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The Mental Health Needs of Justice-Involved Persons

A Rapid Scoping Review of the Literature

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About this document
This report is based on a scoping review by a team of researchers at the Canadian Mental Health Association (CMHA), who analyzed existing research and policy documents on the mental health care needs of justice-involved persons in Canada's criminal justice system and in peer jurisdictions. It aims to guide future research and policy development by highlighting what is currently known about this topic and what knowledge gaps may exist in the literature on mental health in the criminal justice system. While it highlights research on the prevalence of mental health problems and mental illness in the criminal justice system, experiences of justice-involved persons with mental health problems and mental illness, and promising practices and principles for mental health care, it is not intended to be a comprehensive review of the literature.

Acknowledgements

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The main offices of the MHCC are located on the traditional and unceded territories of the Algonquin people. These lands are now home to many diverse First Nations, Inuit, and Métis communities. We would like to thank the Elders and caretakers of the land, both past and present, and acknowledge the strength and resiliency of Indigenous peoples across Canada.

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Contents

Executive Summary ... i

Who experiences mental health problems in the criminal justice system? ... i

Prevalence rates and mental health risks ... i

What are the pathways to justice involvement for people with mental health problems and illnesses? ... ii

What are the experiences and needs of people with mental illnesses and mental health problems involved in the justice system? ... ii

Describing the experiences of justice-involved people ... ii

Pathways and gatekeepers: Accessing mental health care inside the justice system ... iv

What evidence-based and promising practices address mental health needs in the criminal justice system and in the community after release? ... v

Mental health diversion and alternatives to incarceration ... v

Interventions and care models for those in custody ... vi

Release, reintegration, probation, and parole ... vii

What principles and concepts should inform the development of programs and policies tailored to justice-involved persons? ... viii

Health-care parity and equivalence ... viii

Continuity of care ... ix

Reconciliation and equity ... ix

Therapeutic jurisprudence and procedural fairness ... x

Systemic reform ... x

Summary: What do we know and what do we need to know? ... x

Overall state of the research: Strengths and weaknesses ... x

Specific recommendations for further research and policy ... xi

Conclusion ... xii

The Mental Health Needs of Justice-Involved Persons: Introduction ... 1

Mental health as an area of concern in the criminal justice system ... 1

The current policy context in Canada ... 2

Scope, research questions, and methods ... 6

Organization of the report ... 8

Who Experiences Mental Health Problems in the Criminal Justice System? ... 10

Prevalence rates and mental health risks ... 10

In Canada ... 11

Comparing Canada to international prevalence estimates ... 20

What are the Pathways to Justice Involvement for People with Mental Health Problems? ... 23

Direct determinants of justice involvement ... 24

Indirect determinants of justice involvement ... 26

Criminogenic factors ... 26

Social determinants of health ... 27

Structural factors driving justice involvement ... 28

Limitations and opportunities in the literature on prevalence ... 29

What are the Experiences and Needs of People with Mental Illnesses and Mental Health Problems who are Involved in the Justice System? ... 31

Describing the experiences of justice-involved people ... **32**
Transition, disruption, and discontinuity ... 32
Coercion, choice, and change ... 34
Segregation and isolation ... 35
Stigma and shame ... 38
Self-injury and suicidality ... 39
Pathways and gatekeepers: Accessing mental health care inside the justice system ... **41**
Diversion and the courts ... 41
Institutional care in custody ... 42
Community corrections and care ... 44
Limitations and opportunities in the literature on access and experiences ... **45**
What Evidence-Based and Promising Practices Address Mental Health Needs in the Criminal Justice System and the Community After Release? ... **46**
Mental health diversion and alternatives to incarceration ... **46**
Diversion mechanisms, including specialty courts ... 46
Interventions and care models for those in custody ... **51**
Specialized programs and approaches ... 51
Models of mental health care provision ... 53
Release, reintegration, probation, and parole ... **56**
Client-focused interventions ... 56
System-focused interventions ... 59
Intersectoral collaborations ... 61
Limitations and opportunities in the literature on evidence-based and promising practices ... **62**
What Principles and Concepts Should Inform the Development of Programs and Policies Tailored to Justice-Involved Persons? ... **64**
Health-care parity and equivalence ... **64**
Independence of clinical care standards ... 66
Continuity of care ... **67**
Reconciliation and equity ... **68**
Culturally safe programming ... 68
Gender-responsive programming ... 69
Recovery ... **70**
Therapeutic jurisprudence and procedural fairness ... **70**
Systemic reform ... **71**
Restriction of segregation and isolation practices ... 71
Transparency and accountability ... 71
Integration and coordination between sectors ... 71
Summary: What Do We Know and What Do We Need to Know? ... **73**
Overall state of the research: Strengths and weaknesses ... **73**
Specific recommendations for further research and policy ... **75**
Conclusion ... **77**
Appendix: Data Charting Tables ... **79**
References ... **81**

Executive Summary

This report reviews recent literature on the mental health needs of justice-involved people in Canada. It is a rapid, conceptual scoping review of both academic and policy sources on the topic, intended to identify priority areas for current and forthcoming discussions. For many critical observers today, jails and prisons have become places of confinement where people with mental health problems and illnesses can be hidden from view. Researchers and policy makers agree that people who live with mental health problems and illnesses are overrepresented in criminal justice systems, in Canada and globally.

We examined the literature through an equity and human rights lens, starting from the position that justice-involved persons, including those convicted of crimes, retain their right to adequate health care, including mental health care, and that identity informs the impact of one's contact with the criminal justice system — both as an individual and as members of groups experiencing structural disadvantage and oppression. Throughout, we draw out two overarching themes: the tension between trying to assure security while providing care, and the overlap between mental health recovery and criminogenic rehabilitation.

The report applies its review of the literature to five research questions regarding mental health needs in Canada's criminal justice system:

1. Of those involved with the Canadian criminal justice system, who experiences mental health problems and mental illnesses, and of what kind?
2. What are the experiences of justice-involved individuals living with mental health problems and/or mental illnesses? What barriers do they experience when accessing mental health care? How do these experiences vary when we account for multiple axes of identity?
3. What evidence-based practices and promising policies, standards, program frameworks, and services best support the mental health of individuals who interact with the criminal justice system?
4. What are the key concepts and values that should inform the design and delivery of programs, policies, and services for justice-involved individuals with mental health problems and/or mental illnesses? How are these, and can these be, tailored to priority populations?
5. What are the strengths and limitations of the existing evidence, and what opportunities exist for future research, performance measurement, and program monitoring?

Who experiences mental health problems in the criminal justice system?

Prevalence rates and mental health risks

The rate of mental health problems and illnesses among justice-involved people is very high; substantially higher than in the general population, and the excess prevalence has been worsening over time. The exact figures reported depend upon the data sources used and the operating definitions of mental illness, mental health problem, or needs.

Symptoms of trauma and experiences of verbal, physical, emotional, or sexual abuse have not always been recognized as part of mental health care needs that should be subject to assessment, but recent

research indicates that histories of trauma and abuse among justice-involved persons outpace these experiences in the community. Rates of attempted suicide and suicidal ideation are also extremely high in Canadian prisons, anywhere from three to 11 times that of the community depending on the population, with First Nations, Inuit, and Métis (FNIM) persons being especially vulnerable.

Canadian rates of prevalence of mental health problems and mental illness in correctional contexts are comparable to rates in the United States (U.S.), the United Kingdom (U.K.), Australia, and New Zealand (N.Z.).

What are the pathways to justice involvement for people with mental health problems and illnesses?
There are a range of determinants and predictors that increase the likelihood that people with mental health problems and illnesses will become involved in the criminal justice system. These determinants may be direct (such as symptoms or diagnosis of a mental illness) or indirect (such as criminogenic risk factors like behavioural or conduct problems; lack of access to the social determinants of health; and structural determinants such as political and historical conditions or marginalization on the basis of race, identification as FNIM, and/or gender).

Persons with mental illnesses who are also experiencing homelessness are among the subgroups of homeless persons who are more likely to encounter the criminal justice system, specifically because they are often charged with misdemeanour nuisance offences and offences related to maintaining their survival.

The possibility of re-arrest is another pathway to justice involvement for people with mental health problems and illnesses. Incarcerated persons with severe mental illness are less likely to be granted full parole; when they are paroled, they are less likely to be able to adhere to the terms of their probation and parole, leaving them susceptible to re-arrest or reincarceration. The most significant predictors of continued justice involvement include lack of referral to services and a high degree of administrative burden on the person (such as meetings or conditions with which to comply). Housing supports are recognized as a necessary factor in the prevention of continued justice involvement for people with mental health problems and illnesses.

Many scholars and experts also attribute the increasing overrepresentation of priority populations in the criminal justice system to a series of concurrent and significant reductions in funding for community-based social services and programs proven to be effective within correctional settings.

What are the experiences and needs of people with mental illnesses and mental health problems involved in the justice system?

Describing the experiences of justice-involved people
Our review of the literature identified the following themes.

TRANSITION, DISRUPTION, AND DISCONTINUITY

Justice-involved people with mental health problems or illnesses repeatedly experience disruption and change, as they are often moved between institutions, courts, available services, precarious housing, and homelessness. This sense of discontinuity is heightened by trends in Canadian justice and corrections: the number of people serving custodial sentences is declining in six of 10 provinces and two

of three territories as of 2019, while eight provinces and territories now have a greater number of adults on remand than serving custodial sentences. Even if jails were suitable therapeutic environments, complex mental health needs take time to address, and stays in jail are both generally short and can have unpredictable lengths due to releases as determined by the courts; this reduces the efficacy of mental health interventions unless there is continuity in the community. Higher jail populations are driven by stricter risk assessments and more restrictive bail conditions.

Those with mental illnesses, particularly if released from court, are disproportionately affected by these changes, being released without possessions — including medication and identity documents — that may be held at widely spread-out provincial institutions that are hours of travel away. The two weeks after release from provincial custody place individuals at a higher risk of death, particularly from substance use and by suicide, a finding also identified internationally. This is a period where uncertainty about housing, health care, and the future are at their peak, mental health stability is threatened, and inadequate transition services can leave people vulnerable.

COERCION, CHOICE, AND CHANGE

In the Canadian context of under-resourced community mental health services, justice involvement may be one of the few ways people can access mental health care. But this access often comes with the cost of being criminalized and potentially entering a cycle of breaching bail conditions or being sentenced to incarceration where access to care services is administered within an anti-therapeutic environment.

Involvement with the justice system, even if it leads to non-custodial sentences or diversion, imposes restriction and, in some cases, new forms of chaos such as institutional coercion, ridicule, and violence; the complexity of imposed conditions; and anxiety over missing appointments. Forms of court-based diversion (such as mental health courts) are predicated on the assumption that unmanaged symptoms of a mental illness are linked to criminalization because of non-adherence to treatment and/or inadequate or inaccessible community mental health services, both offering and imposing new forms of responsibility.

SEGREGATION AND ISOLATION

It is not uncommon for incarcerated people with mental illnesses or expressing symptoms of a mental illness to be placed in segregation or solitary confinement. They will experience segregation and solitary confinement far more often than their counterparts without a mental illness. Segregation is, according to the literature, the most common institutional response to a mental illness, particularly suicidal ideation, even though the safety and mental health of incarcerated individuals with mental illnesses is often significantly compromised by isolation and segregation.

In the early 2010s, the proliferation of "tough on crime" laws in Canada curtailed visitation and reduced the rates of parole. Incarcerated persons with mental illnesses were disproportionately affected by these laws, though they are already less likely to experience or be granted a right to visitation.

The Correctional Investigator of Canada maintains that the use of seclusion to manage people with mental illness is not consistent with current evidence, best practice, or correctional expertise, all of which indicate that the factors that prevent self-injury in prison are less time locked in a cell, access to employment, access to individual counselling, enrolment in programs, and regular contact with family and/or loved ones.

STIGMA AND SHAME

People with severe mental illness are often more visible to the police due to their greater visibility in public spaces. They are also often perceived as a risk and a threat to public safety, which not only reinforces stigmatizing attitudes toward people with severe mental illness, but also increases their risk of being apprehended. Some people with mental illnesses may enter the criminal justice system without a diagnosis because they come from communities where stigma, in combination with limited access to health services, reduces rates of awareness and help seeking.

Canadian experts maintain that, within the criminal justice system, people with mental illnesses are frequently defined by their diagnoses, the implications of which include being labelled with a tag that "sticks" to the person and contributes to their perceived and actual social isolation and hampers their ability to re-enter their communities upon release.

The stigmatizing attitudes and behaviours perpetuated by corrections professionals and by community-based mental health providers, who may feel unprepared to serve justice-involved clients, have a detrimental impact on the experiences of justice-involved people with mental illnesses.

SELF-INJURY AND SUICIDALITY

Incarcerated persons typically do not engage in self-injury to manipulate corrections staff. A considerable amount of research exists to confirm that disciplinary or punitive responses do little to mitigate the risk or reduce the rates of self-injury among incarcerated persons.

Pathways and gatekeepers: Accessing mental health care inside the justice system

DIVERSION AND THE COURTS

Diversion refers to programs that stay or suspend charges, or adopt alternative sentencing procedures, if an accused person consents to a path of treatment. Diversion programs have been recognized as important facilitators of access to care for justice-involved people. However, this is partly an outcome of care scarcity.

Those appearing before mental health courts (MHCs), or before ordinary courts with mental health-related support services, have high levels of unmet needs and a lack of connection to supports before coming into contact with the justice system. Specialized diversion for youth can be particularly effective because mental health problems and justice involvement can often co-occur at the onset of adulthood, and supportive programming can make a significant difference in this regard.

INSTITUTIONAL CARE IN CUSTODY

In Canada, correctional mental health care is consistently understaffed and has very high turnover rates. Vacancy rates are high in federal and provincial institutions, hovering around 8.5 per cent overall and around 30 per cent for specific roles (such as psychologist). Specifically, substance use, suicide risk, and adjustment problems (mental health problems caused by entering incarceration) occupy the mental health staff who are available, leaving other serious problems under-detected and under-treated. Pharmacotherapy is widely recognized as playing a primary role — sometimes a monopoly — in corrections mental health care. In qualitative studies, justice-involved persons have indicated they feel medication is administered to manage their behaviour and not to promote recovery.

The literature indicates that mental health care in correctional settings should have several components: screening at, or soon after, admission; referral to further assessment for those with positive screenings;

24-7 emergency care access for those in crisis, including suicide prevention; primary care in every institution; and access to intermediate and specialized psychiatric care.

While screening tools may be validated to be delivered by non-specialized staff, informal observation is also a key element of diagnosis, and in correctional environments, staff can miss emergent signs of mental health problems or crises that fall short of dramatic, strange, or threatening behaviour.

Primary care services in federal institutions in Canada are overloaded because intermediate care has not been universally or adequately funded, and regional treatment centres (which provide tertiary/intensive care) are extremely restricted in capacity with very high bars to admission; not all who require this level of care can access it. Recent audits of mental health care in the Canadian corrections system have recommended that intermediate mental health units, comprehensive staffing, appropriate treatment of self-injury and suicidal ideation, and restrictions on segregation are needed to enhance access to quality of mental health care.

COMMUNITY CORRECTIONS AND CARE

Formerly incarcerated people often return to neighbourhoods that are often in highly disadvantaged areas, with their own threats to mental health recovery and risk factors for recriminalization. Such circumstances can remain even for people who are successfully linked to services, since those services often cluster in the same neighbourhoods where people first encounter determinants of criminalization, such as networks of substance use, violence and, for women, abuse and sex work. These circumstances can contribute to the “revolving door” effect of rapid recriminalization for those with mental health problems or mental illnesses, especially if restrictions on housing and employment that stem from having been justice involved make it difficult to remain engaged with treatment.

Reviews of probation services suggest the system is not accurately matching probationer mental health needs to level of services, with low-risk probationers often sent to specialized services and high-needs probationers often lacking access to coordinated and justice-focused mental health care.

What evidence-based and promising practices address mental health needs in the criminal justice system and in the community after release?

Mental health diversion and alternatives to incarceration

DIVERSION MECHANISMS, INCLUDING SPECIALTY COURTS

In Canada, people with mental illnesses may be recommended for MHC or other forms of court-based diversion. “Accused” persons with a mental illness who elect to participate in MHC are subsequently required to comply with an individually tailored treatment program designed by an MHC team, which may include any number or combination of justice and mental health professionals.

MHCs are evaluated with growing frequency and are often cited as a promising practice in the literature on interventions, but evaluations are still developing. In some provinces, mental health diversion programs have been found to be most effective for those with the least complex and least severe needs (combined mental health and criminogenic).

Diversion can be successful in helping people avoid the legal system, but it has been critiqued on the basis that it does not always help people enter the mental health system. Overall, the evidence that

diversion programs reduce time in jail is stronger than the evidence that they improve symptoms or quality of life for justice-involved people with mental illnesses. Experts recommend that criminal behaviour among justice-involved persons with a mental illness is best reduced via programs that address the social determinants of health (such as homelessness or unemployment), criminogenic risk (such as criminal thinking and antisocial networks) and problematic substance use.

Interventions and care models for those in custody

SPECIALIZED PROGRAMS AND APPROACHES

Dialectical behaviour therapy (DBT) and cognitive behavioural therapy (CBT) are the most commonly adapted and effective interventions for incarcerated persons with mental illnesses. Overall, DBT has been found effective in reducing recidivism and improving engagement with mental health care. Its focus on emotion regulation and interpersonal skills has been found to be effective for symptom reduction in those with difficult-to-treat mental illnesses associated with mood and personality, and to reduce expressions of suicidality and non-suicidal self-injury.

Several programs have been developed to support priority populations by recognizing their unique needs and experiences within and outside the criminal justice system. A health clinic established for women incarcerated in a large, maximum-security facility improved access to "comprehensive, gender-specific services in a timely manner." The literature addressing programming for specific priority populations tends to focus on FNIM people, though that does not mean such programs are widely available.

MODELS OF MENTAL HEALTH CARE PROVISION

There is quite a bit of agreement about a series of minimum standards and best practices to ensure justice-involved persons have full and equal rights to care that is appropriate for their mental health needs in accordance with recognized standards. Livingston's (2009) review of minimum standards and best practices in correctional mental health and substance use services remains an important milestone in synthesizing evidence on models of care:

- screening on intake and referral to assessment as needed
- treatment services, matched with levels of need
- suicide prevention
- transitional services before and after release from custody
- community-based services during supervision and reintegration

The STAIR model — screening, triage, assessment, intervention, and reintegration — outlines what some maintain are the "essential requirements" needed in service provision in prison settings. The key components of this model are as follows:

- **Screening.** First stage: use validated tools to identify presenting issues that require immediate intervention and trigger referral.
- **Triage.** Detailed assessment of the individual's mental health needs and current level of functioning, with triage to service.
- **Assessment.** Specialist evaluation.
- **Intervention.** Should be comprehensive, agile, and culturally competent.
- **Reintegration.** Transition needs to be planned well in advance of release.

Some researchers have found that STAIR can address more common mental health problems, reduce demand on already overworked teams, and improve the well-being and rehabilitation of incarcerated persons.

Release, reintegration, probation, and parole

CLIENT-FOCUSED INTERVENTIONS

In the past 20 years, several valid, evidence-based or evidence-informed models have emerged for risk assessment, but experts note that few of these support planning for effective intervention. The literature recognizes the risk-need-responsivity (RNR) model, assertive community treatment (ACT) and forensic assertive community treatment (FACT), and forensic intensive case management (FICM).

RNR is often recognized as the most influential model to include both risk assessment and approaches for effectively treating people with criminogenic needs. It has been recognized as a leading example of evidence-based practice because it is linked to the real, human service needs of clients. The treatment is delivered in a way that considers the learning style, motivation, identities, abilities, and strengths of the person and is thus, in theory, mental health responsive.

ACT is a suite of intensive and multidisciplinary treatment, rehabilitation, and support services designed for those who may struggle or find it challenging to engage in typical mental health services. However, it is challenged by clients' criminogenic needs. To overcome these challenges, ACT can be enhanced to include criminogenic risk, extensions to the model that have become known as FACT and FICM. FACT and FICM demonstrate limited yet promising bodies of evidence but differ from ACT in that the dual goal is to reduce the risk of recidivism and promote recovery.

In addition to these models, specialized probation is often frequently cited as a promising, client-centric model for people with mental illnesses. Despite variation in case management style, structural characteristics, and implementation of treatment mandates, there are common features across specialized probation programs: the protection of public safety and the rehabilitation and recovery of justice-involved clients.

SYSTEM-FOCUSED INTERVENTIONS

Promising practices in systemic reform focused on interventions in community reintegration after release from custody. Livingston et al.'s (2008) review of best practices in mental health care for justice-involved people includes the following elements of successful community reintegration and supervision: ongoing screening; the prevention of revocation, including incentives to comply and graduated responses to breach; a specialized case management model like FACT or FICM; and specialized mental health caseloads for probation and parole officers.

The best-practice approach to release and community supervision planning is known as the APIC model:

- *Assess* by creating a risks/needs inventory.
- *Plan* by identifying critical periods and preparing clients, such as by supplying adequate medication until follow-up with primary care providers and preparing benefits reinstatement.
- *Identify* the right services in the community relevant to the client's needs.
- *Co-ordinate*, ensuring implementation of the plan by connecting with stakeholders and averting gaps in care.

In Canada, the federal corrections system has been pursuing implementation of wrap-around planning for some time, though there is an absence of independent evaluation evidence regarding quality and effectiveness. Upgraded planning processes for people with a mental illness leaving custody depend upon community resources, including support with education, employment, housing, and child care, and their success is influenced by the availability of those resources and the willingness of those who administer them to engage with clients who have histories of justice involvement.

INTERSECTORAL COLLABORATIONS

Improving mental health care within justice and corrections may require recognizing that no one stakeholder group has the expertise, resources, and authority to act effectively on their own. Depending upon the specific situation addressed, these collaborations and alliances can take one of several forms. In some cases, health care in corrections — both in institutions and the community — is exploring more effective team-based multidisciplinary strategies that recognize the importance of independent clinical expertise.

There are many calls for this collaboration and reviews of best practices for how such collaborations might work. However, there are fewer empirical evaluations of how such collaborations have worked in practice. Livingston et al.'s review (2008) of best practices lists the following elements of successful interagency and intergovernmental collaboration:

- ensuring continuity across institutions through boundary-spanning experts (especially care providers licensed to operate in multiple venues, such as jail and hospital)
- regular stakeholder meetings
- locating leadership and accountability within the team
- establishing a case-finding procedure that emphasizes early identification
- standardized training on mental health issues and increasing the awareness of options for diversion and treatment
- public investment in community resources

In Ontario, a collaborative interministry model has been operating since 1997 in the form of the human services and justice coordinating committees (HSJCCs), which have provincial, regional, and local committees with representatives from the ministries of health, attorney general, solicitor general, community safety, and correctional services, as well as police services and service providers. The committees operate as planning tables and develop solutions to identified gaps and needs for individuals with special needs across juncture points within the criminal justice system.

What principles and concepts should inform the development of programs and policies tailored to justice-involved persons?

Health-care parity and equivalence

In the context of mental health care in the criminal justice system, parity of care has two important elements: first, a quality health-care standard equivalent to that found in the community; second, ensuring that medical decisions with respect to mental health are taken independently of decisions regarding corrections and the administration of justice. Thus, parity means that mental health recovery is not eclipsed by criminogenic needs in rehabilitation planning but recognized as a human right on its own.

A key priority area to enhance quality of care in prisons is to ensure correctional staff receive training in crisis intervention and de-escalation techniques, so they can better identify incarcerated persons who are at risk of experiencing mental health emergencies.

In April 2019, the Ontario Court of Appeal ordered the federal government to establish a review of solitary confinement that is independent from prison administrators. Despite this policy, some experts find that national direction and oversight is lacking with respect to the frequency and appropriate use of physical restraints in regional treatment centres, and that amendments to Bill C-83[*] did not fully address the lack of oversight necessary to ensure discretion is properly used and still does not "adequately safeguard the independence of prisoners' health services."

Continuity of care

The principle of continuity of care is critical when transitioning into custody, between institutions in custody (including to and from hospital), and into the community both from custody and hospital. To ensure continuity, correctional health care should be integrated with the overall health-care system — particularly in provincial and territorial institutions where people serve short sentences or are on remand. A lack of care continuity in the community for justice-involved individuals with mental illnesses leads to circumstances where their mental health and well-being are at risk of deterioration in communities that lack the appropriate resources for ongoing treatment and support.

An important first step in reconciling this is to organize housing for individuals leaving custody. Most experts recognize housing as a form of care and identify housing to be the biggest single factor in a successful transition to the community.

Reconciliation and equity

It is consistent with previous reviews of this literature to note that women and FNIM persons, as groups, are much more studied in the literature than immigrant, refugee, ethnocultural, and racialized (IRER) or lesbian, gay, bisexual, transgender, queer and two-spirited (LGBTQ2+) populations.

CULTURALLY SAFE PROGRAMMING

Culturally safe and responsive mental health programming, which is informed by an understanding of the experiences and barriers faced by priority populations and aims to address stigma and improve perceived and actual care quality, can increase the uptake of mental health care in correctional facilities.

Correctional Service Canada (CSC) implemented its Aboriginal Justice Strategy (AJS) to address the overrepresentation of FNIM persons in the federal corrections system. However, anti-oppression critiques of the AJS in relation to FNIM women concluded that it has not been effective in reducing justice involvement because it does not address the structural violence affecting some communities, namely, poverty, sex work, untreated mental illnesses, and addictions.

GENDER-RESPONSIVE PROGRAMMING

When developing risk-need-responsivity care models, trauma-informed practices are encouraged, given the recognition that trauma is a risk factor (as well as a primary care factor) for women's criminalization. The literature suggests that programs ensure a focus on increasing internal control and establishing safe interpersonal connections. In addition, screening tools, staff training, and treatment models need to be

[*] *An Act to Amend the Corrections and Conditional Release Act and Another Act.*

validated separately with women to overcome the inappropriate and overuse of diagnoses such as borderline personality disorder and the lack of recognition of internalizing disorders.

RECOVERY

Recovery is an approach that underpins and guides contemporary mental health services throughout the world. The principles that underpin recovery-oriented mental health supports are

- a sense of connectedness to supportive networks
- a belief in hope and trust in the essence of a recovery process
- trust in oneself to overcome stigma
- a sense of purpose and meaning in life
- a sense of control over one's life.

Therapeutic jurisprudence and procedural fairness

Therapeutic jurisprudence means that to uphold the relationship between crime and punishment, jurisprudence should consider individuals' mental health problems that could influence the experience of their sentence, particularly given the conditions of confinement.

Systemic reform

Experts have consistent recommendations for systemic reform of the justice and corrections systems with respect to people who have mental health problems and illnesses, including the restriction of segregation and isolation practices, greater transparency and accountability, and integration and coordination between sectors.

Although there is no one ideal model to enhance coordination and co-operation between sectors, the Correctional Investigator of Canada suggests

- developing partnerships between the corrections system and provincial hospitals
- increasing the use of community providers
- facilitating the transfer of specialized services to health-care authorities in the provinces.

Summary: What do we know and what do we need to know?

Overall state of the research: Strengths and weaknesses

Our report confirms and expands on the following findings of a 2015 stakeholder consultation reported by Crocker et al:

- On prevalence and risk, there is a lack of longitudinal and comparative data in Canada.
- On correctional models of care, we still lack gold standards for treatment models that include alternatives to segregation and effective training models for staff.
- On institutional governance and reform, we lack knowledge on the efficacy and cost effectiveness of policies and practices surrounding mental health and justice issues.
- On recovery and public safety, we need to know more about how to measure and evaluate the recovery orientation of services and the relationship between recovery and public safety.
- Finally, on data collection, we need to build platforms for data sharing and pooling our national data.

In Canada, our sample of the literature is skewed toward those who are in custody, and within that sphere, toward those held in federal institutions. Information on provincial and territorial populations in custody is more limited. Areas of the country with very serious rates of incarceration, such as the prairie provinces and the territories, are nearly absent in our sample.

