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MENTAL HEALTH AND CRIMINAL JUSTICE POLICY FRAMEWORK

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Collaborating Centre*

*Fully affiliated with the
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About CAMH

The Centre for Addiction and Mental Health (CAMH) is Canada's largest mental health teaching hospital and one of the world's leading research centres in its field. CAMH conducts groundbreaking research, provides expert training to healthcare professionals and scientists, develops innovative health promotion and prevention strategies and advocates on public policy issues with all levels of government.

CAMH's strategic plan for 2020-2023, [One CAMH](#), re-affirms our commitment to promoting public policies that are responsive to the needs of people with mental illness, including substance use disorders. As one of the three pillars of this plan, CAMH is committed to 'Inspire' by building a world where prejudice and discrimination that create barriers to belonging for people with mental health illness no longer exist – a world where Mental Health *is* Health. CAMH aims to be a champion for health equity, social justice and inclusion. To help achieve these goals, CAMH communicates evidence-based policy advice to stakeholders and policymakers.

About this document

This report is part of a series of policy framework documents that review evidence, summarize the current environment and propose evidence-informed principles to guide public policy in Ontario.* It updates CAMH's 2013 *Mental Health and Criminal Justice Policy Framework* to reflect and account for new evidence and recent policy developments. Its purpose is to provide a model for mental health and criminal justice policies that effectively address the criminalization of mental illness and to inform federal and provincial initiatives in this area.

* The other CAMH policy frameworks focus on alcohol, cannabis, housing, prescription opioids, primary care and problem gambling. They can be found at be <https://www.camh.ca/en/driving-change/influencing-public-policy>

Executive Summary

There are numerous and interconnected reasons why people with mental illness are over-represented in the criminal justice system, including structural poverty, racism and trauma. A lack of access to mental health care and supports is another crucial factor. Without access to care and supports some people with mental illness may commit crimes or behave in ways that draw police attention to their unusual behaviours. How police respond to these interactions is an early predictor of the likelihood of further involvement in the criminal justice system and how the court system reacts further sets the course. If a person with mental illness ends up in jail, they frequently experience more severe symptoms of their illness. They can also become isolated from community supports and services, are at increased risk of homelessness upon discharge and are more likely to come back into contact with the criminal justice system.

To break the cycle and reduce the criminalization of people with mental illness we need to address the range of factors that contribute to the over-representation of people with mental illness in the criminal justice system, including structural poverty and institutionalized racism. While we touch on these important issues in this paper, our main focus is the intersecting mental health and criminal justice components of the criminalization of mental illness. We look at the importance of a well-resourced, comprehensive and integrated mental health care system. We highlight the need for police officers who can respond safely and compassionately when interacting with people with mental illness in the community. We talk about court support services and specialized courts that can help people with mental illness participate fully in court proceedings that affect them. Our paper provides clarity on the Not Criminally Responsible (NCR) designation and notes the crucial role of a well-connected and well-resourced forensic mental health system. And we highlight the ongoing struggle that people with mental illness experience when trying to access mental health care and supports in the federal and provincial corrections systems.

Our paper concludes by offering governments and decision-makers guidance for developing public policies that will reduce the criminalization of people with mental illness. The following six principles for a comprehensive approach to mental health and criminal justice are provided:

1. Preventing people with mental illness from entering the criminal justice system must be a priority
2. People with mental illness who become involved in the criminal justice system should have access to range of diversion and release options
3. People with mental illness in the corrections system should receive evidence-informed mental health care and supports
4. People with mental illness involved in the criminal justice system should be treated with respect and dignity and their safety made paramount
5. There should be collaboration and coordination between the criminal justice system and the mental health system
6. Policy decisions should be evidence-informed and research should be supported

Why mental health and criminal justice policy is important

People with mental illness, including those with substance use disorders, are over-represented in the criminal justice system. This over-representation is increasing over time.¹ The reasons why people with mental illness end up in the criminal justice system are numerous and interconnected. Societal factors such as stigma, structural poverty, racism (particularly anti-Black and anti-Indigenous racism), inadequate housing and trauma can increase risk, as can co-occurring mental health and substance use problems. Policing and criminal justice policy can also increase criminal justice involvement. As well, there are instances when mental illnesses result in behaviours that lead to a criminal justice response. The overrepresentation of people with mental illness in the criminal justice system is often referred to as the “criminalization” of mental illness.

While the criminalization of mental illness is associated with a wide variety of social factors that disproportionately affect people with mental illness (e.g. structural poverty, racism, criminal justice policy), the mental health sector also plays a role. Specifically, lack of access to appropriate mental health treatment and supports is a crucial factor that can contribute to the criminalization of people with mental illness.² Without access to supports and services, some people with mental illness may commit crimes or draw police attention to their unusual behaviours. How police respond to these interactions is an early predictor of the likelihood of further involvement in the criminal justice system and how the court system reacts further sets this course. If a person with mental illness ends up in jail, they frequently experience more severe symptoms of their illness, can become isolated from community supports and services and are at increased risk of homelessness upon discharge.³ They are also reliant upon mental health services in the corrections system, which are inadequate.⁴ Involvement in the criminal justice system further increases the stigma and discrimination that people with mental illness already experience.

It is imperative that the criminalization of people with mental illness be addressed and that individuals receive the support, care and treatment that they need and to which they are entitled. To reduce the criminalization of people with mental illness we need public policies that focus on: addressing structural poverty and institutionalized racism; preventing involvement in the criminal justice system; ensuring diversion opportunities are available and accessible; and providing equitable mental health care and supports in correctional facilities.

In this paper we focus on the intersecting mental health and criminal justice components of the criminalization of mental illness. Other issues of direct relevance (anti-Black and anti-Indigenous racism; structural poverty; drug policy) will be touched on but will be addressed in more detail through other policy and advocacy work from CAMH.

What we know

Prevention

Preventing people with mental illness from becoming involved in the criminal justice system requires governments to make mental health care a priority,⁵ particularly services for people with serious mental illness. Experts agree that a well-resourced, comprehensive and integrated mental health care system can help people with mental illness get the care and supports that they need to remain in their communities and avoid the criminal justice system. Evidence further suggests that targeted interventions for people with mental illness who have other risk factors that increase their likelihood of criminal justice involvement (e.g. untreated schizophrenia, substance use disorder, history of anti-social behaviour) can reduce the chances that these individuals become involved in the criminal justice system.⁶ Efforts to prevent the criminalization of people with mental illness also need to address the social determinants of health.⁷ People with mental illness who are homeless are more likely to become involved in the criminal justice system, pointing to the crucial need for better access to affordable and supportive housing for people with mental illness.⁸

Community crisis response

A key component of an integrated mental health system, and crucial for preventing the criminalization of people with mental illness, is rapid access to community crisis response. Right now, in part because of underfunding in the mental health system, people with mental illness who experience a crisis in the community are met by police. Dispatching police to a person experiencing a mental health crisis implies that such behaviours are dangerous or criminal and that force is the required and appropriate response (rather than compassion and understanding). It also increases stigma. Being met by police can heighten apprehension and fear in those experiencing a crisis and pose real risk of physical or psychological harm - particularly amongst Indigenous, Black and other racialized people. Further, police officers are not trained in mental health crisis response to the extent of health care workers, nor should they receive this level of training. Police are not mental health crisis workers and should not be expected to take on this additional role. In some cases, police may be able to refer people in crisis to a mobile crisis intervention team (MCIT) which pairs a specially trained police officer with a mental health clinician who can provide assessment, support and referral services (see more on MCITs in the Police section). The concern amongst experts and advocates, however, is that MCITs are still a criminal justice- led response to a health crisis and they perpetuate stigma. As CAMH and others have noted, a mental health crisis should be met with an emergency health care response, just like a physical health crisis.⁹

There are a variety of international community crisis response models, though limited research has been conducted on these models. In the United Kingdom, for example, Crisis Resolution and Home Treatment Teams consisting of a variety of mental health professionals provide intensive home support for people experiencing acute mental health crises and in Sweden, the Psychiatric Emergency Response Team of specialized nurses and paramedics arrives via mental health ambulance to provide support to people experiencing severe mental health crises in the community. Both of these community crisis response models receive positive feedback from service users.¹⁰ In Toronto, service users speak highly of the Gerstein Centre mobile crisis team where peers with lived experience of mental illness provide care and support to people experiencing a crisis in the community.

