People with Mental Health and Cognitive Disabilities & Access to the Justice System

Report on a Review of the Literature

Submitted to
Justice Canada,
Family, Children and Youth Section

Submitted by
IRIS – Institute for Research and Development on Inclusion and Society
Written by Doris Rajan

March 26, 2015

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PART ONE: PROJECT OVERVIEW

1. The Issue

People with disabilities experience multiple challenges when interacting with the justice system as both victims of domestic violence and also when they are involved as potential offenders when conflict occurs inside and outside of the home. Challenges are most evident when people with mental or cognitive based disabilities, i.e. intellectual, Traumatic Brain Injury (TBI) or mental health[1] come in contact with first responders, such as the police, largely due to communication barriers and the presentation of differential, easily misunderstood, heightened behaviour.

The fact that people with disabilities experience higher rates of victimization than the non-disabled population intensifies the need for a more effective response by the justice system. Victims with disabilities often remain in abusive relations, are not likely to report the abuse and if they do, are often not believed (DisAbled Women's Network Canada, 2011).

People with disabilities experience higher rates of victimization in their living environments than the non-disabled population, for example a study conducted by Samuel Perrault outlined how 65% of all violent crimes against people with disabilities[2] were committed by someone the victim knew and further people with disabilities were between 50 to 100% more likely to have experienced spousal violence than persons without disabilities (VECOVA Centre for Disability Services and Research, 2011). We also know that for women with disabilities, this rate is significantly higher than for both men with disabilities and women without disabilities. Almost 80% of women with disabilities have experienced physical violence by their intimate partners compared to 29% of women without disabilities (Roeher Institute, 2004). Studies indicate that women with disabilities are sexually assaulted at a rate at least twice that of the general population of women (Roeher Institute, 2004). The rate for women with intellectual disabilities is even higher than other women with disabilities.

While this review focuses on the experiences of people who come in contact with first responders in situations of crisis, the barriers to justice for victims with disabilities is important to review because such barriers are also relevant in the context of a potential offense.

[1] Many labels are used to refer to this diverse group of people who have been diagnosed with impairments such as depression, schizophrenia, and/or bipolar disorder. In this report we have chosen to use the term "mental health" disability because it is the most common term in the literature. There are other labels i.e. psychosocial, psychiatric, consumer or psychiatric survivor, mental health user , etc. that are also used in reference to this disability.

[2] Disability in this context is defined as an Activity Limitation as per the Stats Canada definition.

The high rate of sexual assault of women and men with disabilities relates to the fact that offenders assume that most people with disabilities cannot and are unable to complain. A Factum developed by the DisAbled Women's Network Canada and the Women's Legal and Education Action Fund explains this, in reference to women with disabilities:

> The women cannot or will not complain or will not be believed if they do complain, and any incidents reported will not be fully investigated or prosecuted. These power dynamics make it extremely difficult for women to resist and report sexual abuse. In some cases they may not even be aware that they can say no to sexual activity initiated by a person who has authority over them (DisAbled Women's Network Canada and the Women's Legal and Education Action Fund, 2011).

Further, even when a victim with a disability actually reports a crime, charges aren't often laid and the abuse is given support to continue:

> Less than 10% of all sexual assaults are reported to police and of the assaults reported, even fewer result in charges being laid. This gap is significantly higher for women with disabilities, with less than 4% of assaults reported to police and charges rarely laid. An interpretation of *CEA* s.16(3) which creates barriers to the admission of evidence of women with disabilities will exacerbate this already serious problem of impunity for sexual offenders who are often serial abusers, "with the consequence that abusers could continue to prey on such victims without fear of being called to account for their actions" (DisAbled Women's Network Canada and the Women's Legal and Education Action Fund, 2011).

Similarly, those people with mental health or cognitive based disabilities who come in contact with the law in times of crisis, may not be able to explain their situation, be afraid of the repercussions to their safety if they do describe it and be fearful that they will not be believed.

For people with disabilities we also have to expand our definition of "domestic" violence beyond spousal or intimate partner violence. This is because the nature of violence against people with disabilities differs from the non-disabled population largely due to an increased vulnerability to abuse given the multiple barriers to full and equal participation in society which results in segregated, often congregated living. People with disabilities also have an increased dependency on others for primary care and financial support. It follows that the perpetrators of abuse are often those charged with providing care or support to a person with a disability. Abuse against people with disabilities often occurs in the context of this care-giving relationship in their living environment.[3]

[3] See *Alive - Your complete source of natural health and wellness*, article "More Caring Caregivers" by Randy Taylor, who references the work of Dick Sobsey, professor of Educational Psychology at the University of Alberta and Director of both the J.P. Das Developmental Disabilities Centre and the John Dossetor Health Ethics Centre in Edmonton. Retrieved from http://www.alive.com/articles/view/21378/more_caring_caregivers.

Therefore the "home" or domestic environment in this context can be a group home, healthcare facility or their private home and the perpetrator of abuse are often formal or informal caregivers, i.e. a family member, healthcare provider, support worker, residential staff or a spouse. In addition it is well documented that people with mental health disabilities are at an increased risk to homelessness. There is increasing evidence that demonstrate that people who have survived TBI (Hwang, 2008) and those that live with intellectual disabilities (Mercier and Picard, 2011), are also vulnerable to homelessness. In this sense, the streets are people's homes where violence and conflict often occur.

An understanding of the attitudinal, communication, procedural and policy barriers that hinder people with mental and cognitive based disabilities' access to justice, will be examined in the context of this population's initial contact with justice in times of conflict or crisis. We have chosen this focus because, as police forces, hospitals and mental health service providers are well aware, many challenges occur when people with intellectual, TBI or mental health disabilities come in contact with the police in their homes or when they are involved with an altercation in public. The challenges that occur highlight the nature of the barriers, gaps in effectively responding and ultimately point us towards directions and strategies for change.

2. Research Design

This research therefore pursues the following goals and objectives:

Goal:
To attain an understanding of the challenges people with intellectual, Traumatic Brain Injuries, mental health and other cognitive related disabilities, experience when coming into contact with the justice system, particularly in situations of domestic violence.

Objectives:
This goal will pursue the following objectives:

1. To identify the nature of the interaction between people with mental health or cognitive disabilities and the justice system at times of crisis;

2. To identify the barriers, gaps and needs of the justice system in responding to people with mental health or cognitive disabilities who are in conflict with the law;

3. To identify promising practices, models, strategies and useful resources that would support justice personnel, particularly first responders, when intervening with people with mental health or cognitive disabilities.

Methods:

Through secondary data collection, this research pursued information on; understanding what the labels of mental health, intellectual and TBI disabilities refers to, the nature of the interaction between people with these types of disabilities and the justice system, the main problems that occur during this interaction, the needs of the justice system, community services and people with disabilities during this period, and the identification of promising practices, strategies, intervention models and resources that have been developed to address these needs.

Using secondary research techniques the review of the literature prioritized relevant publications and resources that were developed in Canada, focusing on first responders when intervening with people with mental health or cognitive disabilities during times of crisis.

The research utilized the following avenues to identify relevant secondary materials:

1) Google web search engine based on keyword searches on:

a. Disability and advocacy websites
b. Police, courts and other justice organizations websites
c. Newspaper and magazine articles
d. Videos
e. Self advocate blogs

2) Access the University of Toronto Library Portal for recent, (10 years) academic publications on this issue.

3) A request for a list of resources and publications was sent to the following organizations:

Autism Society Canada http://autismsocietycanada.ca/
ASC puts special focus on providing information, referral and resources for parents and other family members who are seeking support for children with autism. This site also provides news, resources and links for youths and adults on the spectrum.

Brain Injury Association of Canada http://biac-aclc.ca/
Improving the quality of life for all Canadians affected by brain injury and promoting its prevention.

British Columbia Schizophrenia Society Provincial Office http://www.bcss.org/
The British Columbia Schizophrenia Society is a non-profit organization founded in 1982 by families and friends of people with schizophrenia; dedicated to supporting each other, educating the public, raising funds for research and advocating for better services for people with schizophrenia and other serious and persistent mental illnesses.

Canadian Alliance on Mental Illness and Mental Health (CAMIMH)
http://www.camimh.ca/
A non-profit organization comprised of health care providers as well as organizations which represent individuals with lived experience of mental illness. Established in 1998, CAMIMH is a volunteer run organization that provides mental health education to the public.

Canadian Council on Social Development Disability
http://www.ccsd.ca/index.php/research/disability-research
A not-for-profit organization that partners and collaborates with all sectors (not-for-profit, philanthropic, government and business) and communities to advance solutions to today's toughest social challenges

Canadian Down Syndrome Society http://www.cdss.ca
A national non-profit organization providing information, advocacy and education about Down syndrome. The CDSS supports self-advocates, parents and families through all stages of life.

Canadian Mental Health Association http://www.cmha.ca/
As a nation-wide, voluntary organization, the Canadian Mental Health Association promotes the mental health of all and supports the resilience and recovery of people experiencing mental illness. The CMHA accomplishes this mission through advocacy, education, research and service.

Canadian Police Knowledge Network (CPKN) http://www.cpkn.ca/about
Canada's leading provider of online training solutions for police and law enforcement personnel. Working with subject matter experts from the Canadian policing community, CPKN develops and delivers highly effective, economical, and engaging e-learning courses to meet the needs of frontline officers.

Centre for Addiction and Mental Health http://www.camh.net/
Canada's largest mental health and addiction teaching hospital, as well as one of the worlds leading research centres in the area of addiction and mental health. CAMH combines clinical care, research, education, policy development and health promotion to help transform the lives of people affected by mental health and addiction issues.

Epilepsy Canada http://www.epilepsy.ca/en-CA/Home.html
A non-profit organization whose mission is to enhance the quality of life for persons affected by epilepsy through promotion and support of research and facilitation of education and awareness initiatives that build understanding and acceptance of epilepsy.

Fragile X Research Foundation http://www.fragilexcanada.ca/index.php?home&lng=en
A non-profit, tax-exempt charity run by parents and volunteer professionals that is dedicated to raising awareness of Fragile X syndrome, funding biomedical research for improved treatment and ultimately, finding a cure for this disorder.

Mental Health Commission of Canada: Canadian Police Mental Health Liaison Information an activity of the Canadian Association of Chiefs of Police
http://www.pmhl.ca/Index.html
This website is designed to provide information, contacts and support to police officers and police services, as well as to the mental health services in their communities, to aid in their work with people experiencing mental illnesses.