For in-custody populations (particularly in federal institutions) there is a relatively high quantity of prevalence information, on mental illness diagnoses and symptoms, self-injury, suicidality, and impairment. The literature is comparatively strong on examining the determinants of criminalization for people living with mental illnesses, a reflection of the long-term concern with the issue. Critical perspectives of the justice system and its treatment of mental illnesses are robust. In our sample of the literature, there is a stark absence of attention to IRER populations, with respect to mental health in the justice context. We were also unable to locate any current, relevant research on LGBTQ2+ Canadians, either as a group, or on experiences at the intersection of mental health, justice involvement, gender, and sexuality.

We reviewed many sources that evaluated promising practices or described evidence-based and best practices regarding mental health care models and specialized interventions. What is missing from our sample are robust studies of scaling-up and broad implementation for these promising practices.

Specific recommendations for further research and policy

As above, we confirm and expand on Crocker et al.'s 2015 consultation. That paper sets out the following as an agenda of challenges to be studied and overcome. They recommend that Canadian jurisdictions

- support families caring for loved ones who experience mental illnesses or mental health problems and who become justice involved
- support community mental health services dealing with aggressive behaviour and offering coordinated services that address mental health needs and criminogenic risks
- establish a consistent, high-quality standard of specialized resources for mental health in correctional settings, one that is separate from substance use and suicide prevention
- have a unified model of care and discharge planning that spans the culture gap between corrections and mental health services in the community
- address inadequate reintegration, including through promoting inclusive community mental health services for those with forensic histories
- address the stigma of justice involvement and mental illness in the media and public discourse.

We see three additional areas for further effort. The first is the development of longitudinal studies of justice-involved populations with mental health problems and mental illnesses that can reliably track their experiences as they traverse the criminal justice system. The second area is the development of a collective impact model for mental health recovery in the so-called "revolving door" population of low-intensity, high-frequency justice involvement of people with complex mental health needs and housing instability. The third area is to more systematically explore the perspectives of mental health care users who are justice involved, combining promising evidence of program effectiveness with collaborative research that can address questions about acceptable care standards, overcoming shame and stigma around mental illnesses, thereby creating a bottom-up answer to the sequential intercept model (see p. 51).

Conclusion

In Canada, a disproportionately high number of people with mental health problems and mental illnesses interact with the criminal justice system. We found widespread agreement that the criminal justice system has become an inappropriate mental health “system” of last resort, if not a system of care, then a system of management. The Canadian and international research and policy literature indicates there are several priorities and principles that, if addressed, could create the conditions for a recovery-oriented system that does not compromise the mental health and justice outcomes of justice-involved people. The time is right for everyone with a stake in this issue — researchers, policy and decision makers, people with lived experience, and justice-involved people and their loved ones — to envision and enact a collective approach to this issue.

The Mental Health Needs of Justice-Involved Persons: Introduction

Mental health as an area of concern in the criminal justice system

This report reviews recent literature on the mental health* needs of justice-involved people† in Canada. It is a rapid, conceptual scoping review of both academic and policy sources on the topic, intended to identify priority areas for current and forthcoming discussions. For many critical observers today, instead of fostering full lives outside of institutions for people with mental health problems, jails and prisons have simply replaced the hospital as places of confinement where people with mental illnesses can be hidden from view.[1] Academic researchers and policy makers agree that people who live with mental health problems and mental illnesses are overrepresented in criminal justice systems, in Canada and globally.

In Canada and the United States (U.S.), there is also a dominant, if not universal, agreement about the modern (re)emergence of the excessive criminal justice involvement of this population. Recent analyses of deinstitutionalization, explored further below, have found that the justice involvement of people with mental health problems and illnesses is driven in significant part by the disappearance of large-scale psychiatric hospitals and the underdevelopment of community services needed to support people in living more independent lives.

This review strives to incorporate multiple perspectives and explore emerging possibilities, rather than assume any one agenda for action. With that in mind, we read the literature through the lens of equity and human rights within the justice and corrections systems, starting from the position that justice-involved persons (including those convicted of crimes) retain their right to adequate health care, including mental health care, and that different people are impacted differently by their contact with the criminal justice system — both as individuals and as members of groups experiencing structural disadvantage and oppression. Throughout, we draw out two overarching themes: the paradoxes of and tension in trying to assure security and care, and the overlap between recovery and rehabilitation.

The first theme emerges from the experience of being justice involved while living with mental health problems and illnesses. The justice and corrections systems are responsible for the security and safety of the public, as well as the rehabilitation and reintegration of those who commit an offence. In Canada, the corrections system also has legal duties of care to those in its custody or under its supervision. People found guilty of an offence in Canada retain all rights not specifically, or by logical necessity, abridged by their sentence (most significantly for this report, this includes the right to health care). But

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* Throughout this document, references to mental illness are inclusive of problematic substance use, including addictions. Similarly, mental health and mental illness services include the full continuum of substance use- and addiction-related services, even when the latter are not explicitly named.

† In this report, the term "justice-involved people/persons" refers to individuals with first-hand or direct experience/ involvement with the criminal justice system. This term, although not person-centred, has been selected for ease of reading in lieu of, for instance, "persons involved with the justice system." Also, it is important to note that, while we recognize that the loved ones and caregivers of those who interact with the criminal justice system are, by extension, also "justice involved," it was beyond the scope of this project to consider their experiences or perspectives.

justice systems, and even more so correctional environments, have not been designed to be therapeutic, and in many cases are counterproductive to the development and maintenance of good mental health.

The second theme points out the ways that justice-oriented and health-oriented services can speak to each other productively and learn from each other. The relationship between living with mental health problems and illnesses and becoming justice involved is complex (and explored below), but mental illnesses do not make people any more likely to commit crimes.[2] It is therefore compelling to find parallels in therapeutic technique and best practice between helping people achieve mental health recovery and addressing criminogenic needs.[*] This relationship between recovery and rehabilitation is sometimes complementary but is also marked by tension, a feature that is reflected in the discussion that follows.

The current policy context in Canada

The multi-jurisdictional context of Canada's criminal justice, correctional, and health-care systems is complex.[3,4] Under our system of divided powers between federal and provincial/territorial governments, the federal government has jurisdiction of criminal law, but the administration of justice in criminal courts and the provision of health care are largely the responsibility of the provinces and territories.

Correctional services are the responsibility of both the federal and provincial/territorial governments. Justice-involved persons who receive a community sentence such as probation, community service work, or fines, or a custodial sentence of less than two years are under provincial/territorial jurisdiction, as are individuals on remand in detention centres (jails) awaiting trial or sentencing. Justice-involved persons who receive a custodial sentence of two or more years, however, are the responsibility of the federal government.

Each province/territory has its own health-care system and mental health legislation. Because mental health acts differ, there are distinct criminal justice responses across provinces and territories as a consequence of how civil mental health acts intersect with the criminal justice system.[5] For example, because of provisions within its mental health act, Ontario is the only province where a criminal court can order a psychiatric assessment to assist with sentencing or a bail hearing.[6] In British Columbia (B.C.), individuals found unfit to stand trial or not criminally responsible for an offence due to a mental illness (NCR-MD) and who are under the purview of the provincial review board are deemed to consent to treatment. In contrast, in Ontario individuals under the provincial review board can refuse treatment if they are competent to consent to treatment under provincial mental health legislation.[7]

Similarly, the provision of mental health care in all correctional institutions is governed by the mental health legislation of the province/territory where it is located, irrespective of whether the institution is a provincial/territorial or federal one.[8] However, responsibility for health-care delivery within correctional facilities and penitentiaries varies across the corrections system. Correctional Service Canada (CSC), a federal government agency, is mandated by the *Corrections and Conditional Release Act* of 1992 to

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[*] Criminogenic needs are characteristics, traits, problems, or issues that directly relate to an individual's likelihood to re-offend and commit another crime. They may be defined as those need areas in which access to treatment will reduce the likelihood of recidivism. As discussed below, they are also referred to as dynamic risk factors or contributing factors to justice involvement.

provide delivery of mental health care in federal prisons and at select sites in the community to facilitate successful reintegration according to parole board conditions.[9,10] While specific statutory provisions exist within the federal prison system with regard to necessary care for incarcerated persons, no similar statutes are in place for provincial corrections systems.[11] Currently, in all but two provinces, responsibility for health-care delivery within provincial correctional facilities rests with the provincial ministry of corrections. Nova Scotia (N.S.) and Alberta transferred responsibility for health care within provincial corrections facilities to their respective provincial health ministries.[12]

This complexity has posed challenges in planning for and meeting the mental health care needs of people involved in the criminal justice and corrections systems[13] and has resulted in a fragmented patchwork of mental health programs and services in Canada's criminal justice and corrections systems.[14] For example, specialty courts, known as mental health courts (MHCs), and court diversion schemes for accused persons with mental illness and/or problematic substance use have emerged in Newfoundland and Labrador (N.L.), N.S., New Brunswick (N.B.), Quebec, Ontario, Manitoba, Saskatchewan, Alberta, British Columbia (B.C.), Yukon, and the Northwest Territories.[15-17]

The goal of these initiatives is to provide specialized care to those before the criminal courts who live with mental illness and/or problematic substance use, often by diverting them from the regular justice system to a special stream in which they can receive treatment and needed supports in lieu of prosecution.[18] Though sharing similar overarching goals, such as improving access to mental health and support services, decreasing the risk of recidivism, and increasing the well-being of accused persons with mental illnesses,[19] these initiatives vary across jurisdictions with respect to eligibility criteria, points of intervention within the court process, use of sanctions for non-adherence with treatment, and procedural guidelines.[20] Few jurisdictions have released frameworks or standards for the implementation and operation of these interventions.[21-23] Moreover, there are relatively few MHCs across Canada (mostly in major cities), and mental health resources to support court diversion schemes vary by locality,[24] resulting in inequities of access to these services.

Similar challenges exist in the provision of mental health services in the corrections system. Apart from Ontario and B.C., which have implemented a common assessment tool across all pretrial detention centres, there is no standardized approach to identifying the presence of a mental illness among people in many provincial institutions.[25] In addition, continuity of care can be impacted in transitions from a federal penitentiary to the community, as the person may lose provincial/territorial health coverage, including drug plan coverage, upon incarceration in a federal prison.[26,27] This serves to restrict access to necessary provincial health services when reintegrating into the community until provincial or territorial health cards are obtained and disability benefits reinstated.

Mental health services within provincial institutions are offered inconsistently, leaving many individuals with mental health problems and mental illnesses without adequate access to treatment and supports.[28] Mental health services offered through federal corrections are usually not accessible to those incarcerated in provincial institutions unless provincial correctional workers are unable to support them.[29] There are also differences in release planning approaches between the CSC and provincial correctional authorities. Release from custody planning and gradual release supports are core services provided at the federal level, but such services are limited within provincial corrections systems,[30] especially among incarcerated persons serving sentences within local detention centres (jails).

These challenges notwithstanding, there have been significant efforts toward addressing the mental health needs of people involved with the criminal justice and corrections systems. In 2012, the CSC released its mental health strategy, which focused on five priorities:

- improving intake screening and assessment
- providing primary mental health care within the regular prison setting
- developing intermediate care units which would provide specialized treatment services, interventions, and/or therapeutic environments within federal prisons
- upgrading facilities and staffing at regional treatment centres, which operate as both a penitentiary and a psychiatric facility, for incarcerated persons experiencing acute illness or significant cognitive impairments
- improving community partnership and providing release planning and mental health support to parolees in the community[31]

A number of measures have been developed and implemented in Canada to address and reduce the rates of overrepresentation among priority populations.[*] One such measure is the Aboriginal Justice Strategy (AJS), which is designed to empower First Nations, Inuit and Métis (FNIM) communities[†] to have "increased involvement in the local administration of justice" and provide "timely and effective alternatives to mainstream justice processes in appropriate circumstances" (para. 1).[32,‡] Established in 1991, the AJS is advanced via two major funding components, the community-based justice programs fund and the capacity-building fund. Since its inception, the AJS has received considerable scholarly attention, which is addressed in subsequent sections. However, it has failed to end the overrepresentation of FNIM people, which has continued to worsen, reaching over 30 per cent of federally sentenced people in Canada in 2020 after years of consistent increase.[33]

In addition, in 2012, the Mental Health Commission of Canada (MHCC) released Canada's first pan-national mental health strategy, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*.[34] The MHCC called for reducing the overrepresentation of people with mental health problems and mental illness in the justice system and providing appropriate treatment, services, and supports to individuals within that system. Recommendations for action included

- increasing the availability of diversion programs and MHCs to divert people with mental health problems from the corrections system
- providing appropriate mental health treatment, supports, and services to individuals in the corrections system and ensuring they have a comprehensive discharge plan for their release into the community

[*] In this report, the term "priority populations" is an aggregate term for those groups who are more at risk of having unmet social determinants of health; this includes First Nations, Inuit, or Métis (FNIM) persons; women and girls; people with disabilities; older adults; lesbian, gay, bisexual, transgender, queer and two-spirited (LGBTQ2+) individuals; gender minorities; and immigrant, refugee, ethnocultural and racialized (IRER) populations.

[†] Throughout this report, peoples-specific language is used to refer to FNIM communities in Canada. The term Indigenous is retained in titles and quotations. The term Aboriginal is retained in the case of direct quotations, and reference to Canada's Aboriginal Justice Strategy and to Indigenous populations in Australia, where the term is typically the norm.

[‡] The AJS also includes the provision of diversion services (for those who commit non-violent property or other lesser offences), community sentencing, and healing programs. The AJS intends to address poverty, mental health problems, and issues with substance use as part of a broader effort to create long-term changes.

- addressing gaps in treatment programs for justice-involved people with complex mental health needs and developing a pan-national strategy that identifies outcomes for mental health services in correctional settings
- increasing the civil mental health system's role in the provision of treatment and services to individuals in the justice system
- providing knowledge and training to police, court, and correction workers and information about local services.

The MHCC subsequently released its *Framework for Action* (the Framework) to outline ways in which uptake of the *Mental Health Strategy for Canada* may be accelerated over a five-year period.[35] The Framework called for improved collaboration across the health, addictions, education, justice, and corrections sectors. It also noted the need for increasing the availability of recovery-oriented services and supports in the criminal justice system and intervening early to help prevent people with mental health problems from entering the justice system. The MHCC noted that it could support these areas through establishing a cross-sectoral collaborative involving federal, provincial, and territorial representatives, subject matter experts, and other stakeholders to develop a consensus on specific actions that could be undertaken to improve mental health services in the criminal justice system. The MHCC also noted the knowledge mobilization role it could take by supporting training initiatives in the criminal justice system and conducting background research on innovative approaches used to support individuals with mental health problems in the justice system.

Many provinces and territories have also prioritized improvements to meeting the needs of individuals with mental health problems in the criminal justice and corrections systems within their respective mental health strategy documents. These include:

- diverting people with mental health problems from the justice system (Alberta, Saskatchewan, Ontario)[36-38]
- improving access to treatment and support services for people in the criminal justice or corrections system (Alberta, Manitoba, N.L., N.S., Yukon)[39,40-43]
- developing and supporting strategies that respond to the specific needs of justice-involved FNIM persons with mental health and substance use problems (B.C.)[44]
- promoting a recovery orientation within mental health and justice services (Manitoba, N.B., Prince Edward Island)[45-47]
- increasing the civil mental health system's role in providing treatment and services to individuals in the corrections system (Manitoba)[48]
- improving coordination and transitions between health and justice systems (Alberta, Saskatchewan, N.L., Quebec, Manitoba, N.B.)[49-55]
- reducing stigma within health services and the justice system (Saskatchewan, Manitoba)[56,57]

Building on the MHCC's recommendations for a pan-Canadian mental health strategy for correctional services, the CSC, in collaboration with provincial/territorial correctional partners and the MHCC, developed the *Mental Health Strategy for Corrections in Canada*.[58] Seven key elements were identified, including

- mental health promotion and stigma reduction
- early identification and ongoing assessment of mental health needs

- provision of a range of mental health treatment and services to alleviate symptoms, promote recovery and well-being, and enable active participation in correctional programs
- suicide and self-injury prevention and management
- dedicated transitional services to support transitions from the community to institutional settings and back to the community
- ongoing staff education and training and outreach to build relationships with community partners.

The complexity of Canada's criminal justice, corrections, and mental health systems pose challenges in coordinating and providing appropriate care to people with mental health problems and mental illnesses who interface with these systems. However, the above-mentioned combination of shared policy priorities across the federal and provincial/territorial governments and pan-Canadian strategy initiatives provide a solid foundation on which to build and spread best practices, promote evidence-based research, and improve collaboration and coordination in the delivery of services for people living with a mental illness who are involved with the law. At the same time, decision makers in Canada's criminal justice system are becoming aware of the unique needs of justice-involved persons who identify with one or more priority populations and are making efforts to address these needs.

Scope, research questions, and methods

This rapid scoping review is designed to provide a snapshot of current knowledge and debate — in both the academic and public policy worlds — of a very broad and complex topic. The scope encompasses the prevalence of mental illnesses among those who are justice involved, as well as the mental health care needs of justice-involved people with mental illnesses in Canada. It understands justice "involvement" as inclusive of arrest and charging, diversion and the courts (including bail), community or custodial sentences (including probation), and re-entry and reintegration to the community after leaving custody (including parole).[*] This review accounts for academic research, including primary research, literature and scoping reviews, public policy briefs and reports, and research briefs and reports produced by organizations whose work focuses on the justice system published between 2009 and 2019. Although the primary focus was on literature produced in or about the Canadian context, we also considered relevant literature published in or about peer jurisdictions (such as the U.S., the U.K., Australia, and New Zealand [N.Z.]).

Of particular importance was how CMHA National and the MHCC's shared commitment to social justice and intersectionality (such as analyses attentive to multiple axes of identity and experience) would be applied to a scoping review of this already complex literature.

Within this landscape of experiences, policies, and interventions, the report reads research and policy through a social justice lens informed by anti-oppression, decolonial, and intersectional frameworks, noting how particular populations — FNIM persons, youth, people of colour, and/or women — are differentially constructed, analyzed, and acted upon while also exerting their own agency and narrative

[*] Although very broad, the scope of the report has some important exclusions. The first is the area of police interactions with people who have mental health problems and illnesses; we begin when people are "brought into" the justice system. The second is that we do not include study of the forensic mental health system(s) in Canada, which care(s) for people found NCR-MD for the offence with which they are charged.

surrounding their mental health and their justice involvement. Informed by secondary research, this report focuses on what is in the literature we discovered and analyzed. Because of this, the report's attention to social justice and intersectionality will often focus on gaps, absences, and silences in this literature. However, to the extent possible, our methods were designed to capture the diversity of populations and perspectives involved in this topic.

The report applies its review of the literature to five research questions regarding mental health needs in Canada's criminal justice system:

1. Of those involved with the Canadian criminal justice system, who experiences mental health problems and mental illnesses, and of what kind?
2. What are the experiences of justice-involved individuals living with mental health problems and/or mental illnesses? What barriers do they experience when accessing mental health care? How do these experiences vary when we account for multiple axes of identity?
3. What evidence-based practices and promising policies, standards, program frameworks, and services best support the mental health of individuals who interact with the criminal justice system?
4. What are the key concepts and values that should inform the design and delivery of programs, policies, and services for justice-involved individuals with mental health problems and/or mental illnesses? How are these, and can these be, tailored to priority populations?
5. What are the strengths and limitations of the existing evidence and what opportunities exist for future research, performance measurement, and program monitoring?

To conduct this scoping review, we began by developing structured search terms. Subject matter experts on the research team brainstormed a comprehensive list of relevant keywords, which were generated based on the following categories: population mental health, priority populations, stage of justice involvement, needs, concepts, and forms of intervention. This list of 68 terms was then converted into a structure that generated compound Boolean search terms covering the most essential elements desired.

These search terms were then run through academic databases (PsychINFO, PubMed, EBSCO Criminal Justice Abstracts, and EBSCO Social Science Abstracts) and Google Scholar. For each search query completed, the first 100 results (sorted by relevance as judged by the search engine) were reviewed, and any result that met the basic inclusion criteria[*] was downloaded into a digital library. All the citations considered — whether included or excluded through screening — were retained as PDF files to be included in data charting. These results were supplemented by hand-searching the contents of select, highly relevant journals, including the *International Journal of Forensic Mental Health,* and the *Canadian Journal of Community Mental Health.* It was productive to hand-search sources for materials, particularly for journals that do not have an impact factor and/or are not indexed in databases.

This resulted in 554 full-text results that met the basic screening criteria. To the academic literature reviewed, we added 144 pieces of Canadian policy literature and government documentation. This latter

[*] Peer-reviewed publications in English from the last 10 years (January 2009-July 2019) that were returned as relevant results to one of the search queries.

set of sources was compiled through simple searches of highly relevant Canadian government websites, such as the CSC's research service, and from the recommendations of subject matter experts.

Title/abstract screening was then applied by a team member to determine inclusion in the study. At this stage we focused on exclusion criteria to manage the scope of the literature covered, screening out papers focused on beyond-scope areas such as pre-arrest police interactions and the forensic mental health system. This resulted in 391 included papers and documents.

The papers were finally divided into two categories: those which, upon a second abstract review, directly addressed one of the five research questions in their findings, and those relevant to the broader question of mental health needs in justice-involved populations which were unlikely to directly address those questions. The first group (n=229) was assigned to team members for a full reading and the completion of source-specific reader reports (see appendix). The second group (n=162) was included in an index by topic (based on abstract review) to add a qualitative picture of the dimensions of the broader literature (but these do not inform the review of the literature).

To comprehensively account for the unique social/cultural locations, experiences, and needs of justice-involved people living with a mental health problem and/or mental illness, each reader report contained a consistent set of prompts that enabled readers to "chart" whether sources accounted for how axes of identity inform the encounters and experiences of justice-involved persons with mental illnesses.[*]

The project team met regularly to compare emerging themes and points of interest and worked collaboratively to structure how the report would incorporate the themes emergent in the literature reviewed.

Organization of the report

The body of the report follows the structure of the research questions, in the five following sections. At the conclusion of each subsequent section, we discuss the gaps and opportunities we observed in the literature reviewed, always with the caveat that our review is robust but not exhaustive.

In the next section, we address the question of our population of interest: what do the research and policy literatures reviewed say about justice-involved people with mental illnesses? First, we review the literature on prevalence rates and mental health risks, noting a high variability in definitions, samples, and areas of focus but also considerable consistency in areas of interest focus and critique. This section also reviews the determinants of justice involvement among people with mental illnesses, separating out theories about the influence of direct (presence of a mental illness), indirect (social determinants of health), and structural factors (such as racism).

The subsequent section explores the question of specific mental health care needs for justice-involved persons, and the experiences of being both justice involved and having mental health problems and mental illnesses. It features the synthesis of studies which either incorporate the voice of justice-

[*] The reports contained a space in which readers could identify which priority populations, if any, were acknowledged by the source, what contextual factors that contribute to interaction with the criminal justice system, if any, were mentioned by the source, and whether the source offered a critique or recommendations of mental health care for priority populations in the criminal justice system.

involved people directly as a method of research or help infer elements of these experiences through analysis and review. To the extent supported by the literature reviewed, we discuss the impact of multiple, intersecting identities or structures of oppression on the lived experience of mental health problems and justice involvement.

Next, we turn to the question of what models, programs, policies, and interventions have been used to meet the mental health care needs of justice-involved persons. Our focus is on addressing health, rather than on criminogenic needs, but it is impossible to fully separate these two domains, which sometimes conflict and sometimes mirror each other in both objectives and methods. First, we attend to the literature on pre-trial and court-based diversion and treatment. From there, we focus on treatment in various forms of secure custody. Finally, we discuss the literature that focused on treatment in the community (whether after, or as an alternative to, custody). This model mixes together forms of justice involvement that are legally distinct (such as probation and parole), trading precision for a focus on the location and conditions of mental health care, specifically.

We then pull back to a wider view on policy and practice, reviewing the principles and concepts that, according to the literature reviewed, might inform more just and more successful mental health care for justice-involved people. These range from concepts that are universally indicated (such as procedural fairness and clinical independence) to principles such as reconciliation and gender-responsiveness, which help situate policy and practice in the broader historical and social context. This section also includes more grounded, but still overarching, arguments regarding systemic reform.

Finally, our report summarizes the literature reviewed with a focus on its strengths and on areas of opportunity and challenge in future research on this topic. Here, we emphasize building bridges between mental health recovery and criminological perspectives on rehabilitation, both in reconciling conflicts between their perspectives and in recognizing common methodological advances and the potential to reform services and systems to better respond to the mental health needs of those affected by the law.

Who Experiences Mental Health Problems in the Criminal Justice System?

KEY FINDINGS

- The prevalence of mental health problems and illnesses among justice-involved people outpaces rates in the community.
  - This excess prevalence has been worsening over time.
- Rates of serious mental illness, such as major depressive disorder, bipolar disorder, and psychotic disorders, are anywhere from two to three times higher for incarcerated persons in comparison to the community.
- Justice-involved persons who are incarcerated are nearly three times more likely to use psychotropic medications.
- Experiences and histories of trauma, including abuse, are more common among justice-involved persons, especially among FNIM men and women, and non-FNIM women.
- In federal institutions, instances of self-injurious behaviour or non-suicidal self-injury have more than doubled in recent years, with fewer individuals having more experiences.

This section explores the dimensions of our population of concern: those at the nexus of mental illness and criminal justice in Canada. This question is divided into two parts. In the first, we summarize the literature reviewed regarding the prevalence of mental health problems and mental illnesses in justice-involved people. In the second, we review the literature that deals with the converse: how do those who live with mental health problems and mental illnesses become justice involved?

Prevalence rates and mental health risks

The prevalence rate of mental health problems and mental illnesses among justice-involved people is very high. It is substantially higher than in the general population, and the excess prevalence has been worsening over time.[59-63] The exact figures reported depend upon the data sources used, and the operating definitions of mental illness, mental health problem, or needs.

Although standards exist for the formal diagnosis of specific mental illnesses, there is no universally accepted standard — in Canada or internationally — for a baseline prevalence rate among incarcerated persons or those elsewhere in the continuum of justice involvement. Incarcerated persons are by far the most commonly assessed for prevalence in the literature we reviewed, and in Canada, information about federal prisons is much easier to obtain than on provincial and territorial institutions. In turn, it is even less common to encounter well-constructed studies of prevalence among justice-involved people before the courts or in community corrections.[64] Our study period of 2009 to 2019 also encompassed significant changes in the way the CSC tracks screening results for mental health problems, with the introduction of more universal and digitized record keeping, which made larger sample studies more feasible.

We present the prevalence information reviewed from the very broad (any symptom of poor mental health), through any diagnosis, to the presence of a serious mental illness, to discussions of the prevalence of trauma, self-injury, and suicidality. We prioritize, wherever available, more recent figures, more purposive and representative samples, and official figures.

While the overrepresentation of people with mental illnesses in the criminal justice system is an identified area of concern, it is equally important to recognize that most individuals with a serious mental illness do not come into contact with the criminal justice system. As we explore in more detail below, victimization and self-harm are of greater concern than perpetration for people with mental illnesses.[65]

In Canada

PREVALENCE OF ANY MENTAL HEALTH SYMPTOM

The broadest possible definition of prevalence is as a population-level assessment for the presence of any symptom of poor or ill mental health. Diagnoses of mental illness are generally made by scoring the presence of several symptoms, in combination with an assessment of impairment or suffering. Therefore, these rates are the highest and should be interpreted with caution when judging care needs, especially unmet care needs.

