CANADA AWARDS FOR EXCELLENCE
PRIX CANADA POUR L'EXCELLENCE
2020
ORDER OF EXCELLENCE RECIPIENT MENTAL HEALTH AT WORK
RÉCIPIENDAIRE ORDRE DE L'EXCELLENCE SANTÉ MENTALE AU TRAVAIL

Mental Health Commission of Canada
Commission de la santé mentale du Canada

National Inventory of Mental Health and Substance Use Services and Supports for People Transitioning Out of the Criminal Justice System

Final Report

Mental Health Commission of Canada
mentalhealthcommission.ca

Ce document est disponible en français

Citation information

Suggested citation: Mental Health Commission of Canada. (2021). *National inventory of mental health and substance use services and supports for people transitioning out of the criminal justice system: Final report.* Ottawa, Canada: Mental Health Commission of Canada.

ISBN: 978-1-77318-261-2

Legal deposit National Library of Canada

Health Canada Santé Canada

The views represented herein solely represent the views of the Mental Health Commission of Canada. Production of this material is made possible through a financial contribution from Health Canada.

Contents

Introduction

Background: Transitions from the criminal justice system

Criminal justice involvement can include a number of phases, such as being stopped by police, arrested, charged, detained, convicted, sentenced, incarcerated, paroled, or otherwise placed under the jurisdiction of the criminal courts. After involvement, individuals who transition from the criminal justice system and back into the community (often referred to in the literature as *reintegration*[*]) confront many challenges. People who are being released from incarceration, in particular, often encounter difficulties related to housing, income and employment, reunion with family or other supports, social isolation, and access to health and social services.[1-7] Broad structural barriers to a successful return to the community include restrictive housing, public, and employment policies, discrimination by service providers, and social stigma.[8] These barriers contribute to a known cycle of rearrest and reincarceration, also referred to as the "revolving door" of the criminal justice system.[9,10]

People living with a mental illness and/or mental health concern are overrepresented in the Canadian criminal justice system, and many who are involved in the system also live with co-occurring substance use concerns.[11-13] While the evidence is mixed, studies show that people living with a mental illness who are released from correctional settings generally do not have significantly higher rates of *recidivism* compared to others who are released.[14-16] However, for those experiencing mental health and/or substance use concerns, transitioning to the community can be highly challenging given their need for specialized supports and/or treatment interventions.[17-20]

Without appropriate and accessible community-based supports and services, plans to start or continue mental health treatment and/or to avoid a return to substance use are easily disrupted.[21] As a result, release from correctional settings is also associated with an acutely enhanced risk for suicide, overdose, and other health-related harms.[22,23] Housing instability and homelessness are well-documented challenges during transitions to the community. They act as barriers to people's ability to connect with mental health and substance use services and therefore to better health and social outcomes.[24-27]

Discharge or release planning and *continuity of care* between correctional settings and the community have been identified as inadequate for various populations, including people living with a mental and/or physical illness and/or substance use concerns.[24-33] People with lived experience of incarceration report that discharge planning often comes "too late" (i.e., immediately before or upon release), and that it would be beneficial to receive more health-related education and community resource information well before leaving custody.[34,35] Community-based programs could also be more sensitive, welcoming, and

[*] See Appendix A for definitions of the italicized terms in this report.

adaptive to the complex instability facing people who are living with mental health and substance use needs and transitioning from criminal justice settings, such as corrections, to the community.[36]

For women who are leaving incarceration, the difficulties associated with community transitions are typically heightened by additional concerns about reunification with children and/or ongoing histories of abuse and trauma.[37,38] For other populations, involvement in the criminal justice system is both disproportionate and disproportionately harmful. For First Nations, Inuit and Métis populations, "the criminal justice system is a form of ongoing colonial and gendered racial state violence" (p. 32).[39] As the fastest-growing incarcerated population in Canada, Indigenous women experience some of the harshest effects of this structural violence and often confront a lack of culturally appropriate care to address concerns such as mental health, trauma, poverty, substance use, and sexual violence.[40-42] There is also a glaring lack of research that engages with Indigenous people who are incarcerated or examines the specific mental health and wellness needs of this population.[43] Similarly, mental health and substance use-related research that meaningfully engages with members of immigrant, refugee, ethnocultural, and racialized (IRER) communities is also lacking.[44] Nonetheless, it is well established that criminalization and systemic racism affect the health of IRER populations and their ability and willingness to access mental health and substance use supports. Because of systemic racism, Black individuals in particular are overrepresented in the criminal justice system and often face a lack of culturally appropriate care.[45,46]

Due to converging crises, the current context is incredibly challenging for the development and practical implementation of accessible mental health and substance use services and supports for people who are involved in the criminal justice system, especially those leaving incarceration. While the risk of death due to overdose is already elevated for people who use drugs upon their release from correctional settings ,[47,48] Canada continues to experience a devastating opioid overdose crisis, caused by intersecting factors such as the ongoing criminalization of drug use, the growing toxicity of street drugs, and barriers to implementing and accessing effective *harm reduction* programs.[49,50] There is an urgent need to scale up efforts to provide opioid use treatment, support services, and broader harm reduction interventions in correctional settings and to retain people who are in such programming upon release. These strategies are associated with outcomes such as reduced overdose and mortality.[51] Moreover, although increasing efforts have been made, as a public health response to the COVID-19 pandemic, to reduce the number of people in correctional settings, the pandemic is likely worsening chances for positive mental health- and substance use-related outcomes for those who are transitioning from the criminal justice system to the community.[52] Other public health measures and restrictions in place in the community — such as social distancing, temporary closures of in-person programs (including harm reduction services), and reduced access to housing supports — may worsen the transitional risks and barriers noted above.

Community-based mental health and substance use services and supports that are accessible to people, especially as they leave correctional settings, have a major role to play in enhancing individuals' quality of life and safety.[53] Now is an especially urgent time to examine and develop an inventory of the mental health and substance use services and supports that are currently available in Canada for people transitioning from the criminal justice system. A *health equity* lens was applied during the creation of such an inventory , which emphasizes the importance of providing equitable opportunities so that everyone can receive health-related services and achieve their full health potential.

How the inventory was developed

Between 2019 and 2021, the Mental Health Commission of Canada (MHCC) consulted with a variety of stakeholders to prioritize areas for action that would address the needs of people living with mental health and substance use concerns who are involved in the criminal justice system. These consultations included the MHCC's mental health and justice executive advisory committee as well as people with lived and living experience of mental illness and substance use who have had such involvement. Together with further discussions at an MHCC-hosted national forum that convened key stakeholders, the consultations revealed an urgent need to better support people who are transitioning from the criminal justice system. The current project to develop an inventory of relevant transitional services arose from this process.

The MHCC engaged with the Centre for Addiction and Mental Health (CAMH) to support the development of this resource. The MHCC and CAMH share organizational commitments to health equity. In practice, these commitments include leading work (such as partnerships, advocacy- and policy-related activities, and research) that aims to reduce inequities in mental health and substance use services and address structural barriers that individuals may face in achieving their full health potential.

A series of steps, including literature searches and an email survey of stakeholders, informed this project. Throughout the process, the teams at MHCC and CAMH held regular meetings to discuss progress and make collaborative decisions regarding its scope and methods, the design and refinement of the inventory, and the creation of a final report. During several project milestones, the teams also consulted with an MHCC advisory committee of subject matter experts. Its members provided feedback on key deliverables, including drafts of the inventory and this report. Consultations throughout the project ensured that deliverables were developed using an iterative and responsive process.

