*, as postponing talking about the incident makes recovery more difficult. Seeking support from friends and family is important. Sudden recall of past traumas (feelings, images, dreams) may be triggered by something in a communicator's current life that needs attention (stress, loss, fear, anger).

Some trauma survivors experience symptoms years or even decades after an incident. Some symptoms never go away. There are both positive and negative events that we literally never completely forget. What matters is that the symptoms don't interfere with normal functioning. Some good can come from any trauma. This includes hope, strength, learning, goals and growth. Looking for and finding the good has a healing effect.

Chapter 4 – Critical Incident Stress Debriefings

Critical Incident Stress Debriefing

Stress can be positive. It helps us to be motivated, productive, and creative. Without stress, there would be no change, growth, or productivity. When *critical incident stress* is encountered, all the coping skills or strategies may not be enough to enable someone to deal with the emotions they are feeling (guilt, frustration, helplessness, blaming themselves for people's injuries or death) as a result of a critical incident.

For a Critical Incident Stress Debriefing (CISD) to be held, the incident will be a major one in terms of the duration or number of people involved, and it will have had a high degree of impact on those involved. Only the personnel who were **directly** involved in the case are eligible to attend. This would include the personnel who responded to the scene, and the dispatchers and/or call takers involved. Each emergency service debriefs its own people. For example, following a major plane crash, the police, fire, and ambulance would have separate debriefings for their people.

The CISD should occur between 24 and 72 hours after the incident, and usually lasts upwards of three hours. The debriefing has two goals,

- to reduce the impact of a critical incident, and
- to accelerate the recovery of personnel after the traumatic event.

A CISD provides opportunities to discuss how the situation has affected the emotions of those persons mandated to be at the scene, and is not to uncover procedural or technical mistakes, either individual or systemic.

Who Conducts the Debriefing?

A *critical incident stress debriefing* is a meeting between two groups, the CISD team and the participants, those people who were involved in the critical incident. The CISD team is a partnership of mental health professionals and peer support personnel from the police, fire, and other emergency services. A CISD team may have between twenty and forty members, up to one-third of these being mental health professionals, and the rest being peer support personnel. From this team, four members are drawn to provide a debriefing when one is

deemed necessary. The goals of the CISD team are to prepare emergency personnel to manage their job-related stress, and to assist emergency personnel experiencing negative effects of stress after exposure to an unusually stressful event.

- The debriefing is typically conducted by a trained leader from the same service being debriefed. They will have received *employee assistance* training. The leader will be backed up by a licenced clinician (a psychologist, for example.). The leader must ensure that a supportive environment is provided for individuals, and that they have opportunities to start dealing with their reactions to the incident.

CISD Process

The debriefing is a structured group meeting which:

- emphasizes ventilation of emotions;
- is designed to put a bad situation into perspective;
- allows participants the opportunity to explore their own feelings, understand others' reactions, and realize that reactions are part of the normal healing process;
- eliminates feelings of isolation, or that someone is going through it alone;
- reviews ways of managing stress, and
- is not an evaluation of performance.

All of the involved persons will be requested to meet at a particular time and place. They will be requested to leave their pagers and cellular phones at the door. Each person will be given a chance to introduce themselves and to discuss what they saw, smelled, heard, etc. and how it impacted them. They are not to be interrupted. Each person is encouraged to talk, but if they do not wish to say much, they are not forced.

The process of a *critical incident stress debriefing* can be broken down into seven phases.

1. Introduction

During this phase the team leader gradually introduces the debriefing process, encourages participation by the group members, and sets out the ground rules for the debriefing. Participants are told about confidentiality, that they are not required to speak but are encouraged to discuss the event, and they are informed that they should not speak for others, only themselves. They are also made aware that in the debriefing, all personnel are equal, there is no rank, and that the session is not meant to be a critique of the event.

2. The Fact Phase

In this phase, the event is recreated through the perspectives of the participants, and their individual roles (jobs) during the event are also discussed.

3. The Thought Phase

Participants discuss what their thoughts were during the stressful event.

4. The Reaction Phase

This phase is designed to move the group members from the cognitive level of intellectual processing into the emotional level of processing. The emotional level is what we feel, and should not be ignored. The CISD encourages members to function on both the cognitive and emotional level, and most groups come out of this phase believing that it is okay for them to have emotions about an experience, as well as thoughts.