Prevalence of any mental health symptom		
Study citation	**Sample and measure used**	**Prevalence**
Correctional Investigator of Canada, 2011; (65) Stewart et al., 2009	1,209 men; includes 177 FNIM men; consecutive admissions to federal penitentiaries; CoMHISS	38% overall screened positive possible mental health problems: • FNIM, 44% • Non-FNIM, 37%
Brown et al., 2015 (66)	491 men and 31 women; includes 40 FNIM people; non-random sample from Ontario detention centres and correctional facilities; RAI-MH	41% overall reported one or more current severe symptoms of a mental health problem: • Men, 41% • Women, 48% • All FNIM people, 75%
Lafortune, 2010 (86)	500 incarcerated men and 171 incarcerated women from Quebec provincial correctional facilities; stratified random sample; administrative correctional files	34% overall screened as having a mental health problem: • Women, 42% • Men, 31%

CoMHISS = Computerized Mental Health Intake Screening System; RAI-MH = Resident Assessment Instrument — Mental Health

Because of its breadth, this method of assessing prevalence was less common in the recent literature reviewed. No studies were found on any symptom measurement in other parts of the justice system (courts) or corrections system (community corrections).

The 2011 report of the Correctional Investigator of Canada (CIC) examined symptom prevalence of serious mental health problems. The report cautioned that mental illnesses are under-reported in prisons due to stigma and (at that time) a lack of universal screening.[66]

In Ontario, a volunteer sample of people in custody compared rates of symptoms between remand[*] and sentenced populations, men and women, and FNIM and non-FNIM persons. Those who were serving sentences (not on remand) or in other forms of detention (immigration detention, parole violation, etc.) were significantly more likely to have current, severe symptoms, as were women and all FNIM persons. Based on their weighting of the sample to represent all incarcerated persons in Ontario, the authors estimated that 13 per cent of those in provincial custody could have unmet mental health care needs.[67]

PREVALENCE OF ANY MENTAL ILLNESS DIAGNOSIS

More common than the "any symptom" literature are documents on the prevalence of any recognized mental illness diagnosis, including major mental illness but also problematic substance use and personality disorder diagnoses. Since trauma is often excluded from this literature, we treat it separately. Here, more current and consistent information is available for Canada at the federal level, and there are a few more studies at the provincial level (we found no current studies on territorial prevalence, despite high rates of reported incarceration in those regions).[68]

Prevalence of any mental health diagnosis		
Study citation	**Sample and measure used**	**Prevalence**
Gretten & Clift, 2011 (89)	120 male youths and 54 female youths; non-random sample from provincial youth custody centres in B.C.; DISC-IV	92% male youth and 100% female youth qualified for one or more DSM-IV diagnoses: • Substance use disorder, 86% males; 100% females • Conduct disorder, 73 males; 84% females • Anxiety disorder, 18% males; 30% females • Mood disorder, 6% males; 7% females • Schizophrenia, 1% males; 2% females
Khan et al., 2016 (69)	13,919 youths and young adults (12-24); population sample within youth and adult provincial correctional centres in Ontario; administrative data: provincial physician billing data	• 42% had a physician visit for mental health services while in custody; among those with a physician visit, primary diagnosis was • Schizophrenia, 9% • Mood disorder, 12%

[*] Those awaiting trial or sentencing (not formally sentenced).

Prevalence of any mental health diagnosis		
Study citation	**Sample and measure used**	**Prevalence**
		• Substance use disorder, 21% • Anxiety disorder, 49% • Other diagnosis, 9%
Correctional Services Canada, 2017 (74) Correctional Services Canada, 2018 (101)	154 women in federal penitentiaries; systematic random sample; SCID-I and SCID-II	79% qualified for one or more current DSM diagnoses: • Mood disorder, 22% • Psychotic disorder, 5% • Substance use disorder, 76% • Anxiety disorder, 54% • Eating disorder, 11% Lifetime prevalence of personality disorder: • Borderline personality disorder, 33% • Antisocial personality disorder, 49%
Beaudette et al., 2016; Correctional Service Canada, 2015; Correctional Service Canada, 2013 (75, 78, 79)	1,110 men (including 230 FNIM men); consecutive admissions to federal penitentiaries; SCID-I and SCID-II	73% qualified for one or more current DSM diagnoses (83% FNIM; 60% non-FNIM): • Mood disorder, 17% (19% FNIM; 17% non-FNIM) • Psychotic disorder, 3% (2% FNIM; 4% non-FNIM) • Substance use disorder, 50% (77% FNIM; 43% non-FNIM) • Anxiety disorder, 30% (32% FNIM; 29% non-FNIM) • Eating disorder, 1% (2% FNIM; 1% non-FNIM) Lifetime prevalence of personality disorder: • Borderline personality disorder, 16% (22% FNIM; 14% non-FNIM) • Antisocial personality disorder, 44% (60% FNIM; 40% non-FNIM)
Sittner, Hartshorn et al., 2016 (77)	94 First Nations arrested youth from two reservations in U.S. and two reserves in Canada; non-random sample; DISC-IV	67% qualified for one or more current DSM diagnoses: • Substance use disorder, 50% • Conduct disorder, 53%

Prevalence of any mental health diagnosis		
Study citation	**Sample and measure used**	**Prevalence**
		• Attention deficit hyperactivity disorder, 8% • Depression, 5%
Lafortune, 2010 (86)	500 incarcerated men and 171 incarcerated women from Quebec provincial correctional facilities; stratified random sample; administrative data: physician visits recorded through provincial health insurance	61% had at least one mental health diagnosis in five years prior to incarceration: • 58% of men, at least one diagnosis • 70% of women, at least one diagnosis
Green et al., 2016 (103)	99 incarcerated men and 21 incarcerated women from provincial correctional facility in Ontario; non-random sample; self-report diagnosis	Self-reported lifetime diagnosis or prior treatment for • Depression, 42% • Bipolar or dysthymia, 21% • Schizophrenia, 5%

DISC-IV = Diagnostic Interview Schedule for Children Version IV; SCID-I = Structured Clinical Interview for DSM Axis I Disorders; SCID-II = Structured Clinical Interview for DSM Axis II Disorders

The prevalence rates in these studies tend to be extremely high relative to the community,[*] but they are also skewed toward a few diagnoses that have important correlations with justice involvement — substance use and personality disorder (antisocial and borderline personality disorders in adults, conduct disorder in youth). These two categories are often outsized in their prevalence relative to other mental health problems, such as psychotic disorders and mood disorders; in many in-custody samples, problematic substance use affects four out of five people.[69-72]

Studies that analyze population differences usually include women, FNIM persons, or both, in comparison with a male, non-FNIM reference group. For both of these populations of concern, the prevalence rates of any mental illness diagnosis — and the conceptual dominance of substance use disorder[†] as a diagnosis — are even higher than the rest of the incarcerated population.[73-76] Only one study was reviewed that presented these two prevalence rates for justice-involved people outside of custody, confirming that personality disorders and problematic substance use played a significant role in the arrests of justice-involved FNIM youth in Canada and the U.S.[77]

Since 2013, Canada's federal corrections service has implemented more universal screening of people being admitted to prison and has been able to produce more consistent prevalence information. The

[*] For comparison, prevalence rates in the general population are available through Statistics Canada.
[†] The term "substance use disorder" has been retained in this paper where it is used in the literature as a diagnostic and analytic category, in order to maintain the accurate representation of our sources.

information released shows significant comorbidity between substance use and other mental health diagnoses. Anxiety disorders are also a significant diagnosis in the sample.[78-80]

The federal corrections service also has recent data on prevalence among incarcerated women. Just as with men, the highest prevalence category reported is problematic alcohol and substance use and antisocial personality disorder, though this is a lifetime estimate. Anxiety disorders among these samples of federally incarcerated women was even higher. Prevalence was also higher for FNIM women.[81] These recent samples are broadly consistent with estimates provided in other sources, such as from the CIC.[82,83] The higher prevalence among incarcerated women has also been noted consistently for at least the past 15 years.[84,85]

At the provincial level, some of literature was based on reviews of studies conducted in Alberta, Ontario, and Quebec among adult populations and in Ontario and Saskatchewan for youth in detention. As elsewhere, the definitions and measures used varied widely, and studies identified rates from 91.7 per cent lifetime prevalence of any disorder among incarcerated men in Alberta[86] (with a heavy burden of substance use disorder) to 33.8 per cent prevalence of any disorder on admission to a Quebec provincial institution. The researchers who reviewed the Quebec study noted that schizophrenic and psychotic illnesses were more likely to be detected than mood disorders such as depression, and that the comparison of the screening rate to the rate at which people self-reported a diagnosis within the last five years (61 per cent) suggested the potential for a high false-negative rate in screening, as opposed to lifetime prevalence estimates.[87]

A study of youth convicted of violent offences, detained in Saskatchewan and assessed by a mental health care team, found a prevalence of over 90 per cent for at least one mental illness diagnosis, with disruptive behaviour disorders being the most common, followed by comorbid diagnoses (of which substance use disorders were a dominant factor).[88] These prevalence rates were similar to those observed in a sample of detained youth in Ontario from the 1990s, in which more than 80 per cent met the criteria for at least one mental illness diagnosis.[89] One study used a screening sample of 205 "young offenders" incarcerated in B.C. Using the term "mental disorder," they report that 92 per cent of male youth and 100 per cent of female youth met their criteria, but their definition is quite broad, including "exposure to physical abuse" and "exposure to sexual abuse." Consequently, the authors note that the rates are higher than those reported elsewhere.[90]

PREVALENCE OF SERIOUS MENTAL ILLNESS

Serious mental illness (sometimes "severe mental illness" or "major mental illness") is a general term for a limited number of diagnostic categories — generally, psychotic disorders (such as schizophrenia), bipolar disorder, and major depressive disorder. The limited nature of the definition tends to make prevalence rates more consistent in the literature reviewed.

Prevalence of major mental illness		
Study citation	**Sample and measure used**	**Prevalence**
Beaudette et al., 2016; (75) Correctional Service Canada, 2015 (78)	1,110 men (including 230 FNIM men); consecutive admissions to	12% qualified for a major mental illness (bipolar disorder, major depression, psychotic disorder):

Prevalence of major mental illness		
Study citation	**Sample and measure used**	**Prevalence**
	federal penitentiaries; SCID-I and SCID-II	• Bipolar I disorder, 2% • Major depressive disorder, 7% • Psychotic disorder, 3%
Correctional Service Canada, 2018 (73)	246 women in federal penitentiaries; SCID-I and SCID-II	52% qualified for lifetime experience of major mental illness; 18% qualified for a current major mental illness
Lafortune, 2010 (86)	500 incarcerated men and 171 incarcerated women from Quebec provincial correctional facilities; stratified random sample; administrative data: physician visits recorded through provincial health insurance	30% received at least one diagnosis for a major mental illness: • Depressive disorder, 21% • Affective psychosis, 9% • Schizophrenic disorder, 6% • Other non-organic psychosis, 7%

SCID-I = Structured Clinical Interview for DSM Axis I Disorders; SCID-II = Structured Clinical Interview for DSM Axis II Disorders

As above, this literature also focused predominantly on incarcerated people in Canada. Just as in the categories above, researchers agree that prevalence in incarcerated populations is very high — often cited at two, three, or four times the rates in the community.[91-93] The effect of gender on prevalence is less clear but still supports a conclusion that women are more affected, with recent sources reporting both unclear or non-significant effects[94-96] or higher rates among women.[97,98] However, the excess rates relative to the community are not as high as in substance use and personality disorders.

Recent corrections survey and screening data in Canada presents an estimated rate among federally incarcerated men of between two and seven per cent for psychotic disorders and 15-19 per cent for mood disorders.[99-101] By comparison, the prevalence rate of current major depressive disorder in the general Canadian population has been recently estimated at five per cent, and psychotic disorders at 1.3 per cent.[102,103] Another method of presenting prevalence suggests an overall rate of 14 per cent for any serious mental illness, with six to eight per cent of federally incarcerated persons requiring psychiatric hospitalization for an acute mental illness at some point in their sentence.[104] One federal survey additionally reports that prevalence of borderline personality disorder (BPD) sits at 11-24 per cent, and that BPD presents, along with psychotic disorders, the highest risk factors for being highly impaired by one's mental health problems or mental illness.[105]

Serious mental illness can also be measured as lifetime rather than current prevalence. Although it may serve as a better estimate of future mental health care needs (because it reflects the possibility of conditions in custody causing worse mental health), this measure was less common in our reviewed papers. In a 2016 in-custody sample of federally sentenced women, there was a 52 per cent reported lifetime prevalence of major mental illnesses, which is much higher than current prevalence.[106] A similar sample of federally sentenced men from 2012 to 2014 separated out mood disorders (lifetime

prevalence: 30.2 per cent) and psychotic disorders (lifetime prevalence: 4.7 per cent), with both higher than current prevalence.[107]

A recent Ontario study relied on self-reports in a sample of 125 volunteers in a provincial institution who responded to a survey. Among this sample, 42 per cent reported depression, 21 per cent reported bipolar disorder, mania, manic depression or dysthymia, and five per cent reported schizophrenia.[108] The survey did not ask whether the condition was current, or had been present at any time in the participant's life.

A third means of assessing the prevalence of mental health care needs among those living with serious mental illness is by studying the use of prescription psychotropic medication in custody. Not surprisingly, the prevalence of psychotropic prescriptions is more common in Canadian federally incarcerated people than in the general population (30 per cent versus eight per cent). There is a concern that high rates of active psychotropic prescription, relative to those in the community, may be a sign of off-label use for the purposes of behavioural control, rather than use for therapeutic reasons.[109] However, off-label use — which is common in medicine generally — appears to be consistent with community rates at 36 per cent, with no group differences based on gender or identification as FNIM.[110] Qualitative studies suggest that incarcerated women experience the prescribing of psychotropic medication as a form of behavioural control in custody that is not recovery oriented.[111]

PREVALENCE OF TRAUMA AND THE SEQUELAE OF ABUSE

Symptoms of trauma and experiences of verbal, physical, emotional, or sexual abuse have not always been recognized as part of mental health care needs that should be subject to assessment.[112] However, incarcerated persons in Canada are more likely than non-justice-involved people to have been victims of trauma, among other barriers to care.[113] Trauma plays a particularly important role in the pathways to justice involvement for women and youth, and trauma often mediates structural factors such as histories of colonial oppression and violence that drive the overrepresentation of FNIM persons and other groups in Canada's systems of justice and incarceration. Symptoms of trauma and experiences of abuse also have broad relevance as precursors to and determinants of mental illnesses that may be overrepresented in justice-involved people, including psychosis.[114]

Past experience of trauma, abuse		
Study citation	**Sample and measure used**	**Prevalence**
Beaudette et al., 2016 (75)	1,110 men (including 230 FNIM men); consecutive admissions to federal penitentiaries; SCID-I and SCID-II	13% assessed as meeting criteria for lifetime experience of post-traumatic stress disorder (PTSD); 11% assessed as meeting criteria for current experience
Correctional Service Canada, 2017 (74)	154 women in federal penitentiaries; systematic random sample; SCID-I and SCID-II	33% assessed as meeting criteria for current PTSD

Past experience of trauma, abuse		
Study citation	**Sample and measure used**	**Prevalence**
Correctional Service Canada 2012 (111)	121 FNIM and 555 non-FNIM people in federal correctional system and enrolled in the methadone maintenance treatment program; non-random sample; administrative data	Sexual abuse history, 49% FNIM; 29% non-FNIM Physical abuse history, 62% FNIM; 30% non-FNIM Mental abuse history, 57% FNIM; 35% non-FNIM
Gretten & Clift, 2011 (67)	120 male youths and 54 female youths; non-random sample from provincial youth custody centres in B.C.; correctional file review	Sexual abuse history, 21% male youth; 42% female youth Physical abuse history, 61% male youth; 54% female youth Neglect, 51% male youth; 63% female youth

SCID-I = Structured Clinical Interview for DSM Axis I Disorders; SCID-II = Structured Clinical Interview for DSM Axis II Disorders

Precise prevalence rates of trauma and/or experiences of abuse for incarcerated people in Canada are lacking in the literature. A Canadian sample of federally incarcerated persons undergoing methadone therapy showed FNIM men reporting histories of trauma and abuse at significantly higher rates than non-FNIM men.[115] These elevated rates have also been measured in the U.S. for justice-involved youth.[116,117] In the absence of specific Canadian data, one study suggests comparing with U.S. rates, where studies suggest a rate between 25 and 90 per cent among incarcerated women.[118,119]

SELF-INJURY AND SUICIDALITY

One of the most acute risks, and serious symptoms, of mental distress in custody is self-injury, which is often non-suicidal in intent. Other acute risks include attempted suicide and death by suicide. Self-injury, sometimes referred to as self-injurious behaviour (SIB) and non-suicidal self-injury (NSSI), has been defined as “the deliberate destruction or alteration of body tissue without conscious suicidal intent” (Favazza, as cited in Smith et al., 2019, p. 21).[120] A recent review of the literature affirms there is a consensus among researchers that rates of self-injury and suicide in Canada among those in custody are very high and outpace those in the community.

Self-injury and suicidality		
Study citation	**Sample and measure used**	**Prevalence**
Power, 2011; Power et al., 2013	150 women incarcerated in federal penitentiaries (56 FNIM women; 94 non-FNIM); non-random sample; questionnaire and OSIBI; 400 women incarcerated in federal penitentiaries (143 FNIM women,	Questionnaire/OSIBI sample: • 61% at least one ever suicide attempt or NSSI incident • 39% at least one ever NSSI incident

Self-injury and suicidality		
Study citation	**Sample and measure used**	**Prevalence**
	257 non-FNIM women); random sample; chart review	• 49% at least one ever suicide attempt • 44% history of both NSSI and suicide attempt • 16% engaged in NSSI while in prison • 11% attempted suicide in prison Chart review sample: • 46% at least one ever suicide attempt or NSSI incident • 23% at least one ever NSSI incident • 41% at least one suicide attempt prior to prison • 11% engaged in NSSI while in prison
Martin et al., 2014	5,154 individuals incarcerated in federal prisons; entire cohort admitted to federal corrections in 2011; CoMHISS	0.7% engaged in one or more NSSI incidents during their first 180 days of incarceration
Lafortune, 2010 (86)	500 incarcerated men and 171 incarcerated women from Quebec provincial correctional facilities; stratified random sample; corrections administrative data:	Overall 26% previous history of suicide attempts: • Men, 23% • Women, 35% Screened having suicide risk at admission: • Men, 4% • Women, 4%

CoMHISS = Computerized Mental Health Intake Screening System; OSIBI = Offender Self-Injurious Behaviour Inventory

Between 2008 and 2013, federal prison self-injury rates more than doubled. From 2013 to 2014, the CSC recorded 578 incidents with only 60 incarcerated women. Incidents are highly concentrated among few individuals with repeat experiences. Researchers studying this self-injury recommended comprehensive and trauma-informed intervention strategies.[121] The CIC's 2018 report found an overrepresentation of incarcerated FNIM persons in self-injury incidents.[122] A 2019 review estimated self-injury prevalence rates (again in federal prisons) of 11-41 per cent for women, and 14-35 per cent for men, based on multiple recent studies.[123]

A recent review of the literature suggests that more than one in five people in custody (federally, and in the provinces and territories) have attempted suicide at least once.[124] Reviews report that Canadian prison suicide rates are anywhere from three to 11 times that of the community (depending upon the

population).[125,126] In 2016, one in three FNIM persons admitted to Ontario correctional institutions, and more than half of those admitted to segregation, were at risk of suicide. This rate is substantially higher than that of non-FNIM persons.[127] One Canadian Institute for Health Information report found that 16 per cent of men incarcerated in maximum security reported at least one suicide attempt in the previous five years.[128]

Both self-injury and suicidality can be a response to the conditions of detention.[129-132] Although young people in custody may be at lower risk for self-injury than adults, they may be more likely to engage in self-injurious behaviour due to the conditions of detention. Their risk of self-harm and suicide increases greatly if they are placed in adult institutions.[133] Maximum security settings also increase rates of self-injury among adult men, suggesting that for adults, too, correctional settings play a role.[134]

Comparing Canada to international prevalence estimates

Canadian rates of prevalence of mental illness in correctional contexts are comparable to prevalence rates in the U.S., the U.K., Australia, and N.Z..[135] Another meta-review on male youth in 10 countries found very high rates of disorder, with substance use and personality disorders being much more elevated than the “major” (Axis I) diagnoses.[136]

International prevalence and incidence rates		
Study citation	**Sample and measure used**	**Prevalence**
James & Glaze, 2006 (137)	479,000 people incarcerated in local jails 705,600 people incarcerated in state prisons 78,800 people incarcerated in federal prisons in U.S.; random sample; SISFCF	Any mental health problem: • Local jail, 64% • State prison, 56% • Federal prison, 45% Substance abuse or dependence: • Local jail, 76% • State prison, 74% • Federal prison, 64%
Stoliker & Galli, 2019 (135)	1,537 men and 379 women aged 50+ years incarcerated in state or federal prisons in the U.S.; nationally representative sample; SISFCF	61% reported symptoms of mental health issues (men 60%; women 70%): • Depressive symptoms, 55% (men: 53%; women: 63%) • Mania symptoms, 36% (men 34%; women 47%) • Psychosis, 11% (men 11%; women 11%) • High alcohol use, 20% (men 22%; women 11%) • High drug use, 26% (men 26%; women 25%)

International prevalence and incidence rates		
Study citation	**Sample and measure used**	**Prevalence**
		23% reported previous mental health diagnosis: • Depressive disorder, 16% (men 14%; women 27%) • Mania, 7% (men 5%; women 12%) • Psychotic disorder, 4% (men 4%; women 4%) • PTSD, 7% (men 6%; women 8%) • Anxiety/panic disorder, 7% (men 6%; women 13%)
Colins et al., 2010 (133)	15 studies including 3,401 incarcerated men adolescents from 10 countries; meta-analysis	Overall pooled prevalence of 70% for at least one mental health diagnosis: • Conduct disorder, 46% • Substance use disorder, 45% • Anxiety disorder, 16% • Mood disorder, 13% • Psychotic disorder, 1%
Fazel & Seewald, 2012 (132)	109 samples including 38,588 incarcerated persons across 24 countries; meta-analysis	Overall pooled prevalence of 4% for psychosis and 11% for major depression: • Psychosis, 4% men; 4% women • Depression, 10% men; 14% women
Dixon-Gordon et al., 2012 (129)	11 studies including 934 incarcerated adolescents and 26,712 adults across five countries; systematic review	NSSI while in custody: • Adolescents, range 5%-24% • Adults, range 0.1%-10% NSSI lifetime: • Adolescents, 7%-11% • Adults, 15%-48%
Fazel et al., 2017 (142)	3,906 prison suicides in 24 high-income countries; meta-analyses to test associations with general population suicide rates	Rates of prison suicide ranged between 23 per 100,000 to 180 per 180,000 across countries: • Canada, 27 suicides per 100,000 Rates of prison suicide compared to general populations ranged from no difference between groups to

International prevalence and incidence rates		
Study citation	**Sample and measure used**	**Prevalence**
		14 times higher among prison populations: Canada, prison suicide rate 2.3 times greater than general population

SISFCF = Survey of Inmates in State and Federal Correctional Facilities; NSSI = Non-suicidal self-injury

In the U.S., studies suggest the rates of any mental health symptom or diagnosis are very high, with 56-76 per cent of prisoners in jails and state prisons meeting at least one criteria (depending on the population and method). As in the studies discussed above, substance use (including comorbidity) and personality disorders are dominating factors in these very high prevalence figures.[137-140] For psychosis, one of the above studies found a figure of 4.2 per cent, and for major depression, 23.9 per cent, slightly higher than in Canada — but with the proviso of high variability between studies.[141,142] The gender differences identified in and by the Canadian literature, with women being more likely than men to have any mental health problem, holds in U.S. studies.[143]

In Australia, at admission to prison, 38 per cent of people reported a history of mental illness. Rates were higher for women and lower for Aboriginal people. Justice-involved youth had very high rates, with 87 per cent having at least one diagnosis of a mental illness, with young women and Aboriginal youth more heavily affected. A substantial recent review identified some of the same research gaps we identified in the Canadian literature. Specifically, there is limited data on justice-involved people outside of custody.[144]

Across high-income countries, suicide among those in prison is consistently higher than it is in the community. Canada's rate is slightly higher than that in the U.S., but lower than most European countries, as well as lower than Australia and N.Z.. This is partly due to different rules around counting.[145,146]

What are the Pathways to Justice Involvement for People with Mental Health Problems?

KEY FINDINGS

- The presence of a mental illness is a direct determinant of increased rates of arrest and justice involvement, raising someone's likeliness to become justice involved through increased visibility to the police due to homelessness and/or problematic substance use.
    - Problematic substance use, personality disorders, and the presence of post-traumatic stress disorder (PTSD) are among the leading risk factors for justice involvement.
    - People with mental illness are more likely to be victims of violence than perpetrators of it.
- Lack of access to the social determinants of health — including adverse events in childhood, low educational achievement, lack of housing, low income and underemployment — are all factors that contribute to justice involvement among persons with mental health problems and illnesses.
- Structural factors such as marginalization, histories of oppression, racism, sexism and patriarchy, continued colonization, and systemic discrimination all contribute to the overrepresentation of priority populations with mental health problems and illnesses in the criminal justice system.
- Deinstitutionalization is a key, historical contribution to the disproportionate rates of justice involvement among people with mental health problems and illnesses.
    - From the 1950s to 1970s, hospital closures were not followed by investment in community supports, resulting in increased rates of justice involvement among people with mental health problems and illnesses.

There is a range of determinants and predictors that increase the likelihood that people with mental health problems and illnesses will become involved in the criminal justice system. These determinants may be direct (such as symptoms of a mental illness) or indirect (such as criminogenic risk factors like behavioural or conduct problems, lack of access to the social determinants of health, and structural determinants such as political and historical conditions or marginalization on the basis of race, identification as FNIM, and/or gender).