One community crisis response model that is receiving attention recently is Crisis Assistance Helping Out on the Street (CAHOOTS). Established in Eugene, Oregon in 1989, the CAHOOTS team, consisting of a medic and crisis worker, is dispatched through the 911 communications centre to provide immediate stabilization and support to people experiencing a mental health crisis in the community. Police back-up is available if needed, but is requested in less than 1% of cases.¹¹ Use of the CAHOOTS team contributes to cost savings in Eugene's annual public safety and health spending.¹²

Despite the limited evidence available on the efficacy of community crisis response models and the need for more research in the area, there is promise that this health focused approach to mental health crises can assist in preventing people with mental illness from involvement with the criminal justice system.

Policing

A historical lack of investment in prevention strategies means that interactions between police and people with mental illness are a common occurrence. In fact, police are often described as informal first responders of the mental health system due to the frequency with which they interact with people with mental illness in the community.¹³ Across Canada, 5% of police encounters involve people with mental illness.¹⁴ In Toronto, that number increases to 15%.¹⁵ Interactions between police and people with mental illness are increasing over time.¹⁶ Between 2007 and 2013, the Ontario Provincial Police saw a 42% increase in mental health calls with a corresponding 65% increase in the time officers spent responding to these calls.¹⁷ Police interact with people with mental illness for a variety of reasons. One study found that 60% of police encounters with people with mental illness involve some type of alleged criminal behaviour (20% violent crime; 40% non-violent crime), while the remaining 40% of encounters involve mental health crises, bizarre behaviours, and/or criminal victimization.¹⁸

The vast majority of encounters between police and people with mental illness are resolved without incident. Unfortunately, when more complicated situations arise, the results can be tragic. Between 2000 and 2016, more than 40 people with mental illness were fatally shot by police in Ontario.¹⁹ Of the 461 fatal police encounters in Canada between 2000 and 2017, more than 70% of victims had a mental illness.²⁰ Black and Indigenous people with mental illness are over-represented amongst victims of fatal police interactions,²¹ though a thorough analysis of the intersection between mental illness and race in the context of police interactions is difficult because this data is not always available.

For people with mental illness, encounters with police can lead to further and ongoing involvement in the criminal justice system or forensic mental health system. That is why preventing involvement with the criminal justice system in the first place is so important. Yet even with investments in prevention strategies, some people with mental illness will come in contact with police in the community and police must be equipped to respond to these interactions safely and compassionately. Fortunately, police have considerable discretion in determining how to address and resolve their interactions with people with mental illness. Applying de-escalation techniques and having access to pre-charge diversion options can help avoid injury or death when people with mental illness are in crisis in the community (or in some cases when they are at risk of crisis). Pre-charge diversion can also be used to assist people with mental illness accused of minor crimes or provincial offences to avoid further criminalization.

De-escalation

Standard police responses that typically diffuse high stress encounters with members of the public can be ineffective or provoke further agitation when applied to a person experiencing a mental health crisis.²² For this reason, de-escalation through communication and negotiation is well-recognized by experts, including people with mental illness, as the preferred response when police encounter a person experiencing a mental health crisis in the community.²³ Calming a person in crisis, or preventing them from further escalation, diffuses the immediate risk and allows police to consider resolving the situation without further criminal justice involvement.

Intensive training in de-escalation techniques has been shown to have a positive effect on officers' attitudes and knowledge about mental illness, better preparing police to respond to situations involving people in crisis and increasing the likelihood that they will connect these individuals to mental health services.²⁴ The challenge is that de-escalation training is not standardized in Canada and the content and frequency of instruction varies from organization to organization.²⁵ Experts recommend that police use-of-force training include a focus on de-escalation and emphasize non-physical interventions, especially for people experiencing a mental health crisis.²⁶ In Ontario, however, most police use-of-force training focuses on the use of weapons with limited time dedicated to teaching officers how to de-escalate situations through communication and negotiation.²⁷ A further challenge is that even when police organizations have enhanced their de-escalation training there remain concerns that this training is not always translated into practice.

Given the potential for de-escalation to save lives and reduce harm, experts have recommended that provincial governments standardize and mandate police de-escalation training²⁸, that this training be trauma-informed and it be designed and delivered by experts including people with lived experience of mental illness.²⁹ Having people with lived experience participate in the delivery of de-escalation training is particularly important given that research shows that direct engagement with people with lived experience of mental illness also helps to address stigma and discrimination.³⁰ In addition, experts have recommended that governments make de-escalation the *required* response when police interact with a person experiencing a mental health crisis³¹ (when it is safe to do so) as opposed to the *preferred* response. Such a condition may result in better translation of de-escalation training into practice. Research looking at innovative approaches to police de-escalation training, such as physiological stress control in conjunction with scenario-based training, also show promise for improving the use of de-escalation techniques in the field.³²

Less lethal force

Discussions on police de-escalation techniques often make reference to less lethal force options such as Conducted Energy Weapons (CEWs), but the use of any type of force should not be equated to de-escalation.³³ While CEWs (commonly known as TASERS) do give police a less lethal option in encounters involving agitation or aggression, they are still weapons and their use is not without risk or lasting psychological injury – particularly for people who are experiencing a mental health crisis.

Mental health advocates have expressed concern that when police have access to CEWs they will by-pass non-violent techniques to calm or subdue a person experiencing a mental health crisis, essentially using force in situations that actually warrant de-escalation. Such fears are reinforced by evidence indicating that police are two times more likely to use CEWs at mental health emergencies than at criminal arrests³⁴ and CEWs are used 28% more frequently on people with mental illness than those without.³⁵ In Ontario, advocates have expressed concern about the potential for overuse of CEWs on people experiencing a mental health crisis due to the relatively low threshold for CEW use in the province.³⁶ Experts have recommended a review and refinement of this threshold.³⁷ A high profile review of CEW use in British Columbia, for example, recommended that officers be prohibited from using CEWs unless a person is causing serious bodily harm or an officer reasonably believes that a person's behaviour will imminently cause bodily harm.³⁸ The review also recommended prohibiting use of CEWs unless de-escalation and other lesser force options have not been, or will not be, effective at eliminating the risk of serious bodily harm.³⁹

There are concerns about the health effects of CEWs on people with mental illness. While research on this topic is limited, some evidence indicates that people with mental illness and/or those using substances may be at greater risk of death after being shocked by a CEW.⁴⁰ It has also been proposed that medications used by people with mental illness may increase their risk of death by CEW.⁴¹ People with lived experience of mental illness have also noted that CEWs can cause psychological trauma.

Other less lethal force options that have been recommended by some coroner's juries and people with lived experience of mental illness include sock rounds/beanbag guns and shields.⁴² Shields in particular show promise for containing people and creating opportunities for further de-escalation attempts.⁴³ Sock rounds/beanbag guns and shields are still physical force options, however, and should be considered only after initial attempts at verbal de-escalation have been unsuccessful.