5. The Symptom Phase

In this stage, the participants are asked to describe their cognitive, physical, emotional, and behavioral signs and symptoms or signals of distress that

- appeared at the scene or within a 24 hour period,
- appeared a few days after the event, and/or
- are still being experienced at the time of the debriefing.

This stage also begins movement back toward cognitive processing.

6. The Teaching Phase

The objective of this phase is to provide participants with as much information as they need to overcome their stress. CISD team members relay information about stress reactions and what can be done to alleviate them. Participants are assured that the reactions they have encountered are normal, and that they should begin to subside with time. Where possible, specific instructions for stress reduction are given.

7. The Re-entry Phase

Otherwise known as the *wrap-up* phase, this is the time when the CISD team members are required to make a summary statement to the group. Handouts with team members' phone numbers should be distributed.

After CISD

After the debriefing is over, the team members must themselves meet to discuss the debriefing that just ended. They critique their performance and handling of the debriefing, and give credit to each other. They need to talk about how the debriefing affected them, and get their emotions out in the open before they go home and perhaps find themselves feeling depressed. The debriefers also need support and get it from one another.

Critical incident stress debriefings should not be used after every critical event, lest they lose their effectiveness. The coping skills participants learn should be continually applied and practised to assist in managing their stress and maintaining control over their lives.

Working through CIS

Traumatic stress tests one's coping mechanisms to the limit. Because of the impact on the psychological system, a variety of coping mechanisms emerge, some healthy, some not so healthy. Overcoming traumatic stress is more of a process than an event, and takes time. The following suggestions are helpful for communicators considering how to manage their post-trauma.

Expect the Incident to Bother You

Take comfort in knowing that the incident will not bother you forever. Though you may never completely forget many incidents, their recall

does not have to cause emotional distress. Your goal should be to heal, not to totally forget the incident. You know you are healed when you are able to think of or talk about the incident without profound emotion.

Eat Well and Maintain Physical Activity

Diet is an important factor in reducing the negative effects of stress. Even though you may not feel hungry, maintaining a healthy diet is essential. Similarly, physical activity is important. Some experts indicate that a good workout is useful within a day or so of a traumatic incident. In any case, regular physical activity patterns should be maintained, whether it is tennis, a run or walking.

Use of alcohol and other drugs tends to suppress symptoms and reduce the ability to deal with the stress emotionally and cognitively. Overuse leaves the body with the original problem as well as after-effects of alcohol or drugs.

Take Time for Fun

Use of alcohol and other drugs tends to suppress symptoms and reduce the ability to emotionally and cognitively deal with the stress. Overuse leaves the body with the original problem as well as after-effects of alcohol or drugs.

Social Support is a Good Thing

This might mean discussions with a colleague or friend, or professional support. If you find the incident is staying with you longer than it should, seek individual counseling. Trained professionals can help you deal with unresolved issues.

Assess Your Work Situation

If you are traumatized by an incident, it may be necessary to take time off from work. Working while being emotionally vulnerable puts you at more risk for an acute stress reaction. On the other hand, work may provide a focus that reduces your tendency to reflect on the traumatic incident. Assess your situation carefully. If you feel ready for action, return to work. If you feel vulnerable, request time off.

Retrain

If your traumatic incident was related to your work performance, you may feel a sense of guilt: *If only I could have ...* In most cases, the *if*

onlys are inappropriate. You probably made the best decision or performed the best procedures under the circumstances. On the other hand, the stress of the situation may have revealed the need for improved procedures and/or techniques, or increased familiarity with tools or equipment.

If you feel that you need to retrain, talk out your concerns with a third party to get a perspective on the validity of your perception. Do not use off-duty time for retraining immediately after the incident. Non-work activities will be more effective in dealing with the CIS.

Stay Connected to Family, Friends and Co-Workers.

Often people react to psychological trauma by keeping it inside. Trauma may be so great that life seems meaningless. By withdrawing, you cause the incident to become larger than life. By remaining involved with others you:

- prevent yourself from becoming obsessed with the incident,
- discover that, though this incident was traumatic, life does go on, and
- ultimately end up talking out the incident and working it through.

Learn or Relearn About CIS

You need facts about what you are going through. By reading up on CIS, you will see that your reactions are normal.