In Canada, scholars, advocates, and policy makers agree that deinstitutionalization has had a significant influence on the overrepresentation of people with mental health problems and illnesses in the criminal justice system. Deinstitutionalization coincided with advances in psychotropic medication and individual therapy in the 1950s and 1960s, both of which engendered the conditions for the advancement of community-based treatment. Concurrently, governments were under considerable political pressure from the public to close institutions as the Canadian public, which, upon becoming better informed of the causes of and treatments for a mental illness, began to react against cases of neglect, overcrowding, and abuse.[147] A critical outcome of deinstitutionalization was a shift away from the automatic institutionalization of people with mental illnesses toward the construction of hospitals in cities and the release of those who had been institutionalized. Between 1959 and 1976, the number of beds in "mental hospitals" in Canada dropped from 65,000 to 21,000.[148]

However, deinstitutionalization was accompanied by a series of unintended consequences, one of which is the overrepresentation of people with mental illnesses in the criminal justice system. Specifically,

many of those who were released into community were not supported in their transition, and the cost savings attributable to hospital closures were not sufficiently reinvested in adequate and sustainable community supports.[149,150] The same period saw a significant expansion of the criminal justice system as a result of crime reduction policies.[151] In turn, a convergence occurred in that the legal response to mental illness became more complex.[152] Studies that measure the prevalence of mental illness in the criminal justice system suggest that much of the growing population of incarcerated people are those with mental illnesses who previously would have been hospitalized.[153] Further, as services disappear or become inaccessible due to cost or wait times, the forensic system remains one of the few ways to ensure access to adequate treatment.[154] For many people with mental illnesses, a criminal charge may be the only way to access psychiatric care if that person is placed in the forensic mental health system.[155,156] Others have found that interaction with the justice system via arrest and/or a criminal charge may be the only way that many people with mental health problems or illnesses are able to access scarce mental health resources in their community.[157] This is especially the case for youth with mental illnesses.[158]

Direct determinants of justice involvement

According to a recent MHCC review, people with severe mental illness are arrested at rates much higher than those without a mental illness.[159] Attention to the higher rates of arrest of people with mental illnesses is not intended to imply they are more violent or more likely to commit a criminal offence. In general, victimization is a greater concern than perpetration for people with mental illnesses. According to recent Statistics Canada data, drawing on the 2014 General Social Survey (GSS) on Canadians' safety (victimization), one in 10 people who live with a mental-health related disability experienced violence in the preceding 12 months, which was more than double that experienced among the population in general. The most common psychiatric diagnoses, including depressive, anxiety, and attention-deficit disorders, have no correlation with violence. Further, when people with severe mental illness become violent, they are more likely to harm themselves than others.[160]

The presence of a mental illness will elevate criminogenic risk.[161] When compared with justice-involved persons without severe mental illness, justice-involved persons with severe mental illness will face higher levels of criminogenic risk factors.[162] Recent research has shown that the prevalence of psychosis increases the likelihood of those with mental illnesses coming into contact with the criminal justice system.[163,164] For many justice-involved people with substance use disorders, their criminal offences are often related to that disorder.[165] In the small number of cases where people with mental illnesses commit violent crimes against others, such actions are influenced by an episode of delusion or psychosis. The evidence indicates, in the majority of cases, that the presence of a mental illness is only indirectly related to the crime.[166]

These disproportionate rates — and the problem of overrepresentation of people with mental illnesses in the criminal justice system — are often viewed through the lens of visibility theory. This theory posits that people who severely need but are not able to access or afford mental health care experience stigma and discrimination, which increases their expression as symptomatic and, consequently, their "visibility" to the public and the police.[167] Visibility is exacerbated by homelessness, and people with mental illnesses who are also experiencing homelessness are more likely to be detected and arrested for minor, nuisance offences or because law enforcement believes arrest will compel them to connect with treatment.[168]

Arrest rates are especially concerning for specific groups of people with mental illnesses. Persons with mental illnesses who are also experiencing homelessness are among the subgroups of homeless persons who are more likely to encounter the criminal justice system, specifically because they commit misdemeanour nuisance offences and offences to maintain their survival and acquire subsistence.[169-171] Many individuals in this group engage in problematic substance use, which, in addition to being criminalized in and of itself, often involves them in the use of criminalized drugs, sometimes results in disruptive and assaultive behaviours that arise from intoxication or else in theft and/or sex work to procure the funds to support their addiction.[172]

These increased rates of arrest, and increased justice involvement more generally, have been linked to the presence of a mental illness in and of itself. This association is stronger with the presence of co-occurring substance use problems. However, the association, while significant, is small.[173-175] In studies of the causes of crimes committed by people with serious mental illness, seven to 11 per cent were directly attributed to symptoms of a serious mental illness.[176]

Unfortunately, the presence of symptoms or a diagnosis of a mental illness can make it very challenging to navigate and ultimately leave the justice system. People with mental illnesses have a more difficult time adjusting to the environment and norms of prison life, and the stressful, often hostile conditions can lead to rapid deterioration of mental health to the point that they languish while incarcerated.[177] Incarcerated persons with severe mental illness are less likely to be granted full parole.[178] When they are paroled, they are less likely to be able to adhere to the terms of their probation and parole, leaving them susceptible to re-arrest or reincarceration.[179] People with mental illnesses very often appear before the courts because they have breached court-ordered conditions,[180] which further increases the risk that they will do so again. Consequently, additional breaches will lead to the imposition of stricter conditions that they will likely be even less equipped or able to manage.[181,182]

One study of justice-involved people with mental illnesses who returned to custody after one year shows that 75 per cent returned to custody due to technical violations of the conditions of their release.[183] In Ontario, the complexity of bail conditions is increasing and sets people with mental illnesses up for failure, in that they will very likely breach these conditions.[184,185] For example, one report found that 81 per cent of bail supervision clients with substance use issues had a bail condition of abstinence from that substance. Others have examined factors that influence continued justice involvement for homeless persons with a mental illness. Roy et al. (2016) found that of the factors that influence re-arrest, the most significant predictors of continued justice involvement were lack of referral to services followed by a high degree of administrative burden on the person (such as meetings or considerable conditions with which to comply).[186]

Although the presence of a mental illness does represent a risk factor for offending, it does not account for most criminal behaviour in the population.[187] One study that examined the relationships between a range of child and adolescent mental illness and criminal offenses committed by young adults found that, after controlling for poverty and juvenile arrest status, criminal behaviour could be attributed to childhood mental illness in 20.6 per cent of cases for females and 15.3 per cent of case for males.[188] In turn, some suggest it is critical for law and policy makers to recognize that justice-involved people with severe mental illness are not a homogenous group and that, as alluded to above, the presence of severe mental illness alone cannot sufficiently explain offending behaviour.[189,190]

Indirect determinants of justice involvement

Criminogenic factors
Legal scholars and experts recognize a series of risk factors directly related to criminal behaviour or crime "production." These factors, known as criminogenic risk factors, may be static or dynamic in nature, and current evidence supports eight central risk factors for criminogenic behaviour that have been found to be applicable to a broad range of people who commit criminal offences. Some criminogenic risk factors are considered static, including criminal history, number of prior incarcerations, and familial history of criminality; they are associated with recidivism but are recognized as unalterable through service delivery. Dynamic risk factors are those that can be modified with therapeutic support: they include pro-criminal attitudes, pro-criminal associates, and substance use.[191] It is this latter category that is relevant for consideration in the literature on mental health and criminal justice, specifically because it accounts for the fact that individuals may have needs that may not necessarily be associated with their criminal behaviour, which can be addressed by and require treatment.

Comorbidity, particularly the co-occurrence of a mental illness and substance use dependence, correlates directly with incarceration.[192-194] A nine-month ethnography of incarcerated people with mental illness found that incarcerated persons with mental health issues constitute those with troubled developmental histories and a combination of problematic substance use, personality related mental illnesses, and serious mental illness.[195] In one sample of justice-involved homeless people with mental illnesses, the leading predictors of justice involvement (at an individual level) were problematic substance use and low impulse control (associated with antisocial personality disorder [ASPD], BPD, or at least traits of personality disorders), along with other leading determinants, including recent victimization and the presence of PTSD.[196]

Studies that have compared rates of reoffence in individuals with and without concurrent mental illnesses (substance use disorders and mental illness) found that those with concurrent mental illnesses were nearly two times more likely to reoffend, even after controlling for factors associated with reoffending.[197] The same study found that those with concurrent mental illnesses had outcomes that were generally poorer than those who experienced substance use on its own or a mental illness on its own, such as higher rates of segregation while in custody.[198] One possible explanation for this is that the co-occurrence of problematic substance use and mental illness will have a detrimental effect on an individual's social functioning, including the capacity for moral decision making and productivity.[199]

The presence of criminogenic factors increase the risk of offending. Conversely, there is a range of protective factors that, when present for or accessible to justice-involved people with a mental illness, support reduced recidivism and meaningful reintegration into the community. For instance, a study that compared justice-involved people with a mental illness who successfully remained in the community for one year with those who returned to custody within the same period found that pro-social partners and friends, familial support, engagement in employment or volunteer work, involvement in mental health support, and motivation to stay in the community were all factors that supported reintegration.[200]

One challenge in understanding the intersection of a mental illness with criminogenic risk factors lies in the complexity in terms of how mental illness is defined. Some models for understanding mental illness are very broad and can include behavioural or conduct problems that are difficult to distinguish or poorly distinguished from mental health problems.

Social determinants of health

While the circumstances that lead to the involvement of people with mental illnesses in the criminal justice system are sometimes influenced by static or dynamic criminogenic risk factors, they are also often influenced by a complex combination of social factors. These factors, collectively referred to as the social determinants of health, have a significant influence on mental health outcomes. They include income and social status, early childhood development, identification as FNIM, social support networks, education, employment and working conditions, gender, personal health practices and coping skills, food security, access to health services, race/racism, and culture.[201]

Experiences of discrimination, racism, and historical trauma are also important social determinants of ill health for particular groups. For example, women experience greater adverse social determinants of health, including gender-based discrimination, than men.[202] This has been associated with having more chronic diseases and a greater number of long-term disability episodes than men.[203] A review of 138 population-based studies of self-reported health and experiences of racism found that 36 per cent of negative physical health outcomes and 72 per cent of negative mental health outcomes examined were associated with self-reported racism.[204] FNIM identity is also associated with poorer outcomes for social determinants of health such as low income, lower education levels, greater food insecurity, and inadequate housing.[205]

Scholars agree the social determinants of health have much more influence on health and illness than do typical biomedical and behavioural markers or risk factors.[206] A number of these social determinants have also been found to be associated with criminal justice involvement. Recent research into the health status of people involved in the justice system in Canada, which has included the status of those with mental illnesses, suggests that adverse events in childhood (abuse, neglect, and trauma), lack of housing, low educational achievement, and low income and unemployment or underemployment are all factors that contribute to justice involvement.[207] Other risky associations stem from histories of recidivism, homelessness, physical health problems, and stigma.[208]

The co-presence of homelessness and mental health problems or mental illnesses frequently correlates with offending behaviour.[209,210] Among homeless adults with mental illnesses, lifetime arrest rates have been found to range from 62-90 per cent, and lifetime incarceration has been found to range from 48-67 per cent. Homeless persons with mental illnesses are among the subgroups of homeless persons who are more likely to encounter the criminal justice system, especially for misdemeanour nuisance offences and property offences related to maintaining their survival and acquiring subsistence. A CSC literature review on justice-involved veterans and their mental health needs identified housing supports as a necessary factor in the prevention of their continued justice involvement.[211]

Other social determinants of health that contribute to justice involvement include timely access to health care. However, a lack of access to treatment facilities is a persistent unmet need across Canada for people with severe mental illness.[212] Many people with a mental illness who are arrested are unable to secure a referral for an assessment in a timely manner, especially individuals who are homeless.[213] More specifically, for people with a mental illness, involvement with the justice system may stem from poorly funded community-based programs, shortages of hospital beds, and increasingly formal and inflexible criteria for civil commitment.[214] A population-based study of 13,919 youths and young adults aged 12-24 who were incarcerated in Ontario correctional centres found that, for 35 per cent who had a mental health-related physician visit during incarceration, the visit was their first contact with mental

health care in the last five years. In turn, many people with a mental illness who are arrested are unable to secure a referral for an assessment in a timely manner and have no other option but to be detained in jail while they await a hospital bed, sometimes with fatal consequences.[215]

Many experts who work at the intersection of criminal justice and mental health are advocating for a shift away from the "criminalization hypothesis," given that there is considerable evidence to suggest that factors other than criminalization are the source of increased arrest rates of people with mental illnesses, since they are at such greater risk of unemployment, poverty, victimization, family breakdown, homelessness, poor physical health, and living in settings in which they are exposed to criminalized substances and crime.[216,217]

These adverse social conditions will persist once people with mental illnesses leave the criminal justice system and will often precipitate their re-entry into it. Given that most sentences are short and marked by repeated transitions, studies have sometimes treated these deprivations as a single continuous problem that stretches between the justice and corrections system and the community.[218-220] In Australia, justice-involved people with comorbid psychosis and addiction who are leaving prison were reported to face poor housing, unemployment, and social exclusion, all of which are thought to contribute to a greater risk of death in the weeks and months post-release.[221]

Structural factors driving justice involvement

Rates of arrest, crime, incarceration, and victimization are increasing among priority populations who experience mental health problems and illnesses. The population of incarcerated persons who identify as a person of colour or as a member of an FNIM community has increased considerably over the past several years. A 2013 report indicated that, in the five years prior, the number of incarcerated people who are part of a racialized community increased by 40 per cent.[222] The majority of those identify as Black or FNIM. In addition, although they remain a small minority of justice-involved persons, the population of justice-involved and incarcerated women and girls is growing, not just in Canada but in many countries.[223] The evidence indicates a number of structural factors — political and socio-economic marginalization, the persistent influence of histories of oppression, and systemic discrimination — contribute to this increased representation and overrepresentation of some priority populations within the criminal justice system. The higher prevalence of these factors in priority populations — Black Canadians, FNIM communities, women and girls**,** LGBTQ2+ populations, youth, and especially the points at which these identifies intersect — is linked in the literature to the continually oppressive structures of colonialism, racism, sexism and patriarchy, and capitalism.[224]

The literature indicates that many of the mental health problems and illnesses, including problematic substance use, for which priority populations are at greater risk, can be directly linked to historical and current marginalization and discrimination. For FNIM populations, mental illnesses and problematic substance use and addictions are linked with historical and current experiences of physical, sexual, and emotional trauma, intergenerational trauma, and substance use[225] and are exacerbated by economic marginalization, poverty, and a lack of access to mental health resources and treatment.[226] As one group of scholars points out, where community mental health resources are scarce, particularly for youth, rates of mental illness and, with them, incarceration increase.[227,228]

Many scholars and experts also attribute the increasing overrepresentation of priority populations in the criminal justice system to a series of concurrent and significant reductions in funding for community-based social services and programs proven to be effective within correctional settings.[229] These reductions in funding occurred in tandem with policy changes that imposed tougher sentencing rules and shifted juridical focus to the criminalization of behaviours and "deviance." As a result, the most marginalized people and groups in Canadian society had access to even less support and more acutely felt the effects of oppression.[230] The population of FNIM peoples in Canada is rapidly growing and, as of the 2016 census, represents 4.9 per cent of the national population. Yet, FNIM peoples are grossly overrepresented in Canada's federal corrections system, where they represent 30 per cent of the population of incarcerated persons.[231] This overrepresentation is attributable to the direct and indirect consequences of historical and continued colonization and the cultural, social, and individual legacies it leaves in their communities and families.[232] In particular, chronic poverty, problematic substance use, racial bias, and systemic discrimination in law enforcement all contribute to the interaction of FNIM persons in the criminal justice system.[233] FNIM youth are overrepresented due to multigenerational histories of abuse, sexual abuse, and neglect, which produce difficult-to-treat trauma.[234,235] The reality of the overrepresentation of FNIM persons in Canada's criminal justice system is consistent across anglophone nations with settler-colonial histories, as there is a link between cultural genocide, resulting trauma, and heavily justice-involved and policed populations.[236]

For many, the presence of mental health problems and illnesses contributes to their pathway to involvement in the criminal justice system, but identification with a mental illness is outpaced by histories of abuse and trauma.[237] For many incarcerated FNIM women, their involvement in the criminal justice system is frequently marked by these histories as well as by experiences of chronic violence and poverty.[238]

Limitations and opportunities in the literature on prevalence

Researchers have identified several challenges with identifying the prevalence of mental health symptoms, problems, and illness in the criminal justice system. Men incarcerated in federal institutions dominate the literature on the health of incarcerated persons, with problematic substance use being a priority subject and limited attention being paid to other mental health indicators and populations.[239]

Overall, government data on key health indicators, including the presence of mental health problems and illnesses, remains limited.[240] At the federal level, data captures a limited range of mental illnesses, as federal corrections has a limited capacity to systematically assess a broader range of illnesses.[241] Consequently, upon admission to a federal penitentiary, there is no capacity to assess for cognitive ability, attention deficit hyperactivity disorder (ADHD), fetal alcohol spectrum disorder(s) (FASD), and other neurological illnesses.[242] Some researchers have concluded the lack of government data on mental health indicators is quite striking given that health and mental health care in correctional facilities is largely delivered by government authorities and agencies.[243]

In addition to challenges with the range of data collected, experts and researchers have also identified shortcomings in the ways the presence and prevalence of mental health problems and illnesses are assessed at the point of entry into the criminal justice system. For example, managers and staff in some institutional contexts (such as provincial institutions in Quebec) raised concerns about the validity of statements given by newly incarcerated persons during screening, whom they felt were more open

about identifying some symptoms (such as acute anxiety or aggression) and not others (depression).[244] The potential for newly incarcerated persons to misrepresent or experience reluctance about their symptoms has been raised by Canadian researchers as a cause of concern about misdiagnosis and overdiagnosis of mental illness.[245] In addition to a reluctance to disclose, individuals may also be in denial about their symptoms or they may worry about being accused of malingering. The potential for misdiagnosis or overdiagnosis may also occur at a clinical and systems level. At the clinical level, cognitive errors are possible, including the inappropriate use of metrics and bias in reporting as well as reluctance to adjust diagnoses made by colleagues.[246] At the system level, Martin et al. (2016) found that institutions often fail to account for the influence of "intake stress" on assessment, recommending that assessment be conducted well after intake, except in cases of urgent need. They conclude that misdiagnosis and overdiagnosis ought to be better understood by the corrections system such that opportunities to improve mental health are not missed and the system does not overintervene in cases that would benefit from lower-intensity treatments.[247]

In this literature, there is no standardized and universal agreement on what should be counted as mental illness or a mental health problem in any given population study. In the absence of such agreement, the measures adopted by any one study are guided by what data is already available or by the orientation of the literature in which the researchers see themselves operating. Consequently, the literature is divided between lifetime and current estimates, between broad and narrow categories (personality and substance use disorders, or psychotic and mood disorders), and between symptoms and formal diagnoses only. This points toward a need to clearly identify a research agenda centred on particular problems and define a methodology that will help get at more specific answers.

What are the Experiences and Needs of People with Mental Illnesses and Mental Health Problems who are Involved in the Justice System?

KEY FINDINGS

- Justice-involved people with mental health problems or illnesses repeatedly experience disruption and change, as they are often moved between institutions, courts, available services, precarious housing, and homelessness.
- In the Canadian context of under-resourced community mental health services, justice involvement may be one of the few ways people can gain the meaningful choice to access care. But this access often comes with the cost of being criminalized and experiencing a loss of freedom.
- Incarcerated people with mental health problems or illnesses are placed in segregation or solitary confinement far more often than their counterparts without a mental illness. Segregation is, according to the literature, the most common response to a mental illness, in particular to suicidal ideation, often due to inadequately resourced care.
- Justice-involved people with mental health problems or illnesses often face a dual stigma, where mental health stigma causes them to be perceived as a risk, and justice involvement excludes them from many forms of social support and services.
- Incarcerated people who attempt suicide or who self-injure are often perceived as manipulative and subjected to escalating cycles of discipline that worsen mental health.
- Correctional mental health care in Canada is consistently understaffed; primary care is overloaded because intermediate and specialized care are not adequately resourced.

In this section, we review the literature and documentation that illuminates some of the needs, barriers, and facilitators to mental health and mental health care. These needs, barriers, and facilitators exist within justice and corrections contexts and within the community for those who have been justice involved or who are at risk. Generally, the literature accounts for experiences and needs by either directly capturing or inferring the experiences of justice-involved people living with mental health problems and illnesses. Based on the literature reviewed, the mental health care needs of justice-involved people could be summarized as follows:

- to receive mental health care in the least-restrictive environment, consistent with principles of justice and public safety and according to *standards of custody* that do not compromise their mental health
- to have a *continuity of care* maintained at all transition points into and out of the supervision of the justice system, access to consistent care providers, and no gaps in medication or treatment that has been determined by a clinician to be necessary
- to have access to the social determinants of good mental health, first and foremost, to *safe and adequate housing*, especially when being released from custody
- to have strong restrictions on the use of *segregation*

- to have internal barriers to accessing available services addressed through *in-reach* (the improvement of existing connections) that addresses stigma, shame, and concerns about care quality
- to provide all health-care services at the *same standards of quality and clinical independence* as services in the community adequately resourced

The subsections that follow describe our review of particular themes in the literature that speak to these needs and their related pathways and barriers.

Describing the experiences of justice-involved people

Transition, disruption, and discontinuity

The literature can be characterized by a strong parallel between concern around continuity of care and the struggle with continuous socio-economic and environmental disruption that justice-involved people with mental health problems and illness often experience. In the experiences of people with mental illnesses, this tension between stability and instability can be seen at various points along the spectrum of justice involvement and can substantially aggravate already difficult attempts at recovery. The Canadian literature on this theme tends to emphasize examinations of the provincial and territorial corrections systems as well as in the transitions between community, courts, and remand.

According to those who uphold the justice system, the parallel between continuity of care and continuous disruption in the lives of justice-involved people with mental illness is a problem with "frequent flyers": individuals who are low-intensity, high-frequency "users" of the criminal justice and corrections systems and who cycle between short sentences in local or provincial/territorial jails and poverty or homelessness. These people often become reinvolved in the justice system through the breach of bail or release conditions because inadequate mental health care impacts their capacity to manage and cope.[248] Many service providers have come to view this experience as normalized, with jails becoming *de facto* points of first contact for mental health care, however fragmented and discontinuous it may be.[249,250]

Short stays in jail, whether on remand or while sentenced for relatively minor offences, make providing mental health care very challenging in practice.[251] Even if jails were suitable therapeutic environments, complex mental health needs take time to resolve, and stays in jail are both generally short and can have unpredictable lengths due to releases as determined by the courts. This reduces the efficacy of mental health interventions unless there is continuity in the community.[252]

Entering custody, whether on remand or sentenced, represents a significant disruption point for those who were already receiving care. That treatment is often suspended until they are re-screened by their institution, and even then, prescription medications and courses of treatment from outside the institution are not necessarily honoured. This can be due to disagreements over diagnosis, often based on screenings conducted by non-mental health professionals, or to real or perceived concerns around drug-seeking, faking, and attention-seeking behaviour.[253]

The changing nature of populations in provincial and territorial corrections poses challenges for services. The number of people serving custodial sentences is declining in six of 10 provinces and two of three territories as of 2019, while eight provinces and territories now have a greater number of adults on

remand than they have serving custodial sentences.[254] In Ontario, as of 2015, 60 per cent of those in custody were on remand.[255] The uncertainty of their length of stay makes providing rehabilitation and housing supports more challenging (in fact, individuals on remand generally do not have access to most correctional programs, or indeed any health care).[256]

The shift toward higher remanded populations is driven by a greater assessed risk for criminally charged individuals, driving more restrictive bail conditions (which those who have serious mental health problems are more likely to breach) or the withholding of bail altogether — which may be associated with a repeated failure to uphold previous conditions.[257-259] For example, one report found that 81 per cent of bail supervision clients with substance use issues had a bail condition of abstinence from that substance.[260] It also found that overcrowding as a result of breached bail leads to the use of segregation as a means of control.[261]

Health-care needs in Canadian corrections are served by a patchwork of services, generally managed by institutions themselves and making use of outside emergency care as needed.[262] For the most seriously ill incarcerated persons, who may experience repeated mental health crises while incarcerated, frequent changes in environment — into segregation or transport between jail and a psychiatric hospital unit and back again — add new sources of fear and anxiety.[263,264] In the absence of high-quality services that span the health/corrections boundary, people returned to jail after being discharged from forensic psychiatric units often disengage with care and have very frequent rehospitalization rates.[265]

Leaving custody can also present many disruptions to mental health treatment and recovery. Those leaving custody face challenges with a loss of correctional health-care coverage, re-establishing identity documents and any social benefits entitlements, and with finding housing, employment, and primary care access.[266] Those with mental illnesses, particularly if released from court, are disproportionately affected, being released without possessions — including medication and identity documents — that may be held at widely spread out provincial institutions that are hours of travel away.[267,268] The international literature identifies this as well. In a longitudinal study that traced the post-incarceration experiences of justice-involved people in Texas with a mental illness, mental health status was found to be the most significant predictor (followed by gender) of barriers to accessing employment and housing following release.[269] In an Australian study, persons living with comorbid psychosis and addiction who are leaving prison were reported to face no or poor housing, unemployment, and social exclusion, all of which were identified as statistically significant contributors to a greater risk of death in the weeks and months post-release.[270]

Housing is consistently identified as one of the greatest — if not the single greatest — determinants of achieving stable recovery while living with serious mental illness.[271-274] Entering custody is a significant risk factor for homelessness due to a loss of tenure,[275] and those with intersecting housing, mental health, and justice needs in Canada find it difficult to secure housing upon release due to restrictive eligibility criteria,[276] and a general loss of affordable housing supply.

These experiences of disruption have serious consequences. The two weeks after release from provincial custody place individuals at a higher risk of death, particularly from substance use and suicide, a finding also identified internationally. This is a period where uncertainty about housing, health care, and the future are at their peak, mental health stability is threatened, and inadequate transition services can leave people vulnerable.[277-279] If mental health problems went unmanaged in custody, the impact will be even greater.[280] Gender- and age-related factors have a significant impact on how these

disruptions are navigated,[281] with women and particularly older women finding it hard to cope with a lack of specialized resources and supports, limited accommodation both in and out of custody, and a return to the same environments that led to their criminalization.[282]

Coercion, choice, and change

For those with mental health problems and illnesses, becoming involved in the justice system can present a paradoxical combination of opportunities for change and experiences of coercion. In the Canadian context of under-resourced community mental health services, justice involvement may be one of the few ways people can access mental health care.[283,284] But this access often comes with the cost of being criminalized, and potentially entering a cycle of breaching bail conditions, or being sentenced to incarceration where access to care services is administered within an anti-therapeutic environment.[285-287]

For example, justice-involved individuals who participate in mental health diversion programs can experience those programs as allowing and supporting positive change, even as they also recognize an element of coercion, to a greater or lesser extent. Studies of men (and one woman) who graduated from an MHC* program in Ontario, and men serving under mental health treatment orders in the U.K. and Denmark, presented significant parallel findings regarding how participants perceive these forms of treatment: as intervening in a struggle with chaos, while offering choice to repair broken relations and build a more stable life.[288-290]

But involvement with the justice system, even leading to non-custodial sentences or diversion, imposes restriction and, in some cases, new forms of chaos. The same Ontario study found that MHC participants "accepted" — in the sense of being inured to — ridicule and physical violence from court officers as a normal aspect of the same justice involvement offering access to services.[291] In the U.K. study, treatment orders were perceived negatively, as participants feared the complexity of upholding imposed conditions and experienced anxiety about missing one of many appointments.[292]

Forms of court-based diversion (such as MHCs) are predicated on the assumption that unmanaged symptoms of a mental illness are linked to criminalization because of non-adherence to treatment and/or inadequate or inaccessible community mental health services.[293] Within these diversion schemes, the promise of a lenient disposition is often made conditional on accepting treatment.[294] This implicit or explicit threat of criminal justice sanctions to promote treatment adherence is commonly referred to as criminal justice leverage in the research literature.[295-298] The diversion processes therefore fuse care and control, aiming explicitly to "improve the . . . integration of existing mental health and social services programs with the criminal justice system" (p. 5).[299] Some diversion schemes may require accepting criminal responsibility for the offence and, in some jurisdictions, may require a formal guilty plea for admission.[300] They evolved from earlier drug courts as part of a problem-solving or wellness model of justice — but drug possession was and is often still a crime, while having a mental illness is not. The treatment conditions required for participation in diversion are thus open to being perceived as coercive, with implications for treatment engagement.[301-303] However, preliminary research in the U.S. has not found a relationship between the use of criminal justice leverage and perceived coercion, satisfaction with treatment, and adherence.[304]

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* MHCs are a kind of alternative, problem-solving justice process for those accused of a crime and living with mental health problems. We discuss the model and evidence for it below in more detail.