Pre-charge diversion

Pre-charge diversion occurs when police officers connect people with mental illness to treatment and supports instead of involving them further in the criminal justice system. Pre-charge diversion is a key factor in addressing the criminalization of people with mental illness because it promotes early intervention and respects an individual's right to access basic needs, such as health care.⁴⁴

Police look at several factors when determining 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.⁴⁵

Most police services in Ontario have access to pre-charge diversion options,⁴⁶ but they are inconsistent across the province and their availability is dependent on the police service as well as the mental health and social services available in the community.⁴⁷ Even when pre-charge diversion options are available, they are not always well used⁴⁸ and there is risk of systematic bias. A lack of community services to refer people to can deter police from using diversion options⁴⁹ and a lack of culturally appropriate mental health services for Indigenous and racialized communities limits police ability to connect people with supports that actually meet their needs.⁵⁰

Police may be hesitant to take people experiencing a mental health crisis to an emergency department due to long wait times, belief that the person will not meet the committal criteria or concern that the person will be admitted but rapidly discharged.⁵¹ Officers may also be reluctant to accompany a person in crisis to the emergency department because they know that their presence can increase the stigma of mental illness, particularly for Indigenous and racialized peoples.⁵² Experts have noted that establishing a formal transfer of care protocol between police services and hospital emergency departments can help improve communication and reduce wait times for police.⁵³

A common pre-charge diversion option used by police is crisis response services.⁵⁴ In Canada, the most common model is the MCIT in which a specially trained police officer and mental health clinician co-respond to a person experiencing a crisis in the community.⁵⁵ MCITs are typically brought in to provide support after the police primary response unit has assessed the situation. There are MCITs who are first responders in mental health crisis situations (e.g. Hamilton's Mobile Crisis Rapid Response Team), but such models are not common in Canada

despite commendation from the Mental Health Commission of Canada.⁵⁶ Common criticisms of MCITs include their lack of universal availability to all police services; limited staffing and hours;⁵⁷ and the need for greater peer involvement.⁵⁸ Also, as noted in the Prevention section, MCITs remain a criminal justice-lead response to a health crisis.

Another concern with MCITs is the lack of program standards. The elements and activities vary amongst teams making it difficult to identify the core components for success and evaluate outcomes.⁵⁹ The limited evidence that does exist demonstrates that MCITs build strong links with community services and reduce pressure on the justice system.⁶⁰ The teams are also viewed positively by people with mental illness and their families.⁶¹ Evidence on whether MCITs are able to prevent crisis escalation or minimize injuries is limited,⁶² though an evaluation of Toronto's MCITs found that injuries occurred in only 2% of interactions and that they were usually minor and self-inflicted.⁶³ It is also uncertain whether or not MCITs are able to reduce hospitalizations (and whether or not this is actually a shortcoming if people who need hospitalization actually receive it),⁶⁴ though MCITs are more likely to bring people with mental illness to hospital voluntarily than regular police units.⁶⁵

Court Supports and Specialized Courts

The criminal justice system is complex and challenging to navigate, especially for many people 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 services and/or have the opportunity to participate in specialized courts. A key component of both court support services and specialized courts is post-charge diversion - linking people with mental illness to appropriate mental health treatment and supports with the goal of preventing further involvement in the criminal justice system.⁶⁶ The challenge is that the numerous iterations of post-charge diversion programs make it difficult to identify best practices⁶⁷ as well as determine the overall effectiveness of these diversion programs.⁶⁸ There is concern among some experts, for example, that post-charge diversion programs do not actually reduce the number of people with mental illness who are remanded in custody (i.e. even those individuals who have access to post-charge diversion may have to wait in jail before participating in the program), therefore not truly 'diverting' people from the criminal justice system. While more research on post-charge diversion programs is clearly needed, some positive outcomes have been associated with participation in court support services, mental health courts, drug treatment courts and Gladue Courts.

Court support services

Court support services typically consist of court support workers (mental health professionals with knowledge of the legal system), lawyers, and Crown attorneys who work together to stay charges for individuals who have a mental illness and low-risk charges and who can be connected to supports and treatment in the community.⁶⁹ While client outcome data on court support services is limited, the evidence that does exist demonstrates that these programs increase access to mental health services, improve mental health functioning and outcomes, and reduce recidivism, hospitalizations and pressure on the criminal justice system.⁷⁰ An evaluation of a court support service in Ontario found that clients who received services had less severe mental health symptoms, a reduced likelihood of homelessness, better ability to live independently in the community and more favourable legal outcomes. Upon discharge from the service, only 4% of clients were incarcerated and 2% were in the forensic mental health system. The service was also credited with making the court process more effective and efficient.⁷¹

Effectiveness of court support services can be compromised if court support workers are unable to link people with mental illness to psychiatrists and hospitals in the community or if people have to wait a long time for services and/or do not receive all of the services that they need.⁷²

Limited resources can also make it difficult to provide court support services to everyone in need.⁷³

While most court support services are affiliated with a community mental health agency, Legal Aid Ontario (LAO) initiated its own court support-type service to increase access to justice for marginalized individuals. The 'C' Court project operates out of the Old City Hall courthouse in Toronto. A LAO staff lawyer and paralegal provide legal representation to people with mental illness who are homeless and who have been charged with offences in Provincial Offences Court. The goal is to make sure these individuals are not fined or jailed for minor offenses and instead are connected to community resources. In its first year of operation, none of the 141 clients supported through 'C' Court were fined or sentenced to jail and 86% had their charges withdrawn or stayed.⁷⁴

Mental Health Courts

Mental health courts are essentially a more formalized court support service that includes participation from a judge and convene regularly in a dedicated courtroom on a dedicated schedule.⁷⁵ While there are various models of mental health courts, most of them typically use a multi-disciplinary team approach to connect individuals with mental illness accused of crimes to treatment and supports, often with the goal of diversion from further involvement in the criminal justice system.⁷⁶ Ontario's 19 mental health courts vary in terms of proceedings, client eligibility criteria, court resources and meeting frequency, but all share a common goal of connecting offenders with mental illness to the treatment and supports that they need and diverting them from further involvement in the criminal justice system when possible.⁷⁷

Mental health courts have demonstrated success in connecting individuals to treatment and supports,⁷⁸ and some evidence shows that they are able to reduce recidivism rates, particularly those courts that have case management services.⁷⁹ Research also suggests that mental health courts that have broader jurisdiction to impose treatment and monitoring and address issues related to substance use, housing, and social assistance can reduce recidivism.⁸⁰ The judge's role as an authority figure that treats participants with dignity and respect is also thought to be a factor that reduces recidivism in this style of court.⁸¹

There are concerns about equitable access to mental health courts. Evidence from the US indicates that white males are over-represented in mental health courts,⁸² despite the fact that racialized men are over-represented in the broader criminal justice system.⁸³ While Canada's race-based criminal justice data is limited, experts (including racialized people with mental illness who have been involved in the justice system) believe this could be a concern in this country as well.⁸⁴

It is worth noting that the mental health court in Kenora has practices in place to better serve Indigenous peoples. This court uses videoconferencing for assessment and intake so that Indigenous individuals do not need to leave their communities to participate in court processes.⁸⁵

Drug Treatment Courts

Similar to mental health courts, drug treatment courts are formalized court settings where judges, Crown attorneys, duty counsel and community partners work together to divert offenders with substance use disorders from further involvement in the criminal justice system and into treatment and other community supports.⁸⁶ The main goals of these courts are to reduce substance use, recidivism and system costs.⁸⁷ Drug treatment courts typically serve offenders with serious drug addictions who have committed non-violent offenses.⁸⁸ In exchange for having their criminal charges stayed, participants in drug treatment courts must participate in an addiction treatment program, undergo random drug testing, make regular court appearances (where a judge reviews their progress and can reward or sanction the individual), and gain control over their substance use.⁸⁹

A review of drug treatment courts in the US and Canada found that they are successful at reducing recidivism rates compared to traditional criminal justice responses.⁹⁰ An evaluation of the Toronto Drug Treatment Court found that less than 15% of graduates reoffended compared to 90% in a control group. Interestingly, this evaluation also found that people who were actively engaged in the program, but did not graduate (i.e. continued to use substances to some degree), had lower rates of reoffending, decreased their substance use and increased their quality of life.⁹¹ This finding may moderate concerns that a substantial number of drug treatment court participants do not actually graduate from the program.⁹² CAMH reporting also found that the Toronto Drug Treatment Court was successful at reducing participants' use of detox, ambulance and emergency room services.