Cumulative Stress

Another type of stress response is *cumulative stress*, and unlike CIS reactions, it is not event-specific. Rather, it is contributed to by factors other than work, such as home-life, and is caused by too many stressful events over time. Cumulative stress is more commonly known as *burnout*. Someone who is too involved in their work, or suffered a critical incident and never dealt with it, may be a candidate for burnout. Symptoms of burnout include:

- depression, fatigue, irritability
- feelings of apathy
- work problems

- reclusive behavior
- cynical or negative attitude
- defensiveness
- increased illness
- energy loss

SECTION 5: POLICY AND LEGAL CHANGE

Chapter 1 – Impact of Public Groups for Social Change

Generation of New Laws

The evolution of past and present laws has often been initiated by some tragedy or series of events that caused a social concern. In other words, our law making process tends to be reactionary.

Before Clifford Olson, the issue of dangerous offenders was a political non-issue. Basically, all *dangerous offenders* (mass murderers and the like) were put to death via the death penalty. Clifford Olson was the first extremely dangerous offender to escape such a fate, as he was brought to trial after the death sentence was removed from the criminal code. The government was faced with the problem that he, or others like him, could actually get out of jail after serving their 25-year sentence. Releasing him, or offenders like him, would not be in the best interest of the public, and so a new law, which enabled society to lock up dangerous repeat offenders indefinitely, was developed.

However, the legislation did not appear overnight. The process is not as simple as outlined above. There are many issues to consider before a law can be written.

- Does the problem affect everyone? Is there a strong common will to have the problem looked at? Home invasions is a good example of such a problem.
- Has a catastrophic event been linked to the problem? For example, three old people were recently murdered following home invasions.
- Are there political ramifications? Is a political party willing to go out on a limb to bring the problem into the spotlight? Are there interest groups whose rights or status may be affected by a

law? For example, Home Invasions in the Asian Community would be considered a specific law regarded as discriminatory.

- Which side of the story is the media covering? Is the media presenting all the facts?
- What will the costs associated with the new law be? How will it be implemented? How will the SOPs of the various agencies be effected?
- Will the law be delayed by a long, heated political debate?

Media Influence on Public Opinion

The way in which an event is presented in the media varies from radio station to radio station, paper to paper, TV station to TV station, from city to city, from province to province, and so on. Why is this? Are the facts not the same regardless of who is covering the story?

Reporters are people. We can all look at the same thing, yet see it in many different ways. Reporters may look at an event from a particular ideological point of view. For example, a reporter, whose views are right wing, covering a logging protest may label the protesters *unemployed tree huggers*, whereas a left-leaning reporter may describe them as *champions of a better environment*. The same event may be presented from a number of different viewpoints. The editorial policy of each news media may direct the slant of the story. The reporters and their editors may be motivated by ratings, and the way they cover a story may be based on sensationalism. For example, some news media may show the blood on the ground at the scene of major car accidents, while the important issue behind the car crash is drunk drivers and speed. News media generally give their viewers/readers what the majority of them want, and may follow various ethical standards. On the other hand, viewers/readers choose the media they are the most comfortable with, and that generally represent their own views.

Effects of Opinions

Lawmakers are affected by opinions. They see and hear the same things the general public does in the media, and they are affected by the opinion of the public. Opportunistically, they may embark on a course of action based on the recommendations of a reporter covering a story.

A classic story from British Columbia is the *Conflict of Interest Laws* in effect for our politicians. In one situation, public opinion was stacked against the Premier after a reporter uncovered that the Premier's wife received a cash gift from a foreign investor. The press covered it as long as there was public interest until the entire affair ended with the resignation of the Premier and new laws being introduced. What if the motivation to tell the story about the Premier was based not upon whether or not the behavior was wrong, but rather that the media or their customers simply disliked the Premier?

Another example of this phenomenon in this century was the campaign launched by the American media against the Government of the United States during the Vietnam War. The media continued to show the atrocities committed by the Americans and showed images of traumatized Vietnamese people. Experts have argued that the war was not lost in the battlefields, but rather back home on the television sets of the nation. Public opinion was altered in part by the media coverage as the public was *traumatized* by what they saw and demanded change through mass protest. At the same time, much of the media coverage was driven by grassroots organizations who demanded that the atrocities be uncovered.

It is not likely that the Allies during WW II would have been able to get away with their bombing of civilian targets in Germany if there had been television coverage like we have today. However, during the recent Middle East Gulf war, the media was kept on a very tight leash and not given information they would have passed on to their viewers. It has taken many years to discover that UN troops were exposed to nerve gas attacks that they did not know about, and that the media were kept from learning about. Much later, after veterans had been suffering from Gulf War Syndrome for years, the probable cause from the nerve gas attacks has surfaced. There is a delicate balance between dictatorial control and freedom of the press.

