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Mental Health and Criminal Justice Policy Framework

October 2013

camh
Centre for Addiction and Mental Health
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A PAHO/WHO Collaborating Centre

Fully affiliated with the University of Toronto

Un Centre collaborateur OPS/OMS

Affilié à part entière à l'Université de Toronto

Purpose

The purpose of this framework document is to:

- facilitate CAMH responses to emerging mental health and criminal justice policy-related issues with all levels of government
- provide a model for the development and implementation of mental health and criminal justice policies that most effectively address the prevention, diversion and treatment/rehabilitation needs of people with mental illness
- share CAMH's perspective on mental health and criminal justice policy
- encourage a convergence of research and practice within CAMH and across the system on mental health and criminal justice issues.

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Why mental health and criminal justice is important

People with mental illness are over-represented in the criminal justice system. The 2011–2012 Annual Report of the Correctional Investigator found that 36% of federal offenders were identified at admission as requiring psychiatric or psychological follow-up, and 45% of male inmates and 69% of female inmates received institutional mental health care services (Sapers & Zinger, 2012). The over-representation of people with mental illness in the corrections system may be increasing over time. Between 1997 and 2010, symptoms of serious mental illness reported by federal offenders at admission increased by 61% for males and 71% for females (Sorenson, 2010).

The reasons why people with mental illness end up in the criminal justice system are numerous. Societal factors such as poverty, inadequate housing and trauma can increase risk, as can substance use problems. There are also instances when mental illnesses actually cause people to behave in ways that lead to a criminal justice response. Whatever the reason, the over-representation of people with mental illness in the criminal justice system is often referred to as the "criminalization" of mental illness.

The criminalization of mental illness is associated with several factors, most notably the lack of access to appropriate treatment and supports (Hartford, Carey, & Mendonca, 2007). Without access to supports and services, some people with mental illness may commit crimes or behave in ways that draw police attention. How police respond to these interactions is an early predictor of one's likelihood to be further involved in the criminal justice system. When people with mental illness are incarcerated they can experience more severe symptoms of their illness, can become isolated from community supports and services (making it even more difficult to access these services upon their release) and are at increased risk of homelessness upon discharge (Ministry of Health and Long-Term Care [MOHLTC], 2006). They are also reliant upon mental health services in the corrections system, which can be inadequate (Schizophrenia Society of Ontario [SSO], 2012; Sapers & Zinger, 2012). Involvement in the criminal justice system can also increase the stigma and discrimination that people with mental illness already experience.

It is imperative that the criminalization of people with mental illness is addressed and that individuals receive the support, care and treatment that they need and to which they are entitled. To address and reduce the criminalization of people with mental illness, it is helpful to use a social justice approach to public policy that focuses on preventing involvement in the criminal justice system, ensuring diversion opportunities are available and accessible and offering treatment/rehabilitation services that meet people's diverse needs.

What we know

Preventing involvement in the criminal justice system

Population-wide strategies outlined by both the Mental Health Commission of Canada (MHCC) (2012) and the MOHLTC (2011) that focus on improving mental health for all citizens, building healthy and resilient communities and intervening early when a person first shows signs of mental illness lay important groundwork. These strategies also need to consider the unique needs of Aboriginal and racialized communities who can be vulnerable to mental health problems (the Provincial Human Services and Justice Coordinating Committee [PHSJCC], 2011).

Research has shown that people with schizophrenia have a higher risk of committing homicide than those with other serious mental illnesses (Schanda, 2005). The chances of committing murder and becoming involved in the criminal justice system can be reduced by ensuring that these individuals receive early and appropriate treatment (Nielssen & Large, 2008). Similarly, people with mental illness combined with other criminal risk factors (e.g., history of anti-social behaviour, substance abuse) can benefit from targeted interventions to reduce problem behaviours that can lead to involvement in the criminal justice system in the first place (Lamberti, 2007). Efforts to prevent the criminalization of people with mental illness should also focus on increasing programs and services that address the social determinants of health (e.g., housing and income) (Sorenson, 2010).

Overall, having access to a well-funded, coordinated and comprehensive community mental health system—with the support of hospital-based specialty care—will help prevent many people with mental illness from becoming involved in the criminal justice system.