The following steps were taken to refine the project scope and identify relevant material:

- **Connections built** with the Canadian Association of Elizabeth Fry Societies (CAEFS) were used to understand their recent work on an inventory of services and supports for criminalized women, girls, and gender-diverse people leaving federal correctional institutions. Their four-year Breaking the Cycle project, launched in 2019, emphasizes the decarceration of women and gender-diverse people in Canada, aiming to facilitate

their long-term reintegration into the community and reduce the number of custodial sentences. This work also focuses on building community capacity and the awareness of resources that criminalized women and gender-diverse people need.[*] As CAEFS staff across different regions are looking at various services and supports (such as legal aid, housing, financial assistance, and family and child-care programs), their project is highly complementary to the inventory developed in this project.

- **Systematic searches** of academic and grey literature (such as websites and reports authored by government, ministry, advocacy, and community organizations) were used to identify available mental health and substance use services and supports for criminal justice-involved persons.[†] In addition to running searches with a series of keywords generated with librarian expertise, grey literature searches were conducted using terms that were considered relevant to First Nations, Inuit and Métis services, such as "healing" and "culturally appropriate care." Grey literature searches were further supplemented by inputting keywords (e.g., "criminal justice" and "mental health") into service-specific search engines, such as regional 211s.
- A **three-question email survey** was sent to approximately 50 stakeholders from relevant organizations and sectors (e.g., provincial/territorial health agencies, non-governmental organizations, clinical and/or research institutes, and criminal justice organizations) across Canada to identify relevant services and supports to inform the inventory and identify gaps in services. The survey findings complement the literature searches and ensure the comprehensiveness of this identification process. The list of knowledgeable stakeholders was constructed based on existing contacts and networks known among MHCC, CAMH, and CAEFS team members.

In the survey, "mental health services and supports" were broadly defined as a range of crisis, inpatient, outpatient, or community-based services for people in need of support in relation to mental health concerns and mental illness. Similarly, "substance use services and supports" were defined as a range of programs that address the use of alcohol and other drugs (e.g., treatment and recovery programs, harm reduction services). Respondents were also invited to list additional services that came to mind.

The following steps were used to categorize and summarize the material:

- The **inventory criteria and categories** were developed using the iterative process of consultation with the MHCC advisory committee. Given the national scope of the project and timelines, it was agreed that inventory entries would be specific to mental health and/or substance use services and supports (as defined above) that are primarily designed for people transitioning from criminal justice settings to the community. As important contextual information and a small number of specific programs emerged for each province and territory, a decision was made to include some programs that serve a wider population but seemed especially promising for

[*] Also see the CAEFS Building Capacity web page.

[†] See Appendix B for a full description of the academic and grey literature search methods.

people who are involved in the criminal justice system. After several rounds of refinement, a set of inventory categories and response options for each program were developed, such as contact information, geographic focus, description and objectives, span of services and supports, and specific populations served.

- The teams **recorded all relevant details and populated the inventory**, a process that included a careful review of program and organizational websites. A bilingual knowledge broker supported these steps for all French-language material.
- The teams **created this final project report**, which also occurred iteratively and in tandem with the process of inventory development. While gathering information on relevant services available throughout Canada and reading through literature search findings, evidence-informed observations of promising practices in mental health and substance use services and supports for people who are transitioning from the criminal justice system (summarized below) were developed. The literature most often cited is in reference to people who had lived experience of incarceration or were in the process of leaving a correctional setting. Included further on in this report, survey respondents shared what they would like to see in reference to the available mental health and substance use services and supports for people making this transition.

Promising practices summary

In general, the academic and grey literature agree that access to transitional services and supports for people leaving correctional settings leads to better engagement with community-based care. In particular, people who receive community-based mental health services tend to be significantly less likely to return to custody or reoffend compared to people who only receive discharge planning or no community-based services.[54] Such outcomes appear to be further improved when services include substance use supports for those who need them.[55]

There were some limitations to the research reviewed. In many studies, the outcomes focus on measures of recidivism and/or any discontinued (i.e., abstinence) or significantly lowered rates of substance use. While these outcomes are important to criminal justice system authorities, they are not the only markers of transitional success and may not always reflect the needs and goals of individuals living with a mental illness and/or substance use concerns.

Further, many studies of interventions to improve mental health and/or substance use outcomes for people experiencing incarceration only (or mostly) include samples of men.[56] More studies involving transitional mental health and substance use services and supports for those who identify as First Nation, Inuit, and Métis, women, gender-diverse, 2SLGBTQ+, and/or as members of older (age 55+) and IRER communities are greatly needed to understand what services these populations desire and find most effective.

Diversion

There can be multiple *diversion* points from the criminal justice system for people living with a mental illness or mental health concerns. These points include pre-arrest (police based), post-arrest (pre-trial), post-sentence/plea (corrections and court based), and post-incarceration (corrections-based programming and community re-entry).[57] Diversion at these points provides a key opportunity to redirect people toward treatment and supportive services that are recognized as more therapeutically effective and beneficial than court and correctional involvement.[58-60] Regarding *mental health court* studies, for example, evidence shows that successful diversion has a number of benefits, including better legal (e.g., lowered rate of rearrest) and clinical outcomes.[61] While a more complete review of diversion practices is outside the scope of this project, a much larger literature supports their use.[62]

Participatory and peer engagement

Wherever possible, the design of community transition services and supports should be participatory, engaging with the people who will use these services so as to understand and respond to their perspectives and needs, which are grounded in lived experience.[63-65] Such approaches are a critical component of achieving health equity and addressing the under-representation of specific populations (e.g., women, First Nations, Inuit and Métis, and IRER populations) in relevant research and service development.[66] A recent example from Canada is a study of Stride Circles, a community partnership that includes trained volunteers and focuses on women's community reintegration after incarceration at federal correctional institutions.[67] Positive experiences of inclusion and belonging emerged when women became members of a support network and were met with openness when forming new and supportive relationships as they transitioned into the community.[68]

As Portillo and colleagues noted,[69] learning from other health and social sectors, peer navigators or support specialists are people who have specific "background or experience that can provide support, guidance, or care for an individual with a similar experience" (p. 320). In a study that examined the transferability of mental health "peer navigators" to working with criminal justice-involved populations, peer navigators had impacts in several areas, including acting as positive role models in community re-entry.[70] Similarly, a study of "peer support specialists" with histories of mental illness and incarceration found that peer training and work supported their own recovery processes through experiences embedded in hope, meaningfulness, and connectedness to others.[71]

Harm reduction resources

The provision of harm reduction resources to people transitioning from criminal justice settings to the community — including the provision of overdose prevention information and equipment — is more than a promising practice: it is potentially life-saving given the heightened risk of overdose upon release. These types of programs are especially

important for people who have lived experience of substance use and incarceration. In a study based in Alberta, a pilot program that provided take-home *naloxone* kits and overdose prevention information to people under provincial correctional jurisdiction who were newly released was regarded by program administrators as a systems collaboration success.[72] Subsequently, the program was rolled out to other Alberta correctional centres, and the authors recommended wider uptake of these harm reduction programs by other provincial correctional systems. Correctional facilities in British Columbia have also employed take-home naloxone programs.[73]

Community-based harm reduction programs exist along a wide spectrum of evidence-informed services and supports, including opioid agonist treatment provided at methadone and Suboxone clinics; needle and syringe programs; supervised consumption (and their satellite) services; naloxone kit distribution and overdose prevention education; drug-checking services; and safer supply initiatives.[74,75] Having the full suite of these programs available provides people who use drugs with a comprehensive set of options to meet individual needs. However, across Canada these programs are at various stages of implementation and accessibility, and some are not available in many smaller and remote communities.