Vicarious Traumatization

The term *vicarious traumatization* became a buzzword within the psychology community in the late 1980s. It refers to the potential negative effect on a person's emotional well-being of seeing violence

or hearing about it. We can be indirectly victimized by violence we have witnessed though we have not experienced it personally.

Public safety communicators may be *victims* of vicarious traumatization. In large urban centres, there are fatal car crashes almost daily, there are knifings and violent assaults against women, there is child abuse, and other dangerous situations in which the police officers dispatched by communicators are in danger.

- How will you deal with this?
- Do you think your attitudes will change about the world?
- Will you perceive it as a violent, horrible place? Will you lose your trust in human beings?
- Will you be able to turn on the TV evening news after working a busy weekend shift?
- What if you have flashbacks to a serious situation every time you watch a police show on TV?

Vicarious traumatization is a slow gradual process. Communicators hear about horrible things on the news, horrible things over the radio at work, and are surrounded by colleagues who may be negative. Words like *cynical* and *burned-out* may be commonly used to describe communication centre personnel.

One can avoid vicarious traumatization by turning off the TV, but communicators who are mandated and paid well to be at their work stations cannot easily turn off the radio. They have to learn how to cope.

They have to be able to debrief themselves physically and emotionally. It is helpful to get lots of vigorous exercise and actively to seek someone to talk to about the traumatic events, as is attending the critical incident stress debriefings offered by the organization.

Public Lobby Groups

Vicarious traumatization can be turned into something positive as well. When something terrible happens, like the murder of a young woman by an offender out of jail on a day-pass, many people are shocked and upset emotionally by the event. Rather than saying “Oh well, what

could we do ...,” some persons turn their trauma into action. They may form a lobby group, a collective of persons who try to get the attention of politicians to facilitate change in a law or practice.

Groups like CAVEAT and CRY are political lobby groups advocating for profound change to the adult parole system and the Young Offenders Act. These groups are fueled and funded by public opinion, and have endured because they are well organized.

Many other grass-roots lobby groups are challenging the laws of Canada with regards to environmental protection and the status of women and children. There are also groups dedicated to preserving the status quo, such as the *gun lobby*.

Value of Belonging

Individuals who get informed about issues and get involved are important to a democratic society like Canada's. There are many grass-roots organizations dedicated to making change around issues like clear-cut logging, youth crime, or the continued violence against women. Communicators who are revolted by what they see and experience both in their line of work and outside it, and who get involved in working for social change, may be better able to survive the vicarious trauma they experience.

Chapter 2 – Policy Changes as a Result of Inquests

Coroner's Inquests

The Coroner is the public official who holds inquests into the events and facts surrounding violent or suspicious deaths. When such deaths occur, the police are responsible for uncovering the facts regarding what happened at the time of the specific incident, and making decisions about arrest and the laying of charges. However, they are not responsible for looking into all facets of the case leading up to and through the handling of the incident. For example, if the current system for acquiring firearms appears to be flawed, it is not the job of the police to point this out. The police are only concerned with the *criminal* incident. Finding out where the system has broken down, or uncovering who may have been negligent, falls under the jurisdiction of the Coroner's Office.

Inquests are initiated at the discretion of the Coroner. The Coroner is charged with examining all relevant facts regarding what went wrong, and with making recommendations about what needs to be changed to avoid similar occurrences in the future. The recommendations may have political ramifications, and their publication is often the focus of considerable public debate.

Role of Inquests on Legal and Policy Change

In 1996, in Vernon, B.C., the mass murder of the *Gakhal* family followed by the suicide of the killer *Chahal* shocked and appalled the community, which struggled for answers about how and why this type of thing could happen in their community. The Coroner's Office was under tremendous pressure to provide reasons why this case ended the way it did.

The report of the inquest provided extensive detail on events leading up to the tragedy and made comprehensive recommendations about the investigation of family abuse, procedures for maintaining police files, and the issuance of permission to possess firearms.

November 6, 1996

Case No. 96-585-0031

Coroner's Court of British Columbia

HELD AT Vernon B.C.