Police

Police officers have been described as the "informal first responders of our mental health system" due to the frequency that they are in contact with those with mental illness (Adelman, 2003). Research suggests that 5% of police dispatches or encounters involve "Emotionally Disturbed Persons" (EDP) (police language for people with mental illness) and 40% of people with mental illness have been arrested at least once in their lifetime (Brink et al., 2011). In Ontario in 2007, over 40,000 police encounters involved people with mental illness and 16,000 police encounters involved apprehensions under the Mental Health Act (Durbin, Lin, & Zaslavska, 2010). These encounters have increased over time.

Mental health calls and Mental Health Act apprehensions in Ontario

	2003/2004	2007
Mental health calls (rate per 100,000)	287	397
Mental Health Act apprehensions (rate per 100,000)	172	232

source: Durbin, Lin, & Zaslavska, 2010.

Sixty percent of police encounters with EDP involve some type of alleged criminal behaviour (20% of which is violent crime; 40% of which is non-violent crime), while the remaining 40% of encounters are unrelated to criminal behaviours and can involve mental health crises, bizarre behaviours, and criminal victimization (Brink et al., 2011). EDP are over-represented in police shootings, stun gun incidents and fatalities (Brink et al., 2011).

Police have considerable discretion in determining how to address and resolve their encounters with EDP. Training and pre-charge diversion can help to improve police interactions with EDP to avoid injury and death and to, when possible, avoid the criminal justice system.

Training

Training police officers to recognize the signs and behaviours related to mental illness and how to respond to someone who is acutely ill can help to mitigate negative interactions between police and EDP. Training police officers to work with people with mental illness reduces stereotyping and stigmatizing attitudes (Brink et al., 2011; Hanafi et al., 2008). Intensive training in de-escalation techniques also has a positive effect on officers' attitudes and knowledge. Training prepares police to respond to situations involving EDP and increases the likelihood that they will connect the individuals that they encounter with appropriate mental health services (Compton et al., 2008).

Mental health training is required as part of the Ontario Police College's training program for new recruits. The Ontario Provincial Police and municipal police services also offer a variety of voluntary and mandatory training programs for their officers (PHSJCC, 2011). In one Ontario study, 84% of police services provided some training to their front line officers, and 59% of police officers had participated in these trainings (Durbin, Lin, & Zaslavska, 2010). Clients and mental health experts have expressed concern that police training is limited and inconsistent. They have noted that ongoing police learning is needed and debriefings after all incidents involving EDP would be useful. The PHSJCC (2011) highlight that there is a lack of provincial standards, such as monitoring and accountability mechanisms, that could ensure that police training in mental health is consistent across Ontario.

Pre-charge diversion

Pre-charge diversion occurs when police officers refer EDP to hospitals or other mental health services instead of involving them further in the criminal justice system. Pre-charge diversion is an important strategy in addressing the criminalization of people with mental illness by recognizing their right to receive healthcare (Sorenson, 2010).

Officers use several factors to determine whether to arrest someone or divert them to the mental health system: the seriousness of the offense; whether the individual is known to police; and whether or not there is a risk of harm to the individual or someone else. Police also use a variety of pre-charge diversion options including connecting the individual to local community mental health services; escorting the individual home; involving crisis response services to take over custody of the individual; or apprehending the individual under the Mental Health Act (MHA) and escorting them to an emergency room (PHSJCC, 2011).

Police may be reluctant to use diversion options. Officers may decide not to take an EDP to hospital due to long wait periods, belief that the person won't meet the committal criteria or concern that the person will be admitted but rapidly discharged (Adelman, 2003). A lack of services to refer people can also deter police from using diversion options (Wilson-Bates, & Chu, 2008). In Ontario, very few police services have formal agreements to transfer care to hospitals, community crisis centres or withdrawal management programs (Durbin, Lin, & Zaslavska, 2010). Pre-charge diversion options are also inconsistent across the province and their availability is dependent on the police detachment and mental health and social services available in the community (PHSJCC, 2011).

Even when diversion options are used, police policy can contribute to the stigma experienced by people with mental illness. In Ontario, any police interaction that involves apprehension and detention under the MHA results in the creation of a non-criminal police record that will show up on a background check and can lead to discrimination in employment. In 2011, guidelines were

developed by the Ontario Association of Chiefs of Police to ensure that mental health information collected by police would not be disclosed on background checks. Approximately 30% of police jurisdictions have implemented these guidelines (Ontario Mental Health Police Record Check Coalition [PRCC], 2013).