For those who are in jail or prison, coercion is experienced much more strongly, including in care contexts. Mental health care in custody is a right, but the health-care needs of incarcerated people are often perceived — by both prisoners and corrections staff — as blurring into issues of institutional security, staff safety, and behaviour control.[305]

A significant prison study found that neither care nor control are totally dominant themes in Canadian in-custody mental health policy and practice, but that there is evidence of both — contact with psychiatric care could be driven both by psychiatric symptoms and patterns of disruptive conduct.[306] Women, including older women, have especially acute experiences of contesting the nature and validity of particular care interventions in Canadian prisons. Women are more likely than men to receive nursing, social work, and psychological care in custody. Gender plays an important role in the provision of mental health care, independent of clinical status and conduct problems.[307] But women also frequently report that they perceive psychiatric medications as a way to control their behaviour, and the absence of clinically independent counsellors pathologizes their histories of trauma and mental health.[308,309]

Although justice involvement can in some cases be a gateway to care access, a large Canadian study showed that implementing universal mental health screening in federal institutions did not close gaps in access to treatment between groups who have disparities in access on the outside — such as some ethnic groups including Black and Asian Canadians. The authors concluded that structural barriers — such as a lack of resources or restrictive policies — are not the only kinds of barriers to care. The lived experience of stigma around diagnosis, accessing mental health care, and concerns about care quality (which can have structural/historical causes) show that, in their design, the voices of incarcerated persons are needed.[310]

Youth experiences of care and control are distinct from those of adults. In some cases, coercion is much sharper and more harmful, with developmental factors both overlooked and used to discount that youth may have reasons or meaningful perspectives on care. Youth are held accountable for impulsive reactions to the stress of custody, and cycles of infraction and punishment prevent implementation of more strength-developing approaches, even when institutions formally adopt those approaches.[311,312]

Segregation and isolation

The use of segregation and isolation in the form of solitary confinement continues throughout correctional facilities in Canada, despite ongoing and vocal criticisms from criminal justice experts and prison-justice advocates.[313-318] Our review of the literature found that it is not uncommon for people with mental illnesses or expressing symptoms of a mental illness to be placed in segregation or solitary confinement, and that people with mental health problems or mental illnesses will be placed in segregation or solitary confinement far more often than their counterparts without a mental illness. Segregation is seen as the only alternative to house incarcerated people with acute symptoms.[319] In many cases, segregation becomes the default option, either because services are unavailable or because people decline mental health care. Segregation is then used to manage behaviour — and sometimes to allow symptoms to worsen to the point where care can be given involuntarily.[320] Segregation is, according to the literature, the most common response to a mental illness, in particular to suicidal ideation,[321] even though the safety and mental health of incarcerated individuals with mental illnesses is often significantly compromised by isolation and segregation.[322] Further, incarcerated individuals with mental illnesses are disproportionately charged with rule infractions and are, in turn, more likely to be placed in solitary confinement on multiple occasions.[323]

Over the past few decades, a series of enacted procedural and policy changes have engendered the conditions for increased incidents of isolation and segregation among incarcerated persons with mental health problems or mental illnesses. For example, there has been a trend in recent years to decrease in-person visitation in provincial institutions in Ontario. A recent report indicated that 25 of 26 provincial institutions are considered maximum security, where the policy is that visits are routinely denied.[324] Such acts of "isolation by policy" also apply to specially built FNIM healing spaces, such as gardens and ceremony space; as of 2017, those built in the Vanier Centre for Women had never been used.[325] In the early 2010s, the proliferation of "tough on crime" laws in Canada curtailed visitation and reduced the rates of parole. Incarcerated persons with mental illnesses were disproportionately affected by these laws, though they are already less likely to experience or be granted a right to visitation.[326]

Segregation separates people with mental illnesses from their social networks and support systems, through restrictions on human contact and visitation, and it increases their risk of violence through self-injury and exposure to discrimination.[327,328] Incarcerated persons with mental illnesses are more susceptible to psychological stressors and emotional pain.[329] Although they would benefit from social contact and interaction to build or maintain psychological well-being, they are instead often placed in segregation units, which cause stress and pain and compromise psychological well-being. For Haney (2017), the experience of isolation is inherently "psychologically destabilizing, because it undermines a person's sense of self or social identity and erodes [their] connection to a shared social reality" (p. 321).[330] He argues that segregation or isolation exacerbates symptoms experienced by those with severe mental illnesses, such as schizophrenia. Our review of the literature also finds that the conditions of segregation are frequently derelict: one report noted that segregated persons occupy cells characterized by substandard and counterintuitive living conditions (such as bright lights that are never dimmed).[331]

According to the CIC, federally incarcerated persons with acute psychiatric symptoms that cannot be appropriately managed or cared for are routinely managed on around-the-clock suicide watch, mostly in long-term segregation or observation cells largely devoid of stimuli.[332] Similarly, a study of older incarcerated people in Canada found that those who were sent to segregation for disciplinary reasons were more likely than not (59 per cent) to report having a diagnosis of mental illness.[333]

In 2017, the CSC reported that incarcerated men who have a personality-related mental illness in combination with other mental illnesses have the highest rates of placement in any type of segregation.[334] Incarcerated persons who exhibit suicidal ideation and engage in self-injurious behaviour are frequently subject to segregation.[335-339] While often a danger to themselves, in most cases people who chronically self-injure are not a danger to others, so relying on security interventions to control or manage their behaviour may actually have the opposite effect.[340] The CIC continues to document cases where the management of self-injury was met with the almost continuous use of seclusion and restraint in environments marked by deprivation.[341] The CIC maintains the use of seclusion to manage self-injury is not consistent with current evidence, best practice, or correctional expertise, all of which indicate the factors that prevent self-injury in prison: less time locked in a cell, access to employment, access to individual counselling, enrolment in programs, and regular contact with family.[342]

Several studies have found that individuals who identify with one or more equity-seeking populations are more likely to experience isolating incarceration experiences, including segregation. In one study, incarcerated Black persons who were assessed with a lower risk of reoffending and lower overall criminogenic needs were 1.5 times more likely to have been placed in maximum security institutions

with limited programming and employment, education, rehabilitative, and social opportunities.[343] In addition, incarcerated FNIM men in Ontario, once placed in segregation, spend an average of 15 continuous days, two more than the average for non-FNIM men.[344]

For many, segregation creates a vicious cycle, in that the isolation and deprivation that underpins it exacerbate rather than eliminate the behaviours it is addressing. Incarcerated persons with a mental illness are often placed in segregation, which some suggest contributes to a fear of reaching out for help.[345] They may also experience anger and emotional dysregulation, which can lead to behaviours cast as disciplinary "problems" that lead to segregation.[346] In Canada, the experience and death of 18-year-old Ashley Smith continues to be relevant in this regard. In the mid-2000s, Smith was remanded in the New Brunswick Youth Centre multiple times over a three-year period, which was marked by her involvement in hundreds of incidents at the centre and numerous attempts at self-harm.

When Smith turned 18, a motion under Canada's *Youth Criminal Justice Act* led to her being moved into the adult system, where she was transferred 17 times among eight institutions over 11 months. During this time, behaviour that was a direct result of her mental illness was met with continually restrictive conditions of confinement.[347,348] Her experience was one of heavy surveillance and severely restricted cell conditions, including sensory deprivation and the removal of everything from her cell, including floor tiles. As a direct result of her continuous, prolonged solitary confinement, her psychological condition deteriorated and exacerbated her self-harm. Yet, her mental illness was never sufficiently addressed, and her exercises of resistance were not understood as indicative of her distress and feelings of powerlessness and isolation. In Smith's own words:

> It can't be any worse then [sic] living a life like mine. . . . When I used to try to hang myself I was just messing around trying to make them care and pay attention. Now it's different. I want them to [f*ck] off and leave me alone. It's no longer a joke. (p. 23)[349]

Some suggest that the more punitive her conditions became, the less any possibility existed of her being recognized as a person with a mental illness who would benefit from treatment.[350] Other experts have concluded that her mental illness was never addressed because institutional security concerns are continuously prioritized over an incarcerated person's mental health problems.[351]

The evidence demonstrates that the injurious effects of solitary confinement begin within a few days and only worsen. These effects include anxiety, depression, anger, confused thoughts, perceptual distortions, paranoia and psychosis, lethargy, insomnia, palpitations, and anorexia.[352] Incarcerated persons in segregation reported the following complaints: depression, feeling "sick of life," trouble eating or sleeping, and fear of losing their mind.[353] For those with pre-existing mental health problems, the symptoms may remain after segregation has ended and can affect reintegration into the regular prison community.[354] It has also repeatedly been found to increase the risk of attempted and completed suicides.[355-358] Recent reports indicate that senior staff in correctional facilities are unaware of some of the mental health struggles endured by those in segregation.[359]

The consequences of segregation and solitary confinement are so deleterious that national and international experts agree on an "absolute prohibition" on placing those with a mental illness in prolonged segregation.[360] In 2012, the CIC aligned his position with that of the former UN special rapporteur on torture, who has stated that segregation does not work to rehabilitate those who are subject to it and, as such, runs counter to what should be the aims of any criminal justice system. To

address the negative experiences of those in segregation, the ombudsman of Ontario recommends terminating indefinite segregation; establishing independent review and oversight of segregation placements; mandating mental health assessments, treatments and reintegration plans; and training staff on incarcerated persons' rights and the effects of segregation on their health.[361]

Stigma and shame

The stigma that continues to surround mental illnesses is not only a key factor in the overrepresentation of people with mental illnesses in the justice system, as reported earlier, it also has a considerable and unique impact on their experiences within the system.[362,363] Stigma and shame inform the circumstances through which people with mental illnesses enter the justice system and influence their experiences within the system.

For people with mental illnesses, and especially for people with severe mental illness, stigma is often a contributing factor to their entry and re-entry into the criminal justice system. For example, some people with mental illnesses may enter the criminal justice system without a diagnosis because they come from communities where stigma, in combination with limited access to health services, reduces rates of awareness and help seeking.[364] Justice-involved people with mental illnesses struggle to access appropriate community-based services, which can reinforce further justice involvement as one of the only pathways to treatment.[365] People with severe mental illness, as noted earlier, are often more visible to the police due to their greater visibility in public spaces. As such, they are also often perceived as a risk and a threat to public safety, which not only reinforces stigmatizing attitudes toward people with severe mental illness,[366] but also increases their risk of being apprehended.[367]

When people with mental illnesses become justice involved, they continue to be stigmatized and to experience the effects of stigma. Upon their initial encounter with the criminal justice system, they may experience pressure to participate in treatment as a means of avoiding prosecution. Although designed to be a diversion from prosecution and a route to treatment, for some, the very name "mental health court" is stigmatizing, and in some areas the name has been changed to support stigma reduction.[368,*] To some experts, MHCs magnify stigma because they convey the notion that people with mental illnesses require institutions and controls that are exceptional in nature. In fact, the root of the problem is seen to lie in addressing gaps and shortages in community-based mental health services.[369] In other jurisdictions, namely the U.K., one study has found that some people refused to apply for or consent to participate in MHCs due to fear of being stigmatized by that participation. They perceived these diversion schemes as worse than drug or alcohol treatment orders.[370] Canadian experts maintain that, within the criminal justice system, people with mental illnesses are frequently defined by their diagnoses, the implications of which include being labelled with a tag that "sticks" to the person and contributes to their perceived and actual social isolation[371,372] while hampering their ability to re-enter their communities upon release.[373]

For those who are incarcerated, the influence of stigma and shame persists and has a detrimental impact on their capacity or willingness to seek help. The prison environment is marked by a culture that promotes toughness and hardness and discourages vulnerability — none of which is conducive to help-seeking behaviour[374] — which makes it difficult for people to self-identify as having a mental health

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[*] One such name change occurred in London, Ontario, where the mental health court was renamed the Youth Therapeutic Court.

problem or a mental illness for fear of reprisal or judgment. This is especially the case for justice-involved men, who are less likely than women to ask for help.[375] It is especially prominent among incarcerated persons engaged in mental health-related self-injurious behaviour because they feel too ashamed to speak up for fear of being stigmatized or subject to disciplinary measures.[376] Incarcerated persons who report suicidal thoughts, or whose behaviour changes with symptoms of mental illness, are aware of but fear the prospect of being put on “suicide watch” and being segregated. They may then intentionally hide their experience.[377]

The stigmatizing attitudes and behaviours perpetuated by corrections professionals and by community-based mental health providers have a detrimental impact on the experiences of justice-involved people with mental illnesses.[378,379] Recent research on prevalence and comorbidity conducted by the CSC is framed through the lens of an incoming person’s failure to be responsible. They are characterized as having worsening symptoms of mental illness over time as a population and as unwilling to engage with correctional plans for rehabilitation and reintegration into the community.[380] Other studies have found that community mental health resources could be reluctant to provide support to justice-involved persons with serious mental illness due to feeling unprepared to handle challenging behaviour.[381,382] Justice-involved persons are more likely to be declined supportive housing by housing providers than other applicants, often because their “support needs were too high” (p. 103).[383] These findings are also borne out in recent Australian research, which identified that people with mental illnesses who are or were justice involved were considered “high-risk” by professionals in community-based mental health and were more likely to be denied access to services.[384]

The harmful effects of stigma are often exacerbated by experiences of oppression, although the literature on this topic remains very limited. In cases where mental health treatment has been ordered, incarcerated persons with serious mental illness may choose not to participate because their marginalized status may inform negative attitudes about mental health services.[385,386] Specifically, the expression of symptoms on the part of justice-involved persons with mental illnesses who identify with any priority population may not be accurately understood by staff and/or misconstrued.[387] The experience of stigma is also compounded by gender, which manifests itself differently for men and women. A qualitative study of older women who were no longer incarcerated found that their status as female “ex-prisoners” subjected them to gendered discrimination and stigmatization.[388] Overall, however, there is scant Canadian and international research that considers the intersection of mental health stigma, justice involvement, and identification with one or more priority populations.

Stigma persists once people with mental health problems and mental illnesses leave the criminal justice system. For those who have charges pending and for those who leave custody, their criminal-justice histories subject them to exclusionary policies that make it hard for them to access community-based services, as providers are unwilling to accept those with criminal charges, even if those charges are still pending.[389,390]

Self-injury and suicidality

Recent research has identified and examined the factors that contribute to self-injury and to suicidality among justice-involved persons. Notably, this work has primarily considered the experiences of incarcerated persons, and not those in community correctional settings (such as probation and parole). The evidence indicates that incarcerated men and women report engaging in self-injury, albeit at different rates, and that not all incarcerated persons who engage in self-injury or express suicidality

have a diagnosis of a mental illness.[391] The literature indicates that risk factors for self-injury and suicidality are multiple and intersecting, and that they are a response to individual-level circumstances and/or institutional-level factors.

At the individual level, incarcerated persons engage in self-injury in part to deal with negative emotions,[392] regulate affect,[393] and/or deal with the symptoms of a mental illness.[394] Other individual-level motivations include a need for communication, violence avoidance, self-punishment, and sensation-seeking.[395] Researchers examined factors associated with injury and suicidality among incarcerated persons who identify with one or more priority populations. Several studies have found that men are more likely than women to self-injure because of feelings arising directly from being incarcerated, whereas women are more likely than men to self-injure because of feelings arising from emotional pain and past trauma.[396] Incarcerated FNIM persons are more likely than non-FNIM persons to self-injure.[397] A 2000 report specific to incarcerated FNIM women in Canada found that experiences of incarceration, and in particular experiences of segregation, were associated with an SIB,[398] though more research is needed to determine if there are differences in the causation of SIB between FNIM and non-FNIM incarcerated people.[399] A recent study that examined suicidality in a group of older, incarcerated persons found that more than 10 per cent of those surveyed had experienced suicidal ideations but had never talked about it for fear of reprisal.[400]

Incarcerated persons typically do not engage in self-injury to manipulate corrections staff.[401] Nonetheless, some of the literature suggests that the strength of this perception takes a toll on corrections staff who understand self-injurious behaviours as a threat to their authority. This, in combination with bearing witness to self-injury, contributes to feelings of frustration, distress, shock, failure, and burnout among corrections staff.[402] Experts conclude that self-injurious behaviours are and should be treated by corrections staff as a sign of mental distress requiring treatment, and that corrections staff ought to receive the requisite training to support incarcerated persons who self-injure.[403]

Other studies have considered the corrections-level factors associated with self-injury, suicidality, and suicide among incarcerated persons. In some studies, the examined prison-level factors were not associated with prison suicide rates, suggesting that prison suicides are likely the result of a complex interaction of different factors and not solely attributable to the prison environment.[404] There appears to be a relationship between conditions of confinement and the propensity for self-injury, where the more depriving and restrictive the environment becomes, the more likely it is for self-injury to occur.[405]

Given that segregation and isolation are often leveraged as institutional responses to self-injurious behaviour and suicidality, segregation and isolation practices are interwoven with and heavily critiqued throughout the literature on self-injurious behaviour. A considerable amount of research exists to confirm that disciplinary or punitive responses do little to mitigate the risk or reduce the rates of self-injury among incarcerated persons.[406] Yet, these practices continue to be employed with regularity. On the contrary, the literature suggests that such responses will in fact exacerbate symptoms of a mental illness and may provoke subsequent self-injury.[407] The CIC reports that there is considerable confusion as to when a use-of-force situation begins and ends when it involves the application of physical restraint equipment to manage self-injurious behaviour. This confusion highlights the lack of alignment between security practices and health-care interventions in the management of self-injurious behaviour. This situation is troubling for front-line staff who manage incidents and for those conducting use-of-force reviews that monitor legal and policy compliance. Regarding those who conduct practice-level reviews,

the CIC raised concerns with the understanding that incarcerated persons who exercise self-injurious behaviour are freely consenting to be placed in physical restraints while surrounded by several uniformed and heavily equipped correctional officers. [408]

The literature also highlights a range of concerns at a systems level, particularly with regard to correctional responses to incidents of self-injury and suicide (attempts or deaths). The CIC reported in 2012 that recently released policy directives for the management of self-injuries have not translated into better compliance with standards of care.[409] This report indicates that there are several ongoing areas of concern at the correctional level, including

- inadequate support and training for staff
- poor or little information sharing between corrections staff and the health/mental health professionals involved in the person's care
- continued understanding of self-injurious behaviour as a security problem, which supports an over-reliance on control/disciplinary responses, such as transferring those who self-injure to maximum security even when they pose a threat only to themselves.[410]

The CIC points out that there have been cases where it intervened in the management of an incarcerated person's self-injurious behaviour and found there was no treatment plan in place and corrections-level staff were unsure how to develop a treatment plan. This concern over the mechanisms in place to respond to self-injurious behaviour was first raised in an earlier annual report, wherein the CIC maintained that deaths in custody are the result of a combination of "compliance issues with respect to responding to situations of medical distress" and inconsistencies in the quality and availability of professional health care across regions and among facilities (p. 28).[411]

Pathways and gatekeepers: Accessing mental health care inside the justice system

Diversion and the courts

Concern about the overrepresentation in justice systems of those with mental health problems has existed for some time, and justice systems, including those in Canada, have made efforts to adapt. Evidence indicates that substantially fewer people with serious mental illness are being incarcerated in Canada compared with rates from 20 years ago — partly because of lower imprisonment rates overall and partly because of the growth in use of NCR-MD.[412] However, as there is a significant population who do not meet the strict criteria of NCR-MD but whose mental health problems are a clear driver of their involvement in the justice system, many jurisdictions in Canada and internationally have developed pre-trial or pre-sentencing diversion programs for people with mental health problems as an alternative to punishment.

Diversion refers to programs that stay or suspend charges, or adopt alternative sentencing procedures, if an accused person consents to a path of treatment. The accused person may be expected to show they accept responsibility for the offence for which they are charged, and in some jurisdictions may be required to enter a guilty plea. The most well-studied of these is the MHC model,* in which multi-

* We discuss the model of mental health courts and some other diversion programs in more detail in the next section on promising practices. Here, the focus is on the role these programs play in the experience of care and care seeking.

disciplinary teams combine mental health and justice professionals, using a non-adversarial approach to support mental health recovery and prevent reoffending.[413] In addition to diversion, some MHCs also deal with issues related to the fitness to stand trial and may also deal with bail or sentencing issues.

Diversion programs are seen as important facilitators of access to care for justice-involved people, though this is itself an outcome partly of care scarcity. Those appearing before MHCs, or ordinary courts with mental health-related support services, have high levels of unmet needs and a lack of connection to supports before coming into contact with the justice system.[414] Specialized diversion for youth can be particularly effective because mental health problems and justice involvement can often co-occur at the onset of adulthood, and supportive programming can make a significant difference in this regard.

In the absence of dedicated diversion programs designed to account for the sustained support necessary for recovery, those with mental illnesses can be quickly returned to custody after technical violations of bail, probation, or parole.[415] However, diversion programs — which implicitly or explicitly threaten a return of criminal charges if treatment is not engaged with — can be experienced as another form of coercion and criminalization.[416] Whether they increase or decrease stigma toward mental health problems is still a current and active debate.[417]

Because diversion programs are discretionary, they are susceptible to gender and/or race biases, or structural factors that shape people's justice involvement. Studies conducted in both the U.S. and Canada show that older, white women are more likely, relative to other accused individuals, to be referred to MHC (and conversely, young black men are less likely).[418,419] In one study conducted in Winnipeg, accused FNIM persons were less likely than white people to be diverted to MHCs,[420] a finding consistent with similar studies in Australia.[421] An Ontario study reported qualitative data suggesting that racialized populations have less access to mental health diversion programs in the province, recommending that the justice system begin tracking race-based data and promoting cultural competence in services.[422]

In addition to the non-clinical characteristics of those who are accused of an offence, the severity of the offence is a strong determinant of diversion to mental health treatment, whether it is screening and assessment for youth[423] or MHC, with more severe charges being less likely to be diverted.[424]

Institutional care in custody

Mental health care in custody should have several components:

- screening at, or soon after, admission
- referral to further assessment for those with positive screenings
- emergency care access 24-7 for those in crisis, including suicide prevention
- primary care in every institution
- access to intermediate and specialized psychiatric care for those who require it[425]

In practice, the prioritization of institutional security and control, in the context of limited resources and diverse barriers, makes accessing quality mental health care in custody very difficult.

Screening for mental health problems at admission to custody has grown in importance and is now — at least by policy — universal in federal corrections in Canada. It is also a popular policy intervention internationally, perhaps in part because it is easy to implement relative to special programs or

investments in advanced care models. In-custody initial assessments tend to use brief tools that are validated for use by those who are not professional mental health staff (such as correctional staff). Screening by non-mental-health professionals is accepted if the tools are validated, but there is evidence of a high false-negative rate when applied to correctional populations[426] and a lack of clinical independence can place a particular lens on reported symptoms, behaviour, and interviewee motivations. Corrections staff may be more likely to interpret responses as attention- or drug-seeking or malingering.[427] While screening tools may be validated to be delivered by non-specialized staff, informal observation is also a key element of diagnosis, and in correctional environments, staff can miss emergent signs of mental health problems or crises that fall short of dramatic, strange, or threatening behaviour.[428] Effective screening and quality mental health care could represent opportunities to address a lack of access to care in the community and a turning-point in the lives of justice-involved people. However, the corrections context is generally antitherapeutic, and challenges to care delivery are enormous.[429,430]

In Canada, correctional mental health care is consistently understaffed and has very high turnover rates. Vacancy rates are high in federal and provincial institutions, hovering around 8.5 per cent overall and around 30 per cent for specific roles (such as psychologist).[431] Roles in correctional mental health are generally understood to be less desirable jobs in a highly competitive field, which means institutions are below capacity. As a consequence, more care work, including triage and less formal risk assessments, falls to corrections staff, whose primary duties are to maintain institutional security, manage incarcerated persons, and ensure staff safety.[432] Primary care services in federal institutions in Canada are overloaded because intermediate care has not been universally or adequately funded, and regional treatment centres (which provide tertiary/intensive care) are extremely restricted in capacity with very high bars to admission. Not all who require this level of care can get it.[433] Specifically, substance use, suicide risk, and adjustment problems (mental health problems caused by entering incarceration) occupy the mental health staff who are available, leaving other serious problems underdetected and undertreated.[434]

There are also system-wide barriers at the federal level including aging infrastructure and a corrections administration that has serious difficulties meeting mandated duties of care, including care quality standards, especially for older incarcerated persons.[435-437] The last 10 years have seen repeated audits and critical reports regarding the availability and quality of necessary mental health care, including suicide prevention, in the Canadian corrections system. The sustained recommendations of these audits have included

- creating intermediate mental health care units
- fully staffing mental health professional positions
- treating self-injury and suicidality as mental health rather than disciplinary problems
- heavily restricting the use of segregation.[438,439]

Notably, access to mental health care within youth detention has been similarly criticized as inadequate.[440,441]

Pharmacotherapy is widely recognized as playing a primary role — sometimes a monopoly — in corrections mental health care. Easy to administer, it is the predominant mode of treatment. In qualitative studies, incarcerated persons, particularly women, report experiencing pharmacotherapy as an intervention not to promote recovery but to manage behaviour.[442,443] In contrast, drug-seeking and

diversion are perennial security concerns, and clinical prescriptions can be questioned or discontinued by corrections staff on that basis. Other forms of therapy, like counselling, albeit not affected by this challenge, are made difficult to administer because of movements, lockdowns, long wait lists, short-term stays, and a lack of priority.[444,445] In shorter-stay provincial institutions, any programming available is also likely to be more "generic" and not gender- or culture-responsive.[446,447]

Community corrections and care

Much of the Canadian literature we reviewed focused on the re-entry of justice-involved people into the community, specifically after serving a custodial sentence. As re-entry is a high-risk time, research focuses on the danger of recidivism and the possibility of breaking anticipated cycles of recidivism, particularly for those with high-support needs (such as formerly incarcerated persons with mental illnesses). Recently, the CSC cultivated more robust linking strategies to services before and after release from federal custody and have published multiple evaluations of these initiatives. They include more robust pre-release planning models and community service partnerships, and this form of preparation can facilitate post-release engagement with care.[448-451] The case for support is often based on public safety and cost metrics.[452]

Formerly incarcerated people often return to neighbourhoods in highly disadvantaged areas, with their own threats to mental health recovery and risk factors for recriminalization.[453] Such circumstances can remain even for people who are successfully linked to services, since those services often cluster in the same neighbourhoods where people first encounter determinants of criminalization, such as networks of substance use, violence, and, for women, abuse and sex work.[454] These circumstances can contribute to the "revolving door" effect of rapid recriminalization for those with mental health problems or mental illnesses, especially if the restrictions on housing and employment that stem from having been justice involved make it difficult to remain engaged with treatment.[455]

Those transitioning from federal custody to community supervision may be housed in community correctional centres, which are residences operated by the corrections service for those on conditional release. Recent audit evidence indicates that these centres are not meeting the needs of residents with mental health problems because centres often lack adequate medical care staff (such as nurses), and parole officers are attempting to fill the gap but without specialized training.[456]

Those released on probation often receive ongoing forensic rehabilitation services to support reintegration, and these services may be paired with mental health care for those that need it. Under best-practice models used in corrections for guiding assessment and treatment (further described below), the level of criminogenic need and mental health impairment should determine the intensity of the services given and the level of coordination needed between corrections and mental health care providers. A recent review of Canadian probation services suggests that the system is not accurately matching probationer mental health needs to service levels, with low-risk probationers often sent to specialized services and high-needs probationers often lacking access to coordinated and justice-focused mental health care.[457]

Limitations and opportunities in the literature on access and experiences

The literature we reviewed on access to and experiences of mental health care in the criminal justice system can be characterized as a series of isolated fragments: case studies on the death of someone in custody, grounded theory, and phenomenological inquiries that chart the experiences of justice-involved individuals and inferences about experience in studies that indirectly touch on the question of experience.

Although much of this literature is informative and rigorous, there are two significant limitations in this sample of the literature. First, the experiences of justice-involved people who identify with one or more priority populations are largely absent. The perspectives of women as a group are sometimes explored, and while the experiences of FNIM persons can sometimes be inferred by the reporting of outcomes, it is usually with little context and rarely by creating space where FNIM persons speak for themselves. Except for one case study, the perspectives of racialized people in Canada is absent.[458]

The second limitation, which is also an opportunity, is the absence of well-constructed studies examining “patient journeys,” including “inmate-patient journeys,” to and through mental health care, or the absence thereof, in the criminal justice system. Such a perspective can emerge in inquiries into deaths, which can in turn generate recommendations for urgent reform. But studies combining a longitudinal approach with first-hand accounts of those with lived experiences would assist in creating a more proactive and systemic agenda for mental health care within justice and corrections contexts.

What Evidence-Based and Promising Practices Address Mental Health Needs in the Criminal Justice System and the Community After Release?