**FINDINGS and RECOMMENDATIONS as a RESULT of the
INQUEST**

Into The Death of GAKHAL, Karnail, et al

SUMMARY OF CIRCUMSTANCES SURROUNDING DEATHS

An inquest at Vernon, British Columbia was held from September 23 through September 27, 1996 into the deaths of the following:

Karnail Singh GAKHAL	Khalvinder Kaur GAKHAL
Balvinder Kaur GAKHAL	Jasbir Kaur SARAN
Jaspal Singh GAKHAL	Darshan Kaur GAKHAL
Harvinder Kaur GAKHAL	Rajwar Kaur CHAHAL
Baljit Singh SARAN	Mark CHAHAL

This Summary applies to each of those ten deaths. It is not intended to be a balanced review of all of the evidence elicited at the inquest but rather directed more at the concerns that came to light and from which ultimately recommendations were made by the jury. Much of what I say will be my interpretation of the evidence. The sole purpose for this is to assist the reader to more fully understand the verdict and the background on which the jurors' recommendations were made. It must in no way be considered as actual evidence presented at the inquest nor in any way be interpreted to replace the jury's findings and recommendations.

Background

April 5th of this year was a tragic day in the life of the community of Vernon. At 10:30 a.m. a 9-1-1 call came in to the police department concerning gunshots. Police went to the scene which was the residence of Kurnail Gakhal, The Gakhal and Saran families were at the residence preparing for the wedding of the Gakhal's youngest daughter. Police found most members of both families dead when they arrived. Others died later that day at the hospital. Nine in all, died that day – all from gunshot wounds administered by Mark Chahal, the estranged

husband of one of the deceased, Rajwar Chahal. Mark Chahal returned to the hotel in which he was staying and, leaving a suicide note, turned a gun on himself and took his own life.

Several years before these events occurred Hardam Adjula from Vernon was on a business trip to Williams Lake where he made contact with the Chahal family. That contact was the initiating point of an arranged marriage between Mark Chahal and Rajwar Gakhal which took place in April of 1994. At the time of the marriage Mark was an accountant working in Burnaby; Rajwar was a dental hygienist in Vernon. They established their new home in Burnaby.

It now appears that from the onset that this marriage was not a happy one. The marriage lasted less than nine months. On about December 23rd Mark and Rajwar visited her sister Jasbir and Roger Saran in a nearby community. Other members of the Gakhal family were there and rather than being a social affair as Mark had anticipated it turned out to be an occasion in which Mark was brought to task for conduct that bespoke of spousal abuse over the course of the marriage. The following day Mark got a call from the Gakhal family advising that they wanted to see him on Christmas day. They arrived, but rather than being a conciliatory visit, the allegations continued from Kurnail Gakhal (Rajwar's father) while other members of the family assisted Rajwar in removing her belongings.

Both Mark and Rajwar had worked prior to their marriage and came into it with substantial assets. Mark became the manager of these and they were divided into three groups, His, Hers and Theirs. On December 28, 1994 Rajwar came to Burnaby with her parents and took out what funds and investment securities she could. Mark was soon to allege that she took about \$80,000 more than she was entitled to. Allegations were made by both that the other improperly hid or disposed of some of their assets. This financial issue was one of two that dominated their divorce proceedings. The other was the alleged cruelty of Mark throughout the marriage.

In early January of 1995 Rajwar went to police in Vernon to (Constable Weatherall) and complained about Mark's conduct alleging spousal abuse. This included a wide variety of allegations including throwing objects at her, choking her, kicking her, pulling her across the floor and

threatening to kill her if she told anyone. In addition she alleged that he jealously controlled her movements and became upset if she paid any attention to any other male persons. At that time, however, she wanted no action taken by the police and would not give a signed statement. She indicated to police that she was not concerned about her safety at that time because she was living in Vernon while Mark was still in Burnaby. She nevertheless was made aware of services for abused spouses (Victim Services, etc.).

Also about this time Rajwar saw a lawyer and a divorce action was commenced, the primary grounds of divorce being mental and physical cruelty. The allegations are most serious and were allegations that Rajwar was never prepared to back off from and, to accept one year's separation as the grounds for the divorce as Mark wanted. She followed this course because of her concern about her reputation in her East Indian Community. She wanted the reasons known as to why she left the marriage.

A meeting in mid January was requested by Mark's family and was held in Vernon. It brought the two families together with a view to seeking a reconciliation. That was not to be the case. Indeed, it seemed to worsen relationships. Mark appeared to come away from that meeting emotionally devastated, his family name besmirched.