Applicable models

A promising model of care that seems applicable to transitional mental health and substance use services and supports is *assertive community treatment* (ACT), which is designed for people living with a serious mental illness and/or associated complexities (e.g., those who find it difficult to engage in treatment). Continuity of care, motivational interviewing and, if needed, integrated substance use treatment are often part of ACT. There is some evidence that ACT performs better than other forms of community-based mental health services.[76] Similarly, *forensic assertive community treatment* (FACT) — an example of ACT-influenced specialty mental health programs for individuals with serious mental illness who are involved in the *forensic* care system — aims to enhance outcomes through partnerships between criminal justice (e.g., probation and parole) and mental health service providers.[77] The FACT approach of ongoing treatment and direct supports to facilitate service access for clients promotes stability and greater connections to other supports such as housing.[78] Although forensic programs were generally excluded from the inventory, FACT is worth mentioning as an evidence-informed model, especially since forensic psychiatric admissions (including clients with comorbid substance use concerns) have increased in Ontario in recent decades.[79]

Critical time intervention (CTI) is a model designed to help individuals through critical periods, such as the transition to the community from correctional settings, shelters, and hospitals.[80,81] According to Lennox et al.,[82] CTI involves "a structured, time-limited form of case management" that aims to improve connections with service providers and other social supports, such as friends and relatives, and provide "practical and emotional support during transition" (p. 77). Increasing evidence shows that CTI can improve continuity of

care and perceived accessibility of services.[83,84] Factors that influence effective CTI implementation include local community resources and correctional settings features (e.g., when correctional facilities are remotely located).[85]

A systematic review of randomized controlled trials of health-related interventions during incarceration and one year after release revealed that both behavioural management interventions involving parole officers and other service providers and community-based re-entry programs focused on substance use treatment can have positive impacts on substance use.[86] In other words, collaborative approaches that engage multiple professionals in service and support provision seem well suited to addressing specific needs.

Respondent perspectives: Identified needs in community transitions

When stakeholders from relevant organizations/sectors across Canada were emailed, they were asked, "What additional types of mental health and/or substance use services and supports would you like to see available to assist individuals to transition out of the criminal justice system?" While some respondents said they were unaware of the kinds of services asked about, many addressed the question and offered additional insights, which were thematically analyzed and organized. Their responses reinforced a number of themes that emerged from the literature. As part of the following summary, some direct quotes were selected to give voice to respondents' perspectives.

Housing

> "The lack of housing has caused many of our clients with mental health issues having to remain at the correctional centre for much longer than necessary." (Yukon)
>
> "Major dilemma in our area is the lack of meaningful employment and safe, affordable housing!" (Ontario)

Mental health and substance use services are important for many people who are transitioning from the criminal justice system, especially those who are leaving correctional settings. However, these services must also coincide and be supported by an adequate provision of other health and social services, such as supports related to housing, physical health, income, employment, education, government-issued identification, family and child care, and recreational activities. Housing was most often cited as critical for individuals to achieve greater stability in their lives. Housing supports help break the cycle of precarious housing and/or homelessness that commonly affect people who are transitioning from the criminal justice system — especially those living with a mental illness— and offer greater likelihood of positive mental health- and substance use-related

outcomes.[*,87]

> "There is a need for a 'halfway house' style housing. This would help the transition and return to the community and help better prepare individuals to living in a group home. Very often, the gap between the institution and community is too big." (New Brunswick)

Numerous respondents specifically mentioned the need for greater *transitional and supportive housing*. Having more transitional beds available, including those with a direct connection to mental health and addiction services, including crisis and emergency services, was highlighted as an important way to provide stability for people who are leaving incarceration and prepare them for living in the community.

> "We need transitional housing support for people leaving custody, including Rent-Geared-to-Income, supportive housing, and programs specific to Indigenous people, women/mothers, and people using substances. We have the organizations and expertise to run programming, but we need the funding to fully staff and support the transitional housing." (Ontario)

In this context, supportive housing generally refers to affordable community housing that is combined with support from mental health and/or substance use program staff. Respondents referenced such housing as a much-needed longer-term strategy to improve the health and wellness of people who have been in contact with the criminal justice system and to reduce the chances of further system involvement.[88]

Culturally appropriate and safe supports

> "Given that Indigenous women are disproportionately represented in both provincial and federal levels of incarceration/criminal justice system involvement, we definitely believe that there is a strong and demonstrated need for culturally safe, trauma-informed, and distinctions-based supports/services for First Nations, Inuit, and Métis women who are transitioning out of the criminal justice system." (national Indigenous organization)
>
> "Greater networks and services offering Métis-specific crisis support, harm reduction, mentoring, counselling, and navigation of services and opportunities would be key. This is a large question, however, and implicates several areas of policy." (national Indigenous organization)

When building the inventory for this project, attention was paid to identifying mental health and substance use services for people transitioning from the criminal justice system that are tailored to and/or provide supports for specific populations. Recognizing that

[*] See the resources available at homelesshub.ca.

there are additional priority populations in relation to criminal justice involvement, mental health, and substance use, the specific populations noted in the inventory include women, people age 55 years and older, and members of First Nations, Inuit and Métis, IRER, and 2SLGBTQ+ communities. Overall, few transitional mental health and substance use services and supports specific to these groups were found. Respondents confirmed this finding in their answers.

Many respondents said that to deliver culturally appropriate and safe supports, more mental health and substance use services designed by and for First Nations, Inuit and Métis communities are needed. Such services can include traditional healing practices, the involvement of Elders, and culturally meaningful, *trauma-informed* care whose approaches address ongoing histories of colonial violence. Gaps were noted in service and support coverage for rural and remote communities, although the need for more services for urban Indigenous populations was also raised.[89]

> "Mental health and substance use counselling services that are specific to individuals who are recently released from prison are needed. These services must also recognize that Black and Indigenous individuals are over-represented in the prison system, and thus provide care that is culturally appropriate." (national advocacy organization)

Services and supports that specifically engage members of IRER communities are also needed, particularly in recognition of the disproportionate impacts the criminal justice system has on Black and other communities of colour. Respondents did not provide much detail about the kinds of culturally appropriate and safe supports needed for IRER communities. On a much broader policy agenda, anti- racism-informed work and change at all systems levels are critical for addressing the barriers and discrimination that impede the development of and access to such services. The Across Boundaries program, a frequently mentioned example from Ontario, provides a range of client-centred mental health services within anti-racism/anti-Black racism and anti-oppression frameworks.*

There were calls for more women- and gender-specific mental health and substance use supports, coupled with greater policies that acknowledge and respect gender-diverse people. Trauma-informed approaches to care were also mentioned in connection with women from structurally marginalized communities. These approaches include supports that recognize the heightened risk of violence for women who may come into contact with the criminal justice system (e.g., women engaged in sex work). A major lack of culturally safe transitional supports specific to 2SLGBTQ+ community members was also noted.

* See acrossboundaries.ca.

> "LGBTQIAA2S+ -specific mental health and addictions services are virtually non-existent or not formalized within the city or particularly within the institutions. These folks are at increased risk of violence and harm when incarcerated and in the community." (Ontario)

Regarding substance use programs, some respondents raised an additional consideration relevant to specific populations. According to these respondents, group programs such as *Alcoholics Anonymous* (AA) and *Narcotics Anonymous* (NA) are found in many communities and are often encouraged by correctional staff and other service providers. However, AA/NA-type programs — as well as numerous addiction treatment facilities that were noted and found in the searches — tend to be based in the Christian faith and are therefore not as relevant or appealing to people from other religious backgrounds or specific cultures.