KEY FINDINGS

- MHCs and other forms of court-based diversion have been positively evaluated in Canada, though they continue to evolve and depend on the availability of appropriate mental health care resources in the community.
- DBT and CBT are evidence-based practices that can effectively address some mental health and criminogenic needs.
- Best-practice models for correctional mental health care exist, such as STAIR (screening, triage, assessment, intervention, and reintegration). However, they are not universally implemented in Canada.
- There is mixed evidence supporting a few different models combining mental health and criminogenic rehabilitation for those leaving custody, including risk-need-responsivity and assertive community treatment models and specialized probation. This is an active area of research and innovation.
- The best-practice approach to release and supervision planning is APIC (assess a risk/needs inventory, plan for a critical period post-release, identify the right services, and coordinate between stakeholders).
- Improving mental health care within justice and corrections may require recognizing that no one stakeholder group has the expertise, resources, and authority to act effectively on their own. Intersectoral collaborations such as Ontario's HSJCCs are developing promising models.

The literature identifies a range of evidence-based and promising practices that address mental health needs both within the criminal justice system and once justice-involved persons are released into the community. Many of these can be characterized as justice-specific versions of stepped care models developed in the community mental health care context.[459,*] The literature identifies evidence-based and promising programs for people with mental health problems and mental illnesses at each point of possible intersection with the criminal justice system, from diversion to release and reintegration. The evidence also revealed several systems-wide interventions that can be categorized as evidence-based and promising practices. These programs and practices are outlined below.

Mental health diversion and alternatives to incarceration

Diversion mechanisms, including specialty courts

Mental health diversion programs are designed to divert people with mental illnesses from the criminal justice system to community-based mental health treatment and other supports. Diversion programs are offered at various juncture points in the criminal justice process but may be broadly organized under

[*] Also see CMHA's stepped care model.

two categories: pre-charge (or pre-booking) diversion and post-charge (or post-booking) diversion programs.[460] Pre-charge programs involve diversion from the justice system before the laying of a criminal charge. Individuals are not charged with a minor offense but instead diverted to mental health treatment without further criminal justice involvement. In contrast, post-charge diversions applied after charges have been laid are generally contingent on an individual's agreement to enter treatment in the community to manage their mental health problems or mental illnesses. It is designed to divert those who commit minor offences, and who would otherwise receive no mental health services, out of custody and into appropriate treatment pathways.[461]

Three forms of post-charge diversion are identified in the literature: jail-based diversion, court-based diversion, or MHC (MHC).[*] Jail-based diversion programs (not used in Canada) are usually operated by jail liaison staff, who undertake mental health assessments and develop treatment plans for individuals in cooperation with community-based mental health service providers, in order to facilitate a bail release with the consent of the prosecutor, judge, and defense lawyer.

Court-based diversion programs employ mental health clinicians, who often work within the courthouse. They undertake assessments and, in negotiations with the prosecutor and defence counsel, develop a treatment plan to help secure a bail release for justice-involved persons with mental health problems. Cases are usually continued for a short period to ensure that the accused person is linked to services and is adhering to necessary treatment before charges are stayed or withdrawn. Diversion happens in multiple courts before multiple judges but occurs at the discretion of the prosecutor.

In contrast, MHCs are diversion initiatives in which the diversion process occurs in one specialized court with a dedicated docket. The judge, Crown attorney, and duty/defense counsel may have specialized training in working with people with serious mental illness and frequently work collaboratively, in conjunction with MHC liaison staff, to link justice-involved people to treatment and supports. "Accused" persons with a mental illness who elect to participate in an MHC are subsequently required to comply with an individually tailored treatment program designed by an MHC team, which may include any number or combination of justice and mental health professionals. These courts frequently monitor participant's adherence with treatment and the promise of dismissed charges is often used as an incentive. In a sense, such interventions ask the person to trade criminalization for access to mental health care or use the threat of criminalization to incentivize participation in care.

In Canada, diversion programs vary across jurisdictions, where in some cases, charges are stayed so long as a diversion plan is in place and, in others, a guilty plea is required for admission[†] to MHC.[462,463] MHCs in particular attempt to achieve a rehabilitative response to what would otherwise have been criminally sanctioned behaviour. The objective of MHCs is to address the underlying causes of criminal behaviour and to advance the philosophy of therapeutic jurisprudence.[464]

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[*] While the literature also identifies post-incarceration diversion programs, in the form of community corrections and forensic assertive community treatment, this section will focus exclusively on pre-incarceration diversion, since the evaluation of post-incarceration diversion was limited to one search result. Further, veterans courts are another form of specialty courts involving people with mental health problems mentioned in the literature, although no detailed evaluation of their operation or outcomes emerged in this review.

[†] This is also the case in some U.S.-based mental health courts (see Frank & McGuire, 2010).

EMERGENT OUTCOMES

Diversion initiatives, especially MHCs, are being evaluated with growing frequency and are often cited as a promising practice in the literature on interventions, which points to a series of factors and conditions necessary for diversion interventions to be successful. For some, diversion is successful when it goes beyond arranging for resources to provide treatment for mental health problems and substance use issues.

Jail-based diversion programs demonstrated high effectiveness in reducing recidivism and moderate effectiveness in reducing the number of days incarcerated and instances of substance use while increasing service utilization and quality of life.[465] Court-based diversion demonstrated moderate effectiveness in reducing recidivism, number of days incarcerated, and substance use while increasing quality of life.[466]

Reviews of MHCs have found that they reduce the risk of recidivism and criminogenic needs.[467,468] MHCs are most effective when they monitor and sanction compliance with recommended treatment and behavioural mandates and provide supportive services to reduce or remove at least some criminogenic, socio-economic, and environmental risks.[469] One review of MHC demonstrated high effectiveness in reducing recidivism and increasing service utilization, moderate effectiveness for reducing the number of days incarcerated and substance use and for enhancing mental health status.[470] A 2019 review, which focused on the processes and outcomes of MHCs, found that participants expressed high levels of satisfaction and feelings of fairness with the process and reported that they experienced low levels of perceived coercion.[471]

There is also an emerging literature examining the outcomes of Canadian diversion programs. Research conducted in Ontario and Alberta found very low recidivism rates for those who completed a program as well as reductions in charges, court appearances, and emergency health-care usage.[472] These results are echoed in a recent evaluation of Winnipeg's MHC. The evaluation found, since 2012, there has been a reduction of days in custody from 6.4 days per month to 2.8 days per month.[473] The evaluators also found that "the program retained a high proportion of clients, observed reductions in days in custody, and most participants saw reductions in charges" (p. 77).[474] In one Ontario-based evaluation of mental health diversion programs (including one MHC), interventions were found to be most effective for those with fewer clinical needs and the least serious criminal charges and criminal history.[475]

Existing evaluations have also identified that MHC positively impacts access to mental health support. In one report, defendants consistently obtained more treatment while participating in MHCs than they did before entry into the MHC and more treatment than similar defendants in traditional criminal court.[476] One pre-post study design of a Canadian MHC in N.B. found that it had a positive effect on recovery in terms of cognitive problems and rates of depression. These findings were consistent for both male and female participants.[477] An early evaluation of N.B.'s MHC found that those who completed it spent more time engaged with mental health care than they did in jail and were much less likely to be incarcerated than justice-involved people with mental health problems who did not appear before an MHC.[478] Another evaluation of this same MHC found statistically significant changes in terms of modest reductions in mental health and criminogenic needs relative to participants' functioning in the 12 months prior to their involvement in MHC.[479] Evaluation of another Atlantic Canadian MHC (now renamed a wellness court) in Dartmouth, N.S., found that the non-adversarial team case-management approach resulted in

treatment plans that better addressed substance use and responsiveness to criminogenic rehabilitation.[480]

Reviews of diversion programs emphasize four success factors: early identification of clients, integrated services through inter-agency and intergovernmental collaboration, regular meetings between service team members, and case-manager involvement across sectors (continuity of care).[481,482] The success of diversion programs is also dependent on the availability of "highly trained staff, a judiciary that is familiar with and supportive of this approach, and effective collaboration with health, mental health and community service providers" (p. 17).[483] These experts emphasize that a multidisciplinary, team-based approach must be standard, where the work of judges and lawyers is supplemented by psychiatrists, psychologists, and social workers who together determine how to best meet the needs of that particular individual.[484]

Comparable recommendations have been made specifically for youth, who are often referred to diversion programs as a preventive measure and early intervention — but are reluctant to participate. For example, a process evaluation of a youth MHC in Toronto found that engaging youth and families in treatment is effective at reducing recidivism, improving youth well-being, and enhancing community safety.[485] Additionally, the authors recommended four components that would make MHC programs more inclusive of youth populations: (1) "be highly structured and target individual skills and beliefs"; (2) "involve a cognitive component that addresses areas such as anger management"; (3) "engage families in treatment and seek to reduce family risk factors"; and (4) "address a variety of risk factors across several contexts" that may compromise treatment engagement (pp. 20-21).[486] It also concluded that youth would be more engaged if they had more input in their treatment, were given incentives to complete treatment (verbal or tangible rewards), and were able to communicate more frequently with treatment providers.[487]

THE CHALLENGES AND LIMITATIONS OF DIVERSION MECHANISMS

Although MHCs emerged in the late 1990s, there remain relatively few evaluations of these interventions and their impact, despite the large number of these initiatives across North America and internationally. A 2011 systematic review that focused on types of post-booking and post-incarceration diversion programs identified, described, and evaluated their effectiveness in terms of rates of recidivism, mental health service utilization, substance use, number of incarcerated days, quality of life, and mental health status.[488] This review concluded that no one method was highly effective in each category.

Evaluators and researchers remain cautious and critical of the application of diversion mechanisms and MHCs. Some reviews of MHCs have found that, because evaluations have only recently been introduced, they cannot yet demonstrate statistically significant reductions in recidivism.[489] For instance, critics have argued that diversion programs, including MHCs, are an expensive intervention that, due to strict eligibility criteria, support a small minority of people.[490,491] Others maintain that, at best, diversion programs offer potential access to community mental health resources, given that such resources are not always available in a timely manner and may not be suited to the specific needs of justice-involved persons.[492] Some conclude that "diversion" is successful in that it helps people avoid the legal system but critique it on the basis that it does not always help them enter the mental health system. One evaluation found that jail-based diversion programs offered limited effectiveness in increasing service utilization and no evidence to demonstrate enhancement of mental health status.[493] Another evaluation of an MHC found limited evidence to demonstrated improved quality of life.[494]

Despite the presence of co-operation agreements between the courts, remand centres, and mental health care systems, diversion mechanisms do not always successfully route people to the mental health care that meets their specific needs.[495,496] In more cases, people are connected to "status quo" mental health care and not to specialized services designed to also address criminogenic needs.[497] Some argue that MHCs do not actually reduce the marginalization of people with mental illnesses but instead promote a unique form of social exclusion that aims to control risky behaviours by rewarding individualized efforts (the promotion of self-regulation and participation in psychiatric interventions) in lieu of system reform.[498] Some reviews indicate that certain populations are inherently better positioned for success, where those who successfully complete a program tend to be older and have a lower mean number of clinical needs and significantly lower non-violent offence severity scores.[499]

The literature raises additional concerns regarding the ways in which diversion programs and MHCs are evaluated. Overall, the evidence that diversion programs reduce time in jail is stronger than the evidence that they improve symptoms or quality of life for justice-involved people with mental illnesses. The reason for this is that studies that evaluate the effectiveness of MHCs and other diversion initiatives, in Canada and internationally, tend to assess effectiveness based on justice criteria (such as reduced recidivism, less jail time) rather than on objective, clinical outcomes (such as reduced problematic substance use, less mental health service use) as assessment measures.[500] Further, the limited capacities and restrictive eligibility criteria for participation means that MHCs exclude a considerable number of people.[501] Some studies caution against establishing a "direct causal relationship" between MHC involvement and improved mental health outcomes, as those who exhibit "better functioning" are more likely to complete MHC programs (p. 499).[502] The authors identified "a limitation of [MHCs] is that none have made use of a theoretically and empirically based risk assessment instrument to aid in case management and treatment planning, nor do they draw from effective models of correctional rehabilitation" (p. 489).[503] Although those with greater need might have had a harder time finding service providers willing to accept them with criminal charges pending, some studies have found no empirical reason to restrict availability of diversion to those with the least serious offences and recommend expanding it, as there is no evidence that diverted persons charged with violent felony offences posed greater risk.[504]

The evidence is replete with recommendations that could improve processes and outcomes of diversion initiatives. For one, experts recommend that criminal behaviour among justice-involved persons with a mental illness is best reduced via programs that address the social determinants of health (such as homelessness, unemployment), criminogenic risk (such as criminal thinking and antisocial networks), and problematic substance use.[505] Others find that, in order to increase completion rates among those who have poorer mental health function, MHCs should develop "supervision and intervention protocols to more effectively respond to noncompliant cases, or consider persistent noncompliance as grounds for removal from the MHC" (p. 499).[506] It has been suggested that mental health literacy and sensitivity training is imperative for judges, first responders, and juvenile justice workers, so that they are better informed of diversion interventions and can make decisions that recommend people to them.[507] Other ways to improve completion rates and reduce recidivism include applying problem-solving measures such as being proactive, asking questions, and reaching out to service providers to create individualized court orders; engaging directly with defendants; ensuring that judges are aware of locally available services; requiring report-backs to discuss progress; allowing alternative sanctions for non-compliance; and using team-based, non-adversarial approaches (without compromising the defendant's interests).[508]

Interventions and care models for those in custody

Specialized programs and approaches
The literature also revealed some promising, specialized programs and approaches that have been implemented in Canada and in peer jurisdictions. Some of these are developed for and directed toward incarcerated persons, while others are directed toward staff who support people in custody. The programs typically developed by the criminal justice system focus on traditional criminogenic needs (such as antisocial attitudes, problem solving, or thinking styles). Another approach has been to adapt structured mental health interventions to justice-involved populations, with an emphasis on clinical features associated with criminality, such as frustration intolerance, underdeveloped social skills, and perceptions of living in a hostile or threatening environment.[509]

There are several, evidence-based programs and therapeutic approaches adapted for incarcerated persons with mental health problems or mental illnesses. One important example is the sequential intercept model, which aims to prevent further involvement in the justice system at various points (each arrow represents a potential point of intervention):

> law enforcement interactions → initial detention and court hearing → jails and courts → custodial sentences → community corrections and support (re-entry, probation, parole)[510]

For instance, the CIC recognizes and recommends the Peer Offender Prevention Service as a best practice for mental health support. Introduced in 2009 at Stony Mountain Institution, a multi-security institution in Manitoba, the service offers 24-7, confidential, peer-based crisis intervention for all security levels and populations. Three or four peer supporters are available at any given time and are typically incarcerated people who are trained to provide peer support by a variety of community agencies that educate them about working with those who experience trauma, anxiety, depression, and about suicide prevention and general mental health.[511] The CIC reports that the service has reduced self-harm incidents and the use of segregation with vulnerable prisoners.[512]

The most commonly adapted interventions are DBT and CBT, which the literature identifies as effective interventions for incarcerated persons with mental illnesses. Jails and prisons routinely receive people with histories of self-injurious behaviour and can thus play an important role in the implementation and sustainability of therapeutic interventions that can address the needs of incarcerated persons in this regard.[513,514] One qualitative systematic literature review that evaluates DBT in correctional and forensic settings worldwide highlighted its effectiveness in reducing recidivism. The evaluation indicated that emotion regulation and interpersonal skills are program elements that have been found to effectively address difficult-to-treat mental illnesses (such as borderline personality disorder [BPD]).[515] Others note that DBT is effective in populations with serious mental illness, particularly those with BPD. When combined with motivational interviewing, DBT can encourage engagement in treatment among people who otherwise lack motivation to be engaged.[516] Another study of the effectiveness of DBT in persons with BPD, which focused on those with a history of stalking offences, found that completion of the six-month program resulted in significantly fewer re-arrests for stalking, compared to those who did not finish the treatment and to published rates of recidivism for stalking.[517] One U.S.-based study evaluated the effectiveness of bibliotherapy — a form of self-guided CBT — in a population of incarcerated men.[518] Men incarcerated in jails and prisons showed a reduction in symptoms of depression relative to controls. Results were clinically significant for about half of those who participated, and they were able to

maintain this reduction over one month of follow-up.[519] CBT and DBT have also been adapted to address the high rates of non-suicidal self-injury among incarcerated persons, but some scholars remain critical of the context in which such interventions are implemented, highlighting the challenge of providing therapeutic services in an inherently non-therapeutic setting such as a jail or prison.[520]

A key area of focus in the literature on specialized programs is their effectiveness in addressing SIB and NSSI and suicidal ideation among incarcerated persons with specific mental illnesses. For example, emotion regulation group therapy, a 14-week treatment program, is one psychological intervention specifically tailored to those with BPD. This program highlights the "consequences of avoiding unwanted emotions and focuses on teaching emotion regulation, and reducing experiential avoidance and NSSI behaviors," and has been found to effectively reduce rates of SIB and NSSI among incarcerated persons (p. 43).[521] A retrospective population-based cohort study that used Canadian self-report prison records found that incarcerated persons who completed a suicide awareness workshop experienced a significant reduction in the incidence of self-injury.[522]

The literature also highlighted programs that have been developed to support priority populations by recognizing their unique needs and experiences within and outside the criminal justice system. One evaluation determined, through focus groups with incarcerated persons and institutional health-care providers, that a health clinic established for women incarcerated in a large, maximum security facility improved access to "comprehensive, gender-specific services in a timely manner" (p. 284).[523] Services included accessing medical and mental health care and identifying opportunities for support with housing, transportation, addictions, and experiences of partner violence upon release. Incarcerated persons who participated found program staff "knowledgeable and empathetic" (p. 284).[524] Conversely, although the program provided timely access to health care and addressed women's unmet health needs, it was not able to address the fragmentation of health-care services, including the administrative challenges associated with health insurance, provider disruptions, short-term facilities and programs, the lack of coordination among facilities, and a sense of being an "unwanted patient" (p. 287).[525]

The literature that addresses programming for priority populations tends to focus on FNIM populations. In particular, such interventions target SIB and NSSI among FNIM persons who are justice involved. A recent study found that culturally informed and culturally based interventions are paramount in reducing SIB and NSSI among incarcerated persons who are FNIM. A qualitative study, oriented around a series of focus groups with corrections staff and incarcerated FNIM persons with a history of SIB and NSSI, used a sharing-circle-based, culture-honouring model that gathered experiences while creating space for prayer, smudging, having medicines in the room, agreeing on rules, the participation of Elders, and the use of a feather as a talking stick.[526] The majority of justice-involved persons who participated described a history of trauma and abuse experiences in childhood and of family substance use. For most, SIB and NSSI predated their status as incarcerated persons and most commonly included cutting.[527] The authors conclude that the culturally informed approach opened up space within which to emphasize the unique experiences of FNIM persons who are justice involved and were disconnected from their culture by incarceration. The focus groups revealed shared views between staff and clients, who agreed on treating the whole person, not just the SIB or NSSI, establishing a "therapeutic alliance," and helping clients develop coping strategies. The sharing circle approach offered a non-judgmental and open environment in which clients could share their experiences but also reconnect with their culture.[528]

In the international context, some evidence exists to indicate the development and effectiveness of youth-centric and gender-responsive programming for incarcerated women. One such example is a U.K. program called Access, which is a psychological intervention to address incidents of SIB and NSSI among justice-involved youth. The program includes physical activity and self-esteem building, and addresses hopelessness.[529] A program in Hong Kong incorporated CBT and positive-psychology concepts to treat symptoms of anxiety and depression as well as criminogenic risk factors.[530] Moderate-to-high-needs women who were recruited to live in a specialized unit practised positive emotional skills with each other and through programming. The program identified reductions in anxiety and depression symptoms, about half of which were clinically significant (although there was no control group present).[531]

Models of mental health care provision

Models of care provision are meant to ensure that the health-care needs of justice-involved people are met while they are in custody, and that they are prepared for release and engagement with services upon release. In the literature reviewed, there is quite a bit of agreement about a series of minimum standards and best practices to ensure justice-involved persons have full and equal rights to care that is appropriate for their mental health needs in accordance with recognized standards.[532] The majority of this work, like that of other themes in this paper, focuses on the experiences of incarcerated persons. Most of these models emerge from the recognition that mental illnesses often remain undetected and, by extension, untreated in incarcerated persons.[533] Our review also found evaluations of a few models that have been specifically developed to implement best practices. Both perspectives are oriented around an interest in developing equitable, effective health care in correctional facilities.

Livingston's 2009 review of minimum standards and best practices in correctional mental health and substance use services remains an important milestone in synthesizing evidence on models of care.[534] The standards and best practices are derived from a human rights context and correctional principles but are also informed by the tension between clinical and security priorities in correctional institutions and upholding the principle that care should be equivalent in quality to that in the community. It divides a model of care into five elements:

- screening on intake and referral to assessment as needed
- treatment services, matched with levels of need
- suicide prevention
- transitional services before and after release from custody
- community-based services during supervision and reintegration[535]

Limitations of space prevent a comprehensive summary of the best practices detailed under this model by Livingston, and a reading of the handbook is recommended. The practices in general highlight a few elements of success that help define effective practice, noting that services should be

- provided across a continuum of intensity
- integrated within and between systems
- matched to individual levels of need
- responsive to diverse populations
- evaluated to generate evidence for improvement.[536]

In Canada, applied models of mental health care provision in correctional facilities vary considerably. Much of the literature we reviewed addressed what principles and standards ought to inform a model of care in correctional institutions. This is particularly relevant given that the needs of justice-involved persons and proposed standards of care in corrections systems can look very different when compared to their counterparts in the community. In short, it is recommended that for incarcerated persons, “essential services . . . include screening for mental disorders [sic] at reception, acute and nonacute treatment services, programs to meet their needs while in custody, and preparation for release and engagement with community mental health services on release” (p. 504).[537]

Many academic and policy experts argue that the model of care must include appropriate and relevant screening (conducted by a professional), assessment, and stabilization. When it comes to best practice in mental health care for justice-involved people in custody, the following interventions have been identified: screening, evaluation, and assessment; fully available mental health and addictions treatment that aligns with community standards; and planned community re-entry with links to care (collaboration and clinical expertise).[538,539] These are emphasized throughout the literature, both in general and for distinct and priority populations.[540]

Some scholars recognize that services are different for different populations, particularly when they pertain to short- and long-stay prisons. In shorter-stay prisons, these scholars recommend screening, assessment, and stabilization, with appropriate handover to community agencies, as the objectives. In longer-stay federal institutions, a full continuum of services must be provided.[541]

In terms of screening and assessment, some recommend that screening instruments are imperative for the justice system to be more equitable to incarcerated persons, because such instruments would provide corrections staff with the “necessary background knowledge to identify persons in custody [who] are at high risk of death or seriously adverse medical outcomes” as a result of a mental illness (p. 6).[542] Given that mental health care and treatment are not the primary focus of correctional facilities, staff members need training to recognize symptoms of a mental illness and signs of self-injury.[543,544] Some have recommended that a national strategy be developed for Canada to address mental health problems and mental illnesses, with a focus on better staff training (including de-escalation training), clinical management plans, the dissemination of best practices, and the development of specialized units to treat those who engage in self-injurious behaviour.[545]

Other studies focused on what should inform models of care for incarcerated persons with concurrent mental illnesses and addictions. Some found that treatment for mental illnesses and addictions ought to be integrated and holistic. When integrated, teams that address substance use, mental health, and primary health care would engage in co-locating services where possible, improving referral links and communication between providers, and making commitments to co-operative care with measurable outcomes.[546] When holistic, teams would offer low-level, flexible interventions (such as mindfulness), leverage the availability of peer mentors at transition points and make sure sufficient funds are allocated to ensure treatment is gender-responsive and trauma-informed.[547] At a systems level, these authors recommend setting up committees to address treatment for those with concurrent disorders.

Other literature that discussed models of care provision highlighted what aspects of mental health and mental illness were currently addressed in correctional facilities or in the criminal justice system more broadly. A report on CSC programs in 2008 indicated that they focused on violence prevention, emotion management, “reasoning and rehabilitation,” and substance use, and that mental health-specific

programming is offered to incarcerated women dealing with emotional and behavioural difficulties and basic skill deficits resulting from severe psychiatric disabilities (p. 44).[548] More recent reports and studies focus on the key concepts and principles that ought to be addressed. These are markedly different and include recommendations that facilities — and the system more broadly — examine and address the relationship between conditions of confinement (such as segregation and deprivation), the propensity for self-injurious behaviour, and the mental health impacts of use-of-force responses.[549]

Some specific models have emerged to enhance the justice system's response to mental illnesses in correctional facilities. In Canada, youth who are convicted of one in a short list of serious violent offences under the *Youth Criminal Justice Act* can be sentenced to intensive rehabilitative custody and supervision, which provides a sentence-long treatment plan and referrals. Eligibility is contingent on the presence of a mental illness diagnosis, affirmation of commitment to the plan, and court approval.[550] While the diagnosis and *Youth Criminal Justice Act*-specificity have been identified as promising, some raise questions about whether transfers to adult court and the cultural/gender validity of screening tools are a factor in access.[551] (In addition, there are other models directed at release and reintegration such as the APIC model, but as they are largely systems-level interventions, they are discussed in the next section.)

Most models of care provision have been developed to enhance the identification and detection of persons with mental illnesses who are incarcerated. The STAIR model — screening, triage, assessment, intervention, and reintegration — outlines what some maintain are the "essential requirements" needed in service provision in prison settings (p. 106).[552] The key components of the model are as follows:

- **Screening.** First stage: validated tools should be used to identify presenting issues that require immediate intervention and trigger referral.
- **Triage.** The individual's mental health needs and current level of functioning are assessed in detail, with triage to service.
- **Assessment.** Specialist evaluation.
- **Intervention.** This should be comprehensive, agile, culturally competent.
- **Reintegration.** The transition needs to be planned well in advance of release.

Some researchers have found that STAIR can address more common mental health problems, reduce demand on already overworked teams, and improve the well-being and rehabilitation of incarcerated persons.[553]

The international literature also highlights variability in care and models of care provision. In N.Z., the prison model of care (PMOC) has been applied to improve the identification of a mental illness in incarcerated persons and has been studied extensively. The PMOC divides the care pathway into five steps: screening, referral, assessment, treatment, and release planning. In one study of the implementation of the PMOC across five institutions, which moved from an in-reach team model to one underpinned by a multidisciplinary ACT model, although results were limited, they were positive — showing improved identification of needs and monitoring and modest uptake of services.[554] One study, which examined the efficacy of the first three steps found that referral led to a triage interview by an in-reach mental health nurse and then to a full psychiatric assessment. The authors conclude that such an outcome requires a strong collaborative effort between correctional health services and prison in-reach

mental health services.[555] In some instances, the PMOC has been adapted for priority populations in N.Z., specifically for incarcerated Aboriginal persons. However, the literature indicated that the effectiveness of those elements was limited because there were too few staff members available to prioritize screening and interpret symptoms in this priority population.[556]

Release, reintegration, probation, and parole

Client-focused interventions

The literature highlighted a suite of client-focused models for assessment and rehabilitation that are directed toward people with mental illnesses who are scheduled for release, reintegration, probation, or parole. Mental health care interventions for justice-involved people leaving custody or serving sentences in the community are often adaptations of or additions to rehabilitation programs that target criminogenic risk. In the past 20 years, several valid evidence-based or evidence-informed models have emerged for risk assessment, but experts note that few of these support planning for effective intervention.[557] In response to this gap, several new models have emerged, which not only contribute to the development of predictive risk instruments, but also offer guidance on effective treatment for justice-involved people. The literature recognizes the RNR model, ACT, FACT, and FICM.

RISK-NEED-RESPONSIVITY MODEL

The RNR model is often recognized as the most influential model to include both risk assessment and approaches for effectively treating justice-involved people. It has been recognized as a leading example of evidence-based practice because it is linked to the real human service needs of clients.[558] The RNR model comprises three core principles:

- **Risk.** Assess the risk factors for re-offending and matching their intensity to a level of service.
- **Need.** Base treatment goals on the specific needs of the person that have caused them to commit offences.
- **Responsivity.** Deliver treatment in a way that takes into account the learning style, motivation, identities, abilities, and strengths of the person.[559,560]

The RNR model recognizes that criminogenic risk factors are multiple and include individual characteristics (such as antisocial cognitions, attitudes, and behaviours) and socio-environmental factors (such as family supports or lack thereof, marital problems, negative peer influences, schooling and/or employment problems, and a lack of leisure or recreational opportunities). RNR principles have been applied to the “management” of justice-involved persons with a mental illness who are under supervision in the community corrections system. Through RNR simulation models, researchers have yielded positive results in reducing recidivism.