A major concern for the 24 drug treatment courts across Canada is funding. Between 2006 and 2014, the Toronto Drug Treatment Court received no funding increases. This resulted in a decrease in the number of full-time addiction support specialists available to provide treatment to participants at the same time the program experienced a 35% increase in the number of participants. In 2015, the Toronto Drug Treatment Court experienced a 20% reduction in funding which contributed to further staffing reductions and a decrease in the number of clients served. Experts note that other drug treatment courts across the country are also struggling to sustain their services.

Gladue Courts

Gladue Courts are not just for people with mental illness, but are worth mentioning as a post-charge diversion opportunity for Indigenous offenders.⁹³ Gladue Courts are part of a broader initiative to address the over-representation of Indigenous individuals in the criminal justice system, many of whom are impacted by mental illness and trauma as a result of colonial policies and practices.⁹⁴ In Gladue Courts, judges take into consideration systemic background factors that have had an impact on an Indigenous offender and prioritize restorative justice options that align with Indigenous approaches to justice.⁹⁵

Gladue Courts are recognized as the most successful strategy amongst a range of Gladue initiatives across the country.⁹⁶ An evaluation of the Gladue Court at Old City Hall in Toronto found that it was meeting all of its objectives, including: avoiding unnecessary pre-trial detention; encouraging effective and culturally appropriate alternatives to incarceration; engaging individuals in the development of their resolution plans; and providing opportunities for Indigenous agencies to engage in rehabilitation of individuals from their communities.⁹⁷ The evaluation concluded that the Gladue Court and its associated programs and services were 'providing a critically important service to [Indigenous] individuals, their families and the larger [Indigenous] community and should be seen as a model for the development of similar initiatives across Ontario and across Canada'.⁹⁸

Forensic Mental Health

People who have committed offenses but are found by a court to be 'Unfit to Stand Trial' (UST) or 'Not Criminally Responsible on Account of Mental Disorder' (NCR) are diverted from the criminal justice system and into the forensic mental health care system. A person is deemed UST if they are unable, due to a mental disorder, to understand the trial process, understand the possible outcomes of their trial, or communicate with their lawyer. Individuals who are UST enter the forensic mental health system, and may be offered treatment or services to support them in becoming fit to stand trial. A person may be deemed NCR if, at the time of the offence, they suffered from a mental illness that made them incapable of appreciating the nature or quality of their actions, or knowing what they were doing was wrong. Similar to people found UST, NCR offenders enter the forensic mental health system where they are provided with rehabilitation and offered treatment for their mental illness. NCR cases account for less than 1% of all adult criminal court cases each year in Canada.⁹⁹ Despite this small number, most people in the forensic mental health system have an NCR designation as opposed to a UST designation.¹⁰⁰

The NCR Regime

The overarching goal of Canada's NCR regime is to protect public safety while ensuring that people with mental illness who have offended get the treatment and rehabilitation that they need. Once a court finds that an individual is NCR, they are diverted from the criminal justice system and come under the jurisdiction of a provincial or territorial review board. The review board conducts a hearing for each individual under its jurisdiction and makes one of three dispositions: an absolute discharge; a conditional discharge; or a detention order. The review board must make the disposition that is "necessary and appropriate in the circumstances", taking into account public safety (its paramount consideration) as well as the offender's mental condition, their re-integration into society, and other needs. If the person is not a "significant threat to the safety of the public", the review board must order an absolute discharge. In 2014, the *NCR Reform Act* was passed which created a category of "high-risk accused". A court may find an offender who has been found NCR to be "high-risk" if certain criteria are met. If this finding is made, the offender is subject to significant restrictions on their ability to leave the hospital, and the time for holding their review board hearings may be extended up to 36 months from the typical 12 months.

Initially, most NCR offenders receive a detention order (~57%) or a conditional discharge (~33%).¹⁰¹ These individuals come under the care and supervision of a designated forensic hospital, which must create a program of rehabilitation and offer treatment and reintegration

opportunities as appropriate. At annual hearings, the review board reviews the individual's mental condition, evaluates their potential risk to public safety, and determines if there should be a change in their disposition order. Individuals given an absolute discharge are no longer subject to the jurisdiction of the review board or the criminal courts, however, they can receive follow up psychiatric care within the civil mental health system. Less than 10% of NCR offenders receive an absolute discharge at their first review board hearing.¹⁰² For others, the process of obtaining an absolute discharge can take much longer and some may never obtain one. A cross Canada study found that all NCR individuals remained under the review board for at least six months, 60% stayed longer than five years and 23% stayed longer than 10 years.¹⁰³ Individuals who commit non-violent or less serious violent offenses move through the review board system more quickly than those who commit serious, violent offenses.¹⁰⁴

Courts in Quebec render more NCR verdicts as compared to Ontario and B.C., raising questions about consistency in how NCR provisions of the Criminal Code are interpreted and applied.¹⁰⁵ There are also significant differences in the trajectories of NCR offenders across the country, leading experts to call for better collaboration and integration at the national level.¹⁰⁶

Who are the people found NCR?

Most NCR individuals (94%) have a serious mental illness such as a psychotic spectrum disorder¹⁰⁷ and many also have a concurrent mental health and substance use disorder.¹⁰⁸ About 2/3 of NCR individuals' index offenses involve crimes against the person (e.g. major assault, uttering threats), though the proportion who have committed serious violence is low¹⁰⁹ and is decreasing over time.¹¹⁰ Murder accounts for 1% of all NCR cases, attempted murder 3% and sexual assault 5%.¹¹¹ Family members are usually the victims in NCR cases involving crimes against the person.¹¹²

The recidivism rate for people designated NCR is relatively low (17% after 3 years) with those who commit severe violent index offenses being the least likely to reoffend (6% after 3 years).¹¹³ Comparably, the recidivism rate in the corrections system is known to range from about 23%-37%.¹¹⁴ People who have committed more crimes prior to their NCR index offense as well as those with concurrent mental health and substance use problems are at greater risk of re-offending.¹¹⁵ Those who are still under the review board are less likely to re-offend than individuals who have received an absolute discharge.¹¹⁶ Less than 1% of re-offenses involve a severe violent crime.¹¹⁷

The profile of NCR individuals is changing over time with an increasing number of young people of diverse ethno-racial backgrounds with substance use disorders who have committed relatively low-level violent crimes entering the forensic system.¹¹⁸ This suggests that mental

health treatment and rehabilitation may need to be tailored to meet the needs of this changing demographic.¹¹⁹ Similarly, women who have been designated NCR tend to have different mental health diagnoses than men (e.g. they have a greater likelihood of a mood disorder or personality disorder) and greater psychosocial functioning which could signal the need for gender-specific forensic services.¹²⁰ Finally, there are fewer Indigenous individuals in the NCR system than would be expected due to their over-representation in the criminal justice system as a whole, indicating that this defense may be under-used with this population.¹²¹