Intensive and individualized care during transitions

> "More individualized, person-centred supports that focus on the strength of the individual transitioning out of the justice system." (Ontario)

Many respondents identified a need for more intensive and individualized case management and followup for people transitioning from the criminal justice system, both in general and especially for those who require mental health and substance use services. This need was connected to the importance of continuity of care, ensuring that people experience transitions with uninterrupted access to care and/or receive access to new services with ongoing support upon community re-entry.

For those who are incarcerated, this type of planning needs to begin well before discharge and include recommendations for well-trained staff and an overall increase in mental health and substance use treatment service providers in correctional settings. In terms of specific needs, several respondents mentioned that more supports designed for people with developmental disabilities are also needed.

An array of low-barrier mental health and substance use services and supports

> "Personally, I find it unfortunate that women must, in the majority of cases, have a referral to access a program specializing in addiction. Also, I think it would be beneficial if they had more access to individual services since some do not like the approach of group therapy. If we had a greater variety of addiction services, we could meet the needs of more women." (Quebec)

Respondents often qualified statements about "more services" with reference to having a

comprehensive array of low-barrier (i.e., readily available, accessible, low or no cost) mental health and substance use services and supports. For example, some mentioned the need for more 24-7 and/or mobile mental health or crisis supports, particularly in smaller and remote communities. Others noted that the need for referrals or applications can serve as a major barrier to accessing certain programs and highlighted a need for additional rapid-access mental health and substance use services. For these reasons, and because of what was found during the searches, a summary of some crisis lines and broadly available mental health and substance use services for every province and territory were added to the inventory. Additionally, *rapid access addiction medicine* (RAAM) clinics were included in the inventory under national programs, as this important clinic model appears in multiple jurisdictions across Canada.

> "An emphasis on a harm reduction approach should be more prominent when suggesting services and supports for substance use. Many clients (particularly those released from custody) may not yet be ready to practice abstinence. Harm reduction helps to reduce stigma, [and] build trust and rapport, but also educate about safety and wellness." (Ontario)

Respondents said there should be a wider variety of mental health and substance services and supports to meet the varied needs of individuals as they transition from the criminal justice system, such as group and individual counselling, evidence-informed and specific types of therapy (e.g., *cognitive behavioural therapy*, *dialectical behavior therapy*), detoxification and withdrawal supports, and other substance use treatment programs. A number of respondents emphasized the importance of providing harm reduction information and supports to people who are transitioning from correctional settings, noting an elevated risk of overdose and individual readiness for other types of substance use intervention. Several respondents also mentioned a need for more ACT and/or FACT programs, which are (as noted above) evidence-informed models.

> "Additional resources attached to the opioid crisis — resources to support teams providing services for individuals with opioid addictions who are at risk of overdose death when transitioning out of correctional environments." (British Columbia)

System navigation and peer support

Finally, system navigation and peer support were cited as important, especially for people who are transitioning from longer periods of incarceration to the community and who may be lacking social supports. Many respondents referenced local John Howard and Elizabeth Fry societies as being designed specifically for people who have experienced incarceration and as well equipped to address their needs.

> "Connection to the local John Howard Society immediately upon someone's release. Agencies to stop working in silos and have a more coordinated care table that draws on the expertise of many to serve the needs of one — probably JHS can lead this as the system navigator through their local reintegration programs." (Ontario)

People with lived and living experience, in the more formal role of peer workers or otherwise, are valuable at all stages of transition from correctional settings to the community but can play especially valuable roles in helping others navigate nearby and available mental health and substance use services, including supports that are culturally appropriate and safe.

Respondents shared recommendations for more peer support programs, including greater use of community-based outreach that involves important day-to-day assistance and navigation (e.g., accompaniment and transportation to mental health and substance use service appointments, reminder calls, and check-ins). As was similarly noted in the literature, respondents highlighted how enhanced systems navigation and peer support can foster feelings of belonging and connectedness, as well as greater skills and autonomy, for people who are transitioning from correctional settings to the community.

> "Navigation is the main service/support in my opinion, particularly from peers (in this case people with lived experience of the criminal justice system) who can gain the trust. Active linkage to needed services and supports is essential. Peers would need to be situated in an organization mandated to provide services to people leaving prison to ensure they have adequate resources to do their jobs and adequate support for themselves as peer workers." (national knowledge exchange organization)

Limitations

This project employed a multi-pronged approach (i.e., organizational collaboration, structured and comprehensive literature searches, and outreach to knowledgeable stakeholders across jurisdictions) to find information on mental health and substance use services and supports in Canada that were specific to and/or promising for people transitioning from the criminal justice system to the community. This approach is one key strength of this work. However, there are limitations to note. Systemic biases likely affected some of the methods. In particular, Google tends to automatically "favour" larger organizations in its algorithms and push popular hits to the top of search results. Some community-led programs, especially in smaller or non-urban jurisdictions, may not be set up for search engine optimization.* As a result, some relevant programs may have been missed by the Google searches and by the email survey distributed to organizations and

* That is, strategies to improve a website's ranking on search engine results.

stakeholders known through institutional networks. Some survey respondents noted that they were unaware of the specific services and supports they were asked about in their jurisdiction.

Further, although feedback was actioned to run additional searches with more terms that would be culturally meaningful to First Nation, Inuit and Métis communities, some valuable keywords may have been missed. A librarian who consulted on the project also advised that adding terms such as "healing" seemed to then exclude some Google search hits about post-release programs. Such issues with identifying culturally relevant terms are important to address more broadly through innovative and collaborative solutions. Ensuring that the inventory becomes a more inclusive living resource will entail additional searches for Indigenous-led services and supports. This process should also involve further discussion and refinement of the definitions of services and inventory inclusion/exclusion criteria in collaboration with Indigenous partners. The definitions and criteria used in the project may not align with Indigenous understandings of services needed to address mental health and substance use.

Given that all provincial/territorial jurisdictions were looked at, the teams strived to adhere to the scope and focus of this project. Many mental health and substance use services and supports are available to the wider community in each jurisdiction, as are programs that provide other services — such as supports related to housing, employment, education, legal aid, identification, and family and child care — that are critical for people who are or have been involved in the criminal justice system. Developing an inventory of all such services would have been exceptionally time intensive and make it difficult to maintain a meaningful focus on mental health services and supports specific to the needs of people transitioning from the criminal justice system.[*]

Conclusion

This report accompanies an inventory specific to the mental health and substance use services and supports that are currently available throughout Canada for people who are transitioning from the criminal justice system. Moving forward, the inventory should be maintained as a living resource. Maintenance and updates need to involve the addition of active services and supports over time and their potential connection to other relevant system navigation tools. Translating this work into easy-to-navigate, user-friendly formats will be an important step that requires further innovation in methods and dissemination, particularly to address some of the limitations noted in this document. Carefully designing how to widely share and promote the inventory content to service providers across Canada

[*] Again, the Breaking the Cycle project by CAEFS, which looks at other types of services and supports for criminalized women and gender-diverse individuals, is an important complement to this work.

must be another major consideration for addressing the lack of awareness about relevant resources and supports that some respondents described.