Ontario Police College http://www.opconline.ca/
The Ontario Police College provides training designed to prepare police officers to safely and effectively perform their duties, while meeting the needs of Ontario's diverse communities.

Plan Institute http://institute.plan.ca/
Plan Institute for Caring Citizenship works to reduce the isolation of people at the margins of society, and to enable the contributions of all members of our community.

Provincial and Territorial Associations for Community Living:

Alberta Association for Community Living http://www.aacl.org/
A family based, non-profit federation that advocates on behalf of children and adults with developmental disabilities and their families.

l'Association du Québec pour l'intégration sociale https://www.aqis-iqdi.qc.ca/
Promouvoir les intérêts et défendre les droits des personnes ayant une déficience intellectuelle et ceux de leur famille.

Community Living Manitoba https://www.aclmb.ca/
Dedicated to the full inclusion of persons of all ages who live with an intellectual disability.

Inclusion BC http://www.inclusionbc.org/
A provincial non-profit organization dedicated to promoting the participation of people with developmental disabilities in all aspects of community life.

Community Living Ontario http://www.communitylivingontario.ca/
A non-profit, provincial association that advocates for people who have an intellectual disability to be fully included in all aspects of community life.

New Brunswick Association for Community Living http://nbacl.nb.ca/
A provincial, non-profit organization that works with and on behalf of children and adults with an intellectual disability and their families.

Newfoundland and Labrador Association for Community Living http://www.nlacl.ca
To work with and on behalf of individuals with an intellectual disability and their families. To advocate for individuals to live as full participants in the community based on the values of Equality, Inclusion and Independence.

Nova Scotia Association for Community Living https://nsacl.wordpress.com/
A province-wide, not-for-profit association of people with intellectual disabilities, families, and others leading the way to build a just and inclusive society.

Nunavut - Nunavummi Disabilities Makinnasuaqtiit Society (NDMS)
http://www.nuability.ca/
To achieve independence, self-determination and full citizenship for all Nunavummiut living with disability.

Prince Edward Island Association for Community Living http://peiacl.org/
A family-based association empowering people with intellectual disabilities and their families to lead the way in advancing inclusion in their own lives and in their communities.

Saskatchewan Association for Community Living
http://www.sacl.org/home/?no_cache=1
Ensure that citizens of Saskatchewan who have intellectual disabilities are valued, supported and included members of society and have opportunities and choices in all aspects of life.

Yellowknife Association for Community Living http://www.ykacl.ca/
A non-profit organization that supports families, children, youth, and adults with intellectual and other disabilities so that they are included and are able to contribute to community life in Yellowknife.

Yukon Association for Community Living
http://www.ycommunityliving.com/home.html
To advocate for and support individuals with developmental disabilities and their families/guardians so they can live as valued citizens, free of discrimination, with all the rights, responsibilities and benefits that implies.

Research Questions

The following questions guided the data collection process:

1. What is the experience of people with mental health or cognitive disabilities who are involved in situations of crisis or conflict with the justice system?

2. Does the justice system have the tools they need to be able to adequately respond to crisis and conflict when they involve people with mental health or cognitive disabilities?

3. What are some examples of promising practices, procedures, policies, resources and community models and partnerships that may assist in addressing the needs of both people with disabilities and the justice system?

3) Report Format

The following report aims to expand on the challenges people with mental health and cognitive disabilities experience when interacting with the justice system, in order to consolidate current information and share some reflections on possible next steps for advancing work on this issue.

It will be important at the onset to attain a better sense of who this population "is" and the nature of their experience of disability in order to dispel stereotypes and to better understand the nature of the barriers to inclusion that this population experiences.

The report then delineates the major challenges, barriers and service gaps that are revealed when this population comes in contact with the justice system. This information will highlight the needs of service providers in the justice system, other relevant sectors and people with disabilities, as well as strategies that have been developed to address these needs. There has been a significant effort conducted to-date in the area of mental health and first responders, yet with the exception of work by the Mental Health Commission of Canada and the Canadian Mental Health Association, much of this work tends to be locally based and thus does not benefit from the learnings cross regions. Therefore, this research attempts to gather, examine and consolidate some of these promising practices in order to share relevant tools, resources and strategies and offer recommendation for next steps on a national level.

PART TWO: THE RESULTS

1. Who are People with Mental Health, Traumatic Brain Injury and Intellectual Disabilities?

There is a great diversity that exists in the population of people with disabilities under the broad categories of mental and physical disabilities. The UN Convention on the Rights for Persons with Disabilities (CRPD) represented a significant shift in the way we understand disability, in that it recognizes that it is the interaction of a person's condition or impairment with their environment that results in "disability". That is, the disability resides in the society not in the person. The CRPD recognizes that disability is a concept that expands and develops and that legislation needs to be able to change and adapt in order to best reflect positive changes within society. Therefore how we define disability changes as our societies become more astute at identifying and removing barriers towards inclusion.

The Secretariat for the Convention on the Rights of Persons with Disabilities referred to as the United Nations Enable, defines disability as follows:

> "Disability" results from the interaction between persons with impairments, conditions or illnesses and the environmental and attitudinal barriers they face. Such impairments, conditions or illnesses may be permanent, temporary, intermittent or imputed, and include those that are physical, sensory, psychosocial, neurological, medical or intellectual.[4]

For many disability activists there is a problem with the language of "impairment" because it implies weakness or something that is *less than* people without disabilities. If we are in pursuit of a human rights approach in relationship to the inclusion of people with all forms of disabilities, then it is useful to understand and include disability as another type of human diversity, i.e. different but equal.

A social justice framework would suggest that society has *disabled* people who have abilities that differ from the majority. This does not mean that we minimize or ignore the difference in ability and in some cases of profound disabilities, i.e. multiple disabilities like severe mental health disabilities coupled with intellectual and physical impairments, it is a much more difficult task to put accommodations in place. However, universal access and/or a human rights approach purports that if the appropriate supports are in place, all people can be included in their community.

[4] This section on the CRPD adapts information from the Canadian Association for Community Living, Toronto Canada 2010 – Power Point entitled: *The UN Convention on the Rights of Persons with Disabilities* and the Human Rights Commission, New Zealand 2011 – Te Kahui Tika Tangata's *What is the UN Convention on the Rights of Persons with Disabilities*. See http://www.hrc.co.nz/ for more information.

The following descriptions of mental health and cognitive based disabilities are therefore best understood in the context of the barriers in society that exclude an individual based on their specific type of disability, rather than assigning medical categories to a person's experience. The impairment therefore is the condition and "*disability*" asks us to see beyond the impairment in terms of the barriers and challenges to inclusion.

Mental Health Disabilities

There is a range of conditions and diagnoses that fall under this heading. These include major depression, schizophrenia, and bipolar disorder. These disabilities are often treated with medications and/or with therapy. Individuals may experience side effects from medication which inhibit clear thinking, interfere with short and/or long-term memory, make it difficult to follow a fast-paced, information-packed conversation, and can lead to metabolic disorders like diabetes Along with over 40 years of social justice activities in the movement, there is a rising effort to move away from pharmaceuticals towards more holistic forms of treatment that focus on peer support, exercise, diet, meditation and mindfulness activities.

Like many social movements, a variety of perspectives have emerged in the advocacy process, i.e. the anti-psychiatry movement which completely rejects the system of psychiatry and the Mad movement which seeks to re-educate, share the experiences of and celebrate people who fall under these labels.

Self advocates and advocates may like to be referred to as *consumers* or *mental health service users*. As the Canadian Mental Health Association explains:

> The term "consumer" refers to a person who has used or is using services provided by the mental health system. There is some debate within our community about the most appropriate term. While some organizations prefer the term "client", CMHA has listened to and heard individuals who have used or are using the mental health system and many of them prefer the term "consumer". This is the word employed throughout our communications.[5]

There is a vast diversity in terms of how advocacy groups and people living with this disability understand their experience and there is not necessarily an agreement or consensus on this. There is a continuum of how this disability is understood, from the medical model where the language of *illness* is used, to more liberal ideas of mental *health, users* or *consumers,* to the radical notion of *psychiatric survivors*.

Professor Bonnie Burstow of the University of Toronto explains the psychiatric survivor or anti-psychiatry conceptualization:

[5] Please see the Frequently Asked Questions section of the Canadian Mental Health Association website for more information www.cmha.ca.

> Psychiatry is predicated on the belief that people called "psychiatric patients" have diseases called "mental illnesses" which put those afflicted and those around them in danger if the diseases are not controlled. The disease theory is similarly unproven, though we tend to forget that fact, for it has become hegemonic and part of the apparatus of governing. That is, it has become part of the "normal" way of thinking about people with certain problems in living (Burstow, 2003).

Traumatic Brain Injury (TBI)

Traumatic Brain Injury occurs when the brain becomes damaged after birth. Different parts of the brain have different functions and the damage depends on which part of the brain has been injured. The effects can range from mild to severe and generally the more severe the injury; the less likely it is that the survivor will return to their pre-injury state. The Brain Injury Association of Waterloo-Wellington explains further:

> Brain injuries can happen to anyone at anytime. They occur suddenly and without warning and in an instant life is changed forever. Every day we participate in activities that produce endless risks for sustaining a brain injury. They can happen while driving a car, riding a bike, playing sports or walking down the street. Many things can damage the brain; a blow to the head, brain tumors, lack of oxygen, brain infections, strokes and aneurysms can all cause brain injuries. (Brain Injury Association of Waterloo-Wellington, 2015).

Further TBI has been defined as a:

> Non-degenerative, non-congenital insult to the brain from an external mechanical force, possibly leading to permanent or temporary impairment of cognitive, physical, and psychosocial functions, with an associated diminished or altered state of consciousness (Medscape, 2015)

Survivors of TBI are more likely to be homeless, experience mental health problems, substance abuse users and have poor physical health (Hwang, 2008).

Intellectual Disability[6]

This disability is also known in some provinces such as Ontario and B.C., as developmental disability, which is a broad label formerly known as “mental retardation” which covers a wide group of different people, i.e. verbal, non-verbal, Down's Syndrome, Autism, etc.. People from this disability community may have delayed or limited development in learning that can affect one’s ability to comprehend, remember or discern. While people labelled this way have a considerable range of cognitive skills, their capacities are often under-estimated. Historically in Canada, people with intellectual disabilities have lived in

[6] This document chooses to use the term intellectual disability because the Canadian Association for Community Living prefers this term over “developmental”. Developmental implies that a person is not fully developed or is “stuck’ at an earlier stage of development and/or that people with intellectual disabilities are “slow” or delayed in development, rather than acknowledging that they are fully developed human beings with a difference in intellectual capacity.

institutions where they experienced wide spread abuse or many people may have lived in highly protective situations with their families. People with this label can be shy or easily intimidated. Also, because they have been denied suitable educational opportunities and segregated from mainstream society, people with this disability often have not had normal social interactions and a chance to learn about their rights (Canadian Association for Community Living and DisAbled Women' Network Canada, 2015).