In RNR models, mental illnesses are treated as “responsivity” variables and are recommended for inclusion to ensure clients engage with treatment, potentially making access to mental health care subsidiary to RNR model applications.[*] The framework posits that the degree of coordination between criminal justice and mental health systems should be determined by the individual’s criminogenic needs and their degree of functional “impairment.” In this framework, probationers with a mental illness receive a supervision and treatment plan jointly developed by correctional and mental health staff.

[*] Compare Guebert and Oliver (2014).

Should there be an increase in criminogenic needs and risk, it is matched by progressively more intensive correctional supervision. From there, it is recommended that “higher levels of functional impairment [be] matched with intensive mental health treatment [and] increases in service intensity . . . necessitate greater coordination and integration between mental health and correctional services” (pp. 76-77).[561]

Although RNR research has yielded positive results, experts recognize that much of the success hinges on the availability of appropriate services, program integrity, and completion rates of program participants.[562] Others suggest that, although RNR seems to be suitable for both adults and adolescents, adolescent-specific needs are different from those of adults and therefore should be incorporated into programs for adolescents, particularly in the case of DBT programs.[563]

ASSERTIVE COMMUNITY TREATMENT MODELS

ACT is also a promising practice for individuals with severe mental illness who are leaving custody through release and reintegration or probation or parole. ACT is a suite of intensive and multidisciplinary treatment, rehabilitation, and support services designed for those who may struggle or find it challenging to engage in typical mental health services. ACT aims to guide individuals through their recovery and support them in living in their community.[*] The literature reveals that ACT has had positive outcomes for justice-involved individuals with moderate-to-severe mental illness who are leaving custody, but it also outlines some remaining challenges. There is some evidence to suggest that when ACT includes formal supervision, it can have a positive impact on rates of recidivism. This finding held true in the international context as well as in the Canadian context.[564] Some experts conclude that traditional ACT models may improve engagement with mental health treatment and support symptom reduction but remain skeptical of their ability to effectively keep persons with mental illnesses out of the criminal justice system.[565,566]

A Danish randomized controlled trial of ACT for psychosis with an early diagnosis used criminal records to evaluate outcomes and found that the intervention did not reduce the risk of conviction, including for violent offences.[567] Another article that examined the effects of structured clinical interventions on recidivism rates among people with mental health problems and mental illnesses indicates uncertainty on the effectiveness of ACT for reducing recidivism, although the authors found ACT to be effective in treating serious mental illness.[568] Some point out that, despite their potential, it is difficult for structured interventions and specialized programs to effect positive change on recidivism rates, primarily due to chronic underfunding.[569]

To overcome these challenges, some scholars recommend enhancing ACT to include criminogenic risks, an extension to the model that has become known as FACT and FICM. FACT and FICM demonstrate limited but promising bodies of evidence. They are different from ACT in that the goal is to prevent re-arrest, receive referrals from local jails, incorporate probation officers into teams, and organize supervised residential components for those with severe mental illnesses and substance use

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[*] An ACT team provides psychiatric treatment and medication support, helps individuals access and maintain access to community services, and supports them in activities of daily living. By and large, ACT teams are multidisciplinary, comprising nurses, occupational therapists, psychiatrists, peer supporters, addiction specialists, and/or social workers who ensure that support is available 24-7.

disorders.[570] Such interventions help ensure that those leaving correctional institutions have access to basic goods and services, with important instrumental supports for housing and employment.

SPECIALIZED PROBATION

In addition to the RNR, ACT, FACT, and FICM models, specialized probation is frequently cited as a promising, client-centric model for people with mental illnesses. Despite variation in operations, such as case-management style, structural characteristics, and implementation of treatment mandates, there are common features across specialized probation programs: the protection of public safety and the rehabilitation and recovery of clients.[571] Research demonstrates that parole and probation officers (POs) who exclusively managed cases of probationers with a mental illness were better able and equipped to develop effective strategies and routines to do this work and to develop/implement supervisory protocols for responding to specific problems of this population.[572] When compared to "standard" POs, specialty POs self-identified as having "substantial" training in mental health and were more likely to rank themselves as being "very effective" at reducing short-term risk of violations and at improving probationers' mental well-being.[573] Specialty POs were also more enthusiastic about and better equipped for resource integration and coordinating care with community treatment providers and social services agencies. Furthermore, they were more likely than standard POs to create teams and take an active role with other agencies.[574] In interviews, justice-involved persons expressed different perceptions of specialty POs compared to standard POs. They found that POs who managed standard caseloads were more likely to attribute a person's justice involvement to individual factors such as lack of social skills. Further, justice-involved persons felt that specialized POs were more likely to report that the purpose of parole was to facilitate access to mental health services. Studies that solicited the perspectives of probationers themselves found that they viewed probation as a second chance, but that they still experience the program as frustrating because it offers limited help and support with basic needs while inflexibly maintaining excessive expectations.[575]

A U.S. study that compared probationers' experiences of three kinds of probation practice, using a validated quantitative instrument and qualitative interview data, concluded that specialty mental health probation had better relationship scores than standard probation, but that MHC team-based probation had the highest scores.[576] Probationers' experience was that the MHC team-based probation created more co-operative and trusting relationships between POs and clients because it has a "multirelational" structure, with co-operative case handling among a team of specialists. Notably, the better relationship scores were not because POs mandated less authoritative or more permissive probation conditions, but rather because they were more transparent in sharing the duties and sanctions handled by the PO.[577]

In addition to the probationers' experiences, some of the literature considers the effects of specialty probation on public safety. One longitudinal observation-based study tested whether specialty probation yields better public safety outcomes than traditional probation by comparing outcomes for both groups of probationers. At the outset, traditional probationers' odds of re-arrest were 2.68 times higher than that of specialty probationers. At the two-year follow-up stage, the estimated likelihood of re-arrest for traditional probationers was 51.8 per cent and just 28.6 per cent for specialty probationers.[578] The authors attribute these differences to, as indicated above, the smaller caseloads specialty POs have, the relationships specialty POs are able to cultivate with their clients, and the more direct participation specialty POs have in their clients' treatment plans and compliance rates.[579]

OTHER MODELS AND PROGRAMS

In Canada, supportive housing models have been implemented to support reintegration. Many of these have been housing-first models. In the well-studied At Home/Chez Soi project, one-third of those who participated were justice involved. Although effective in maintaining housing tenure, studies found it was not effective in preventing further criminal justice involvement.[580] Some experts have recommended, to address this challenge, that such programs incorporate a criminogenic lens.[581]

In addition to these models, other person-centred, community-based models have been proposed in the Canadian and international contexts. In Canada, many of these models are designed for justice-involved persons from FNIM communities. One exploratory investigation found, over the past few years, that there has been an increase in the proportion of justice-involved FNIM persons being granted mental health-related conditional releases.[582] A presentation discussing programs and services for FNIM women in Ontario's correctional facilities highlighted three programs — First Voice, Understanding the Journey, and the Healing Journey — and found that these programs are likely to assist with successful reintegration.[583] In order to either support Aboriginal women in charting a path not inclusive of prison or reduce their recidivism when released, traditional methods such as the healing lodge, the medicine wheel, emotional freedom techniques, responsible activity therapy, and storytelling are being used effectively. Through these approaches, FNIM women are empowered to take pride in their culture and language, which has positively impacted their mental health and general well-being.[584]

In the international context, the critical time intervention (CTI) model has been effectively used in the U.K. with groups of justice-involved persons with serious mental illnesses. CTI involves a three-step process that pairs the person with a designated CTI worker to develop individualized treatment planning based on connections with community-based service providers, monitor service plan implementation and adjustment, and transfer care and supervision to long-term community supports.[585]

The literature also highlights a range of evidence-based and promising practices in mental health care that have been effectively adapted to reduce recidivism in those leaving custody. One such example is recidivism-focused CBT, which addresses criminogenic needs while supporting the individual in developing interpersonal skills and accepting community standards. One study highlighted four comparable recidivism-focused programs, each of which reduced recidivism in justice-involved populations, albeit not those with a mental illness.[586] Each program was designed to help justice-involved persons problem solve and develop or enhance their capacity for cognitive processing and/or moral reasoning.[587]

System-focused interventions

Just as evidence-based interventions in institutions must be supported by a rational and strategic model of care, promising programs for reintegration and community care also need to be similarly supported. Livingston et al.'s 2008 review of best practices in mental health care for justice-involved people includes the following elements of successful community reintegration and supervision:

- ongoing screening
- the prevention of parole revocation, including incentives to comply and graduated responses to breach
- a specialized case management model (such as FACT or FICM, discussed above)
- specialized mental health caseloads for probation and parole officers[588]

The best-practice approach to release and community-supervision planning is known as the APIC model:

- Assess by creating a risks/needs inventory.
- Plan by identifying critical periods and preparing clients, such as by supplying adequate medication until followupfollow-up with primary care providers and preparing benefits reinstatement.
- Identify the right services in the community relevant to the client's needs.
- Coordinate, ensuring implementation of the plan by connecting with stakeholders and averting gaps in care.

Implementing something like the APIC model is the responsibility of the government body supervising the client. For example, the CSC has recognized that neither pre- nor post-release interventions alone ensured consistent engagement with either mental health or rehabilitation treatment. This engagement lowers rates of hospitalization, substance use, reincarceration, and death and so represents a key intermediate outcome. Findings regarding the need for wrap-around planning are similar in established programs internationally, in the U.K. and Australia.[589]

In Canada, the federal corrections system has been pursuing implementation of wrap-around planning for some time, though there is an absence of independent evaluation evidence regarding quality and effectiveness. Since 2005, the CSC has run a community mental health initiative (CMHI) that has two components: clinical discharge planning and referral to community mental health services for those leaving custody. They conducted a preliminary evaluation of its effectiveness in 2010 and a full evaluation in 2014 but with the sole outcome of interest being a reduction in recidivism, using police and CSC data. The evaluations found that connections to community mental health services, which would often include ACT adapted to address criminogenic needs, were effective at reducing recidivism, but that clinical discharge planning was not. The evaluators recommended including housing assistance and service brokering in the CMHI model, but it is not known yet whether these have been incorporated and to what level of success. [590,591]

An evaluated program from Ireland provides an international comparison to the CMHI. This evaluation of the pre-release planning program in the Irish prison service identifies the same driving factors behind system reform: fragmented community services and a critical high-risk period following release from custody. The program used security of housing tenure and engagement with mental health support as its outcomes, as well as recidivism (via re-imprisonment data). It included family supports and follow-up on care handover via a telephone support line. The evaluation found improved rates of connection to mental health care and improved housing outcomes but little or no reduction in re-imprisonment risk.[592]

Some provinces have developed community transition programs for those leaving provincial custody that have a mental health or addictions services focus. B.C.'s transition teams project focuses specifically on opioid use disorders. In our sample of the literature we found no current evaluations of the effectiveness of these programs.[593,594]

Upgraded planning processes for people with a mental illness leaving custody depend upon community resources, including support with education, employment, housing, and child care, and their success is influenced by the availability of those resources and the willingness of those who administer them to engage with clients who have histories of justice involvement. Women can have higher release-planning needs than men, and those who have served lengthier sentences may have lost family connections and other safety nets.[595,596]

Intersectoral collaborations
Improving mental health care within justice and corrections may require recognizing that no one stakeholder group has the expertise, resources and authority to act effectively on their own. Depending upon the specific situation addressed, these collaborations and alliances can take one of several forms. In some cases, health care in corrections — both in institutions and the community — is exploring more effective team-based multidisciplinary strategies that recognize the importance of independent clinical expertise. To reduce the overrepresentation of people with mental illnesses in the criminal justice system, governments are recognizing the need for inter-ministry collaborating bodies, and stakeholder groups are convening their own networks to make change. MHCs and correctional models of care that make use of multidisciplinary teams would also be examples of intersectoral collaboration.

There are many calls for this collaboration and reviews of best practices for how such collaborations might work. However, there are fewer empirical evaluations of how such collaborations have worked in practice.[597] For diversion strategies, such as MHCs, Livingston et al.'s 2008 review of best practices lists the following elements of successful interagency and intergovernmental collaboration:

- ensuring continuity across institutions through boundary-spanning experts (especially care providers licensed to operate in multiple venues, such as jail and hospital)
- regular stakeholder meetings
- locating leadership and accountability within the team
- establishing a case-finding procedure that emphasizes early identification
- standardized training on mental health issues and increasing the awareness of options for diversion and treatment
- public investment in community resources[598]

The latter can be a significant determining factor in the success of MHCs and similar programs. Outcomes can depend on the availability of social determinants of mental health such as housing and employment or income support, making community partnerships crucial.[599] Dewa et al. (2012) also published a review of success factors in Ontario court-support programs, modelled as collaborations between mental health and criminal justice sectors, which add to the above list:

- mental health support providers making space for themselves in local court systems through partnership and education
- taking the time needed to overcome the inherent tension between mental health and justice, using specialized training to help team members understand each other's perspectives
- learning to provide mental health services to a broad population, including those with comorbid substance use and behavioural challenges
- public investment in service coordination among hospital and court and community resources.
- anti-discrimination initiatives including incentives, education, and, if necessary, sanctions[600]

For health care in custody, a preferred option by many stakeholders is to transfer authority and budget from authorities responsible for the administration of corrections to ordinary health authorities in the jurisdiction. In Canada, provincial health authorities already manage forensic mental health care services (though the review boards remain part of the justice system), and these services are already important partners in emergent psychiatric care in some provinces.[601] The arguments in favour of integrating

health-care system professionals in corrections are multiple. They include greater experience with managing and innovating health-care systems, better morale, and less professional isolation for health professionals working in corrections, the potential for a more seamless approach for patients that follows them through transitions, and the necessary independence of clinical decision making from matters of discipline or institutional security.[602-607,*] Several jurisdictions in Canada are at some stage of negotiating such partnerships or transitions, but up-to-date information on the exact models being implemented is not covered in our sample.

HSJCCS IN ONTARIO

In Ontario, a collaborative inter-ministry model has been operating since 1997 in the form of HSJCCs, which have provincial, regional, and local committees with representatives from the ministries of health, attorney general, solicitor general, community safety, and correctional services, as well as police services and service providers supporting individuals with mental health problems, addictions, developmental disabilities, fetal alcohol syndrome, and acquired brain injury involved in the justice system. The local and regional committees operate as planning tables, bringing together justice professionals and human service providers to coordinate services across sectors and develop solutions to identified gaps and needs for individuals with special needs across juncture points within the criminal justice system. The provincial-level committee supports the collective efforts of regional and local committees, promotes a consistency of approach across the province (while acknowledging regional diversity), identifies provincial services and policy issues, and prepares policy recommendations for government on improvements to services and process at the juncture of justice involvement and human services. The provincial committee also promotes knowledge sharing through a biannual conference, which acts as a community of practice for professionals in both the justice and broader health domains, and through a website that includes a resource library and descriptions of projects undertaken by local, regional, and provincial committees.[†] For now, this model seems to be unique to Ontario, though similar initiatives may be in the early stages elsewhere.

Community justice centres (CJCs) may be an emerging model of service co-location and delivery, combining justice functions with access to health and social services with an aim to both improve public safety and offer wrap-around access to services for vulnerable populations who are at risk of involvement with the justice system. Specifically, CJCs are viewed as a potential response to the disruptive cycle of short-term provincial incarceration and homelessness experienced by vulnerable people, including those with mental illnesses. They would be operated provincially, and three are being planned in Ontario, but as of yet no service model regarding how the disciplinary teams would interact has been published or evaluated in Canada.[608]

Limitations and opportunities in the literature on evidence-based and promising practices

In a recent review of the literature on mental health and justice involvement, McCormick et al. (2015) identified a conceptual split between clinical studies extended to cover justice-involved people as a special population, and RNR literature that considers mental health to be a possible factor in addressing

[*] For evidence from the U.K., see Awofeso (2010).

[†] For more information, consult the human services and justice coordinating committee at hsjcc.on.ca.

recidivism. For the first type of study, the overrepresentation of people with mental illnesses in the justice system is an unsolved problem. Such studies inquire into the prevalence, risk, and reasons for mental illnesses in this population. For the second type of study, mental health is only relevant insofar as specific symptoms interfere with criminal rehabilitation or pose criminogenic risk.[609]

This perhaps simplified schema helps to interpret the literature we reviewed as a whole, particularly on interventions, programs, models of care, and policies. It is both a limitation and an opportunity that mental health care plays this dual role — sometimes overlapping, at other times in conflict — in the treatment of justice-involved people. Both "pure" mental health interventions (based exclusively on the right to care) and those tied to rehabilitation can suffer from barriers to access and low acceptability or perceived quality, particularly among those in custody.[*]

Further research is needed to understand what factors influence success in implementation for evidence-based and best-practice models, including acceptability and intrinsic desirability to clients and adaptations to justice and correctional environments — both by mental health care models and by institutions and existing programs.

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[*] Compare Cross et al. (2012) and Simpson and Jones (2018).

What Principles and Concepts Should Inform the Development of Programs and Policies Tailored to Justice-Involved Persons?

KEY FINDINGS

- Current and former justice-involved persons do not receive care comparable to their counterparts in the community.
  - They regularly face barriers to high-quality mental health care, such as having limited clinical treatment programs, suitable therapeutic environments, and practitioners with the specialized skill sets and competencies to support them.
- Correctional institutions across the country are experiencing a severe shortage of mental health care professionals.
- The mental health care professionals in place struggle to secure or maintain the decision-making autonomy that would ensure they can best meet the needs of those who access their services.
- Integration between correctional and non-correctional health care is critical to reducing interruptions in mental health care between the system and the community.
  - Affordable and supportive housing is essential in this regard, ensuring that people can continue on their recovery journey.
- FNIM people who are justice involved benefit from access to treatments, programming, and supports that are culturally safe and responsive to their specific needs; justice-involved women benefit from gender-responsive programming.
- Recovery, therapeutic jurisprudence, and procedural fairness have been identified as approaches that have positive outcomes for justice-involved persons.
- Canadian jurisdictions need to make significant progress toward system reform, including restrictions on the use of segregation and integration between the health and justice sectors.
- Investments in community mental health care services are essential to ensure they are accessible and adequately equipped to support justice-involved clients, while linking to wrap-around services and supports.

Health-care parity and equivalence

Parity is the notion that mental health should have equal status with physical health and should be valued proportionately and equitably within health-care systems. In the context of mental health care in the criminal justice system, parity of care has two important elements: first, a quality health-care standard equivalent to that found in the community; second, ensuring that medical decisions with respect to mental health are taken independently of decisions regarding corrections and the administration of justice.

The literature consistently reiterated recommendations that the health (including mental health) care services incarcerated individuals receive be on par with those delivered to their counterparts in the

community.* Thus, parity means that mental health recovery not be eclipsed by criminogenic needs in rehabilitation planning and be recognized as a human right on its own.[610] These recommendations are grounded in the right to equivalence of care — a component of the United Nations General Assembly's *Basic Principles for the Treatment of Prisoners*, a resolution adopted and proclaimed in 1990.[611] However, some jurisdictions may encounter system-level barriers that hinder their capacity to adopt or achieve the principle of care equivalence on a national level. In these jurisdictions, including Canada, health-care provision in many correctional facilities is within the jurisdiction of provinces and territories. This results in a mosaic of health-care provision arrangements that are carried out in the absence of national quality standards.[612,613]

The literature on equivalent quality of care for justice-involved people aligns with one of two areas of focus. The first pertains to the challenges incarcerated persons encounter with care delivery that compromise the likelihood they can or will access high-quality mental health care.[614] For example, the CIC indicates that the CSC finds it challenging to address the needs of women who chronically engage in self-injury, given the lack of clinical treatment programs or suitable therapeutic environments.[615] In such instances, women are transferred to provincial forensic custody. While this has led to significant improvements in overall mental health functioning, it raises the point that transfer should not be a substitute for treatment.[616] Such challenges have been identified in correctional facilities in Ontario and are attributed to alarmingly low health-care standards relative to the community and to high vacancy rates in corrections-based health-care positions.[617]

IN CUSTODY

Studies and reports underline this problem by noting that, even with the most serious of intentions for reform, corrections systems do not specialize in designing and administering contemporary health care.[618] This notion of creating an integrated health-care system that serves people in custody, as well as those in the community, was also recognized as a promising solution in the Canadian context — not only because the principles of care in the correctional setting would align with those in the community, but also because health ministries, not justice systems, would be responsible for the mental health care of incarcerated persons.[619,620] In N.S. and Alberta, responsibility for health care has been transferred from justice to health ministries, which seems to be resulting in improved continuity of care as well as reduced costs and rates of recidivism.[621] In the U.K., the *National Service Framework for Mental Health* aimed to address these challenges by emphasizing the importance of an integrated mental health strategy that concurrently addresses incarcerated persons and the community.[622]

Ensuring and maintaining quality of care also requires consistent record keeping of health care indicators.[623] Not only does this include recording the proportion of incarcerated persons who access pharmacological treatments and/or psychotherapy, it also includes recording their perceptions of how fairly or equitably treatments are delivered and the efficacy of those treatments. In addition, it means qualitatively and quantitatively accounting for prison-specific environmental factors — incarcerated persons' self-harm rates and experiences of assault, exposure to environmental hazards, levels of daily physical activity, and engagement in education, employment, and vocational training[624] — all of which are necessary in holistic health care. One way of proactively identifying risks in prisons is to reinforce safety measures that address the needs of incarcerated persons who are at risk of developing a mental illness or are experiencing an increase in symptoms of their existing mental illness.[625] Administrators and

* Compare Cross, et al. (2012) and Simpson and Jones (2018).

correctional officers in prisons need to be cognizant of the signs of a mental illness in their surroundings and "take an active role in observing and controlling the milieu" (p. 25).[626] The literature also recommends educating correctional staff about self-injury among incarcerated persons such that staff are equipped to associate self-injury with underlying and often unaddressed mental health issues.[627] As identified in the literature, a key priority area to enhance quality of care in prisons is to ensure correctional staff receive training in crisis intervention and de-escalation techniques, so they can better identify incarcerated persons at risk of experiencing mental health emergencies.[628] Cross-training between mental health and corrections staff within institutions can build mutual respect, knowledge transfer, and improve practice in this area.[629]

IN THE COMMUNITY

The second element of the literature in this area explores the lack of adequate and accessible community mental health care services, especially those with the specialized skills to accept justice-involved clients (which contribute to keeping them out of custody).[630] Those who want better care for justice-involved people must also advocate for reinvestments both in community mental health supports and psychiatric beds.[631] Here, integration is also pertinent, for it has been proposed that team-based approaches with shared case files and co-located services may ensure that those supporting justice-involved clients with mental health problems or mental illnesses actively work together to provide wrap-around supports. Improved linkages between the corrections system in Canada and community mental health services is considered a significant recent accomplishment. It is possible that such connections could work to improve the capacity of mental health services to accept justice-involved clients while intervening at a critical point and helping them avoid reincarceration.[632]

Independence of clinical care standards

Clinical decisions must be made independently of disciplinary or security decisions, and this should be reflected in the structure of justice and corrections organizations that may encounter people with mental health care needs. In its most recent report, the CIC and others recommend that the independence of clinical care is paramount, and that correctional institutions can achieve it by separating health care and prison administration from a personnel and budgetary perspective.[633] Yet, the independence of clinical care has been an ongoing area of concern in federal and provincial correctional systems.

Independence of clinical care means, for example, not having health-care staff in a correctional institution report to correctional administrators while making decisions regarding the appropriateness of force, restraint or segregation, or about the need for advanced, specialized, or emergent health care.[634-636] However, clinical independence has been flagged as a continued concern, particularly in the federal corrections system, because the responsibilities of health-care workers are often concurrently straddling the realms of health-care provision and the administration of disciplinary measures.[637]

The importance of the independence of health-care providers was identified by expert commentators on recent amendments to Bill C-83, which amended the *Corrections and Conditional Release Act* to, among other things, eliminate the use of administrative segregation and disciplinary segregation. Ivan Zinger, for example, noted that the bill would "entrench in legislation the clinical independence and autonomy of prison health-care professionals. This measure would effectively mean that clinical decisions could not be overruled or ignored by non-medical prison staff" (para. 7).[638]

The notion of distinguishing between medical treatment and the physical use of force to prevent crises in correctional facilities is highlighted in the reviewed literature. The CIC makes note of a CSC policy that cautions against considering the use of restraints as a medical treatment. Instead, the policy regards the use of restraints as a "'reportable' use of force" subject to applicable procedural safeguards, including monitoring during the entire period restraints are used (p. 15).[639] In April 2019, the Ontario Court of Appeal ordered the federal government to establish a review of solitary confinement independent of prison administrators.[640] Despite this policy, some experts find that national direction and oversight is lacking with respect to the frequency and appropriate use of physical restraints in regional treatment centres,[641] and that amendments to Bill C-83 did not fully address the lack of oversight necessary to ensure that discretion is properly used and still does not "adequately safeguard the independence of prisoners' health services" (para. 3).[642]

Clinical independence is recognized as one of several key principles for any proposed model of correctional health services. The recent independent review of Ontario corrections, *Corrections in Ontario: Directions for Reform,* emphasized the need for clinical independence, concluding that "health care professionals can operate and provide services independently within the public safety and security context of a correctional setting" (p. 215).[643]

In order to maintain the independence of clinical care without negatively influencing attempts to establish care integration, the CSC has been gradually developing a client advocate role to ensure that incarcerated persons' needs are not overlooked.[644] To this end, some researchers have considered the voices of incarcerated persons when it comes to clinical independence. Existing research demonstrates that justice-involved people notice and value clinical independence, or clinician autonomy, in both emergency and non-emergency situations.[645] A study that investigated "patient-inmate" perspectives on psychiatric services in prisons determined that clinician autonomy is critical in ensuring that supplementary services — group sessions, advocacy, and the fostering of interpersonal and social connectedness — are delivered in a way that best meets the needs of those who access psychiatric services in prison.[646] This study concludes that, when clinician autonomy is compromised or rendered non-existent, clinicians are unable to provide tailored and person-centred services, which makes any services irrelevant to the material and immaterial needs of persons who need them the most.[647]

Continuity of care

Continuity of care means that clinical relationships, psychotherapy, counselling programs, and access to medication should follow people through transitions and not be interrupted for non-clinical reasons. The literature affirmed the importance of the continuity of care principle when transitioning into custody, between institutions in custody (including to and from hospital), and into the community (from custody or hospital). While care continuity during transitions from custody is typically discussed as a consideration in preventing the re-emergence of symptoms of mental illness and to reduce recidivism, care continuity during transitions from mental health-related hospital stays is discussed as a way to prevent contact with the criminal justice system.[648-650]

To ensure continuity, correctional health care should be integrated with the overall health-care system — particularly in provincial and territorial institutions where people serve short sentences or are on remand.[651] Some experts maintain that integration would enhance the health and well-being of justice-

involved individuals inside correctional facilities and ensure care continuity in the community. Continuity is expected to not only improve the health outcomes of justice-involved individuals post-release, but also to have economic benefit.[652-654] Nevertheless, the reviewed literature identified the existence of inherent operational and infrastructural barriers that compromise the effectiveness of intersectoral work, such as the need for health-care workers to obtain clearances to visit correctional facilities and the risk of unexpected denials or disruptions.[655] Other researchers point out that a lack of care continuity in the community for justice-involved individuals with mental illnesses leads to circumstances where their mental health and well-being are at risk of deterioration when communities lack the appropriate resources for ongoing treatment and support.[656]

The reviewed literature prioritizes care continuity in the community after release from custody.[657] An important first step is to organize housing for individuals leaving custody.[658] Most experts recognize housing as a form of care and identify housing as the biggest single factor in a successful transition to the community. Justice-involved individuals themselves also care most about securing housing, as it maintains their contact with care, granting them a chance to avoid the poor relationships and habits that may have contributed to their incarceration in the first place.[659]

Another consideration for post-release continuity of care entails screening for mental health risk and needs and providing treatment options accordingly.[660] The literature indicates that post-release care continuity is particularly important to prevent the relapse of symptoms in youth transitioning into the community from custody.[661] Population-based administrative data of correctional facilities in Ontario from 2010 to 2012 indicated that young people with mental illnesses entering the corrections system had very low contact with community health services and were often receiving mental health care for the first time while in custody.[662] This indicates that the lack of care continuity in the community may put those living with severe mental illnesses at a higher risk of incarceration.