There are significant gaps across Canada's regions in the mental health and substance use services and supports that are specific to the needs of people who encounter the criminal justice system. These gaps commonly include a deficiency in tailoring such services and supports in ways that meet the needs of specific populations, especially First Nation, Inuit, and Métis communities, women and gender-diverse individuals, IRER populations, older individuals, and others. The inventory and report provide new and further evidence of these gaps as well as the need for greater advocacy in these areas. Continuing and finding new ways to engage with programs that serve the needs of specific communities are critical components of achieving health equity and will require dedicated time and attention.

This project has also highlighted a number of systems issues in relation to transitional or community reintegration services for people who are leaving incarceration. These transitions are typically very complex, especially for people living with a mental illness and/or substance use concern. Often, relevant services and supports are designed to focus on individual risk factors, with less attention to pressing social-structural barriers (e.g., those related to poverty and stigma). This lack of attention to broader solutions is itself a major barrier, especially given the ongoing stigma that is felt and experienced by people who come into contact with the criminal justice system. Clearly, there is much work ahead in service identification and awareness that is beyond the scope of this project. Ideally, this report and inventory will inform that work and recommend health equity and stigma reduction as guiding approaches.

References

[1] Barrenger, S. L., Draine, J., Angell, B., & Herman, D. (2017). Reincarceration risk among men with mental illnesses leaving prison: A risk environment analysis. *Community Mental Health Journal, 53*(8), 883-892. https://doi.org:10.1007/s10597-017-0113-zlink.springer.com/article/10.1007%2Fs10597-017-0113-z.

[2] Harding, D. J., Wyse, J. J. B., Dobson, C., & Morenoff, J. D. (2014). Making ends meet after prison. *Journal of Policy Analysis and Management, 33*(2), 440-470. https://doi.org/10.1002/pam.21741

[3] Hu, C., Jurgutis, J., Edwards, D., O'Shea, T., Regenstreif, L., Bodkin, C., Amster, E., & Kouyomdjian, F. G. (2020). "When you first walk out the gates . . . where do [you] go?": Barriers and opportunities to achieving continuity of health care at the time of release from a provincial jail in Ontario. *PLoS One, 15*(4), Article e0231211. https://dx.doi.org/10.1371/journal.pone.0231211

[4] Salem, B. E., Nyamathi, A., Idemundia, F., Slaughter, R., & Ames, M. (2013). At a crossroads: Reentry challenges and healthcare needs among homeless female ex-offenders. *Journal of Forensic Nursing, 9*(1), 14-22. https://doi.org/10.1097/jfn.0b013e31827a1e9d

[5] van Dooren, K., Claudio, F., Kinner, S. A., & Williams, M. (2011). Beyond reintegration: A framework for understanding ex-prisoner health. *International Journal of Prisoner Health, 7*(4), 26-36. https://doi.org/10.1108/17449201111256880

[6] van Olphen, J., Eliason, M. J., Freudenberg, N., & Barnes, M. (2009). Nowhere to go: How stigma limits the options of female drug users after release from jail. *Substance Abuse Treatment, Prevention, and Policy, 4*, Article 10. https://doi.org/10.1186/1747-597X-4-10

[7] Visher, C. A., & Travis, J. (2003). Transitions from prison to community: Understanding individual pathways. *Annual Review of Sociology, 29*, 89-113. https://doi.org/10.1146/annurev.soc.29.010202.095931

[8] Barrenger, et al. (2017). Reincarceration risk among men with mental illnesses leaving prison: A risk environment analysis.

[9] Denton, M., Foster, M., & Bland, R. (2017). How the prison-to-community transition risk environment influences the experience of men with co-occurring mental health and substance use disorder. *Australian and New Zealand Journal of Criminology, 50*(1), 39-55. https://doi.org/10.1177/0004865815620703

[10] Harrison, L. D. (2001). The revolving prison door for drug-involved offenders: Challenges and opportunities. *Crime and Delinquency, 47*(3), 462-484. https://doi.org/10.1177/0011128701047003010

[11] Beaudette, J. N., & Stewart, L. A. (2016). National prevalence of mental disorders among incoming Canadian male offenders. *Canadian Journal of Psychiatry, 61*(10), 624-632. https://doi.org/10.1177/0706743716639929

[12] Fazel, S., & Seewald, K. (2012). Severe mental illness in 33,588 prisoners worldwide: Systematic review and meta-regression analysis. *British Journal of Psychiatry, 200*(5), 364-373. https://doi.org/10.1192/bjp.bp.111.096370

[13] Michalski, J. H. (2017). Mental health issues and the Canadian criminal justice system. *Contemporary Justice Review, 20*(1), 2-25. https://doi.org/10.1080/10282580.2016.1226817

[14] Fazel & Seewald. (2012). Severe mental illness in 33,588 prisoners worldwide: Systematic review and meta-regression analysis.

[15] Mahentharan, M., Kouyoumdjian, F. G., de Oliveira, C., Iwajomo, T., Simpson, A. I. F., Jones, R., & Kurdyak, P. (2021). Prevalence and predictors of reincarceration after correctional center release: A population-based comparison of individuals with and without schizophrenia in Ontario, Canada. *Canadian Journal of Psychiatry*. *6*(4), 339-348. https://doi.org/10.1177/0706743720953018

[16] Michalski. (2017). Mental health issues and the Canadian criminal justice system.

[17] Dean, K., Parsons, V., Yee, N., Mackinnon, T., Chaplow, D., & Lines, K. (2013). *The justice system and mental health: A review of the literature*. Australian Government National Mental Health Commission. https://www.mentalhealthcommission.gov.au/getmedia/8e26fc6a-da7b-4b34-a724-536f10af375a/Monitoring/The-justice-system-and-mental-health.pdf

[18] Denton, et al. (2017). How the prison-to-community transition risk environment influences the experience of men with co-occurring mental health and substance use disorder.

[19] Kirwan, A., Curtis, M., Dietze, P., Aitken, C., Woods, E., Walker, S., Kinner, S., Ogloff, J., Butler, T., & Stoové, M. (2019). The Prison and Transition Health (PATH) Cohort Study: Study protocol and baseline characteristics of a cohort of men with a history of injecting drug use leaving prison in Australia. *Journal of Urban Health, 96*(3), 400-410. https://doi.org/10.1007/s11524-019-00353-5

[20] Wilton, G., & Stewart, L. A. (2017). Outcomes of offenders with co-occurring substance use disorders and mental disorders. *Psychiatric Services, 68*(7), 704-709. https://doi.org/10.1176/appi.ps.201500391

[21] Walker, S., Higgs, P., Stoové, M., & Wilson, M. (2017). Narratives of young men with injecting drug use histories leaving adult prison. *International Journal of Offender Therapy and Comparative Criminology, 62*(12), 3681-3707. https://doi.org/10.1177/0306624X17747829

[22] Farrell, M., & Marsden, J. (2008). Acute risk of drug-related death among newly released prisoners in England and Wales. *Addiction, 103*(2), 251-255. https://doi.org/10.1111/j.1360-0443.2007.02081.x

[23] Kouyoumdjian, F. G., Kiefer, L., Wobeser, W., Gonzalez, A., & Hwang, S. W. (2016). Mortality over 12 years of follow-up in people admitted to provincial custody in Ontario: A retrospective cohort study. *CMAJ Open, 4*(2), E153-E161. https://doi.org/10.9778/cmajo.20150098

[24] Crocker, A. G., Nicholls, T. L., Seto, M. C., Roy, L., Leclair, M. C., Brink, J., Simpson, A. I. F., & Côté, G. (2015). Research priorities in mental health, justice, and safety: A multidisciplinary stakeholder report. *International Journal of Forensic Mental Health*, *14*(3), 205-217. https://doi.org/10.1080/14999013.2015.1073197

[25] Harris, M., Gadermann, A., Norena, M., To, M., Hubley, A. M., Aubry, T., Hwang, S., & Palepu, A. (2019). Residential moves and its association with substance use, healthcare needs, and acute care use among homeless and vulnerably housed persons in Canada. *International Journal of Public Health*, *64*(3), 399-409. https://doi.org/10.1007/s00038-018-1167-6

[26] Hu, et al. (2020). "When you first walk out the gates . . . where do [you] go?": Barriers and opportunities to achieving continuity of health care at the time of release from a provincial jail in Ontario.