Crisis response services

Police/mental health crisis response services are common pre-charge diversion programs that exist across North America. There are various manifestations of crisis response services, though most consist of teams of specially trained police officers working in collaboration with mental health specialists who respond to incidents involving EDP who are in acute distress. Depending on the nature of the circumstance, their goal is to defuse the situation on-site or transfer/refer the individual to mental health services. In Ontario, the majority of police services have some type of mental health crisis response service, though actual use of these services is minimal (Durbin, Lin, & Zaslavska, 2010). Minimal use is likely due to timely availability of the service, officer awareness of the service or police determination that the service is not needed in a particular situation.

There are a variety of crisis response services across Ontario, but they are not standardized or monitored (PHSJCC, 2010). Evaluation of these services is also limited and most of the research in the area focuses specifically on crisis training for officers and not on the implementation of crisis response services as a whole. The program research that does exist demonstrates the benefits of these services. Crisis intervention teams in the U.S. have reduced rates of injury for officers and EDP, increased referrals to treatment facilities instead of jails, reduced recidivism, improved relationships between police and people with mental illness and enhanced police morale (Dupont & Cochran, 2000). Crisis response teams can also reduce psychiatric morbidity by accurately identifying psychiatric emergencies and rapidly referring people to appropriate treatment (Strauss et al., 2005).

Mental health courts and post-charge diversion programs

The criminal justice system is complex and challenging to navigate, especially for those with mental illness. The Accessibility for Ontarians with Disabilities Act (AODA) requires that courts be accessible and accommodate those with disabilities, yet people with mental illness continue to experience barriers to full participation in court proceedings that affect them. Some individuals receive assistance from court support workers (mental health professionals with knowledge of the legal system) who assist people with mental illness and their families to navigate the legal process and link people to necessary mental health supports and services (MOHLTC, 2006). Due to lack of mental health screening in courts, however, assistance from court support workers and referrals to mental health services only occur if needs have been identified by the individual or others involved in their case.

A key component of court support programs is post-charge diversion. With the goal of diverting people with mental illness from further involvement in the criminal justice system, court support workers, lawyers and Crown attorneys have created programs where a person may have their charges stayed if mental illness is a factor, if the charges are low-risk and if supports and treatment can be provided in the community (Chaimowitz, 2012).

Client outcome data on court support and diversion programs is limited, but what information that does exist is positive. The MOHLTC (2006) cite findings that court support/diversion programs increase access to mental health services, improve mental health functioning and outcomes, reduce recidivism and hospitalization and reduce pressure on the criminal justice system. An evaluation of a court support program in Ontario found that clients who received

services had less severe mental health symptoms, reduced likelihood of homelessness, better ability to live independently in the community and more favourable legal outcomes. Upon discharge from the program, only 4% of clients were incarcerated and 2% were detained through the Ontario Review Board. The program was also credited with making the court process more effective and efficient (Aubry et al., 2009).

Effectiveness of court support and diversion programs can be compromised by several factors. A study of court support programs in Ontario found that court support workers had difficulty linking people with mental illness to psychiatrists and hospitals in the community and that people were waiting for long periods of time for services and/or were not receiving all of the services that they needed (Dewa et al., 2008). Staff at an Ontario court support program reported that they were only able to work with those in greatest need because of limited resources relative to demand and that more people with mental illness could be referred to the program if greater capacity existed (Aubry et al., 2009).

In several cities across Canada, people with mental illness have access to mental health courts that are specifically designed to meet their unique needs and challenges and have connections to community resources. Evaluations of these types of courts are limited, but international research indicates that mental health courts that have broader jurisdiction to impose treatment and monitoring and address issues related to substance use, housing, and social assistance reduce recidivism (Schneider, 2010).

"Not Criminally Responsible" and forensic mental health

"Not Criminally Responsible on Account of Mental Disorder" (NCR) is an important historical and legal defense for people who, according to the Criminal Code of Canada, were suffering from a mental illness that made them incapable of understanding their actions at the time they committed a criminal offense. These individuals are provided with treatment through the forensic mental health system instead of being punished in the criminal justice system. Not all people with mental illness who commit crimes are judged to be NCR—only a very small number whose criminal acts are deemed to have been caused by their mental illness. Ontario Review Board data indicate that approximately 0.001% of individuals charged with a criminal code violation are adjudicated NCR each year (approximately 250–280 persons). Few individuals with an NCR designation have committed serious violent offenses such as homicide, attempted murder and sexual offenses (8.1%) (Crocker et al., 2013), though a significant number have committed assault (40.7%) (Latimer and Lawrence, 2006).