Fetal Alcohol Spectrum Disorder (FASD) is often included under the category of intellectual disability. FASD refers to disabilities that occur as a result of the exposure to alcohol during pregnancy (Public Health Agency of Canada, 2015). FASD is not a curable condition and does have a lifelong impact on individuals. The effects of FASD including "alcohol-related birth defects, can vary from mild to severe and may include a range of physical, brain and central nervous system disabilities, as well as cognitive, behavioural and emotional issues." (Public Health Agency of Canada, 2015).

People with disabilities and other marginalized statuses

It is important to also recognize that people with these mental health and cognitive based disabilities are people of colour, refugees and immigrants and therefore share the same barriers to being included in Canadian society that other racialized and immigrants experience. Barriers for immigrants and refugees include, poverty, economic insecurity, unemployment, foreign credentials not recognized, racism, discrimination and inadequate and/or overcrowded housing (Canadian Association for Community Living and DisAbled Women' Network Canada, 2015).

Refugees with disabilities may have fled war and violent conflict where many women have experienced sexual violence. Refugees may have lost everything they owned and experienced the death of loved ones, i.e. their parents or even their own children.[7] Immigrants, people of colour and especially the refugee populations are susceptible to mental health problems particularly Post Traumatic Stress Disorder and depression. In addition, as Across Boundaries a mental health centre that works specifically with people of color in the Greater Toronto Area recognizes, the experience of racism has a significant impact on mental health (Across Boundaries, 2015).

The Canadian Mental Health Association also stresses the need to acknowledge that the Lesbian, Gay, Bisexual, Trans (LGBT) communities face higher risks to mental health issues because of social exclusion, lack of support and understanding, discrimination, hate crimes and harassment, violence and the experience of poverty (Canadian Mental Health Association, Ontario Division, 2015).

[7] This section adapts content from the Ontario Council of Agencies Serving Immigrants and the Ethno-Racial People with Disabilities Coalition of Ontario's *Welcoming and Inclusive Communities Accessibility Project Workshop Modules.* Written by Doris Rajan. January 2012.

In the context of the justice system it is also important to be able to distinguish between typical adolescent behaviour and mental health in teenagers and young adults. As Camia Weaver of *Here to Help*, a mental health and substance abuse information site in B.C. explains:

> Puberty and adolescence are hormonal and emotional roller coasters. This is complicated by elements of rebellion, risk-taking behaviour, poor judgment and mood swings, including anger, euphoria and depression. It was recently discovered that these elements are partly due to a spurt of brain development in the frontal lobes occurring at puberty and continuing through the early twenties (Weaver, 2015).

In addition, the period of late teens and the early 20's is usually when the onset of a mental health disability such as depression, bipolar and schizophrenia will occur. This article outlines the importance of distinguishing between what is typical teenage or young adult rebellion and a young person with a mental health disability, so that a person is not being punished for their disability and is given the benefit of early intervention and healing (Weaver, 2015).

Who this population is: A Reflection on the Literature

In the review of the literature the focus was on mainstream Canadian publications that were developed to examine and/or address the issue of people with mental health or cognitive disabilities and the justice system. In the majority of the documents reviewed at worse, there is a general omission of the issues effecting racialized, immigrants, refugees or First Nations and Inuit populations and at best a nominal reference to these communities.

An exception to this can be found in the Ontario document entitled, *Police & Mental Health - A Critical Review of Joint Police/Mental Health Collaborations in Ontario* where they stress the need to increase community based mental health and addictions supports to deflect individuals coming into contact with the justice system, including the need to look at further marginalized populations:

> Across the province, individuals from Aboriginal and racialized communities are increasingly coming into contact with the justice system and increasingly being incarcerated. Individuals from these communities have unique needs and face multiple barriers to accessing the social determinants of health, including income, employment, education and housing. These communities are vulnerable to mental disorders and addictions, as well as criminalization (Provincial Human Services and Justice Coordinating Committee, 2011, p.46).

A document entitled, *Mental Illness and the Criminal Justice System: A Review of Global Perspectives and Promising Practices*, sheds light on the importance of recognizing the intersection of mental health, violence, homelessness and substance abuse which can intensify psychiatric symptoms. This report also emphasized the need to not pathologize

the experience of mental health, rather recognize the impact of social and economic deprivation when it intersects with mental health, in the context of crime:

> Persons with mental illness are at greater risk of being poor and living in “settings that are rife with illicit substances, unemployment, crime, victimization, family breakdown, homelessness, health burdens, and a heavy concentration of other marginalized citizens (Butler, 2014, p. 10).

A salient point noted in the literature is the conflation and/or lack of specificity and distinctiveness between mental health, intellectual and TBI disabilities. This lack of clarity may find it origins in the Criminal Code of Canada itself, where the broad term "mental disorder" is used in a medicalized context:

> "Mental disorder" is defined in section 2 of the *Criminal Code* as a "disease of the mind". It is a question of law for the trial judge to determine what constitutes a "disease of the mind" or a "mental disorder". The Supreme Court of Canada's judgement in *R.* v. *Cooper* [1980] 1SCR 1149 as stated in *R*. v. *Rabey* [1980] 2SRC 513 is the authority on the meaning of "disease of the mind":
>
> …. Disease of the mind embraces any illness, disorder or abnormal condition which impairs the human mind and its functioning, excluding, however, self induced states caused by alcohol or drugs as well as transitory mental states such as hysteria and concussion (Canada, 2015).

Some of the documents reviewed recognize the need to include TBI and intellectual disability in the discussion, yet do so in an imprecise and/or perfunctory manner. For example the report *Police & Mental Health - A Critical Review of Joint Police/Mental Health Collaborations in Ontario* states that their work focuses on "serious mental illness, developmental disability, acquired brain injury ...fetal alcohol syndrome" yet the report exclusively focuses on mental health and does not include information that is specific to either TBI or intellectual disabilities (Provincial Human Services and Justice Coordinating Committee, 2011, p.15).

In addition, in a section on definitions in this same publication, intellectual disability is incorrectly included as a mental health condition:

> Mental disorder: the Criminal Code of Canada identifies mental disorder as a disease of the mind.[3] For the purposes of this report; the term “mental disorder” is used to refer to individuals with diagnosed and/or undiagnosed mental health conditions, including severe mental illnesses, developmental disabilities and other mental health related conditions. (Provincial Human Services and Justice Coordinating Committee, 2011, p.3).

This is problematic because the experiences and barriers in accessing justice for people with intellectual disabilities differ from those for people with mental health disabilities.

Therefore if these differences are not acknowledged the strategies, community-based models and promising practices that are developed will not be effective in addressing the distinct barriers and needs of people with intellectual disabilities.

For example if a police officer responds to a domestic violence call where one of the people involved has an intellectual disability, this individual may not comprehend what is happening and may have a different way of verbally communicating, e.g. repetitive words, limited verbal ability, the use of sounds other than words, etc.. If however this individual is presumed to have a mental health disability and is deemed to not be a danger to themselves or others, the police officers may call a mobile crisis team to attend to their needs. Mobile crisis teams however are designed to meet the needs of people with mental health disabilities and the personnel would likely not be equipped to support this person with communication nor would they be knowledgeable of what services exist for people with intellectual disabilities in their community.

The difference in the intervention between these two disability communities when they come in contact with the justice system, prompted the Canadian Association for Community Living to develop a brief to the Standing Senate Committee on Legal and Constitutional Affairs in April 2005, which read:

> Experience in Canada has shown, and research has confirmed, that people with what are considered even the most 'severe' intellectual disabilities can be supported to live in the community. Intellectual disability is not remediated by medical interventions. This fact has often led to people with intellectual disabilities, who have been deemed not criminally responsible or unfit to stand trial, being confined for many years in forensic mental health facilities (Canadian Association for Community Living, 2005).

As delineated in the CRPD, it is imperative that we shift the focus off the "impairment", to addressing the exclusionary attitudes and environments that result in people being "disabled". With this as our framework for understanding mental health and cognitive disabilities, another difficulty was identified in the language used in many of the materials reviewed, where the framing of disability was purely medical. We see this in important documents such as the Chiefs of Police's *Contemporary Policing Guidelines for Working in the Mental Health System,* where the central tenet is stated as:

> Each police organization should foster a culture in which mental illness is viewed as a medical disability not a moral failure, and in which people with mental illnesses are treated with the same degree of respect as other members of society (Provincial Human Services and Justice Coordinating Committee, 2011, p.25).

This statement is contradictory in that on the one hand it is certainly progressive in its recognition of people's basic human rights and the need to address discriminatory practices and attitudes, yet on the other hand it pathologizes the disability with no acknowledgment of systemic barriers that this population experiences. That is, rather than acknowledging the lack of resources, services and community supports that would address

the social determinants of health, it suggests that people with mental health disabilities become involved with police largely due to the nature of their disability.

The Canadian Police Knowledge Network course entitled *Recognition of Emotionally Disturbed Persons* also uses the language of illness and sets out to teach people how to identify the type of disability. As the following two, of nine, learning objectives indicate:

- Define "mental illness"
- Define "emotional disturbed person" and describe the category system that can be used to help first responders identify the types of emotionally disturbed persons.[8]

This is problematic because it is clear in review of resources that these definitions may be limited and, as will be elaborated on in section four to follow, training materials will need to be designed closely with disability advocacy and self advocacy organizations to ensure accuracy of people's experiences and resultant behaviours that might prompt justice system involvement.

There is a recognition in the literature however of the importance for police officers to acquire more knowledge on who people with mental health and cognitive disabilities are. The notion of "people in crisis" as used in an independent review of the use of lethal force conducted by Frank Iacobucci for the Toronto Police Service (Iacobucci, 2014), is perhaps more constructive because it's focuses on the behaviour that brings people in contact with the police, alerting you to the potentiality of a mental health or cognitive based disability.

The next step would be to arrive at appropriate characterizations of the experience of people living with these disabilities, to enable the identification of suitable interventions and support services in the community during times of crisis.

[8] Please see the Canadian Police Knowledge Network Course Catalogue. (n.d.). Retrieved March 20, 2015, from http://www.cpkn.ca/course_redp.