[27] John Howard Society of Ontario, O'Grady, W., & Lafleur, R. (2016). *Reintegration in Ontario: Practices, priorities, and effective models*. John Howard Society of Ontario. https://johnhoward.on.ca/wp-content/uploads/2016/11/Reintegration-in-Ontario-Final.pdf

[28] Antoniou, T., Mishra, S., Matheson, F., Smith-Merrill, D., Challacombe, L., Rowe, J., DiCenso, A. M., Kouyoumdjian, F. G., Wobeser, W., Kendall, C., Loutfy, M., Tsang, L., Kanee, L., & Strike, C. (2019). Using concept mapping to inform the development of a transitional reintegration intervention program for formerly incarcerated people with HIV. *BMC Health Services Research, 19,* Article 761. https://doi.org/10.1186/s12913-019-4595-y

[29] Crocker, et al. (2015). Research priorities in mental health, justice, and safety: A multidisciplinary stakeholder report.

[30] Hu, et al. (2020).

[31] Khanna, S., Leah, J., Fung, K., Antoniou, T., & Kouyoumdjian, F. (2019). Health care utilization by people with HIV on release from provincial prison in Ontario, Canada in 2010: A retrospective cohort study. *AIDS Care*, *31*(7), 785-792. https://doi.org/10.1080/09540121.2018.1556383

[32] Lennox, C., Stevenson, C., Edge, D., Hopkins, G., Thornicroft, G., Susser, E., Conover, S., Herman, D., Senior, J., & Shaw, J. (2020). Critical time intervention: A qualitative study of the perspectives of prisoners and staff. *Journal of Forensic Psychiatry and Psychology, 31*(1), 76-89. https://doi.org/10.1080/14789949.2019.1665699

[33] Walker, et al. (2017). Narratives of young men with injecting drug use histories leaving adult prison.

[34] Hu, et al. (2020).

[35] Walker, et al. (2017).

[36] Hu, et al. (2020).

[37] John Howard Society, et al. (2016). *Reintegration in Ontario: Practices, priorities, and effective models.*

[38] van der Meulen, E., De Shalit, A., & Ka Hon Chu, S. (2018). A legacy of harm: Punitive drug policies and women's carceral experiences in Canada. *Women and Criminal Justice*, *28*(2), 81-99. https://doi.org/10.1080/08974454.2017.1307160

[39] Murdocca, C. (2020). Re-imagining "serving time" in Indigenous communities. *Canadian Journal of Women and the Law*, *32*(1), 31-60. https://utpjournals.press/doi/10.3138/cjwl.32.1.02

[40] Martin, C. M., & Walia, H. (2019). *Red women rising: Indigenous women survivors in Vancouver's Downtown Eastside.* Downtown Eastside Women's Centre. https://dewc.ca/wp-content/uploads/2019/03/MMIW-Report-Final-March-10-WEB.pdf

[41] Mental Health Commission of Canada. (2020). *The mental health needs of justice-involved persons: A rapid scoping review of the literature*. https://www.mentalhealthcommission.ca/English/media/4415

[42] Murdocca. (2020). Re-imagining "serving time" in Indigenous communities.

[43] Perdacher, E., Kavanagh, D., & Sheffield, J. (2019). Well-being and mental health interventions for Indigenous people in prison: Systematic review. *BJPsych Open*, *5*(6), Article e95. https://doi.org/10.1192/bjo.2019.80

[44] Mental Health Commission of Canada. (2019). *Cannabis and mental health: Priorities for research in Canada.* https://www.mentalhealthcommission.ca/English/media/4273

[45] Khenti, A. (2014). The Canadian war on drugs: Structural violence and unequal treatment of Black Canadians. *International Journal of Drug Policy*, *25*(2), 190-195. https://doi.org/10.1016/j.drugpo.2013.12.001

[46] Wortley, S., & Owusu-Bempah, A. (2011). The usual suspects: Police stop and search practices in Canada. *Policing and Society*, *21*(4), 395-407. https://doi.org/10.1080/10439463.2011.610198

[47] Farrell & Marsden. (2008). Acute risk of drug-related death among newly released prisoners in England and Wales.

[48] Merrall, E. L. C., Kariminia, A., Binswanger, I. A., Hobbs, M. S., Farrell, M., Marsden, J., Hutchinson, S. J., & Bird, S. M. (2010). Meta-analysis of drug-related deaths soon after release from prison. *Addiction, 105*(9), 1545-1554. https://doi.org/10.1111/j.1360-0443.2010.02990.x

[49] Canadian Research Initiative in Substance Misuse. (2019). *National injectable opioid agonist treatment for opioid use disorder operational guidance*. https://crism.ca/projects/ioat-guideline/

[50] British Columbia Office of the Provincial Health Officer. (2019). *Stopping the harm: Decriminalization of people who use drugs in BC*. https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/special-reports/stopping-the-harm-report.pdf

[51] Malta, M., Varatharajan, T., Russell, C., Pang, M., Bonato, S., & Fischer, B. (2019). Opioid-related treatment, interventions, and outcomes among incarcerated persons: A systematic review. *PLoS Medicine*, *16*(12), Article e1003002. https://dx.doi.org/10.1371/journal.pmed.1003002

[52] Public Health Agency of Canada. (2020). *From risk to resilience: An equity approach to COVID-19. The chief public health officer of Canada's report on the state of public health in Canada 2020.* https://www.canada.ca/en/public-health/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/from-risk-resilience-equity-approach-covid-19.html

[53] Stewart, L. A., Farrell-MacDonald, S., & Feeley, S. (2017). The impact of a community mental health initiative on outcomes for offenders with a serious mental disorder. *Criminal Behaviour and Mental Health*, *27*(4), 371-384. https://dx.doi.org/10.1002/cbm.2005

[54] Stewart, et al. (2017). The impact of a community mental health initiative on outcomes for offenders with a serious mental disorder.

[55] Stewart, et al. (2017).

[56] Kouyoumdjian, F. G., McIsaac, K. E., Liauw, J., Green, S., Karachiwalla, F., Siu, W., Burkholder, K., Binswanger, I., Kiefer, L., Kinner, S. A., Korchinski, M., Matheson, F. I., Young, P., & Hwang, S. W. (2015). A systematic review of randomized controlled trials of interventions to improve the health of persons during imprisonment and in the year after release. *American Journal of Public Health*, *105*(4), e13-e33. https://dx.doi.org/10.2105/AJPH.2014.302498

[57] Livingston, J. D., Weaver, C., Hall, N., & Verdun-Jones, S. (2008). *Criminal justice diversion for persons with mental disorders: A review of best practices*. Canadian Mental Health Association (B.C.). https://cmha.bc.ca/wp-content/uploads/2016/07/DiversionBestPractices.pdf

[58] Heilbrun, K., Pietruszka, V., Thornewill, A., Phillips, S., & Schiedel, R. (2017). Diversion at re-entry using criminogenic CBT: Review and prototypical program development. *Behavioral Sciences and the Law*, *35*(5-6), 562-572. https://doi.org/10.1002/bsl.2311

[59] Michalski. (2017).