Canada's NCR regime

Historically, the overarching goal of Canada's NCR regime has been to balance public safety with the treatment and rehabilitation needs of mentally ill offenders. An individual adjudicated NCR would be diverted to a provincial or territorial review board who would make one of three dispositions: an absolute discharge; a conditional discharge; or a detention order. The review board would base its decision on whether the individual is a "significant threat" (defined as "real risk of serious physical or psychological harm" to others) and would order the disposition that is the "least onerous and least restrictive" to the individual based on this determination of risk. A study of several review boards found that at the first hearing, 51% of NCR individuals were given detention orders, 29.3% were given conditional discharges, and 9.8% were given absolute discharges. An absolute discharge was more likely to be given to individuals charged with non-violent offenses (Latimer & Lawrence, 2006).

The forensic mental health system focuses on providing NCR individuals with the treatment and rehabilitation that they need to become well. These programs operate similarly to civil mental

health programs and are based on psychosocial rehabilitation principles and clinical best practices (Ministry of Health [MOH], 1999). Individuals given a detention order or conditional discharge must participate in treatment in a psychiatric hospital or in the community through hospital–community partnerships. Individuals given an automatic discharge are not required to participate in forensic mental health programs. However, they are encouraged to follow up with supports and services within the civil mental health system.

NCR individuals on conditional discharge or detention orders must meet with the review board at least yearly to assess their progress and active participation in their recovery, to review their potential risk to public safety and to determine if there should be a change in their disposition order. The average length of time individuals remain under the jurisdiction of a review board varies depending on the data analyzed. Latimer and Lawrence (2006) found that all NCR individuals stayed in the system at least six months, 60% stayed longer than five years and 23.3% stayed longer than 10 years. Crocker et al. (2013) found that in their sample of 165 NCR individuals accused of serious violent offenses, 49% were absolutely discharged after an average of two-and-a-half years under the review board. The 51% still under review board jurisdiction had been there over five-and-a-half years. Regardless of time spent under the review board, the recidivism rates for the NCR regime are much lower than federal prison recidivism rates.

Recidivism rates

Not Criminally Responsible (NCR) Regime	Federal Corrections System
7.5% – 10.4% (Livingston et al., 2003; Crocker et al., 2013)	**41% – 44%** (Bonta, Rugge, & Dauvergne, 2003).

Recent changes to the NCR system

In February 2013, the federal government introduced Bill C-54, which recommends several changes to NCR legislation. Bill C-54 introduces three main groups of proposed amendments. The first is a set of proposals to increase the notification and involvement of victims, including more notice of review board hearings and opportunities to provide victim impact statements at these hearings. Second, Bill C-54 makes public safety the paramount consideration in review board decision making, de-emphasizing the importance of balancing it with the treatment and rehabilitation needs of the NCR individual. It also changes review board requirements to make all disposition orders "necessary and appropriate under the circumstances," and changes the definition of "significant threat," thereby lowering the threshold of risk that is necessary to remain under the review board's jurisdiction. Finally, Bill C-54 creates a category of "high-risk" offenders who are subject to severe restrictions on community passes and whose review board hearings can be extended up to 36 months.

The changes proposed by Bill C-54 shift the focus of NCR legislation from treatment and rehabilitation (while being cognizant of public safety) to punishment and security. Placing tougher restrictions on people in the name of public safety compromises NCR individuals' rehabilitation and their ability to successfully reintegrate into the community. As noted, data support the success of the current regime, and many experts in the field of forensic mental health have expressed concerns that Bill C-54 will compromise their ability to provide the best clinical care possible to NCR individuals. Despite the testimonials of these experts, Bill C-54

passed third reading in the House of Commons in June 2013. The only amendment to the bill was that the impact of the changes to the regime be reviewed in five years time.