2. The Nature of the Interaction with the Justice System.

Mental Health Disabilities

Much of the literature comments on the high number of people with mental health disabilities involved in the criminal justice system, whether that is at first contact with the police or in the over-representation in prisons. Many of the reports identified the de-institutionalization process of the 1960s leading to the lack of adequate community supports, resources, services and appropriate housing, as the reason for this increase.

The literature also acknowledged that police now have an expanded role in interacting with people with mental health disabilities becoming as one article stated "frontline professionals who manage these individuals in crisis"(BC Schizophrenia Society, 2006, p. 5). Further, it is felt that police are being put in a position where they are forced to play this role without the expertise, skills or supports. It is clear from many of the documents reviewed that the police have found themselves playing this role because of their duty to 1) protect the safety of the community and 2) protect individuals with disabilities (BC Schizophrenia Society, 2006, p.5; Butler, 2014).

Police officers do not have the expertise or experience needed to play this role, yet find themselves having to be the "gatekeepers" to mental health services, that is, charged with making critical decisions regarding who gets treatment and who does not(BC Schizophrenia Society, 2006, p.5; Butler, 2014, p.5).

The BC Schizophrenia Society's report *Police Intervention in Emergency Psychiatric Care: A Blueprint for Change,* identifies the lack of available emergency hospital beds and long waiting times for intake as the most common challenge faced by police officers when working with people with mental health disabilities. Their main point is that people in a psychiatric crisis are not getting the care they need and in addition, police have to waste their valuable and costly time waiting for people to be admitted"(BC Schizophrenia Society, 2006, p. 3). It was stated that prisons and the justice system have become the "default" for mental health services"(BC Schizophrenia Society, 2006, p. 4). In addition, the connection is drawn between the lack of hospital beds and more people with mental health disabilities being arrested (Butler, 2014, p. 8).

Some of the articles discussed the common myth that people living with mental health problems are more likely to become involved in violent behaviour. Studies have shown that people with mental health disabilities are in fact, more likely to be victims of violence and are no more likely to commit violent acts than the general population (Canadian Mental Health Association, Ontario,2011).

Further, when people with mental health disabilities come in contact with the law, it tends to be in the context of less serious offences, with the occasional explosive situations (Butler, 2014, pp.6-7). The interaction of police with people with mental health disabilities tends to takes more time than other interventions and there is repeated contact with the same individuals.

People with mental health disabilities come in contact with the police through:

- Public or family's request for help;
- Minor disturbances;
- Being a victim of crime;
- Threatening someone;
- Being at risk or need of practical support (no offence); and
- Suicide intervention.

When people with mental health disabilities do get arrested, usually drugs and alcohol are involved and there is non-compliance and/or fighting with police officers or others (Butler, 2014, p.9). Another finding is that the risk of violence is higher for substance abusers than with people who have been identified as having a mental health disability (Butler, 2014, p.13).

The Mental Health Commission of Canada in their report on people with mental health disabilities and police interactions, noted the increased attention given to the need for police personnel too be knowledgeable and trained in de-escalation techniques when dealing with people with mental health disabilities in crisis situations,(Coleman, T. and Cotton, D,2014).

Intellectual Disabilities

While there is considerably less information on people with intellectual disabilities and their interaction with the justice system, it is evident that there is an over-representation of individuals with intellectual disabilities in prison and pre-trial detention (Major, G. and Dupras, L, 2008).

In December 2014 the Canadian Association and People First of Canada in collaboration with the Office for Disability Issues, Employment and Social Development Canada (ESDC) hosted a policy forum entitled *Ensuring Equality in the Justice System for People with Intellectual Disabilities: Fifth Annual Policy Forum on Inclusion & Canadians with Intellectual Disabilities* in Ottawa. This event brought key government representatives from Corrections Canada, Justice Canada and Employment Skills Development Canada, together with subject matter experts in the community and non-profit with people with intellectual disabilities and their families who have experienced challenges with the justice system. This forum was one of the first national events to focus on the justice system and people with intellectual disabilities.

At this affair People First of Canada a national organization representing people with intellectual disabilities, shared some insights into the experience of people with intellectual disabilities when interacting with the justice system as potential offenders, key points include:

- May not want their disability to be recognized;
- May not understand their rights but pretend to understand;
- May not understand commands, instructions, etc.;
- May be overwhelmed by police presence;
- May act upset at being detained and/or try to run away;
- May say what they think officers want to hear;
- May have difficulty giving facts or details of the offense/crime;
- May be the first to leave the scene of a crime and the first to be caught; and
- May be confused about who is responsible for the crime and 'confess' even though they are innocent[9]

L'Association du Quebec pour l'integration sociale developed a report entitled: *Towards an Inclusive Approach to Justice: Intake and Treatment Procedures for People with Disabilities Involved in the Justice System* that outlined the findings of a research initiative that took place between 1997 to 1998. The research set out to investigate the experiences of people with intellectual disabilities with the justice system in Quebec, the challenges faced by service providers and if there are governing policies and processes in relationship to people with intellectual disabilities (L'Association du Quebec pour l'integration sociale, 1999). The following summarized their findings:

- Most players in the justice system have a poor understanding of intellectual disability;

- No policies on dealing with people with intellectual disabilities;

- Lack of collaboration or coordination of key sectors;

- Rehab centres think once there is a crime it is the Ministry of Justice responsibility and the Ministry of Justice thinks its Rehab's responsibility;

[9] Contact People First of Canada at info@peoplefirstofcanada.ca for their Power Point presentation entitled *The Justice System Ensuring Equality in the Justice System for People With Intellectual Disabilities*. Presented on December 1, 2014, Ottawa . Contact E-mail: info@peoplefirstofcanada.ca.

- No resources to support people with intellectual disabilities, just mental health;
- Many government agencies only serve offenders not victims;
- Victim services are ill equipped to serve people with intellectual disabilities;
- Various networks do not know about each other and do not connect, i.e. Victim services, Rehab, etc..
- People with intellectual disabilities have no support to interact with these complex systems; and
- Authorities don't distinguish between mental health and intellectual disabilities.

Representatives from Justice Canada and Correctional Service Canada outlined any information that they had involving people with intellectual disabilities and the justice system sharing presentations related to law enforcement, the courts and tribunals, the experience of incarceration and the process of reintegration. The experiences of people with intellectual disabilities and the justice system is a relatively new area of focus, particularly in comparison to the mental health sector.

A representative from Corrections Canada's Mental Health branch at this forum, indicated that they were aware of offenders in the Canadian correctional system with "intellectual disabilities, learning impairments or neurological impairments as a result of substance abuse, brain injury or disorders such as FASD."[10] In this presentation, information on the following observations of people with intellectual disabilities in the prison system were shared:

- Although cognitive deficits are associated with areas related to successful functioning in the community, they do not appear to pose a particular security challenge in correctional settings;
- Offenders with intellectual impairments may have trouble detecting patterns, generating alternatives, learning from experience, and understanding information taught in programs or groups; and
- Adapted interventions like correctional programs could help these offenders manage impulsivity and poor planning associated with their cognitive deficits.[11]

[10] Contact Correctional Service Canada Kathleen Thibault, Senior Policy Analyst, Mental Health Branch Kathleen.Thibault@csc-scc.gc.ca for more information.
[11] Contact Kathleen Thibault, Senior Policy Analyst, Mental Health Branch, Correctional Service Canada Kathleen.Thibault@csc-scc.gc.ca.

Due to the fact that the issue of people with intellectual disabilities experience with the criminal justice system is a relatively new area of focus in Canada, the policy forum invited Jenny Talbot the director of the *Care Not Custod*y program at the Prison Reform Trust in the UK, to share the findings of a study entitled *No One Knows* which examined the experiences of adult offenders with intellectual disabilities in UK prisons (Loucks, D., 2007). [12]

Key findings include:

- Around four-fifths of prisoners with intellectual disabilities had difficulties reading prison information;
- Three-quarters had difficulties filling in prison forms;
- Two-thirds had difficulties in verbal comprehension skills; and
- Two-thirds had difficulties making themselves understood.

Traumatic Brain Injury

For people living with Traumatic Brain Injury, studies in the United States and more recently in Canada have identified that people with a history of TBI have an increased vulnerability to criminal activities and are over-represented in correctional facilities (Colantonio et al, 2007). For example, a study of four Ontario prisons found that 50.4% of males and 38% women had a history of TBI (Colantonio, 2014, p. 1). This points to the critical need for the identification of TBI and routine screening for a history of TBI in all stages of a person's interaction with the justice system. This is important in order to understand people with TBI's behaviour, needs and the most appropriate intervention. For example, survivors of TBI may experience memory loss, resulting in their forgetting to make court appearances or they may require instructions or procedures to be written down in order for them to absorb and remember the information (Colantonio, 2007, p.1359).

3. Problems that Occur

The vast majority of the literature focused on barriers, problems and gaps in services for people with mental health disabilities in contact with the justice system. The nature of the problems can be categorized in six theme areas; 1) The pronounced lack of resources and funding for mental health resources and services in Canada; 2) The lack of coordination of various levels of government and similarly, the lack of collaboration between provincial ministries; 3) The lack of formalized collaboration between community health

[12] It is important to note that in the UK and as reflected in the *No One Knows* the term Learning Disabilities refers to people with intellectual disabilities.

and social services and police agencies; 4) Problems associated with education and training for police officers; 5) Problems with existing programs that attempt to address this issue and 6) The infringement of people with mental health disabilities rights when interacting with the justice system.

Lack of resources and funding for mental health services

The majority of the materials that exist on this issue focused specifically on problems with the practices, procedures and protocols of key actors in the justice system. This may be due to the fact that these reports and/or resources were often led by justice organizations, police services or justice groups in collaboration with national mental health organizations. In addition, many of the reports and resources were developed in response to incidents that occurred between police officers as first responders and people with mental health disabilities in crisis.

The nature of the problem however differed greatly when reviewing newspaper articles, television news segments and academic papers, where these authors stressed the need to shift the focus off of strengthening police services, to the root cause of the problem, i.e. the pronounced lack of resources and funding for community-based mental health services and supports in this country.

The case being made was that federal dollars are being prioritized to the correctional system, " increasing Corrections budgets by 54% or $3.12 billion from 2012-2013" at the expense of the mental health system, i.e. "an inadequate amount of money is allocated to mental health services, i.e. only " 7 cents of every healthcare dollar on mental health" (Operation Maple, 2015).