[60] Seto, M. C., Basarke, S., Healey, L. V., & Sirotich, F. (2018). Correlates of mental health diversion completion in a Canadian consortium. *International Journal of Forensic Mental Health*, *17*(1), 1-12. https://doi.org/10.1080/14999013.2017.1405123

[61] Seto, et al. (2018). Correlates of mental health diversion completion in a Canadian consortium.

[62] Canadian Agency for Drugs and Technologies in Health. (2017). *Mental health courts and diversion programs: Guidelines*. https://www.cadth.ca/sites/default/files/pdf/htis/2017/RB1115%20-%20Mental%20Health%20Courts%20Final.pdf

[63] Hu, et al. (2020).

[64] Janssen, P. A., Korchinski, M., Desmarais, S. L., Albert, A. Y. K., Condello, L., Buchanan, M., Granger-Brown, A., Ramsden, V. R., Fels, L., Buxton, J. A., Leggo, C., & Elwood Martin, R. (2017). Factors that support successful transition to the community among women leaving prison in British Columbia: A prospective cohort study using participatory action research. *CMAJ Open, 5*(3), E717-E723. https://doi.org/10.9778/cmajo.20160165

[65] McLeod, K. E., Bergen, C., Roth, K., Latimer, C., Hanberg, D., Stitilis, B., Buxton, J. A., Fels, L., Oliffe, J. L., Myers, N., Leggo, C., & Elwood Martin, R. (2019). Participant-driven health education workshops with men transitioning from prison to community. *Health Promotion Practice*, *20*(1), 8-11. https://dx.doi.org/10.1177/1524839918816328

[66] Mental Health Commission of Canada. (2020). *The mental health needs of justice-involved persons: A rapid scoping review of the literature.*

[67] Fortune, D., Arai, S. M., & Lyons, K. J. (2020). Relational possibilities for women leaving prison: Renewed hope for inclusion and belonging. *Contemporary Justice Review*, *23*(1), 3-21. https://doi.org/10.1080/10282580.2019.1700367

[68] Fortune, et al. (2020). Relational possibilities for women leaving prison: Renewed hope for inclusion and belonging.

[69] Portillo, S., Goldberg, V., & Taxman, F. S. (2017). Mental health peer navigators: Working with criminal justice-involved populations. *Prison Journal*, *97*(3), 318-341. https://doi.org/10.1177/0032885517704001

[70] Portillo, et al. (2017). Mental health peer navigators: Working with criminal justice-involved populations.

[71] Barrenger, S. L., Maurer, K., Moore, K. L., & Hong, I. (2020). Mental health recovery: Peer specialists with mental health and incarceration experiences. *American Journal of Orthopsychiatry*, *90*(4), 479-488. https://dx.doi.org/10.1037/ort0000450

[72] Pijl, E. M., Bourque, S., Martens, M., & Cherniwchan, A. (2017). Take-home naloxone kit distribution: A pilot project involving people who use drugs and who are newly released from a correctional facility. *Canadian Journal of Criminology and Criminal Justice*, *59*(4), 559-571. https://dx.doi.org/10.3138/cjccj.2017.0001.R2

[73] Office of the Provincial Health Officer of BC, BC Centre for Disease Control, & BC Coroners Service. (2016). *British Columbia Overdose Action Exchange: Supplementary material: Primers.* https://www.bccdc.ca/resourcegallery/Documents/BCOAE-supplementary-materials.pdf

[74] Strike, C., Hopkins, S., Watson, T. M., Gohil, H., Leece, P., Young, S., Buxton, J., Challacombe, L., Demel, G., Heywood, D., Lampkin, H., Leonard, L., Lebounga Vouma, J., Lockie, L., Millson, P., Morissette, C., Nielsen, D., Petersen, D., Tzemis, D., & Zurba, N. (2013). *Best practice recommendations for Canadian harm reduction programs that provide service to people who use drugs and are at risk for HIV, HCV, and other harms: Part 1*. Working Group on Best Practice for Harm Reduction Programs in Canada. https://www.catie.ca/ga-pdf.php?file=sites/default/files/BestPracticeRecommendations_HarmReductionProgramsCanada_Part1_August_15_2013.pdf

[75] Strike, C., Watson, T. M., Gohil, H., Miskovic, M., Robinson, S., Arkell, C., Challacombe, L., Amlani, A., Buxton, J., Demel, G., Gutierrez, N., Heywood, D., Hopkins, S., Lampkin, H., Leonard, L., Lockie, L., Millson, P., Nielsen, D., Petersen, D., . . . Zurba, N. (2015). *Best practice recommendations for Canadian harm reduction programs that provide service to people who use drugs and are at risk for HIV, HCV, and other harms: Part 2*. Working Group on

Best Practice for Harm Reduction Programs in Canada. https://www.catie.ca/sites/default/files/bestpractice-harmreduction-part2.pdf

[76] McKenna, B., Skipworth, J., Tapsell, R., Madell, D., Pillai, K., Simpson, A., Cavney, J., & Rouse, P. (2015). A prison mental health in-reach model informed by assertive community treatment principles: Evaluation of its impact on planning during the pre-release period, community mental health service engagement and reoffending. *Criminal Behaviour and Mental Health*, *25*(5), 429-439. https://dx.doi.org/10.1002/cbm.1942

[77] Heilbrun, et al. (2017). Diversion at re-entry using criminogenic CBT: Review and prototypical program development.

[78] Michalski. (2017).

[79] Penney, S. R., Seto, M. C., Crocker, A. G., Nicholls, T. L., Grimbos, T., Darby, P. L., & Simpson, A. I. F. (2019). Changing characteristics of forensic psychiatric patients in Ontario: A population-based study from 1987 to 2012. *Social Psychiatry and Psychiatric Epidemiology*, *54*(5), 627-638. https://dx.doi.org/10.1007/s00127-018-1619-6

[80] Draine, J., & Herman, D. B. (2007). Critical time intervention for reentry from prison for persons with mental illness. *Psychiatric Services*, *58*(12), 1577-1581. https://doi.org/10.1176/ps.2007.58.12.1577

[81] Jarrett, M., Thornicroft, G., Forrester, A., Harty, M., Senior, J., King, C., Huckle, S., Parrott, J., Dunn, G., & Shaw, J. (2012). Continuity of care for recently released prisoners with mental illness: A pilot randomised controlled trial testing the feasibility of a critical time intervention. *Epidemiology and Psychiatric Sciences*, *21*(2), 187-193. https://doi.org/10.1017/S2045796011000783

[82] Lennox, et al. (2020). Critical time intervention: A qualitative study of the perspectives of prisoners and staff.

[83] Lennox, et al. (2020).

[84] Tomita, A., & Herman, D. B. (2015). The role of a critical time intervention on the experience of continuity of care among persons with severe mental illness following hospital discharge. *Journal of Nervous and Mental Disease*, *203*(1), 65-70. https://doi.org/10.1097/NMD.0000000000000224

[85] Barrenger, S. L., Kriegel, L. S., Angell, B., & Draine, J. (2016). Role of context, resources, and target population in the fidelity of critical time intervention. *Psychiatric Services*, *67*(1), 115-118. https://doi.org/10.1176/appi.ps.201400108

[86] Kouyoumdjian, et al. (2015). A systematic review of randomized controlled trials of interventions to improve the health of persons during imprisonment and in the year after release.