Increased demand in the forensic system

The new restrictions imposed by Bill C-54 will also add to the growing challenge of being able to accommodate and provide the best possible treatment to an increasing number of individuals entering the forensic mental health system. While the number of NCR individuals is small compared to the criminal justice system as a whole, the number of people in the forensic mental health system has increased substantially since the NCR law was introduced in 1991, particularly in Quebec and Ontario. From 1992–2004, there was a 102% increase in the number of cases admitted to review boards across Canada (Latimer & Lawrence, 2006). CAMH found that the number of Review board patients admitted to its services increased by 87% between 2000 and 2005. The increase in number of NCR individuals puts a strain on the forensic system and particularly on the demand for inpatient beds. CAMH has noted that this demand is acutely felt in the Greater Toronto Area and Hamilton where there are chronic bed shortages, versus eastern Ontario where there is an over-supply of beds. They have called for a better distribution of beds across the province to address this problem.

To ease bed pressure and improve treatment for clients, CAMH has focused on building partnerships and strengthening integration with community resources. We have implemented creative solutions such as the development of transitional rehabilitative housing which allows for greater community integration of low-risk clients while maximizing the use of hospital based forensic services for clients who are higher risk and have more complex mental health problems. These solutions, however, will not be sufficient when Bill C-54 passes and more NCR individuals are staying in the forensic system for longer periods of time.

The corrections system

Due to a lack of access to diversion opportunities, or because of the nature of their crimes, a significant number of people with mental illness end up in the corrections system. Provincial jails (for those who have not completed the trial and sentencing process or for those serving sentences less than two years) and federal prisons (for those serving sentences greater than two years) can be particularly difficult and challenging places for people with mental illness. While there is debate about whether some people with mental illness should be in prison or not, there should be no debate about the services that they receive when they are in prison. All inmates have a fundamental right to healthcare, including mental health care, and the Corrections and Conditional Release Act outlines the obligations of the corrections system to provide this care. Inmates with mental illness are also entitled to the same treatment and rehabilitation services as those in the general population.

Prevalence of mental illness and screening practices

There are various estimates on the prevalence of mental illness in the corrections system. Correctional Service Canada (CSC) identified 13% of male inmates and 29% of female inmates in federal prisons as having mental health needs at admission—rates that have doubled between 1997 and 2008 (Sapers & Zinger, 2012). Within the provincial system, the Ministry of Community Safety and Correctional Services (MCSCS) indicated that 15% of inmates required a clinical intervention for mental illness (2008). They also noted that mental illness is far more prevalent in the remand population (those who have not completed the trial and sentencing process) where the number of mental health alerts has increased by 44.1% in the last decade.

More female inmates have had previous hospitalizations for mental illness (30.1%) than their male counterparts (14.5%) (Sapers & Zinger, 2012). CSC data also reveal that 50% of women

in federal prisons have histories of self-harming behaviour, over 50% have current or previous addictions to drugs, 85% have history of physical abuse and 68% have a history of sexual abuse. The proportion of Aboriginal inmates with serious mental illness has fluctuated between 5–14% from 1996–2009, yet the over-representation of this population in the correctional system as a whole—Aboriginal people account for less than 4% of the Canadian population, but 21% of the federal prison population—and their significant over-representation in self-injurious incidents, indicate that there are serious mental health needs in this population that need to be addressed (Simpson, McMaster, & Cohen, in press; Sapers & Zinger, 2012).

The data highlight the significant number of mental health problems in jails and prisons. However, these numbers may actually underestimate the prevalence and severity of mental illness in the corrections system. In order to accurately identify who is in need of assistance and what type of services that they need, effective screening and assessment practices are required. While the CSC has recently implemented improved admissions screening, the SSO (2012) found that screening practices in provincial and federal institutions are generally inadequate and inconsistent.

Access to mental health treatment and services

Inmates with mental illness have a right to the same mental health treatment and services as those in the general population, including access to medication, counselling, rehabilitation and social support. In federal prisons, most mental health care is provided at one of five Residential Treatment Centres (RTC). The purpose of the RTC is to provide treatment, stabilize offenders and return them to the general inmate population. Inadequate resourcing of RTCs, however, has lead to deterioration in services and these centres are no longer able to provide a full spectrum of mental health care (Service, 2010). RTC services are also in such demand that offenders are released too early and are quickly in crisis again (Sorenson, 2010). The high demand on RTC services also means that they are only available to those with the most acute mental illness and other inmates are left untreated or with limited clinical attention. RTCs also have difficulty serving offenders with the most complex behaviours. These offenders receive very little mental health services and are instead placed in segregation as a security measure (Service, 2010).