Reporter Christie Blatchford of the National Post concurs with this perspective citing the "failure and inadequacy of the mental health system" as the "elephant not in the room" during the Ontario coroner's inquest of the Toronto shooting deaths of three people with mental health disabilities (Blatchford, 2013).

University of British Columbia researchers Jade Boyd and Thomas Kerr conducted a case study of four Vancouver Police Departments' (VPD) reports on the issue of mental health, and found that the reports "reproduce negative discourse about de-institutionalization" and further stigmatize people with mental health disabilities (Boyd and Kerr, 2015). In a news article the authors explain the core of the problem as they see it:

> The VPD reports…shift discourse and practice away from health and community supports, social supports, livable housing and peer-run organizations for those most affected," it states. "Re-institutionalization and secure units in hospitals are assumed to be a solution, alongside increased surveillance. Thus, the VPD's production of the mental health crisis and their proposed solutions have material effects." (Lupick, 2015).

The authors believe more money should be directed to the improvement of community mental health supports, affordable housing and increase the number of peer-run organizations, rather than increasing the number of hospital beds, increased surveillance and the " re-institutionalization" of people with mental health disabilities (Lupick, 2015).

The BC Schizophrenia Society takes a somewhat different take on the situation, while also emphasizing the need for the strengthening of community mental health supports, they believe the "lack of available hospital emergency room space and long waiting times for intake procedures" is the primary problem with police intervention in situations involving people in a mental health crisis (BC Schizophrenia Society , 2006, p.3).

Lack of government coordination and lack of collaboration of provincial ministries

The inadequacy and lack of appropriate community-based mental health supports may relate to the lack of inter-ministerial collaboration and cross-sectoral governmental support. In the development of the document, a *Blueprint for Change*, the BC Schizophrenia Society stated that key service providers consulted including, police, healthcare providers and other justice system workers, consistently stated that there was a pronounced lack of coordination between various systems involved with this issue (BC Schizophrenia Society , 2006, p.10).

Conflicting jurisdictional policies, issues of confidentiality and the lack of provincial inter-ministerial communication often leads to people not getting the comprehensive support that they need when they interface with the justice system. For example, a few reports discussed the problem of the lack of sharing of information between police and health services due to provincial legislation. The Personal Health Information and Protection Act in Ontario is an example of this, where consent is needed from an individual before information about their mental health can be made privy to the police (Provincial Human Services and Justice Coordinating Committee, 2011, p. 8). This information would help police officers make important decisions on how to best fulfil their duties to protect both the community and the person with a disability.

In the Toronto review of police encounters with people in crisis Frank Iacobucci emphatically states that an effective mental health system needs the support of governments to ensure that people are averted from going into crisis in the first place, thus lessening contact with the justice system:

> As I emphasize in the Report, there will not be great improvements in police encounters with people in crisis without the participation of agencies and institutions of municipal, provincial and federal governments because, simply put, they are part of the problem and need to be involved in the solution(Iacobucci,2014, p.9).

We see this concern also expressed in B.C. where it was stated that people with mental health disabilities, particularly those with more acute cases, will not receive the type of

support and services that they need, unless governments and the community are more integrally involved.

> While resource limitations are an obvious concern, the *lack of coordination and information sharing* between government ministries, regional authorities, and community agencies is just as often identified as the culprit. Everyone is aware that, to some extent, results are typical of a system that is bifurcated with so many separate lines of accountability (BC Schizophrenia Society , 2006, p.10).

Lack of collaboration between health, community based mental health services and the police

It is evident in the literature that police service associations are increasingly recognizing the need to link with mental health services, as noted by the Brantford Ontario Police Service department; "One change that we have recently made is reaching out to mental health professionals to help our training." (Ball, 2014).

Yet even though there is a strong awareness that collaboration between the police and the mental health sector is important, for the most part, linkages with mental health services is left to the good judgment of individual police departments, with no standard protocols for collaboration.

In addition, there is a disconnect between hospital and community based mental health programs, that results in more responsibilities put on the police:

> A fundamental issue is that while mental health services in British Columbia are primarily community-based, for the most part they do not interact in a coordinated manner with hospital inpatient services. Other studies have noted that this lack of integration is one peril of community initiated program coordination, and that further work to overcome the schism between hospital and community care is imperative(BC Schizophrenia Society , 2006, p.5).

Problems associated with education and training for police officers

The scan of the literature indicated that there is a growing body of high quality educational curriculum and initiatives including notable work developed by the Atlantic Police Academy, the Calgary Police, the Edmonton Police and the Justice Institute of British Columbia (Coleman and Cotton, 2014, p.38). The problem however is that there is no comprehensive strategy for implementation that would require more time allocated to training periods and a commitment of police services across the board to the importance of ongoing learning and skill development.

The Mental Health Commission of Canada's report entitled *TEMPO: Police Interactions A Report towards improving interactions between police and people living with mental health problems* outlined a number of issues related to training materials, these include:

- Lack of inclusion of people with mental health disabilities in the design and delivery of educational resources;

- At times not even involving mental health professionals, nor introducing local mental health service providers to new officers which could lead to a working alliance;

- Negative perspectives and attitudes towards people with mental health disabilities demonstrated by use-of-force instructors; and

- Failure to apply what is learned such as de-escalation techniques and appropriate communication when facing a crisis (Coleman and Cotton, 2014, pp.6, 71).

The report suggests the need for further research to determine the reasons why police officers are not applying their training in times of a perceived or real crisis. This could be due to inadequate teaching of the techniques and the absence of an adult education learning strategies (Coleman and Cotton, 2014, p.71).

Another gap in training and education that was identified in the literature was that existing guidelines, protocols and relevant legislation were not being promoted and/or implemented. For example the *Contemporary Policing Guidelines for Working with the Mental Health System* developed by the Canadian Association for Chiefs of Police in 2006 sets out best practise procedures, ideas on specialized personnel, useful resources and guiding principles on working with people living with mental health disabilities(Provincial Human Services and Justice Coordinating Committee, 2011, p.25).

While this document states that the guidelines should be implemented by " every police service or police detachment across the country, regardless of size or geographical location", there are no accountability mechanisms, nor standardized training curricula to educate officers and police departments on its content (Provincial Human Services and Justice Coordinating Committee, 2011, p. 24).
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In addition, some of the reports indicated that neither the police nor service providers in the mental health sector were sufficiently knowledgeable of their provincial Mental Health Act.

> When considering specific things that can help us move forward in BC, one encouraging fact is that British Columbia is fortunate in having good mental health legislation although some professionals in the mental health field do not know the Mental Health Act well and therefore misinterpret it or underutilize it (BC Schizophrenia Society , 2006, p.11).

Problems with existing programs

While there are many examples of crisis intervention services throughout the country documents reviewed felt that the lack of program standardization resulted in less effective services. For example, the review of police and mental health collaborations in Ontario found that without monitoring and standardization, important components of crisis services such as peer representation may be absent:

> Consumer/survivor representatives highlighted the need for mental health crisis services that are peer-led and designed by consumers/survivors themselves. They stated that having peer support during a mental health crisis can result in more positive outcomes for the individual (Provincial Human Services and Justice Coordinating Committee, 2011, p. 7).

Another issue with crisis intervention services was that even though a community may have, for example a mobile mental health team or a specialized officer, a study found that; "despite widespread adoption of one of these approaches actual use of on-site responses was quite low, with about half of respondents saying they implemented the response in less than 25% of encounters."(Butler, 2014 p. 24).

A repeated problem that was identified in many of the reports, was that while existing diversion programs appear to increase a person's service utilization resulting in an improvement in their mental health status, such programs were limited in their effectiveness for recidivism. Related to this, people who are released after short stays in hospitals, receive no follow-up or aftercare, creating a revolving door scenario.

Infringement of rights when interacting with the justice system

Another issue identified in the literature was that in the name of treatment, people with mental health disabilities may experience their rights being compromised with forced admissions and/or interventions. Community treatment orders (CTO) and assertive community treatment can violate a person's rights and freedoms when they are used as "a coercive mechanism for psychiatric treatment. CTOs also have the potential of criminalizing people with mental health disabilities because police officers are charged with the authority to "apprehend individuals who are in breach of a CTO." (Provincial Human Services and Justice Coordinating Committee, 2011, p. 9).

Also, while most reports agreed that mental health records should be made available to the police for purposes of ensuring community safety and optimal support to an individual in times of crisis, these records should never be made available to employers or the public (Provincial Human Services and Justice Coordinating Committee, 2011, p. 13).

People with Intellectual Disabilities and TBI

While work in the area of people with intellectual disabilities in the justice system is growing, there is still minimal Canadian material on the subject. There is much to learn however from the UK experience as described in the paper entitled *No One Knows* where key problems identified include:

- They are at risk of continued offending because of unidentified needs and consequent lack of support and services;
- They are unlikely to benefit from conventional programmes designed to address offending behaviour; and
- They are targeted by other prisoners when in custody; and
- They present numerous difficulties for the staff who work with them, especially when these staff often lack specialist training or are unfamiliar with the particular challenges with this group of people(Loucks, 2007).

Results from a literature review outlined in the report, *FASD and Access to Justice in the Yukon* found that Canada is the leader in research on FASD and access to justice in the world. The report outlines many barriers that people with FASD experience when they try to access justice, including:

- Not being able to understand legal advice, nor the process when attempting to obtain legal assistance;
- Not able to communicate with lawyers and police officers;
- Miss appointments due to their difficult in coping with everyday tasks and poor memory capabilities;
- Justice system personnel do not understand the disability which is often invisible, and thus are unable to refer the person to appropriate, non-legal community services and supports; and
- People are often living with multiple barriers such as extreme poverty, addictions and other disabilities including physical and mental health (Hornick et al, 2008, pp.43- 45).

4. Needs: Justice System, Community Services and People with Disabilities

The UN Convention for the Rights of Persons with Disabilities, ratified by Canada in 2010, represents a dramatic shift in international law. Article 12.3 'Equal Recognition Before the Law' requires that States Parties take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity. The provision of support to help articulate your needs and demonstrate one's credibility in the justice system is an essential dimension of exercising one's legal capacity. The following section uses the UN Convention as the framework for understanding people with mental health and cognitive disabilities' needs.

The specific problems experienced by people living with mental health and cognitive disabilities when interacting with justice services as just outlined, are useful in identifying the specific needs for all key stakeholders including, justice personnel, community health and social services and people with disabilities.

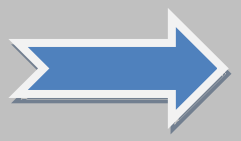
The table on the next page outlines the key areas identified in the literature where improvements and strategies could focus in relationship to the recognized problems.