[87] Human Services and Justice Coordinating Committee. (2020). *Housing and justice report: Improving supportive housing for justice-involved individuals with mental health and addiction issues*. https://hsjcc.on.ca/wp-content/uploads/HS JCC_Housing-Justice-Report_EN.pdf

[88] Human Services and Justice Coordinating Committee. (2020). *Housing and justice report: Improving supportive housing for justice-involved individuals with mental health and addiction issues.*

[89] Les Femmes Michif Otipemisiwak — Women of the Métis Nation. (2019). *Final report: Building a Métis women's blueprint*. https://en2.metiswomen.org/wp-content/uploads/2020/05/Building-a-Metis-Womens-Blueprint_FINAL_April-30-2020-1-converted.pdf

Appendix A: Glossary of terms

Alcoholics Anonymous (AA) is an international self-support network for individuals seeking a sobriety approach to alcohol-related problems.

Assertive community treatment (ACT) is a model of care designed to improve community-based care for people living with a serious mental illness or associated complexities such as difficulty with following treatment.

Cognitive behavioural therapy (CBT) is a highly structured and time-limited form of psychotherapy focused on addressing challenging thoughts and behaviours.

Concurrent disorders refers to co-occurring problems or illnesses, particularly co-occurring mental health and substance use concerns.

Continuity of care refers to the quality of health and social service care that individuals receive over time.

Critical time intervention (CTI) is an intervention model designed to help individuals through critical transitional periods such as the transition to the community from correctional settings, shelters, and hospitals.

Dialectical behaviour therapy (DBT) is a form of psychotherapy focused on building healthier ways to manage stress, mood, and relationships.

Discharge or release planning refers to the process of preparing individuals for their release from incarceration and community re-entry.

Diversion refers to processes and opportunities for redirecting people away from the criminal justice system.

The **federal correctional system** in Canada oversees people who have been convicted of criminal offences and sentenced to two years or more. The Correctional Service of Canada manages federal correctional institutions and supervises persons under conditional release in the community.

Forensic assertive community treatment (FACT) is a type of specialty mental health program for individuals living with one or more serious mental illnesses who are involved in the forensic care system.

The **forensic care system** provides service to individuals who have been involved in the criminal justice system while experiencing one or more serious mental illnesses. Typically in Canada, this system provides mental health care for persons who have been found not criminally responsible on account of mental disorder and those deemed unfit to stand trial.

A **halfway house** is a type of setting designed for people who have been involved in the criminal justice system to assist with their community re-entry.

Harm reduction comprises an array of policies, services, and practices that aim to reduce the negative health and social impacts associated with substance use, drug policy, and drug laws.

Health equity is the principle that all people should have equal access to opportunities to achieve their highest health potential, independent of differences in social, economic, and demographic status.

Mental health court is a type of criminal law court for people with lived and living experience of mental illness or mental health concerns.

Naloxone is a medication used to counter the effects of opioid overdose.

Narcotics Anonymous (NA) is an international support network for people seeking recovery from use of drugs other than alcohol.

The **provincial/territorial correctional systems** in Canada are responsible for managing people who are on remand, are convicted and sentenced to less than two years, or are in immigration detention.

Rapid-access addiction medicine (RAAM) clinics offer quick access to care for people living with substance use concerns.

Recidivism refers to the tendency for people who have been previously involved with the criminal justice system to be re-exposed to the criminal justice system.

Reintegration refers to the transition away from criminal justice settings such as correctional facilities and back to the community.

Transitional and supportive housing includes temporary types of accommodation designed to help people move away from homelessness or precarious housing to permanent housing. Supportive housing includes affordable community housing combined with dedicated support from mental health and/or substance use program staff.

Trauma-informed practice and policies recognize the complexities of personal, family, and community experiences of trauma. They incorporate what is needed to prevent re-traumatization including acknowledgement of the contributing cultural and systemic forces and power dynamics such as colonialization, social exclusion of diverse people, and systemic racism. These policies facilitate journeys of mental health recovery through compassionate care, consumer choice, flexibility, and opportunities for self-mastery and resilience-building.

Appendix B: Academic and grey literature searches

Academic articles were identified through searches using database-specific subject headings and keywords in natural language. The following databases were searched: Medline (including Epub ahead of print, in-process, and other non-indexed citations), APA PsycInfo, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Criminal Justice Abstracts, and Scopus. A medical librarian developed the search strategies with input from the research team.

The search strategy comprised three concepts: criminal justice, reintegration, and mental health services. The first concept defined the population, using subject headings and text words connected to criminal justice-related descriptors and settings. The second concept aimed to capture the period of transitioning out of the criminal justice system, using terms such as "reintegration" and "re-entry," and pairing time or transition descriptors with criminal justice-related settings or terms using a proximity operator. The final concept operationalized the notion of mental health services through subject headings and text words related to interventions for mental health, mental illness, and substance use. This concept also includes health promotion, health education, and health literacy in order to capture literature that describes harm reduction education in this manner.

Once combined, a Canada filter was added to limit results to articles written about services available in Canada. To do this, a filter was created to search targeted fields for national, provincial/territorial, and major city names, as well as terms more specific for First Nation, Inuit and Métis communities in Canada.

The year limits applied were 2015 to present (September 2020). No language limits were applied. With the assistance of a bilingual knowledge broker, the librarian also ran simplified searches in the French-language resources Érudit and Persée to capture additional material written in French.

The reference lists of relevant papers were also searched for additional sources, including key sources that may have pre-dated 2015. All academic references were stored and organized in a reference manager software (Refworks).

For the grey literature, a multi-method strategy search was used, including structured Google searching. The Google searches were also limited to results with all the provinces and territories occurring as a word.

Additional searches were conducted using terms that were considered relevant to First Nations, Inuit and Métis services; for example, "healing" and "culturally appropriate care."

Google searches were limited to the most recent year to control volume of hits and to capture relevant information about currently available services and supports. Supplemental

Google searches were also executed using the document type PDF as a limit to ensure that any full reports or relevant publications were captured.

While Google is a great resource for finding grey literature, it has a tendency to push the most popular hits to the top of the list, and the librarian noted that many of the same search results would appear for each province or territory. Regional and local 211 services and the Directory of Canadian Not for Profit Associations were searched to further complement the grey literature strategy, using project keywords such as "criminal justice" and "mental health." When potentially relevant organizations and services were found, their websites were consulted for additional information and to determine relevance for the inventory component of this project.

A total of 1,360 academic references were found via the database searches (i.e., Medline, including Epub ahead of print, in-process, and other non-indexed citations = 350 results; APA PsycInfo = 270; CINAHL = 267; Criminal Justice Abstracts = 177; Scopus = 276; and Érudit and Persée = 20). Most articles were not relevant for the purposes of identifying currently active services and supports in Canada. The articles and other resources cited in the report reflect studies and resources that provide key context regarding transitions to the community from the criminal justice system.

Mental Health Commission of Canada | Commission de la santé mentale du Canada

Mental Health Commission of Canada

Suite 1210, 350 Albert Street
Ottawa, ON K1R 1A4

Tel: 613.683.3755
Fax: 613.798.2989

mhccinfo@mentalhealthcommission.ca
www.mentalhealthcommission.ca

@MHCC_ /theMHCC /1MHCC @theMHCC
/Mental Health Commission of Canada
/theMHCC