The SSO (2012) conducted a comprehensive review of mental health services within provincial jails and found that these services are inconsistent across institutions. Specialized assessment and treatment is provided to various populations in provincial treatment centres, though the referral and assessment processes are unclear as are the types of services provided. Some individual treatment is offered on-site at all prisons (e.g., medication management), but it is unclear if mental health staff are actually available on-site at each institution and if corrections staff have participated in mental health training. Overall, the SSO concluded that mental health services are inadequate and inconsistent across provincial jails.

Safety and security concerns

Offenders with mental illness are extremely vulnerable in the federal and provincial corrections systems. These individuals report feeling unsafe and frequently being the victims of intimidation and violence by other offenders (Sorenson, 2010) and correctional staff (SSO, 2012). Inmates with mental illness do not manage well in prison as demonstrated through disruptive behaviour, aggression, violence, withdrawal, and refusal or inability to follow orders and rules (Sapers & Zinger, 2012). Self-injury and suicide are also prevalent. CSC data indicate that there were 822 incidents of self-injury involving 304 offenders in the fiscal year 2010–2011, a rate that doubled during the previous five years. The suicide rate in the federal corrections system is seven times greater than the national average, and in the fiscal year 2010–2011 there were 54 attempted suicides and 4 completed suicides. All four offenders who completed suicide had mental illness and had previously attempted suicide. CSC data also show that one-third of self-injury attempts, and three of the four completed suicides, occurred in segregation units.

Due to a lack of understanding of the symptoms of mental illness and misinterpretation of behaviours associated with mental illness, correctional officers often respond with security measures instead of with appropriate crisis response and mental health treatment (Sorenson, 2010). Common interventions to manage self-injury in prison include physical handling, restraints, pepper spray and segregation (Sapers & Zinger, 2012) Segregation is overused in prison and jails to address behaviours related to mental illness (SSO, 2012). Prolonged segregation can exacerbate symptoms of mental illness, cause irreversible psychological and physiological harm and is considered an inappropriate response for dealing with offenders with mental illness (Sapers & Zinger, 2011).

Discharge planning

Comprehensive discharge planning is important for inmates with mental illness to ensure their successful transition back into the community. At the federal level, a Community Mental Health Initiative was established in 2005 to better facilitate this transition. Difficulties still persist though as some physicians and community mental health programs do not accept referrals from offenders (Service, 2010). At the provincial level, discharge planning is challenged by a lack of institutional policies and procedures, as well as community services unwilling to provide support to offenders (SSO, 2012). Not being connected to community resources upon discharge is thought to affect recidivism rates, and Brown (2009) confirmed that criminal justice system re-contact rates were significantly higher for inmates with mental illness than those without.

Successful discharge planning requires adequate medication, appointments with outpatient clinics, psychiatrists or counselling services and the involvement of prison and parole authorities. Forensic Assertive Community Treatment (FACT) models may also help to keep people with mental illness engaged with mental health services after discharge as well as keep them from re-engaging with the criminal justice system (Simpson, McMaster, & Cohen, in press).

Vulnerable populations

There are certain populations with mental illness who are at an increased risk within the corrections system. SSO (2012) refers to the "dire" situation of the remand population. These individuals are not screened for mental illness until they are formally charged and their access to treatment and programming is almost non-existent. Female inmates do not have access to mental health supports and services that address their unique challenges (e.g., history of physical and sexual abuse) and Aboriginal inmates have very limited access to culturally appropriate programs/services, and are less likely than other inmates to receive mental health care while they are incarcerated (SSO, 2012). Aboriginal and female inmates are also at risk of not being able to access appropriate mental health care within the federal corrections system.

Principles for a comprehensive Canadian approach to mental health and criminal justice

1.

Canadians should have access to prevention and intervention programs that reduce the likelihood of involvement with the criminal justice system.

Examples of action that results from this principle:

- Investment and implementation in comprehensive mental health strategies by all levels of government.
- Mental health strategies address the over-representation of Aboriginal people and racialized communities in the criminal justice system.
- Children, youth and adults showing early signs of mental illness have timely access to appropriate services.
- All Canadians with mental illness have access to appropriate and comprehensive services, treatments and supports that meet their diverse needs.

2.

People with mental illness who commit criminal offenses should have opportunities to be diverted from the criminal justice system to the mental health system.