Problems and Related Needs: Justice System & People with Mental Health Disabilities

*** For citations see Endnotes**

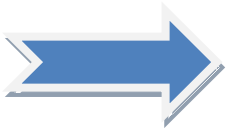
PROBLEM	NEED
Lack of resources/funding for mental health services **Lack of government coordination & lack of collaboration of provincial ministries**	Investments need to be made in:[1] ✸ Follow-up and ongoing support programs, i.e. specific types of therapy, housing ✸ Ensure timely access to care with increased resources in hospitals ✸ Mandated case management ✸ Early intervention programs ✸ More safe beds ✸ More services in rural areas
Lack of collaboration between health, community based mental health services and the police	Types of collaborations needed: ✸ Ensure each police department has a Mental Health unit[2] ✸ Increase mental health diversion programs[3] ✸ MOU between hospitals and police to triage cases faster[4] ✸ Mental health services work closer with hospitals and psychiatrists[5]
Problems associated with education and training for police officers	Training needs include; ✸ Learning priorities, i.e. understanding MH, anti-stigma, de-escalation/defusing interactions, ethical decision-making, human rights; anti-oppression, i.e. anti-racism, homophobia and intersectional analysis .[6] ✸ Opportunities to meet/establish links with mental health and cross-sectors services[7], ✸ Selection of trainers ✸ Transform police culture [8] ✸ Limit use of Tasers[9] ✸ Training on relevant legislation and acts[10] ✸ Include MH service providers, people with disabilities, their families in the development/delivery of training.[11] ✸ Consumer/survivors led research on best practices ✸ Education for individuals and their families, i.e. use of 911, their rights, developing representation agreements, etc. [12]
PROBLEM	**NEED**

Problem with existing crisis intervention programs



- Standardization and services in each municipality
- Peer designed and led crisis services [13]
- More involvement of social justice and consumer-survivor groups in crisis programs[14]

Infringement of rights



- Program review and evaluation of community treatment orders
- Review, adhere to and develop accountability standards for assertive community treatment orders[15]
- Put into practice Article 12 of the CRPD, i.e. people's right to have support in exercising their legal capacity by developing interventions that safeguard one's autonomy and increase access to community supports and treatment, where forced institutionalization is the last resort.[16]

People with intellectual disabilities and TBI

As noted earlier it has become increasingly evident that these populations experience barriers in accessing justice. The needs of people living with cognitive disabilities when interacting with the justice system, may share similar challenges as those people living with mental health disabilities, however the nature of their needs differ.

There is a need to conduct more detailed research on the practical needs of both these populations when they come in contact with the justice system. A starting point may be to analyze the provisions, protocols and resources that have been developed to-date in the mental health field in order to identify the differences, build on the commonalities and expand on structures and systems that are already in place.

Research conducted by IRIS - the Institute for Research and Development on Inclusion and Society, has identified the following needs of people with intellectual disabilities in the justice system,(Canadian Association for Community Living and DisAbled Women' Network Canada, 2015)

- Need to have assistance in explaining what constitutes abuse and why they may be in conflict with the law;
- Often need a support person who understands how an individual communicates, in order for them to express what is happening to them or what they understand has happened;
- Need information on their rights and the services that are out there for them in times of victimization and/or conflict with the law; and
- Justice services need to understand how to provide accessible services for people with intellectual disabilities, i.e. use of plain language, pictures instead of word, etc.

The research conducted by l'Association du Quebec pour l'integration sociale on the experiences of people with intellectual disabilities in the justice system, offers comprehension descriptions of the needs identified with recommendations for addressing those needs. Five sets of recommendations are outlined:

1st Set: ***Intake and Treatment Procedures -*** This includes the need to develop specific guidelines for police, justice and correctional professionals and to develop specific measures to help people with intellectual disabilities as witnesses and victims to fulfil their role to the best of their ability;

2nd Set: ***Types of Cooperation to be Developed*** - This includes the need for each government and public authority to define their jurisdictions and positions regarding people with intellectual disabilities, better collaboration among social services for individuals with intellectual disabilities, their families and the judicial process, and the need to develop protocol agreements;

3rd Set***: Information to be made available*** - This includes the need to develop a directory of professionals in each region, the need to make information from Association for Community Livings accessible to the justice system, and to simplify and adapt information for people with intellectual disabilities;

4th Set: ***Training and Professional Development*** - for all members of the justice system including police, judges, Crown prosecutors and attorneys; and

5th Set: ***Individuals and Families -*** Support individuals and families in exercising their rights (L'Association du Quebec pour l'integration sociale, 1999).

For people living with FASD, the following needs were identified as key to achieving justice for this community:

- The recognition of the disorder through assessment and diagnosis;
- Educate justice system staff on the nature of FASD through formal training; and
- Alternative types of sentencing (Hornick et al, 2008, p. 37).

This report on FASD developed in the Yukon also stressed the need for a concentrated focus on the needs of First Nation youth who experience this disability more so than the non-First Nation community.

> In Saskatchewan, she said that a male Aboriginal youth has a greater chance of going to jail than completing high school. The formal justice system is failing to address the overarching needs o f Aboriginal youth who experience conflict with the law. There is a need to get at the roots of the problem if there is to be any true resolution (Hornick et al, 2008, p. 16).

The UK initiative *No One Knows* identifies the following key needs for people with intellectual disabilities in their interaction with the justice system, from first contact to prison:

- Shared awareness training that involve people with intellectual disabilities as co-trainers;
- Services for people with intellectual disabilities working with prison staff, especially officers ;
- Diversion where necessary;
- A whole prison approach; information sharing protocols, i.e. prison, health, social care and education;

- Reasonable adjustments , i.e. digital clock and 'easy read' information and applications; and
- Individual plans; 'what support might help?'(Loucks, 2007).

An organization called *Opportunities for Independence Incorporated* in Winnipeg offered insights on the needs of people with intellectual disabilities and those living with mental health issues, in their presentation at the aforementioned Ottawa policy forum in 2014:

- Relationships and understanding between advocacy groups, i.e. the offender and local Associations for Community Living;
- Training for Correction Services Canada decision makers, Parole Boards and officers;
- Do not combine people with mental health disabilities and those with intellectual disabilities;
- Need to have more services in rural areas;
- Formalize protocols in transition and planning for discharge;
- Community Notification procedures must be reviewed;
- Address racial/cultural bias in justice system, i.e. Aboriginal and newcomer overrepresented in the system;
- Need to challenge Minimum Mandatory sentencing;
- Avoid the movement towards civil confinement, using Not Criminally Responsible pleas; and
- Adhere to best practice and research based support and treatment for people with intellectual disabilities. [13]

[13] From Power Point presentation by Rick Rennpferd Executive Director, Opportunities for Independence -Winnipeg during the *Ensuring Equality in the Justice System for People with Intellectual Disabilities, Fifth Annual Policy Forum on Inclusion & Canadians with Intellectual Disabilities*, December 1, 2014 - Ottawa.

5. Promising Practices, Strategies and Resources

An analysis of the literature points to five strategic areas of focus to improve people with mental health and cognitive disabilities' access to justice; 1) the development of a mental health policy framework, 2) promising police training curriculum, 3) attention paid to the police recruitment process, 4) collaborative programs, protocols and guidelines for cross-sectoral information sharing, 5) promising education and training for other key sectors, including healthcare, as well as for individuals and their families.

This section ends with an annotated description of key resources and tools that have been developed in Canada.

A Mental Health Policy Framework

The most essential and overarching strategic direction towards concrete systemic change would involve governments working with all key stakeholders in the expansion of community based mental health supports, including more peer-run organizations and a significant increase in the number of affordable supportive housing units. Literature that was not developed by the police or justice system emphasized that we need to shift our focus from fortifying police services, to investing in services that will support people with mental health and cognitive based disabilities to live a higher quality of life.

Many of the reports reviewed, highlighted that this was the crux of the problem, however their study's mandate was to analyze the interaction of police services and people with disabilities, thus most strategies identified were specific to changes in the criminal justice system.

CAMH outlined a *Mental Health and Criminal Justice Policy Framework* which provides a comprehensive approach that focuses on prevention, diversion and treatment(Centre for Addiction and Mental Health, p.14).

Key components of this strategy include:[14]

- Priority 1: Promoting mental health across the lifespan, which includes supports to caregivers and the importance of early intervention and includes the identification of intellectual disability in the early years;

[14] From Power Point presentation by Patrick Baillie entitled: Addressing how the justice system responds to the mental health needs of individuals with intellectual disabilities during the *Ensuring Equality in the Justice System for People with Intellectual Disabilities, Fifth Annual Policy Forum on Inclusion & Canadians with Intellectual Disabilities*, December 1, 2014 - Ottawa.

- Priority 2: Foster recovery and well-being; uphold rights - This includes collaboration with service providers, individuals and families; removing workplace barriers; and updating legislation and policies across jurisdictions/sectors to achieve alignment with the CRPD;

- Priority 2.4 - Reducing the over-representation of people living with mental health disabilities in the criminal justice system, and provide appropriate services, treatment and supports to those who are in the system, including; enhance diversion programs, provision of mental health services in custody and ensure comprehensive discharge plans, increase "civil" mental health services within justice system; and provide police, court and corrections workers with knowledge and training on mental health and information about services available in their area;

- Provide access to services and supports to further marginalized populations including:

    - Improve coordination of services for people living with mental health problems or illnesses who also have developmental disabilities or neurodegenerative disorders, and increase skills and knowledge for all those who provide services to them.
    - Address diversity, including Northern populations
    - Address the needs of First Nations, Inuit, and Métis
    - Mobilize leadership, improve knowledge, foster collaboration.

Promising Police Training Curriculum

The Canadian Alliance on Mental Illness and Mental Health's review of police training and education, outlined key criteria for an effective and successful training program for police:

- Selection of appropriate 'trainers,' including those who are both subject matter experts and who are operationally credible;

- Inclusion of local mental health professionals for the purposes of providing reliable information as well as to assist police to form local connections with mental health agencies;

- Integrating people with mental illnesses and their families into the training in order to provide direct experience with this population;

- Using a variety of forms of media including participatory strategies;

- A focus on cognitive determinants of behaviour including attitudes, exercise of discretion and stigma; and

- Adaptability of the curriculum to reflect the population receiving education/training (e.g. new officers versus specialized teams versus dispatch personnel) as well as including local community needs (Cotton et al, 2010, pp.5-6).