The forensic system

Canada's forensic mental health system offers people who have been designated UST and NCR with the treatment and rehabilitation that they need to become well. These programs operate similarly to civil mental health programs and are based on the principles of psychosocial rehabilitation and clinical best practices.¹²² While UST and NCR cases comprise only a fraction of all cases passing through the criminal justice system, the number of people in the forensic mental health system has increased substantially since the original NCR law was introduced in 1991. From 1992 to 2004, there was a 102% increase in the number of cases admitted to review boards across Canada.¹²³

Ontario's forensic system is one example of a provincial/territorial forensic mental health system that is under particular strain. Between 1987 and 2007 yearly admissions to the Ontario Review Board (ORB) rose at an average of 6.5% each year,¹²⁴ though there was a 30% decline in new cases between 2007 and 2012.¹²⁵ Even though the number of new forensic patients is decreasing somewhat, the forensic system remains under intense pressure as average length of inpatient stay is rising and time to absolute discharge appears to be increasing as well. As a result of both new and ongoing forensic cases, the total number of people under the ORB increased from 400 in 1992 to approximately 1750 in 2012.¹²⁶

The increasing number of people under the ORB consistently outpaces resources within the forensic system and diminishes the ability of forensic mental health services to provide patients with the best possible care and treatment. CAMH's outdated forensic inpatient facilities are overflowing and typically run at a 102% occupancy rate. This means that there can be lengthy wait times for inpatient beds and patients have to wait in higher security settings than their clinical needs require. It also means that CAMH is unable to accommodate individuals with serious mental illness who are in correctional facilities and need acute inpatient treatment. The high inpatient occupancy rate is also due to a lack of mental health supportive housing for forensic patients who have been approved for community living by the ORB. These individuals remain in hospital instead of being able to take the next step in their treatment and rehabilitation by living in the community under forensic outpatient care.

To ease bed pressure and improve treatment for clients, CAMH has focused on building partnerships and strengthening integration with community resources. CAMH has also implemented creative solutions such as the development of transitional rehabilitative housing that allows for greater community integration of low-risk clients while maximizing the use of inpatient forensic services for clients who are higher risk and have more complex mental illnesses. Unfortunately, there is still not enough mental health supportive housing to meet the growing demand on the forensic system, or the mental health system more generally. CAMH's forensic inpatient units are also not able to meet these demands and are in need of expansion and modernization to improve safety and meet the changing needs of forensic patients.

The Corrections System

Due to systemic bias, a lack of pre-charge diversion, challenges in the court system and/or because of the nature of their crimes, a significant number of people with mental illness end up in the corrections system where the mental health care that they receive, or do not receive, can break or reinforce the cycle of criminalization.

Whatever pathway has led to incarceration, all people with mental illness in provincial correctional facilities (for those on remand or those serving sentences less than two years) and federal correctional facilities (for those serving sentences greater than two years) have a fundamental right to health care, including mental health care. The UN Standard Minimum Rules for the Treatment of Prisoners (the 'Mandela Rules') states that prisoners should have access to the same standard of health care that is available in the community and that clinical decisions are to be made by health care professionals. In Canada, the *Corrections and Conditional Release Act, 1992* outlines the obligations of the federal corrections system to provide health care to offenders and in Ontario, the *Ministry of Correctional Services Act, 1990* outlines the health care duties of the provincial corrections system. (It should be noted that the *Correctional Services Transformation Act, 2018* was passed in the Ontario legislature in May 2018 that updated the obligations of the province when it comes to health care in provincial correctional facilities, but this law has yet to come into force). Despite these obligations, there are people with mental illness in both the federal and provincial corrections systems who are not receiving the mental health care that they need and this can compromise their successful re-integration back into the community.

Mental illness, suicide and overdose

Mental illness is 2 to 3 times more common in Canadian correctional facilities than in the general population.¹²⁷ In 2016, 26% of males in the federal corrections system had a mental health need and 50% of females had a mental health need.¹²⁸ By 2018, almost 80% of female offenders in federal corrections met the criteria for a mental illness.¹²⁹ Serious substance use problems are also seen in 80% of newly admitted offenders.¹³⁰ In Ontario's provincial corrections system about 35% of offenders have a mental health alert on their file and amongst female offenders, this increases to 50%.¹³¹ The percentage of Ontario's offender population with a mental health alert has increased by an average of 6% a year since 1998/1999.¹³²

Deaths related to mental illness are an ongoing concern in correctional facilities. The suicide rate in federal prisons is approximately five times the national average.¹³³ Suicide is the most common type of non-natural death among federal offenders and accounted for about 12% of all deaths in correctional facilities in 2018/2019.¹³⁴ Between 2009/2010 and 2015/2016, 67 federal offenders died by suicide and the majority of them had an identified mental illness

(76%) and/or a history of substance misuse (76%).¹³⁵ In 35% of cases, the offender had recently experienced a change in their psychiatric medication.¹³⁶

Suicide deaths are decreasing as a portion of non-natural deaths in federal prisons, but that is corresponding with an increase in overdose deaths.¹³⁷ Between 2012/2013 and 2016/2017 there were 330 overdoses in federal corrections, of which 7% were fatal.¹³⁸ Opioids were involved in 91% of fatal overdoses with fentanyl being the most common substance.¹³⁹ Offenders involved in overdoses had histories of substance use, mental illness and self-injurious behaviours.¹⁴⁰

Female, Indigenous and Black offenders

Female and Indigenous offenders are more likely to have complex, severe mental illness.¹⁴¹ Fifty percent (50%) of women in federal prisons have histories of self-harming behaviour, over 50% have current or previous substance use disorders, 85% have histories of physical abuse and 68% have histories of sexual abuse.¹⁴² While female offenders are involved in less than 1% of overdose incidents¹⁴³, most of those who are involved in these incidents have histories of mental illness, including substance use disorder.¹⁴⁴

Over 50% of Indigenous offenders have received a mental health service in federal prison.¹⁴⁵ Indigenous offenders are overrepresented in self-injurious incidents, suicide attempts¹⁴⁶ and suicides¹⁴⁷ and are more likely to be segregated than other offenders.¹⁴⁸ Almost all Indigenous female offenders have a mental health diagnosis (93.7%) and most (92%) have moderate or high substance use needs.¹⁴⁹ Indigenous female offenders are also overrepresented in overdose incidents.¹⁵⁰ Indigenous peoples are overrepresented in Canada's corrections system as a whole and this overrepresentation has increased significantly over the past 10 years.¹⁵¹ Indigenous adults account for 5% of the general population, but account for over 30% of federally sentenced offenders.¹⁵² Indigenous women account for 42% of federally sentenced female offenders,¹⁵³ a population that has increased by almost 74% over the past 10 years.¹⁵⁴ In Ontario, Indigenous people make up 2% of the population, but account for 13% percent of the province's corrections population.¹⁵⁵ The criminalization of Indigenous peoples is a lasting effect of colonialism that must be addressed more broadly, however the significant number of Indigenous individuals currently in prison and their high rates of mental illness, substance misuse, self-injurious behaviour and suicide indicate that there are serious mental health needs in this population that must also be addressed.

There is very little information on the experience of racialized offenders in Canada's prisons and particularly on their need for and ability to access mental health care. What is known is that Black Canadians make up 3% of the population, but account for 8% of federally sentenced offenders.¹⁵⁶ Similar to Indigenous offenders, the criminalization of Black people is a broader

issue that goes beyond the scope of this paper. It is important, however, to recognize that Black offenders are more likely to be classified as maximum security and are overrepresented in involuntary segregation and use of force incidents.¹⁵⁷ Black offenders have also reported that their health care and cultural needs are not met in federal corrections.¹⁵⁸ These experiences must be considered when addressing mental health care in correctional facilities.

Mental health treatment and services

Offenders with mental illness are extremely vulnerable in the federal and provincial corrections systems. These individuals report that they feel unsafe and are the victims of intimidation and violence by other offenders¹⁵⁹ and correctional staff.¹⁶⁰ Offenders 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.¹⁶¹ This can be influenced by the interruption, change or discontinuation of offenders' medications when they are admitted into a correctional facility.