Examples of action that results from this principle:

- Pre-charge diversion programs and mental health crisis teams are widely implemented by police departments across the country.
- All Canadians with mental illness who enter the criminal court system have access to court support and diversion programs.
- More access to Mental Health Courts across the country.
- Not Criminally Responsible (NCR) legislation balances public safety with the treatment and rehabilitation needs of the offender.

3.

People with mental illness who commit offenses should have access to high quality, culturally appropriate mental health care.

Examples of action that results from this principle:

- Community mental health agencies are equipped to provide services to people with mental illness who have committed offenses.
- Mental health screening in correctional institutions is comprehensive, ongoing and consistent.
- Individuals on remand are immediately screened for mental illness and have access to the full range of mental health services available in correctional facilities.
- The corrections system provides access to appropriate and comprehensive services, treatments and supports that meet the diverse needs of all inmates with mental illness (with special consideration for female and Aboriginal inmates).

- Discharge planning is a priority in correctional institutions. People with mental illness are connected to appropriate community resources before they are discharged.
- Forensic inpatient beds are appropriately distributed across the different regions to meet the demand.

4.
Treatment and rehabilitation of offenders with mental illness should be part of the correctional system's core mandate and philosophy.

Examples of action that results from this principle:

- The corrections system has a mental health strategy that explicitly outlines its role in providing mental health care to inmates.
- Correctional institutions instill and support a culture where access to treatment and rehabilitation is seen as a priority for inmates with mental illness.
- Correctional institutions balance a criminal justice philosophy of safety, security and risk management with a mental health philosophy of treatment, rehabilitation and recovery.

5.
People with mental illness in the criminal justice system should be treated with respect and dignity and their safety paramount.

Examples of action that results from this principle:

- All employees and representatives of the criminal justice system receive education and training on how to interact compassionately and respectfully with people with mental illness.
- Police and correctional officers receive initial and ongoing training on appropriate crisis intervention techniques for dealing with people who are in distress.
- All mental health education and crisis intervention training is standardized, monitored and subject to ongoing evaluation.
- Segregation for people with mental illness is used only in exceptional circumstances for short periods of time. Prolonged segregation for people with mental illness is not used at all.
- Offenders with mental illness are consulted in the planning and development of mental health and criminal justice system strategies, programs, services and training.

6.
Laws, policies and programs should encourage integration between the criminal justice system and mental health system to enhance access to services, improve quality of care and facilitate transitions between systems.

Examples of action that results from this principle:

- Police departments, courts and correctional facilities have formal and informal referral partnerships with family physicians, local hospitals, community mental health services and other community resources.
- Correctional facilities have partnerships with psychiatric hospitals to temporarily transfer care of people with serious mental illness and behavioural disturbances whose mental health needs cannot be met in correctional institutions.

- Forensic mental health programs have partnerships with community mental health services and housing programs.
- Mental health policy, program and funding decisions within any part of the criminal justice system are made within a whole system context to ensure seamless services and the best use of limited resources.

7.
Government decisions and legislation should be based on evidence and best practices and research in the area should be supported

Examples of action that results from this principle:

- Government decisions are grounded in a thorough understanding of the causes and effects of the criminalization of mental illness.
- Government decisions are informed by best evidence on the positive and negative impacts of different approaches to mental health and criminal justice related to offenders with mental illness (e.g., prevention, diversion and treatment versus "tough on crime" approaches).
- Any criminal justice policy changes that affect people with mental illness are subject to rigorous and transparent evaluation.
- Government provides support and funding for research and evaluation on Canadian-based approaches to mental health and criminal justice.

Conclusion

The criminalization of mental illness needs to be addressed so that people with mental illness can access the treatment and supports they require to live their best lives. A social justice approach that focuses on prevention, diversion and treatment/rehabilitation can help minimize the number of people with mental illness who come in contact with the criminal justice system, provide diversion options for those who do become involved, and ensure that treatment and supports are available at any point throughout the system. The principles above are grounded in this approach and we urge governments at all levels to consider them. Finally, the principles are founded on research and expertise in the area of adult mental illness. While many of the principles are relevant to other populations in the criminal justice system (e.g., youth, people with addictions), policy development in these areas would benefit from more specific examination of the issues.

The Centre for Addiction and Mental Health (CAMH) is Canada's largest mental health and teaching hospital, as well as one of the world's leading research centres in this area. CAMH combines clinical care, research, education, policy development and health promotion to transform the lives of people affected by mental health and addictions issues.

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