Concerns were raised at various times during the inquest relating the processing of Mark Chahal's applications relating to his acquisition of firearms and to gun laws generally.

In the year prior to his marriage to Rajwar Gakhal, Mark had applied for and received a Firearms Acquisition Certificate (FAC) which is the first step to be taken in the acquisition of firearms. In March of 1995 he applied for a permit through the Burnaby detachment of the RCMP and purchased a semi-automatic handgun. A check in the Police Information Retrieval System (PIRS), a police computer data base system, indicated that he was a spousal abuse suspect on a Vernon RCMP file. The permit was approved and the gun was registered for target practice. A second handgun was acquired in June of 1995 to be used for the same purposes.

The year of 1995 was emotionally hard on both Mark and Rajwar. Their doctors, counsellors and others spoke about their fragile state.

Rajwar sought counselling and other support from various community resources. Mark kept much more to himself but did receive counselling on two occasions in February and was described by his counsellor as “quiet, gentle and sad”.

In early March of 1995 Rajwar attended at the Vernon RCMP complaining about nuisance calls from her estranged husband. Mark was contacted and asked to quit making the calls (which he denied) but the calls did not continue after that request.

The divorce proceedings continued during 1995, the key issues being monetary settlement and the cruelty basis for the divorce. In January 1995 examinations of discovery took place. Evidence was given of Mark’s very rude conduct on occasion through those discoveries. That event appears to have been an emotional low for both of them. A pretrial meeting in March 1996 clearly indicated there was going to be no settlement and that a lengthy divorce hearing was in store. Mark’s lawyer was discharged shortly after this and it appears to me that this was the final turning point, the end of the line for Mark. The money issue went unresolved and, in particular, the divorce action was to proceed in May on the grounds of Mark’s alleged mental and physical cruelty to his wife. Whatever the outcome it would be a devastating black mark on his character and reputation.

In late January 1996 following the discoveries, Rajwar spoke to Constable Weatherall at the Vernon Detachment about Mark’s conduct at the discoveries. She had prepared a written statement at that time but declined to leave it with the Constable indicating she would add to it and bring it in at a later date. She in fact did this, probably mid to late February. However, this document contained much more than the complaints about Mark’s conduct at the discovery. In particular she stated in this document:

“I am very scared and terrified of him and am very concerned about my safety, I am also concerned for the safety of my family members. Mark has made various threats directed at me and my family members. He has been making threatening phone calls (about death threats) to my sister (File #96-4180 Abbotsford Police Department).”

In this regard, a complaint had been laid on February 16, 1996, by Rajwar's sister, Jasbir Saran, to the Police Department in Abbotsford indicating that Mark Chahal had made death threats against her stating, "You fuckin' bitch – I'm spending money but you're going to the grave. You fuckin' bitch." On a second occasion he said, "I want double money bitch. Double money or you bitches all die." Constable Weatherall who was in charge of Rajwar's file was not on duty in Vernon during most of February and did not, in fact, learn of the existence of Rajwar's document until the day of the fatal shootings. The document was apparently taken at the front desk of the detachment and placed directly on file without being brought to anyone's attention. Constable Weatherall testified that, had it come to her attention, she would have taken action. Questions put by the jury concerning the above indicated their concern about the handling of this document and the fact that the Vernon file and the Abbotsford file were not somehow mated.

Evidence indicated that on March 27th, Mark Chahal purchased a ten round magazine clip for one of his handguns and that he practised shooting at his gun club several days later. On April 4th he rented a car at the Kelowna Airport, drove to Vernon and checked in at a local hotel. The following morning he attended at the Gakhhal residence where the shootings occurred. He returned to his hotel and shot himself.

The tragic deaths occurred on April 5th and we all must wonder if Mark's conduct could have been predicted. Could steps have been taken to see that his emotional needs were better attended to or could steps have been taken against him in the law enforcement area?

Evidence indicated that there is little assistance available for the abusing husband or partner, nor is there a system in place to get or encourage abusing spouses to seek help.

Other Issues Raised

Documents

During the inquest many concerns were raised relating to documents. The information stored in documents and computer systems is often vital to the operations of the agency, industry, etc., in which it is collected. That is, information stored in the right place and readily

accessible, is often important for the proper running of the organization.