Federal Corrections

Offenders in the federal corrections system are often unable to access timely and effective mental health care¹⁶² and this is particularly true for female offenders.¹⁶³ Federal offenders with acute and complex mental illness are supposed to receive treatment and stabilization at one of five Residential Treatment Centres (RTCs), but inadequate resourcing has led to deterioration in services and these centres no longer provide a full spectrum of mental health care.¹⁶⁴ They also do not offer treatment to all offenders with acute and complex mental illness. Those whose sole mental illness is substance use disorder or anti-social personality disorder are not normally accepted into RTCs.¹⁶⁵ Other concerns with RTCs include: patient-staff ratios that are below acceptable standards; staff not having the skillsets to treat patients with complex mental illness; and problems with the physical infrastructure.¹⁶⁶

There are fewer than 200 RTC beds for male offenders and only 20 for female offenders, with no standalone mental health treatment facility for women.¹⁶⁷ Female offenders with acute and complex mental illness are typically treated in maximum security units where staff are not equipped to meet their needs and other offenders can be negatively impacted by deteriorating behaviours.¹⁶⁸ The limited capacity of RTCs to meet the clinical needs of offenders with acute and complex mental illness can result in the over-use of security measures such as physical restraints and segregation, even for those who are at high risk of self-injury and/or suicide.¹⁶⁹

The Office of the Correctional Investigator has made several recommendations to improve mental health care in federal prisons, including enhancing clinical independence (health care is currently the responsibility of Correctional Services Canada (CSC) and not the federal Ministry of Health) and developing transfer agreements with community psychiatric hospitals to treat

those with more complex illnesses.¹⁷⁰ Creating more intermediate mental health care beds has also been proposed to ensure that those with serious, but less acute mental illness get the treatment that they need.¹⁷¹ CSC has begun to develop intermediate mental health care units however, a preliminary review of these units indicate that they are primarily diverting offenders away from segregation instead of serving a therapeutic purpose.¹⁷² The government did recently pass *Bill C-83* to reform segregation in prisons (see more below) and it is understood that this legislation will be supported by further investments in and improvements to mental health care in corrections, including a focus on prevention, early intervention and patient advocacy.¹⁷³

While not specific to mental health, federal correctional facilities offer a range of culturally specific programs and services that can provide additional support to Indigenous offenders with mental illness,¹⁷⁴ though better access to and availability of these programs is needed.¹⁷⁵ Healing Lodges, for example, provide Indigenous communities the opportunity to provide care and custody to Indigenous offenders through agreements with CSC. Indigenous offenders who are released from Healing Lodges are more likely to successfully integrate back into the community than those who have been discharged from other CSC institutions.¹⁷⁶ Unfortunately, Healing Lodges are not widely available across the country due to various challenges with the program.¹⁷⁷

Provincial Corrections

Ontario's correctional facilities have difficulty meeting the needs of offenders with complex illnesses,¹⁷⁸ particularly those with serious mental illness.¹⁷⁹ Reviews have found that mental health care and services in the province's jails are inadequate and inconsistent¹⁸⁰ and that access to prescription medications, counselling and programming is limited.¹⁸¹ In 2015, new correctional policies were introduced that require mental health screening upon admission, ongoing mental health assessments, Care and Treatment Plans and alternatives to segregation for offenders with mental illness.¹⁸² Due to lack of supports and resources, however, these policies have not translated into practice and the province's jails continue to rely on segregation to manage those with mental illness.¹⁸³

Mental health care that is available in provincial corrections is not always equitable. The three treatment centres that offer specialized care to offenders with mental illness are only open to male offenders, despite the higher proportion of female offenders with mental health alerts¹⁸⁴ (though the provincial government recently announced funding for dedicated mental health units for female offenders with acute mental health needs).¹⁸⁵ There is also limited mental health care and services that address the unique challenges experienced by female offenders (e.g. motherhood, histories of physical and sexual abuse).¹⁸⁶ Indigenous offenders have very limited access to culturally appropriate programs and services and they are less likely than

other offenders to receive mental health care while incarcerated.¹⁸⁷ There is also concern that the remand population, who make up about 2/3 of all offenders in provincial prisons,¹⁸⁸ have significantly limited access to mental health care¹⁸⁹ and community programming.¹⁹⁰ This is particularly concerning given that those on remand engage in self-harm and die by suicide at higher rates than offenders who are serving sentences.¹⁹¹

Similar to the federal system, part of the reason for the inadequate provision of health care is the lack of clinical independence and the tendency to prioritize security concerns over health care needs.¹⁹² Health care in provincial correctional facilities is delivered by the Ministry of the Solicitor General and there is no requirement for this Ministry to align its health care provision with that of the provincial Ministry of Health. The lack of alignment between the two Ministries impacts the quality of health care provided in correctional facilities as well as the continuation of health care between jail and community (which is crucial given the short amount of time many offenders spend in provincial correctional facilities).¹⁹³ To address these challenges, the Independent Advisor on Corrections Reform proposed the creation of a new model of holistic health care in Ontario's correctional facilities that includes transferring provision to the Ministry of Health.¹⁹⁴ The *Correctional Services Transformation Act (2018)*, while not yet in force, outlines the province's plan to provide equitable health care in jails, establish clinical independence, develop community connections and ensure that there are mental health care teams in all facilities. No explicit transfer of health care provision to the Ministry of Health is included in the *Act*. However, in the summer of 2018, an Expert Advisory Committee did provide the province with a plan to transform health care in correctional facilities, including the transfer of care provision to the Ministry of Health. The province has not yet acted on the committee's seven recommendations.

The Forensic Early Intervention Service: Improving mental health care in Ontario jails

While the provision of adequate and consistent mental health care in the province's jails remains a major challenge, one program is demonstrating success in connecting people with mental illness to the care and supports that they need. The Forensic Early Intervention Service (FEIS) is Ontario's first forensic mental health service embedded within provincial correctional facilities and is a partnership between CAMH and the Government of Ontario. FEIS operates at the Toronto South Detention Centre (TSDC) and the Vanier Centre for Women (VCW). The program uses the Screening, Triage, Assessment, Intervention and Re-integration (STAIR) model which is based on key service elements required for correctional mental health services¹⁹⁵, with the addition of a two-stage screening process and an integrated care pathway outlining how mental health services should be organized and provided to people entering the corrections

system. STAIR also includes monitoring and measuring techniques as a core function of the model.¹⁹⁶

FEIS aims to build links between the forensic and criminal justice systems by providing mental health screening and assessment to offenders whose serious mental illness may make them UST or may qualify them for an NCR defense. Offenders that meet these criteria become clients of a multi-disciplinary FEIS team from CAMH. They receive brief therapeutic interventions, psycho-education, referrals to additional mental health services and a coordinated re-integration plan (if applicable). Offenders with mental illness that do not meet the criteria for FEIS may receive brief case management from FEIS and are referred back to the correctional health care staff for support. At TSDC, FEIS also co-ordinates access to CAMH's High Needs Service where offenders experiencing an acute mental health crisis can be transferred to the hospital for short-term care.