Based on these reviews of police training for dealing with people with mental health disabilities, the TEMPO (Training and Education about Mental Illness for Police Organizations) model was developed. The Canadian Alliance on Mental Illness and Mental Health report examining police education in Canada's police agencies suggest that the TEMPO model for learning is comprehensive, multi-leveled and contains the preferred learning content(Cotton et al, 2010, pp.5-6).

The TEMPO training deems the following components as essential to be addressed in police training:

- procedural justice;
- the stigma and attitudes of police personnel;
- the de-escalation/defusing of crisis situations;
- the desired outcomes of interactions with PMI;
- the meaningful involvement of persons with lived experience and their families in the design and delivery of police education and training; and
- the criticality of rigorous evaluation of both basic and in-service education and training to determine the efficacy of same (Cotton et al, 2010, p72).

The Toronto Police Service's Independent Review recommended nine areas of focus for effective police officer training:

1. Containment techniques for containing crisis situations
2. Communication and De-escalation
3. Subject Safety: recognizing the value of the life of a person in
4. Use of Force: making more clear that the Use of Force Model is a code of conduct that carries (i) a goal of not using lethal force and (ii) a philosophy of using as little non-lethal force as possible; and that the Model is not meant to be used as a justification for the use of any force;
5. Firearm Avoidance
6. Fear: including discussions of officers' fear responses

7. Stigma: addressing and debunking stereotypes and stigmas concerning mental health.
8. Experience and Feedback: incorporating mental health and crisis situations into a larger number of practical scenarios.
9. Culture: includes resisting the aspects of the existing culture that do not further TPS goals and values with respect to interactions with people in crisis (Iacobucci, 2014, pp.17-18).

An emerging area of focus in police education is around the issue of police officers, especially first responders, and their own mental health. A national three day conference took place in Mississauga Ontario in February 2015, to discuss the mental health and well-being of police officers. At this conference a number of promising practices were shared including;

- Ottawa Police Service participation in a pilot project entitled "The Real You";
- The "Road to Mental Readiness Program" adopted by the Calgary Police and now the Hamilton Ontario Police. (Weaver, 2006).

The Ottawa Citizen also developed a series on the mental health of police officers which portrayed the stress of police work and how the Ottawa Police Service has adapted their procedures to meet these challenges (Yogaretnam, 2015).

Police Recruitment

In Frank Iacobucci's review of the use of lethal force for Toronto Police Services he listed a series of eight recommendations related to the hiring of new constables. The following presents a summary of the recommendations that were presented to the TPS in this area (Iacobucci, 2014, pp.15-16):

1. Mandatory application qualifications to require a Mental Health First Aid course;

2. Preference be given to applicants who engage in community service, have previous involvement in the area of mental health either through a family member or service work and have completed a post secondary university degree;

3. Amend application information on the TPS website ensuring that applicants demonstrate the above qualifications in their application submissions;

4. Actively recruit officers from educational programs such as nursing, social work and/or programs related to supporting people with mental health disabilities;

5. Hire new constables from other "metrics of diversity" that have an educational background, specialized skills and/or life experience;

6. Psychologists should participate in the new constable selection process in order to assess positive traits, absence of mental health issues and/or "undesirable personality traits." A list of positive traits should be identified by the TPS with psychologists and be used in this screening process;

7. Psychologists should be involved in the hiring decision-making process for new constables; and

8. Evaluate the effectiveness of the psychological screening tests.

Collaborative Programs, Protocols & Guidelines for Cross-sectoral Information Sharing

There are a number of models for police collaboration with healthcare, mental health and other community service sectors found in the literature. These types of liaisons have proven to be effective in identifying, assessing and better supporting offenders with more significant mental health disabilities (Butler, 2014, p. 30).

In Canada the Mobile Crisis Team (MCT) program is the most common example of partnership with police and the mental health sector. The program is usually a partnership with a hospital and police service organization, where police officers and mental healthcare practitioners respond to 911 calls potentially involving someone in a mental health crisis. The Canadian Mental Health Association lauds MCT because of its ability to get mental health workers to a crisis faster, resulting in saved police hours (Canadian Mental Health Association- Ontario, 2014).

Other ideas and examples of police-hospital liaisons include:

- The HELP Team Protocol in Chatham-Kent Ontario where the Emergency department at Chatham-Kent Health Alliance is notified when a police officer is coming with an individual in a mental health crisis. The crisis nurse is alerted ahead of time and conducts an assessment to admit the individual or arrange for follow-up care in the community (Provincial Human Services and Justice Coordinating Committee, 2011, p. 37).

- Protocol between Durham Regional Police Services in Ontario and the Ontario Shores Centre for Mental Health Sciences focuses on "high risk" situations when police intervention is needed in the hospital. When police officers arrive on the scene, hospital staff relinquishes control to the officers to "secure the ward with appropriate use of force." A follow up call is initiated by Ontario Shores to ensure

that the right procedures were adhered to and how they could have handled this better in the future (Provincial Human Services and Justice Coordinating Committee, 2011, p. 38).

- The B.C Schizophrenia Society's *Blueprint for Change* report offers a number of examples of protocols that have been developed between police and hospital emergency departments in Montreal, Winnipeg, Cornwall, and Vancouver (B.C Schizophrenia Society, 2006, Appendix F).

- The Provincial Human Services and Justice Coordinating Committee (HSJC) in Ontario, is a network of 14 Regional HSJC Committees. An Info Guide was developed in April 2013 targeted to police and hospitals aimed at reducing emergency department wait-times for people in a mental health crisis accompanied by a police. This guide outlines promising procedures and practises for both the police and hospital staff (Provincial Human Services and Justice Coordinating Committee, 2013).

Other promising practises involving collaboration between police divisions, services, individuals and families include the idea of building a "circle of support" around a person at risk of coming in contact with the justice system. The Guelph Enterprise in Guelph and Wellington County of Ontario, utilize this approach where a circle of support is built around a vulnerable person. A group of key service providers, i.e. CMHA, City of Guelph, Wellington Social Services, Guelph Police Services, etc., meet weekly to identify and discuss a plan for an individual who may have entered the service system.

This grassroots approach works as follows:

> At the meetings one agency will bring up a person they've had contact with who may be at risk. They will work together with the appropriate agencies to make a plan toconnect them with services (Warren, 2015).

As identified earlier in this report the sharing of police related mental health information has been problematic and viewed as an impingement on a person with a disabilities' rights. As a response to this issue, protocols and guidelines have been developed to protect the confidentiality and privacy rights of a person who had dealings with the police during a mental health crisis. For example, the Police Reference Check Program developed by the Toronto Police Services (TPS) sets out to protect a person who has been apprehended under the Mental Health Act. All employers requesting information must sign a Memorandum of Understanding with the TPS and the information is released directly to the client only (Provincial Human Services and Justice Coordinating Committee, 2011, p. 38).

Lastly, the independent review of the Toronto Police Services (TPS) offered many ideas and recommendation on the ways in which the mental health system and the TPS could work in a more coordinated manner, including (Iacobucci, 2014, pp. 11-14):

- Establishing a cross-sectoral committee composed of member of the TPS, 16 psychiatric facilities, the three relevant local health authorities, emergency services and community mental health organizations;
- Develop a protocol for sharing of health information;
- Creation of a voluntary registry to be accessed only in cases of emergency;
- Mutual training initiatives;
- Involve government policy makers;
- Advocate for better community supports;
- Develop an approach for reducing Emergency wait times;
- Educate officers on available mental health resources; and
- Create more opportunities for community gatherings.

Training for other key sectors and individuals and their families

In the literature there are a few examples of education and training opportunities that are geared specifically to healthcare providers related to mental health and justice. Content focuses on legislation, consent, capacity issues, criminal law as well as how to support individuals and family members during times of crisis (Provincial Human Services and Justice Coordinating Committee, 2011, p. 33-34).

Key Resources and Tools

The Provincial Human Services and Justice Coordinating Committee describes a number of innovative resources in the area of police training, cross-sectoral programs with the police, and resources for individuals and their families. The section to follow highlights some of these tools and resources that were consistently referenced.

In the area of police training the well established Canadian Police Knowledge Network has a number of training modules on tips for working with people in crisis, including; *Excited Delirium Syndrome* and *Recognition of Emotionally Disturbed Persons* .[15]

Not Just Another Call is a practical guide for police officers to assist them in their interaction with people with mental health disabilities, developed by CAMH and St Joseph Health Care in London Ontario. The guide aims to enhance learning for police offices in the areas of; 1) understanding mental health, 2) on the requirements and rules of legislation, and 3) the type of resources that are available to help refine their skills (Centre for Addictions and Mental Health, 2004).

There is also an Info Guide developed by the Provincial Human Services and Justice Coordinating Committee that offers strategies for community service providers for communicating with correctional facilities in Ontario. (Provincial Human Services and Justice Coordinating Committee, 2012).

Amanda Butler and the International Centre for Criminal Law Reform and Criminal Justice Policy 's report which reviews efforts to respond to people with mental health disabilities interacting with the justice system, outlines promising models in the areas of crisis intervention teams, examples of mobile mental health units and educational models. This review outlines and describes the content of training modules in eastern Canada, Calgary, Ontario and B.C. (Butler, 2014).

Cotton and Coleman (2010)offer a syllabus of BC- Crisis Team training modules that include a wide variety of materials and differential training methods on topics such as mental health and medications, client and family panels, disclosure issues between the health sector and the police and even a comedy troupe on the issue of mental health (Coleman & Cotton, 2010).

The Memphis Police Department used by police departments in the United States is considered one of the best crisis intervention team models in North America. The foundation of the program is the community partnership of the police and people living with mental health disabilities and their families, where a specialized team is able to respond to a crisis placing the individual's well-being at the core (Butler, 2014, p. 16). Frank Iacoubucci's report recommends that Toronto Police Service develop a CIT program modeled on the Memphis approach (Iacoubucci, 2014, p.25).

In Barrie Ontario, the Canadian Mental Health Association, the Royal Victoria Regional Health Centre with the Barrie Police conduct an annual Crisis Intervention Training conference(McInroy, 2015).

[15] Visit the Canadian Police Knowledge Network website at www.cpkn.ca for specific course outlines.

The tool "Brief Mental Health Screener" developed at the University of Waterloo, will be used by front-line officers with the Ontario Provincial Police to assist them in responding and better communicating with healthcare providers in hospitals (Bezruki**,** 2014)

Film and video resources are effective educational tools which allow the viewer to witness people's experiences in an immediate and more visceral manner. A good example of this is the film *Crisis Call* which shares the perspectives of various people involved in a mental health crisis, in this film, the police, including police officers involved in fatal shootings, an Aboriginal psychiatric survivor who discusses her multiple layers of oppression and abuse by the system and others (Skyworks, 2003).