Rajwar Gakhil saw several counsellors and a medical doctor in the year or so following the marriage breakup, and when she learned that her husband's lawyer was searching for records in the discovery process, it appears she became very concerned and on three separate occasions took documents without authorization. Recommendation #13 is made in response to that situation.

Various witnesses addressed the issue of inappropriate storage of documents, of inadequate cross-referencing, or inadequate classification and lack of information sharing between agencies working for a common cause. Reference was made to the two police data storage and retrieval systems, Police Information and Retrieval System (PIRS) and Canadian Information Centre (CPIC). Reference also was made to the designation of K files (police files dealing with violence against women in relationships). In both cases concrete suggestions were made for the improvement of these systems (Recommendations 4, 5, 6, 15 and 25).

Questions from the jury in particular were directed at various police witnesses asking about filing, cross-referencing practices and the clear designation of the officer in charge of a particular file. These concerns were reflected in recommendation 8(b), 8(c) and 8(d).

Education and Resources

One of the key focuses throughout this inquest was on violence against women in relationships. The inquest explored safety and resources available to women and, as well touched on resources for the abuser that are or should be available to them in assisting them to curb their abusive practices. Various witnesses including Violence Against Women in Relationships policy workers, counsellors, doctors, psychologists and police addressed these issues. In so doing, it became clear that although the government policy in regard to violence against women in relationships was basically sound and acceptable, in many instances its implementation could be improved if the front-line service providers were more thoroughly trained. Improved public education was also essential. Reference here should be made to recommendations 3, 9, 19, 11, 17 and 23.

Firearms

The Chief Provincial Firearms Officer for British Columbia (CPFO) gave evidence at the inquest and explained the intricacies of gun law legislation. He outlined positive changes already made in British Columbia as a result of the Vernon tragedy. Coupled with this was evidence from Burnaby Police Officers concerning the processing of Mark Chahal's FAC and permit applications. Various concerns were raised. One of the chief ones was that spouses or partners were not automatically interviewed when their spouse/partner or ex-spouse/partner was making application for an FAC or when the actual application was made for a permit to acquire a restricted weapon. As well, the need for greater use of police computer data systems, PIRS and CPIC, was suggested when police investigators were reviewing applications for the various certificates and permits. Recommendations regarding the use of firearms are found in recommendations 19, 20, 21, 22, 26 and 27.

The background to recommendation #20 arises from the fact that application forms for carry permits, and permits to acquire restricted weapons are not nearly as comprehensive as is the FAC application and the jury is recommending that those applications be made as comprehensive as the FAC applications and that in addition data based systems be better utilized.

Recommendation #22 makes reference to questions on the FAC questionnaire which were used at the time Mark Chahal made his application for a FAC. The information requested by those questions is as follows:

Have you been treated for threatened or attempted suicide, depression, behavioral problems or emotional problems, or are you currently under treatment or taking medication for such?

Have you been treated for alcohol or drug abuse or are you currently under treatment or taking medication for such?

With respect to recommendation #26, BC-4 and BC-5 are instructions from the CPFO regarding applicant screening and revocations of all firearm related certificates licences, permits and authorizations possessed by a person. A copy of that document is attached.

Concluding Remarks

At this inquest it became clear from the onset of the inquest that each member of the jury was most attentive and that from their extensive questioning of witnesses, it was also clear that they had a very good grasp of the various issues that presented themselves. It is not an easy task for a jury to articulate sound recommendations at the conclusion of an inquest with issues as complex as were apparent in this inquest. They deserve our commendation for a job very well done.

Pursuant to Section 3 (d) of the Coroners Act, the following recommendations are directed to the Chief Coroner for British Columbia to disseminate them to appropriate persons, agencies and ministries of the government as noted below.

RECOMMENDATIONS Supported Priority

1. That the Attorney General's policy, definition and guidelines "Violence Against Women in Relationships" include threats against extended family members as reasonable grounds to proceed on this policy decision tree.
2. That a full investigation of all alleged abuse/threats include direct contact with victim and perpetrator and follow-up with members and other possible witnesses, regardless of the family members and other wishes of the complainant.
3. That training for police and justice system workers relating to violence against women in relationships reinforce that extended family are important when compiling information.
4. That policy clarify that the K-file designation (Violence against women in relationships) be assigned immediately on the opening of the file.
5. That concurrent or subsequent complaints from any jurisdiction be coordinated and cross referenced through CPIC and PIRS. The K-designation should be noted on the PIRS system, and CPIC system and be in the same location on each type of screen, and on related paper documentation.
- 6a) That Officers document the date and results each time a PIRS and CPIC review is done.
- b) All municipal police detachments must keep PIRS up to date with respect to all files, and gun acquisitions.
- 7 Develop a risk assessment tool to help front line police and victim assistance workers to evaluate and/or screen persons who may be either predisposed to violence or have the potential to harm spouses or family members.
- 8.a) Distribute copies of this verdict and recommendations to all victim assistance/services programs and Crown Counsel throughout the province for their information and discussion purposes.