FEIS began clinical operations at TSDC in 2015 and between that time and 2017 the number of referrals to the service increased from 1212 to 2203 and the number of ongoing FEIS clients more than doubled.¹⁹⁷ During the first nine months of operation at VCW, FEIS received 1214 referrals accounting for 58% of all new admissions to the correctional facility.¹⁹⁸ An evaluation of FEIS found that it was successful at improving access to and engagement in mental health care and treatment for offenders, coordinating and facilitating client cases through the criminal justice and forensic systems, and enhancing continuity of care via improved communication between courts, jails and forensic hospitals.¹⁹⁹ Collaboration between FEIS and corrections staff also contributed to enhanced quality and coordination of care for offenders with mental illness.²⁰⁰

Substance Use Treatment and Harm Reduction

Federal Corrections

Opioid Use Disorder (OUD) is a growing and challenging problem across Canada, including in the corrections system. In 2015, 30% of federally sentenced women and 21% of federally sentenced men had a history of injection drug use.²⁰¹ Canadian guidelines for the treatment of OUD strongly recommend Opioid Agonist Treatment (OAT) with buprenorphine/naloxone as a first-line treatment while recognizing the benefits of other OATs such as methadone.²⁰² Evidence demonstrates that Methadone Maintenance Treatment (MMT) and other treatment and harm reduction services like needle exchange programs have positive impacts on both offenders and correctional facilities.²⁰³ CSC offers MMT as part of a broader suite of OAT and harm reduction measures, such as naloxone and the Prison Needle Exchange Program (PNEP).²⁰⁴ Offenders with substance use disorders also have access to peer support, Narcotics Anonymous and substance abuse programming.²⁰⁵ For example, CSC's Integrated Correctional

Program Model uses Cognitive Behaviour Therapy-based interventions to help offenders address their substance abuse and other factors that contributed to their criminal activity.²⁰⁶

Despite the variety of substance use and harm reduction programming offered by CSC, not all offenders who need these services actually receive them. The PNEP, for example, has inherent restrictions to enrollment leading few offenders to participate in the program.²⁰⁷ While the CSC reports that 79% of offenders with a known substance use disorder have been enrolled in or are currently involved in a substance use treatment program (FY 2015-2016), only about 7% of the correctional population was receiving OAT as of April 2017.²⁰⁸ Recently, the Correctional Investigator expressed concern that CSC was not providing adequate substance abuse treatment or programming and called for more substance abuse services, including improved access to OAT.²⁰⁹

Provincial Corrections

There is concern about limited access to quality treatment, counselling, programming and harm reduction alternatives for offenders with substance use disorders in Ontario's correctional facilities.²¹⁰ A 2018 Coroner's Jury that reviewed the overdose deaths of eight offenders in the province's jails made numerous recommendations to improve outcomes for offenders with substance use disorders. These recommendations included the need for individualized care and treatment plans, training for all staff on the signs of overdose and naloxone administration, well-communicated harm reduction policies, connections to substance use programs upon discharge and tracking of overdoses and naloxone usage.²¹¹ According to the Solicitor-General, 80% of these recommendations are completed or underway, however, the recent overdose of six offenders in one Ontario correctional facility has reignited concerns about how well provincial jails are meeting the needs of offenders with substance use disorders.²¹²

Segregation

Segregation is overused in Canada's correctional facilities to manage people with mental illness as well as those at risk of self-harm and suicide.²¹³ Prolonged segregation can exacerbate symptoms of mental illness, cause irreversible psychological and physiological harm and is an inappropriate response to offenders with mental illness.²¹⁴ The Mandela Rules prohibit the use of segregation for prisoners with physical or mental disabilities in situations where it could lead to exacerbation of symptoms. They also prohibit segregation for more than 15 consecutive days for all offenders. While the Mandela Rules are important international guidelines, it is actually several court decisions across Canada that have fueled recent reforms in segregation at the federal and provincial levels.²¹⁵

Federal Corrections

There has been a significant reduction in the use of segregation in federal correctional facilities over the past few years along with a decline in the average length of time offenders spend in segregation.²¹⁶ Reduction in the use of the segregation has not had a negative impact on the safety and security of offenders or correctional services staff.²¹⁷ Deaths in segregation have also declined recently, though suicide still accounts for 90% of all non-natural deaths in segregation and suicides in segregation comprise about 37% of all suicides in the federal corrections system.²¹⁸

In October 2018, the federal government introduced Bill C-83, *An Act to amend the Corrections and Conditional Release Act and another Act* that officially eliminated segregation and replaced it with Structured Intervention Units (SIU) where more opportunities for human contact and programming are to be provided. Offenders in SIU are required to spend a minimum of 4 hours outside of their cell every day and two of those hours must include an opportunity to interact with others. *Bill C-83* also provides more autonomy to health care providers, including the requirement that offenders in SIU receive daily health care visits and be referred for a mental health assessment when displaying signs of distress. SIUs do not differ physically from segregation, however, and offenders are still housed in segregation cells.²¹⁹ *Bill C-83* does not put a limit on the number of consecutive days an offender can spend in a SIU and some critics have referred to SIUs as just ‘segregation by another name’²²⁰ or ‘segregation light’.²²¹ Concerns have also been raised recently that the expert advisory panel tasked with oversight of SIU implementation have not been able to fulfill their mandate because they were not given the data they needed to complete this task.²²²

Provincial Corrections

While the use of segregation is decreasing in the federal corrections system, it has been increasing in Ontario’s correctional facilities despite an overall decrease in the number of people in jail.²²³ An Independent Review in 2017 found that about 575 offenders were in segregation on any given day and 70% of these individuals were on remand.²²⁴ Offenders with mental illness or those at risk of suicide were more likely to be in segregation and spend longer in segregation.²²⁵ The review found that the number of offenders with mental illness or suicide-risk alerts in segregation was increasing even though the number of offenders with mental illness or suicide-risk alerts in the overall corrections system did not increase during this time.²²⁶ Some offenders were spending weeks and months in segregation and the review found that in 2016, 1300 offenders spent 60 or more aggregate days in segregation.²²⁷ A more recent report from Ontario’s Auditor General found that from April 2018 to April 2019 almost 2/3 of offenders in segregation for over 60 days had a mental health alert on file and that these offenders were in segregation for an average of 146 aggregate days.²²⁸

The 2017 Independent Review found that Ontario's policies for segregation in corrections were insubstantial and implemented inconsistently across the province.²²⁹ Safeguards, oversight mechanisms and data collection were weak and there were problems with staffing and infrastructure.²³⁰ The review said that inadequate mental health care was the reason for the increase in people with mental illness and suicide-risk alerts in segregation.²³¹

Based on recommendations from the Independent Review, the Ontario government included measures to reform segregation in the *Correctional Services Transformation Act (2018)*. Along with improvements to mental health care, the *Act* prohibits the use of segregation for people with mental illness and those at risk of self-harm or suicide. It also requires regular mental health monitoring for any offender in segregation. The *Act* also capped the number of consecutive days that an offender can spend in segregation at 15. As noted earlier however, while the *Correctional Services Transformation Act (2018)* was passed in 2018, it has not yet been put into force.

Discharge planning and supports

Offenders with mental illness are more likely to come back into contact with the criminal justice system than offenders without mental illness.²³² Poor discharge planning that sees offenders with mental illness released to no fixed address and without adequate medications contributes to this cyclical pattern,²³³ as do release plans with unrealistic expectations that set people up to breach conditions.²³⁴ Therefore, comprehensive discharge planning is crucial for offenders with mental illness to ensure that they successfully transition back into the community and stay there.