The Provincial Human Services and Justice Coordinating Committee review, highlights education for healthcare providers in the context of the justice system. The Ontario Hospital Association and its Provincial Leadership Council's *A Practical Guide to Mental Health and the Law in Ontario*, is a toolkit for those working in the mental health sector which explores issues around criminal law, consent and capacity issues (Provincial Human Services and Justice Coordinating Committee, 2011; Ontario Hospital Association, 2010).

For people with mental health and other cognitive disabilities and their families there are many resources to assist them in navigating the criminal justice system and directing them to supports that they might need. Some examples include:

- Fact sheets developed by *LawFacts* a legal information resource with Legal Aid Ontario which outlines the legalities around psychiatric examinations and custody (Legal Aid Ontario, 2015).

- The Human Services and Justice Coordinating Committee (HSJCC) have developed an "Info Guide" which offers successful approaches to communicating with correctional centres (Provincial Human Services and Justice Coordinating Committee, 2013).

- The Ontario chapter of CMHA offers diagrammatic resources that outline information on navigating both the Adult and Youth Criminal Justice & Mental Health Systems (Canadian Mental Health Associations-Ontario, 2014).

- CAMH offers a series of information sheets geared to individuals and families, i.e. *What Happens Inside the Forensic Mental Health System*[16] (Centre for Addictions and Mental Health, 2015).

- The Kitchener Human Services and Justice Coordinating Committee have developed a comprehensive resource entitled *Mental Health the Justice System and You - Understanding the Process and the People that Can Help* which is designed to prepare families, friends and people living with a mental health or intellectual disability at every phase of the justice system from the initial interaction with the police to an explanation of the roles of various justice system personnel and processes such as pre-trial, guilty plea, trial, sentencing and the appeal. The resource uses a fictional character and walks you through the process providing useful tips for families on what to expect and how one might most successful engage (Kitchener Human Services and Justice Coordinating Committee, 2010).

Developing practical tools from the research

This review of the literature highlighted the fact that there are a number of good research reports whose findings could be converted to practical and concise tools for front-line workers and police departments. For example it would be a useful endeavour to translate some of the research results outlined in the Yukon Department of Justice report on FASD, into straightforward tools that could assist justice personnel. The following suggestions for dealing with individuals with FASD in the courtroom would be useful information to have quick access to (Hornick et al, 2008, pp. 24-26):

- all statements and questions should be short and to the point;
- chunk information into small pieces (for what you are presenting to the individual, and in what you expect to receive back);
- ask a question in several different ways;
- all communication must be as concrete as possible;
- read all materials out loud to those who need it; and
- speak slowly.

The Chiefs of Police's *Contemporary Policing Guidelines for Working in the Mental Health System* offers some guidelines or principles that represent some really practical best practise tips. For example the following four guidelines from this document would be useful information in the form of a resource (Cotton, D., & Coleman, T. G, 2006):

- Each police organization should have one or more identified personnel who are responsible for issues related to people in the community with mental illnesses;
- Each police organization should identify and develop a relationship with a primary contact person within the local mental health system;

- Each police organization should have an identified contact person in the emergency services department of any and all hospitals with which they do regular business; and

- Each police service should have available a directory or other print material that provides descriptive and contact information for mental health agencies in the area for employees as well as people with mental illnesses and their families.

This same document states that "dispatch personnel and those taking calls" need to be able ask "the necessary questions and recognize signs that mental illness may be a factor." (Cotton, D., & Coleman, T. G, 2006). Again the development of a list that identifies those pertinent questions would a useful resource for dispatchers.

Many of the reports outlined similar types of principles, guidelines and/or best practices which would be valuable to consolidate and synthesize towards a more unified standard of promising practices.

PART THREE: CONCLUSIONS

A principled human rights approach

The encounter between people with mental health issues, or people with intellectual or cognitive disabilities, and first responders is shaped by legal mandates, health care imperatives, social service delivery systems, intersecting cultural assumptions about mental health, disability, ethno-racial-cultural status, and a host of other socio-economic factors. As examples of people with mental health disabilities who encounter police in ways that end in violence, incarceration or death gain media and political profile, pressures are growing on governments, mental health systems and community advocates to find more effective ways to respond. In an era of resource constraint, and high profile examples that saturate broadcast and social media, the tendency is often to see the problem as a failure of systems to protect individuals and the public.

This review of recent literature and approaches to more effectively manage this encounter clearly point instead to the need for a principled human rights approach with a focus on safeguarding autonomy, ensuring access to support to exercise legal capacity, and enabling access to community supports, care and treatment as needed. While it is imperative to focus on strengthening the collaboration of the justice system with the healthcare, social service sector and individuals and their families, attention must be prioritized to address the problem at its core, i.e. the need to invest in a community-based support system that would effectively assist people with disabilities to live with the supports they need to be safe, healthy and valued in the communities that they live in. With the ratification by Canada in 2010 of the UN Convention on the Rights of Persons with Disabilities (CRPD), there is a clear obligation to reorient and redesign systems to respond more effectively in ways that advance the rights and inclusion of people with mental health and other disabilities.

Article 1 of the CRPD states its overall purpose, to "promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities and to promote respect for their inherent dignity". Among over 50 Articles, the Convention recognizes the right to liberty (Article 14), integrity of the person (Article 17), rights to freedom of expression (Article 21), to privacy (Article 22), to be free from torture and inhuman treatment (Article 15), right to equal recognition before the law (Article 12) which obligates governments to ensure people have access to the supports they require to exercise legal agency in healthcare and other decision making, without discrimination on the basis of mental or other disability; access to justice (Article 13), and the right to community supports to live independently in the community.

With respect to the interface between mental health treatment, civil commitment and mental disability, the United Nations Office of the High Commissioner for Human Rights has issued a strong interpretation of Article 14 of the CRPD (right to liberty) as it applies to mental health law:

> Article 14, paragraph 1 (b), of the Convention unambiguously states that "the existence of a disability shall in no case justify a deprivation of liberty". .... As a result, unlawful detention encompasses situations where the deprivation of liberty is grounded in the combination between a mental or intellectual disability and other elements such as dangerousness, or care and treatment. Since such measures are partly justified by the person's disability, they are to be considered discriminatory and in violation of the prohibition of deprivation of liberty on the grounds of disability, and the right to liberty on an equal basis with others prescribed by article 14.[17]

In fact, a fully-realized human rights approach in this area would shift away from separate mental health law, all together, with its primary focus on managing civil commitment and involuntary admission and treatment, as proposed in the 'fusion model' (Szmukler, Daw and Dawson, 2010). This model calls for establishing a framework for promoting and protecting the right to legal capacity that would apply to all citizens and include provisions for people to access the supports they may require to exercise their legal capacity (Bach and Kerzner, 2010); and health care consent and emergency treatment legislation which would similarly be universal. Northern Ireland is the one jurisdiction in the world that is poised to move in this direction after many years of consultation, a 2007 public consultation report that laid out the approach (Bamford, 2007); and a set of proposals for law reform issued in 2014 by the government (Government of Ireland, 2014).[18]

As this literature review shows, there is a growing emphasis on a principled human rights approach to managing encounters between first responders and people with mental health disabilities and intellectual or cognitive disabilities. This approach sets a high bar. It requires shifting from a 'protection and civil detention based on mental disorder' approach, to one that focuses more clearly on whether people have capacity, how their capacity can be supported, what set of interventions can be made available to de-escalate a situation and ensure effective community-based supports are in place. A principled human rights approach does not deny the need for detention, as a very last resort, but it lays out clearly the steps that must be taken before arriving at this point, requires that mental disability not be a ground for detention, and that safeguards need to be followed along the way to maximize autonomy while meeting needs and minimizing harm.

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[17] Please see the United Nations, Office of the High Commissioner for Human Rights, *Annual report of the High Commissioner for Human Rights to the General Assembly*. A/HRC/10/49, presented 26 January 2009, para. 48-9.

[18]Please see the Government of Ireland, Minister of Justice 'Draft Mental Capacity Bill: Consultation Document,' Author: Belfast, May 2014. Available online: http://www.dhsspsni.gov.uk/mental_capacity_bill_consultation_paper.pdf

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ENDNOTES

for

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[1] BC Schizophrenia Society, 2006; Butler, 2014, p. 5; Provincial Human Services and Justice Coordinating Committee, 2011, p.9.

[2] Mental Health units, i.e. the Ottawa Police Service, whose main responsibilities include; Connecting people with community resources during and after a crisis occurs, Providing support to front-line officers in relation to the Mental Health Act in Ontario, and Working with mental health community services.

[3] Provincial Human Services and Justice Coordinating Committee, 2011, p.6.

[4] Provincial Human Services and Justice Coordinating Committee, 2011, p. 7; Coleman, T. and Cotton, D., p.9.

[5] BC Schizophrenia Society, 2006, p.6.

[6] Provincial Human Services and Justice Coordinating Committee, 2011, p.11.

[7] Provincial Human Services and Justice Coordinating Committee, 2011, p.6.

[8] Iacobucci, 2014, p. 8 and 14; Coleman, T. and Cotton, D., p.71.

[9] Canadian Mental Health Association in Ontario has a position paper recommending that police limit the use of Tasers which are used to subdue or restrain an individual, often used on people experiencing a mental health crisis (CMHA Conducted Energy Weapons(Tasers) and emphasized the need to have trained officers in each police service unit in appropriate interventions in mental health crisis and their involvement with Crisis Intervention teams. They also call for more accountability and monitoring of Taser use (Canadian Mental Health Association, Ontario, 2008).

[10] BC Schizophrenia Society, 2006, p.11.

[11] A good example of this is the OPP consultation with the community to develop their mental health strategy- " OPP is visiting communities in each of the regions policed by OPP seeking input from mental health consumers, care-providers and advocates." (Ontario Provincial Police, 2015).

[12] Provincial Human Services and Justice Coordinating Committee, 2011, p. 6. ; Kitchener Human Services and Justice Coordinating Committee, 2010.

[13] Provincial Human Services and Justice Coordinating Committee, 2011, p. 7.; Iacobucci, 2014, p. 8;

[14]Iacobucci, 2014, p. 8

[15] Provincial Human Services and Justice Coordinating Committee, 2011, p. 9-10.

[16] Bach, M. and Kerzner, L., 2010.