Supported Priority

- b) That one file system on all complaints involving Violence In Relationships be done. Copies of all related complaints made in other police agencies be kept on file at the detachment closest to the complainant.
 - c) That all complaints involving the same complainant and suspect, if violence in a relationship is involved in any of the complaints, should be assigned to the same investigating member.
 - d) Complaints involving same suspect and extended family members of the original complainant be assigned to this master file, and investigating member.
- 9.a) That there be education for police officers regarding violence in relationships, the cycle of violence and risk factors after relationship breakdown in consultation with community agencies.
- b) That the above agencies continue working towards an integrated and cooperative model in relation to Violence Against Women in Relationships and that funding adequately address the training and resource requirements to accomplish that.
- 10a) That the above agencies collaborate to improve public education about the risk factors during a relationship breakdown and subsequent separation.
- b) And, to increase the awareness of what is presently available in the community and how to access these resources, (i.e. counselling, crisis lines, 1-800 numbers) through public notices (i.e. TV ads).
11. That the above agencies explore Intervention opportunities at the complaint level so that counselling may be offered at an earlier opportunity, especially to abusers.

Supported Prio

rity

12. Ensure that Victim Services/Assistance and other government referral programs set a standard of minimum qualifications for counsellors and volunteers.
- 13a) That file security measures be adopted whereby front-line workers seek authorization from supervisors before allowing anyone access to files. File security should include positive identification of persons authorized to view the file.
 - b) Workers should be present at all times when files are being reviewed.
14. That provincial policy be developed for verbal and written information intake and documentation handling. Where such policy already exists, police officers, front-line clerical staff and filing clerks should receive refresher training to ensure these policies are adhered to.
15. Ensure that staff involved in PIRS and CPIC checks on Firearms Acquisition Certificates (FAC) and permits are adequately trained.
16. That this case be reviewed by each of the above agencies for educational purposes.
17. That professional publications arising out of the above agencies include material to assist the various professions in identifying possible interventions for clients who may be involved in relationship breakdowns and aware of spousal assault or threats within that relationship, and provide any other useful educational information.
18. That a copy of this Verdict of Inquest and recommendation be provided for informational purposes and in support of community initiatives addressing violence in relationships and coping skills for both partners on relationship breakdowns.

19. That Spouses or ex-spouses, partners or ex-partners be required references on FAC applications, registrations, permits to carry, and permits to transport.

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rity

20. That the PIRS system, CPIC system and the Protection Order Registry be checked on each and every application for restricted weapon acquisition and Transport to Carry permits, registrations and review with applicant questions 35a & b (or add them to application form).
21. That the length of validity of a FAC permit be reduced to 1 year and the fee increased to offset the additional cost.
22. Regarding question #31 and #32 (on FAC application), some verification of these responses such as a signed doctors' note or verbal verification, with onus on applicant to supply information.
23. An independent auditor through the Attorney General's office to randomly assess police detachments' interpretation of the Violence Against Women policy and advise and/or assist as necessary for further education or improvements. Findings should be related to all police agencies without disclosing particulars of any detachments to maintain anonymity.
24. Request longarms become restricted weapons, and become registered.
25. That CPIC provide a data base for firearms registrations, peace bonds, restraining orders and domestic violence files; or create some other Canada-wide registry (i.e., special interest persons).
26. That instructions BC-4 and BC-5 of the CPFO be adopted as policy with respect to the Firearms Act, with the exception of removing from BC-4 #C.1.6 the words "where possible".
- 27a) The carry permit be limited to one area. If going out of that area, person must apply for special carry permit.

- b) The Permit to Carry be restricted to one weapon unless special circumstances are noted.
- 28. Types of ammunition available for purchase be reviewed.
- 29. Steps be taken to reduce discovery procedures to reduce stress and perhaps eliminate the necessity of both partners to be in the same location.