Ensuring that offenders are released with stable housing is key to successful re-integration, though this remains a significant challenge for offenders being released from both federal and provincial correctional facilities.²³⁵ It is also vital that offenders with mental illness be connected to employment or other forms of financial assistance as well as community services.²³⁶ Those with concurrent disorders need access to substance use treatment.²³⁷ Successful discharge planning for offenders with mental illness also 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, for example, can assist in keeping offenders with mental illness engaged with mental health services after discharge as well as keep them from reengaging with the criminal justice system.²³⁸ Continuity of care is also important. Offenders who are enrolled in mental health and/or substance use programs before discharge and are able to continue these programs in the community after discharge are more likely to remain in treatment and are less likely to re-offend.²³⁹

Federal Corrections

At the federal level, CSC's Community Mental Health Initiative (CMHI) provides individualized discharge planning for offenders with mental illness and specialized community mental health services at select parole sites.²⁴⁰ CMHI staff also work with local agencies to provide support to offenders with mental illness upon discharge.²⁴¹ Evidence demonstrates that offenders who receive specialized community mental health services at parole sites are significantly less likely to reoffend and return to custody than those who only receive individualized discharge planning supports.²⁴² Difficulty in finding physicians and community mental health providers who will accept referrals from offenders being discharged from correctional facilities²⁴³ may explain why dedicated specialized community mental health services appear to be most effective for this population. CSC can also connect offenders with mental illness to other programs that contribute to successful discharge such as community-based Methadone Maintenance Programs for those with a history of problematic opioid use and Section 84 release plans for Indigenous offenders.²⁴⁴ A Section 84 release plan involves collaboration between the Parole Board of Canada and an Indigenous community to set conditions for an offender who wants to be discharged to their home community. These release plans are under-used for various reasons.²⁴⁵

Provincial Corrections

Discharge planning in Ontario's correctional facilities is inadequate and inconsistent. Policies provide little direction to staff on when and how to establish effective discharge plans for offenders and only 5 out of 26 facilities have a staff member solely dedicated to discharge planning.²⁴⁶ The vast majority of offenders do not receive quality discharge planning and those on remand rarely receive any discharge planning services at all.²⁴⁷ This is concerning because even a short stay in jail can disrupt housing, employment and medical care.²⁴⁸ While overall discharge planning is lacking, offenders with mental illness appear to be a priority and those who are involved in the FEIS program receive the most comprehensive discharge supports.²⁴⁹ The *Correctional Services Transformation Act, 2018* includes improvements to discharge planning.

What we can do

Addressing the criminalization of mental illness must be a priority for governments and decision-makers. Given the various factors that can lead a person with mental illness to become involved with the criminal justice system and the numerous prevention, diversion and treatment alternatives, CAMH offers six principles to guide public policy in this area.

Principles for a comprehensive approach to mental health and criminal justice

1. Preventing people with mental illness from entering the criminal justice system must be a priority

Examples of action that results from this principle:

- The connection between mental health, social determinants of health and criminal justice system involvement is well-recognized and guides development of prevention-focused public policy.
- Public policy seeks to reduce the over-representation of Indigenous, Black and other racialized people at the intersection of the criminal justice and mental health systems by addressing root causes, including anti-Indigenous and anti-Black racism.
- Investments in mental health care are a priority. Mental health care receives the same recognition and funding as physical health care.
- People with mental illness are readily able to access a range of evidence-informed mental health care and supports to meet their diverse needs. Access to care is equitable across the country.
- People with mental illness with additional risk factors for criminal justice involvement/re-involvement receive targeted mental health-focused interventions.
- Community crisis response models replace police response models. People with mental illness who experience a crisis in the community have rapid access to emergency mental health care. Community crisis workers are readily dispatched to provide mental health care to any person in crisis at any time and in any place.
- People with mental illness, including those involved in the criminal justice system, have a livable income and access to a range of affordable and supportive/supported housing options.

2. *People with mental illness who become involved in the criminal justice system should have access to range of diversion and release options*

Examples of action that results from this principle:

- All police services have pre-charge diversion programs and/or referral partnerships with local community mental health and social service agencies. Programs and partnerships offer culturally appropriate care and supports.
- All police services and local emergency departments have a transfer of care protocol for people with mental illness brought to hospital under provincial mental health legislation.
- Evidence-informed court supports and post-charge diversion are available to everyone with mental illness who enters the criminal court system.
- There is equitable access to evidence-informed mental health courts, drug treatment courts and Gladue Courts across the country.
- All offenders with mental illness who meet the criteria for a NCR defense are able to pursue this defense. NCR provisions of the Criminal Code are interpreted and applied consistently across the country.
- Forensic inpatient facilities are able to accommodate all offenders designated UST or NCR in a safe and timely manner.
- People with mental illness in the corrections system have access to culturally appropriate custody (e.g. Healing Lodges) and community-based sentences.

3. *People with mental illness in the corrections system should receive evidence-informed mental health care and supports*

Examples of action that results from this principle:

- Health care practices in federal and provincial corrections comply with the UN's Mandela Rules.
- Health care in correctional facilities is provided by a separate health care entity. Mental health care is part of this entity and under the direction of forensic mental health care experts.

- Correctional facilities use the STAIR model to identify mental health needs and guide mental health care provision.
- Mental health care is equitable and meets the diverse needs of women, Indigenous peoples, Black people and members of other racialized and/or historically marginalized populations. Offenders on remand receive the same evidence-informed mental health care and supports as the sentenced population.
- The full range of evidence-based interventions for substance use, including harm reduction programs and supplies, are made available to all offenders who need them.
- The federal and provincial corrections systems balance the need to manage institutional safety and security with an individual's right to access mental health care.

4. *People with mental illness involved in the criminal justice system should be treated with respect and dignity and their safety made paramount*

Examples of action that results from this principle:

- It is an expectation of all employees and representatives of the criminal justice system that they interact compassionately and respectfully with people with mental illness.
- De-escalation through communication and negotiation is the default response in all police interactions with people in crisis.
- Police officers and correctional officers receive trauma-informed, mandatory, standardized and practical de-escalation training as new recruits and on a regularly-scheduled and ongoing basis.
- The threshold for CEW use aligns with Justice Iacobucci's recommendation: CEWs should only be used when 'a subject is causing bodily harm or poses an immediate risk of bodily harm to the officer or another person, and no lesser force option, de-escalation or other crisis intervention technique is available or effective'.²⁵⁰
- Correctional officers receive training in trauma awareness, de-escalation, crisis intervention and recognizing/responding to overdoses.

- Segregation in correctional facilities is used only as a security response, never a health care response. Correctional authorities work to eliminate the use of segregation. Segregation is subject to external oversight.
- People with diagnosed serious mental illness are never placed in segregation.
- Regular mental health monitoring is provided to all offenders in segregation or segregation-like facilities.
- People with lived experience of mental illness are involved in the planning and development of mental health and criminal justice system strategies, programs and trainings.

5. There should be collaboration and coordination between the criminal justice system and the mental health system

Examples of action that results from this principle:

- People with mental illness experience a continuity of their mental health care, including substance use treatment, as they transition through the criminal justice system and particularly as they move from the community to the corrections system and vice versa.
- People with mental illness in correctional facilities receive comprehensive discharge planning that includes connections to mental health care, medications, social services, and other community resources before discharge.
- Correctional facilities have partnerships with forensic mental health inpatient programs to temporarily transfer care of offenders with mental illness in need of acute mental health care.
- Forensic mental health programs have partnerships with supportive housing programs and community mental health services.
- Government policy supports and enhances connections between the criminal justice system and the mental health system.

6. Policy decisions should be evidence-informed and research should be supported

Examples of action that results from this principle:

- Government policy reflects an understanding of the criminalization of mental illness and strives to address this problem through prevention, diversion and treatment.
- Police, courts and corrections collect data, including race-based data, and measure impact of their prevention, diversion and/or treatment practices (or lack thereof) on people with mental illness.
- There is support and funding for (further) research on/evaluation of:
 - Community crisis response models to measure effectiveness and establish best practices.
 - De-escalation/crisis intervention training for police and correctional officers to determine how best to translate training into practice.
 - CEWs to assess their impact on people with mental illness and others in crisis.
 - Court supports and specialized courts to establish best practices.
 - Other issues/interventions at the intersection of mental health and criminal justice.
- Research and evaluation results are used to inform government policy

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