Reconciliation and equity

Mental health care in justice and corrections should recognize the structural factors that influence the lives of people who become justice involved, including abuse related to intergenerational trauma, experiences of sexual and physical abuse shaped by gender and patriarchy, and community problems arising from racial and colonial oppression. Awareness of the dimensions of these problems is relatively strong in the literature we reviewed, but some marginalized groups are more visible than others, and much less of the literature was actively engaged in grappling with what these differences might mean in terms of structuring mental health care and justice policy.

It is consistent with previous reviews of this literature to note that women and FNIM persons, as groups, are much more studied in the literature than IRER or LGBTQ2+ populations.*

Culturally safe programming

The literature consistently highlighted the need for culturally informed and responsive mental health programming. Such programming, which is informed by an understanding of the experiences and barriers faced by priority populations, and aims to address stigma and improve perceived and actual care quality, can increase the uptake of mental health care in correctional facilities.[663,664] In the Canadian

* Compare Schizophrenia Society of Ontario (2012).

context, the importance of culturally responsive programming is pronounced when considering the experiences of incarcerated FNIM persons. In 2012, the Schizophrenia Society of Ontario found that, often, incarcerated FNIM persons are "forced to choose between culturally sensitive programming or ability to stay close to their community and maintain family ties," due to scarce services being geographically spread out (p. 23). The lack of culturally informed programming responsive to the specific needs of racialized groups or FNIM persons in the criminal justice system is not exclusive to Canada. In Australia, where there is also an overrepresentation of Aboriginal incarcerated persons with a mental illness in correctional facilities, recommendations have been made to work with Aboriginal communities to ensure that diversion programs are culturally informed.[665]

The CIC indicates that the CSC continues to face challenges in accommodating and responding to diversity in the criminal justice system.[666] However, despite the growing awareness — among researchers, policy makers, and justice system experts — of the issues specific to incarcerated FNIM persons and, despite making recommendations to address their unique needs, challenges persist in Canadian correctional facilities. The CIC's 2008-09 annual report suggested appointing a deputy commissioner for Indigenous corrections to address the specific concerns of FNIM persons incarcerated in federal correctional facilities. This appointment would also entail developing and implementing FNIM-specific programming that incorporates healing plans and Elder assessments to a greater extent.[667] Further, the CIC recommended developing a national diversity awareness training plan to ensure correctional staff receive the necessary training in cultural competency, diversity, and sensitivity awareness.[668] Another recommendation was to develop an ethnicity liaison officer role at each correctional facility, responsible for addressing the specific needs of incarcerated persons who are racialized.[669] In 2013, the CIC suggested identifying incarcerated persons with severe mental illness, having external health experts review their cases, and developing health-focused treatments for them. Overall, these recommendations are expected to ensure that incarcerated persons who are racialized have access to culturally responsive treatment, which has been shown to reduce recidivism and their overrepresentation in correctional facilities.[670]

As noted, the CSC implemented its Aboriginal Justice Strategy to address the overrepresentation of FNIM persons in the federal corrections system. However, one recent anti-oppression critique of the AJS in relation to FNIM women concluded that it has not been effective in reducing justice involvement because it does not address the structural factors of criminality in some communities, namely poverty, violence, sex work, mental illnesses, and addictions.[671]

In addition to the AJS, a number of measures have been implemented to better identify and meet the needs of a more ethnoracially and culturally diverse population of incarcerated persons. The CSC has evolved its organizational structure to support this work. It has struck diversity committees (national and regional ethnocultural advisory committees, a national advisory council on diversity, a national diversity committee); added cultural programs and awareness activities; launched sensitivity and diversity training; and developed staffing initiatives aimed at increasing the representation of employment equity groups (targeted recruitment, a diversity and employment equity committee, and mentorship and leadership programs).[672]

Gender-responsive programming

The reviewed literature also emphasized the need to ensure that assessment and treatment programs in correctional facilities are gender-responsive, which they must be to be effective. When developing risk-

need-responsivity care models, trauma-informed practices are encouraged, given the recognition that trauma is a risk factor (and a primary care factor) for women's criminalization.[673] The literature suggests that programs ensure a focus on increasing an internal locus of control and establishing safe interpersonal connections.[674] It also suggests that risk-need-responsivity models can work effectively with both women and men if gender-responsive elements are included. Nevertheless, screening tools, staff training, and treatment models need to be validated separately with women to overcome the inappropriate and overuse of diagnoses such as BPD and the lack of recognition of internalizing disorders.[675] Overall, the literature indicates that integrating gender-specific and trauma-related considerations when developing assessment and treatment strategies for incarcerated individuals is likely to enhance the effectiveness of rehabilitation programs.[676] In turn, this is likely to result in a reduction in recidivism and prevention of the initial involvement with the criminal justice system.[677]

Recovery

Recovery is not a novel concept in the mental health literature.[678] Rather, it is an approach that underpins and guides contemporary mental health services throughout the world.[679] According to the literature, involvement with the criminal justice system is a barrier to recovery or rehabilitation among homeless individuals with severe mental illness (such as major depressive disorder) and problematic substance use (such as alcohol use disorder).[680] However, once individuals with a mental illness are incarcerated, recovery continues to be an essential goal of programs delivered to them. This concept was found to be particularly important for justice-involved youth with mental health problems, as it engenders the conditions through which youth can receive care and develop effective coping strategies for ongoing symptoms in an effort to maintain a meaningful life in their communities and set goals for the future.[681] The literature identifies several principles to be considered when developing recovery-centred mental health treatment programs:[682]

- a sense of connectedness to supportive networks
- a belief in hope and trust in the essence of a recovery process
- trust in oneself to overcome stigma
- a sense of purpose and meaning in life
- a sense of control over one's life[683]

Together, these five principles constitute a framework often referred to as CHIME (connectedness, hope and optimism, identity, meaning and purpose, and empowerment).[684] Additionally, a multidisciplinary Canadian stakeholder report identifies two other principles to inform care models for justice-involved individuals with mental illnesses. These principles involve ensuring, on a conceptual level, that services have a recovery orientation and emphasize a productive and positive relationship between public safety and recovery.[685]

Therapeutic jurisprudence and procedural fairness

Therapeutic jurisprudence is an interdisciplinary approach to reform that seeks to positively impact the mental health and well-being of justice-involved individuals.[686] It means to uphold the relationship between crime and punishment but recognizes that jurisprudence should consider individuals' mental

health problems and their capacity to influence the experiential dimension of sentences, particularly given the conditions of confinement.[687] Across the literature, researchers and experts emphasize the importance of this principle, particularly because the philosophy dominating the criminal justice system tends to favour public safety and security in a way that contradicts therapeutic approaches.[688] In practical terms, the CIC recommends that front-line security staff exercise approaches that facilitate therapeutic responses, rather than escalating security responses to address criminality that inherently results from unmet mental health needs.[689,690]

Systemic reform

The notion of systemic reform, as indicated in the reviewed literature, is grounded in an emphasis on the need to acknowledge structural deficiencies in the correctional mental health care system. This is recommended to administrators who are advised to understand the mental health vulnerabilities of incarcerated persons with self-injurious behaviour.[691] However, even when individuals with a mental illness encounter the criminal justice system, the literature indicates that the barriers to support further complicate the mental health of justice-involved persons. The following paragraphs highlight the specific areas of the criminal justice system where reform recommendations were emphasized in the literature.

Restriction of segregation and isolation practices
Concerns are frequently expressed in the literature regarding the prevalent use of solitary confinement in Canada for individuals with mental health issues. In such instances, the literature recommends limiting and even terminating segregation practices while investing resources for in-person family visits and recreational programs.[692,693] Additionally, and when solitary confinement is necessary, administrators should ensure daily visits by a mental health professional to assess the person’s tolerance to being in isolation.[694]

Transparency and accountability
According to the CSC, the mental health strategy promises plans to address priority areas, though these have not been made public.[695] This raises transparency concerns, particularly in a climate where prisons are failing to meet required human rights standards.[696] In such instances, the literature recommends that the courts hold correctional authorities accountable.[697]

Integration and coordination between sectors
Recommendations for an integrated system that focuses on the specific needs of justice-involved persons, not the metrics of the departments, have been emphasized for justice-involved youth.[698] Overall, the literature recognizes a need for the enhanced coordination of services for individuals with mental health issues.[699]

Although there is no one ideal model to enhance coordination and co-operation between sectors, the CIC suggests

- developing partnerships between the corrections system and provincial hospitals
- increasing the use of community providers
- facilitating the transfer of specialized services to health-care authorities in the provinces.[700-702]

These suggestions are said to enhance the way health services are delivered in correctional services in Canada and have been shown to improve treatment response among incarcerated persons with serious mental illness.[703,704]

To achieve an effective integration between the criminal justice system and the health-care system, a report on the recommendations in a meeting of key stakeholders identified several guiding principles.[705] These principles allude to the importance of ensuring data consistency, transparency, and information sharing (via cross-ministerial panels) to deliver holistic individualized services and address risk factors to prevent interaction with the criminal justice system.[706] Undoubtedly, the complexity of designing coordination and co-operation between the criminal justice system and health-care system must be acknowledged. However, the literature finds value in such investments in terms of reducing recidivism, enhancing the well-being of individuals with serious mental illness, and reducing costs.[707]

Summary: What Do We Know and What Do We Need to Know?

Overall state of the research: Strengths and weaknesses

We have reviewed a large sample of the literature that addresses our research questions, published (for the most part) over the past 10 years in both academic research and public policy. The scope of the potential readings on the topic is very broad, and given the time available, we cannot claim to have examined the literature exhaustively. However, many of the strengths and weaknesses identified below are mirrored by other recent reviews on this or similar topics, which gives us confidence that we can end this review with a credible representation of the state of the topic and the areas where interested researchers may look next.

In November 2014, health, social and legal professionals, academics, and people with lived experience as a justice-involved persons with mental health problems or mental illnesses came together for the National Research Agenda Meeting on Mental Health, Justice, and Safety to identify research priorities related to the intersection of the mental health, criminal justice, and public safety system. The following areas were identified as needing further research by the concurrent review and consultation process:

- On prevalence and risk, there is a lack of longitudinal and comparative data in Canada. We don't know enough about interprovincial differences and profiles of mental illnesses that stretch across different domains of justice involvement (such as community corrections, jail, and prison).
- On correctional models of care, we still lack gold standards for treatment models that include alternatives to segregation and effective training models for staff.
- On institutional governance and reform, we lack knowledge on the efficacy and cost-effectiveness of policies and practices surrounding mental health and justice issues.
- On recovery and public safety, we need to know more about the relationship between recovery and public safety, the best housing and supportive services models, and how to measure and evaluate the recovery orientation of services.
- Finally, on data collection, we need to build platforms for data sharing and pooling our national data.[708]

Our findings confirm and expand on those of Crocker et al.'s 2015 review. In Canada, our sample of the literature is skewed toward those who are in custody and, within that sphere, toward those held in federal institutions. There is a strong likelihood this is due to a combination of sampling features — with federally incarcerated persons being a relatively time-stable, and a literally captive, population of potential research participants — and formal mechanisms of transparency. The federal government's corrections system has both a robust in-house research service and an independent watchdog producing detailed, high-quality reports.

Information on provincial and territorial populations in custody tends to be visible in the literature to a degree correlated with population, with Ontario and B.C. predominating in the English literature. The parameters of our study, which excluded studies published in languages other than English, likely limited

our ability to examine Quebec-based studies, and this represents an important future area of review. Areas of the country with very serious rates of incarceration, such as the prairie provinces and the territories, are nearly absent in our sample. There are no shared standards on what and how provincial and territorial governments should report regarding justice-involved populations. Some exceptions, such as Ontario's reporting on segregation, are the result of specific court orders imposed on the government.

For in-custody populations (in particular federal ones), there is a relatively high quantity of prevalence information on mental illness diagnoses and symptoms, self-injury, suicidality, and impairment. As noted in the section on prevalence, sample quality and definitions vary considerably, with an overreliance on convenience samples such as admission cohorts and volunteer responses from non-random survey distribution. For justice-involved populations that are not in custody, there is far less current Canadian data available. Study of these populations tends to focus either on in-depth, qualitative examinations of personal experiences or on program evaluations. Regarding prevalence and risk, the need for services and care continually outpaces access.

The literature is comparatively strong on examining the determinants of criminalization for people living with mental illnesses, a reflection of the long-term concern with the issue. Critical perspectives of the justice system and its treatment of mental illnesses are robust. However, there are distinct differences in the amount of attention paid to the experiences of priority populations. There is a relatively strong literature on the specific experiences of women, in terms of how their mental health needs differ from those of men, the determinants of their justice involvement, and the need for gender-responsive programming. The overrepresentation of FNIM persons in the Canadian justice and corrections systems also surfaced in the literature, along with some discussion of culture-responsive and culture-honouring interventions. The context of colonialism and structural racism is often accepted as a fact but less often explored substantively in terms of mental health.

In our sample of the literature, there is a stark absence of attention to racialized groups such as Black or Asian Canadians with respect to mental health in the justice context. This gap persisted after additional, more specific searches of the literature were added during the analysis. The reasons are not fully clear within the scope of this project, and any explanation would be speculative. There is a well-established research finding that some ethnic and cultural groups are much less likely than others to seek out or accept referrals to mental health care.[709] However, that would seem to make research exploring their experiences more, rather than less, valuable. We were also unable to locate any current relevant research on LGBTQ2+ Canadians, either as a group or on experiences at the intersection of mental health, justice involvement, gender, and sexuality.

We reviewed many sources that evaluated promising practices or described evidence-based and best practices regarding mental health care models and specialized interventions. This remains a lively area of research but with a core of well-accepted findings on effective therapy — if people can access it. What is missing from our sample are robust studies of scaled up and broad implementation for these promising practices. This absence, however, is likely not due to a lack of interest on the part of researchers and advocates, but rather because many of these practices remain nascent.

In general, it could be said in the Canadian context, and to some extent internationally, that there is significant agreement on many dimensions of the nexus between mental illnesses and criminal justice involvement, and a healthy body of knowledge regarding options for moving toward better, healthier outcomes. However, the nature of the justice and corrections systems — along with an underlying

scarcity of community mental health resources — makes charting a path forward difficult. Many voices seem to be missing from the conversation.

Specific recommendations for further research and policy

As in the previous section, we are expanding on recommendations recently explored by mental health and justice stakeholders and published by Crocker et al. in 2015. That paper sets out the following as an agenda of challenges to be studied and overcome. They recommend that Canadian jurisdictions

- support families caring for loved ones who experience mental illnesses or mental health problems and become justice involved
- support community mental health services dealing with aggressive behaviour and offering coordinated services that address mental health needs and criminogenic risks
- establish a consistent, high-quality standard of specialized resources for mental health in correctional settings, one that is separate from substance use and suicide prevention, has alternatives to segregation available, and is shared between institutions and jurisdictions
- have a unified model of care and discharge planning that spans the culture gap between corrections and mental health services in the community
- address inadequate reintegration, including through promoting inclusive community mental health services for those with forensic histories, safe and adequate housing, support services, specialized mental health probation caseloads, a boundary spanning liaison role, and improved intersectoral communication
- address the stigma of justice involvement and mental illness in the media and public discourse.[710]

We conclude this report with three areas where further research and thought leadership may be especially constructive, based on our reading of the recent literature. The first is the development of longitudinal studies of justice-involved populations with mental health problems and mental illnesses — particularly the majority who are not imprisoned federally on long sentences — that can reliably track their experiences as they traverse the criminal justice system. Such studies could follow participants as they move in and between the contexts of custody, supervision, rehabilitation, recovery, housing, and homelessness, and could use purposeful, high-quality sampling techniques. The scale and scope of such research may in turn necessitate research, alongside supports to create more enduring and engaged relationships between researchers and participants. Such relationships would increase researchers' understanding of the pathways and barriers to care at various juncture points in the criminal justice system.

The second area is the development of a collective impact model for mental health recovery in the so-called "revolving door" population of low-intensity, frequently justice-involved people with complex mental health needs and housing instability. Collective impact relies on having many stakeholders agree on a single measurable vision — often a single outcome — and negotiating among themselves on how each can contribute to effecting change using their own resources, strengths, and values. Often a single foundation, or a facilitating organization, stewards the coordination of the collective impact, and these models might be both adapted and replicated for each province or territory. Correctional facilities repeatedly house people who are unable to follow bail conditions for essentially minor offences due to

mental health problems, and the reform of practices around bail and bail supervision should be part of this collective impact agenda.[711]

The third area is to more systematically explore the perspectives of mental health care users who are justice involved. This would combine promising (but preliminary) evidence of program effectiveness with collaborative research that can address questions about acceptable care standards, overcoming shame and stigma around mental illnesses, preventing the victimization of people within the justice and corrections system, and mapping pathways to services and supports from the perspective of user needs, thereby creating a bottom-up answer to the sequential intercept model. This move would facilitate the sharing of knowledge and promising practices aimed at meeting the care needs of people with mental health problems and illnesses in the justice system and minimizing their future involvement in this system. It would also ensure that the needs and preferences of individuals within the justice system inform the provision of recovery-oriented services and supports.

Conclusion

In Canada, a disproportionately high number of people with mental health problems and mental illnesses interact with the criminal justice system. Not only do they experience higher rates of criminalization as a result of their mental illness, once they become justice involved, they also experience barriers to equitable, safe, culturally safe, and gender-appropriate mental health services, as well as post-release stigma and the risk of reincarceration. Those incarcerated due to their justice involvement are at risk of a decline in their mental health as a result, regardless of whether they have a diagnosis of mental illness or problematic substance use.

In conducting this rapid scoping review, our objectives have been to

- report on literature that accounts for the rates at which people with mental illness and/or mental health problems are involved in the justice system and to identify how these rates compare across priority populations in Canada
- identify what the literature indicates about services and supports currently identified as best practices for justice-involved persons with mental illnesses and/or mental health problems
- determine what the literature concludes about barriers this population experiences when working to meet their mental health needs, highlighting evidence of disparities among priority populations
- report on evidence-based concepts and guiding principles that experts recommend be incorporated into the design and implementation of mental health services and programs for justice-involved individuals.

We found widespread agreement that the criminal justice system has become an inappropriate mental health "system" of last resort, if not a system of care, then a system of management. Research on this topic in Canada has focused on people in custody and — secondarily — on how to keep people from entering custody. There is less information about how the standards of detention themselves may be responsible for declines in mental health, the role of trauma in the mental health-criminal justice connection, and whether it is preferable to separate mental health care needs from criminogenic risks.

Because the problem is widely recognized, but with contested boundaries, models of practice — both in justice and health care — are lively with innovation. Many promising practices have produced preliminary evidence that they may be effective at addressing mental health care needs for justice-involved people. However, the diversity of approaches — and the difficulty of scaling up best practices — are partly the result of an absence of consensus on a society-wide response to the central issue of overrepresentation.

Throughout the research for and the writing of this report, we endeavoured to the greatest extent possible to read this literature through the lens of intersectionality to meaningfully account for the experiences and needs of justice-involved persons. As many justice-involved persons living with mental health problems and illnesses are likely to identify with one or more priority populations, members of these groups face additional barriers and unique challenges where programs and services are concerned. Because models of mental health and illness are deeply touched by identity and culture, this is an area where adopting an intersectional viewpoint via the secondary literature is especially complicated, and there is a pressing need for new voices to be included in the conversation.

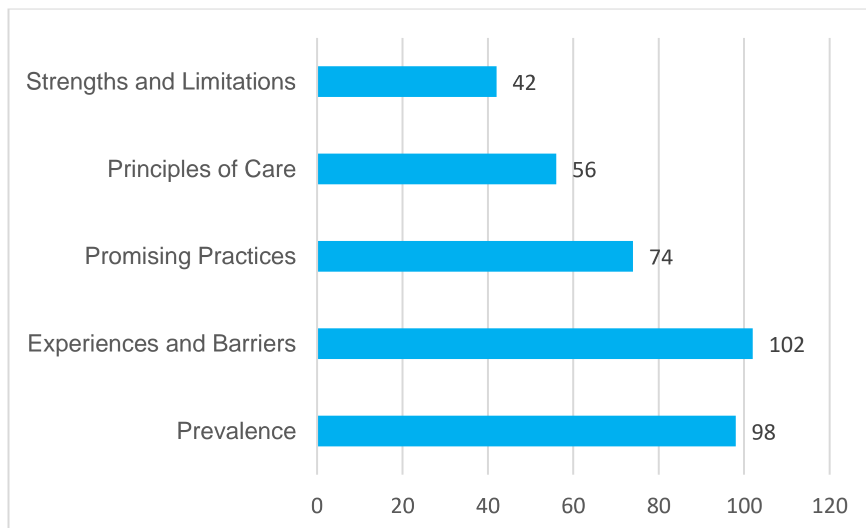
The Canadian and international research and policy literature indicates that there are several priorities and principles that, if addressed, could engender the conditions for a recovery-oriented system that does not compromise the mental health and justice outcomes of justice-involved people. Mental health care is not accessible unless it is delivered in environments consistent with the principles of human rights, justice, and public safety. At all entry and transition points, continuity and consistency in care are paramount. For justice-involved persons with mental illnesses and mental health problems to meaningfully benefit from mental health care and programming and reintegrate into the community with the possibility for promising outcomes, mental health must be accounted for proportionately and equitably in the criminal justice system. The time is right for everyone with a stake in this issue — researchers, policy makers and decision-makers, people with lived experience, and justice-involved people and their loved ones — to envision and enact a collective approach.

Appendix: Data Charting Tables

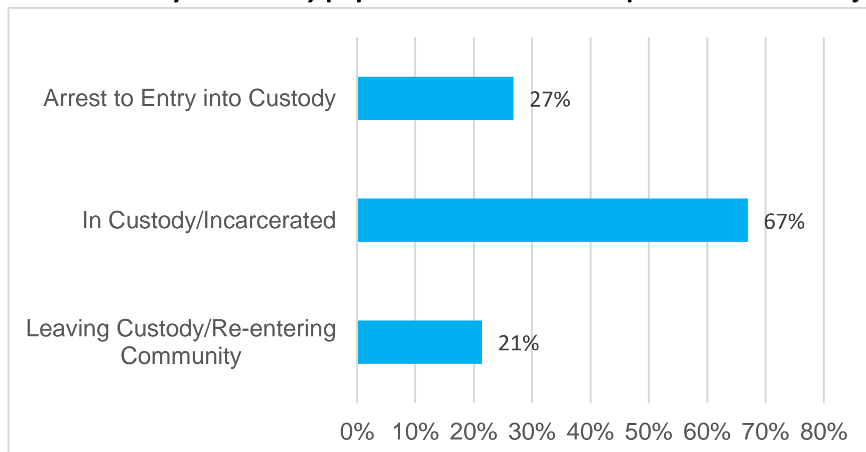
Met basic inclusion criteria for acquisition (English search results)	765
Excluded at first title/abstract review (not relevant to research topic)	-373
Excluded at second title/abstract review (did not directly address a research question)	-163
Number of fully reviewed papers	**229**

The following charts illustrate how the papers reviewed addressed the relevant dimensions of the review. In all cases, the number of papers reviewed will not add up to 100 per cent because many addressed more than one dimension of research.

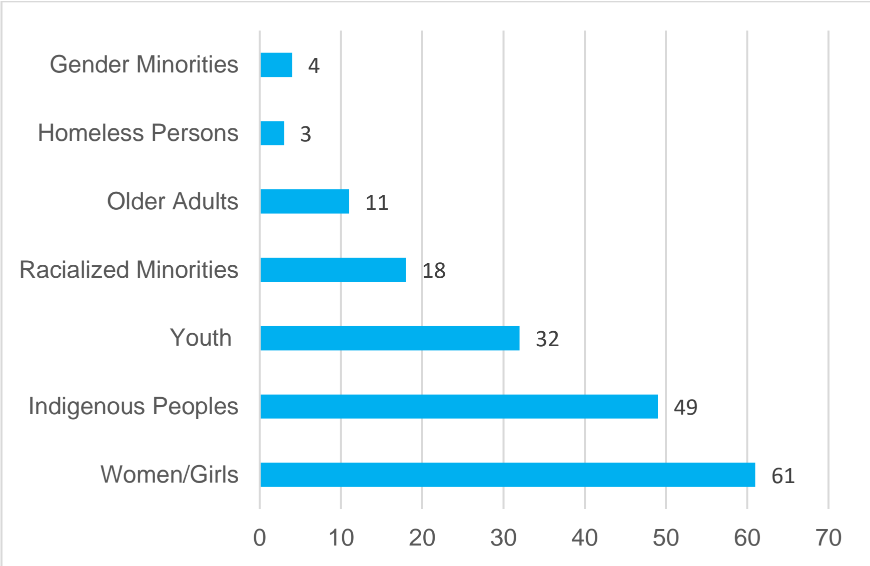
Breakdown by how many papers addressed which research questions



Breakdown by how many papers addressed which phases of criminal justice system involvement



Breakdown by how many papers addressed which populations of special interest



References

[1] Chaimowitz, G. (2012). The criminalization of people with mental illness [Position paper]. *Canadian Journal of Psychiatry, 57*, Insert 1-6.

[2] Cotter, A. (2014, April 23). Firearms and violent crime in Canada, 2012 (Cat. No. 85-002-X). *Juristat.* Statistics Canada. https://www150.statcan.gc.ca/n1/pub/85-002-x/2014001/article/11925-eng.htm#archived

[3] 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,* 205-217. https://doi.org/10.1080/14999013.2015.1073197

[4] Simpson, A. I. F., McMaster, J. J., & Cohen, S. N. (2013). Challenges for Canada in meeting the needs of persons with serious mental illness in prison. *Journal of the American Academy of Psychiatry and the Law, 41*, 501-509.

[5] Schneider, R. D. (2015). *The mentally ill: How they became enmeshed in the criminal justice system and how we might get them out*. Department of Justice Canada. https://www.justice.gc.ca/eng/rp-pr/jr/mental/index.html

[6] Schneider, R. D. (2015). *The mentally ill: How they became enmeshed in the criminal justice system and how we might get them out*.

[7] Schneider. (2015).

[8] Simpson, et al. (2013). *Challenges for Canada in meeting the needs of persons with serious mental illness in prison.*

[9] Correctional Service Canada. (2019). *Health services.* https://www.csc-scc.gc.ca/health/index-eng.shtml

[10] Correctional Service Canada. (2017). *Health services.* https://www.csc-scc.gc.ca/politiques-et-lois/800-cd-eng.shtml

[11] Schizophrenia Society of Ontario. (2012). *Provincial correctional response to individuals with mental illnesses in Ontario: A review of the literature.* https://www.schizophrenia.on.ca/SSO/media/SOO/PolicyAndAdvocacy/Papers/Provincial-Corrections-Literature-Review-Final-March-2012.pdf

[12] Schizophrenia Society of Ontario. (2012). *Provincial correctional response to individuals with mental illnesses in Ontario: A review of the literature.*

[13] Simpson, et al. (2013).

[14] Flegel, K., & Bouchard, F. (2013). Let us get prison health care out of jail. *CMAJ, 185*, 281. https://doi.org/10.1503/cmaj.130149

[15] Trach, N., & Mardon, A. (2016, October 27). Looking at mental health courts: Should Alberta pursue them? *Law Now, 41*(2). https://www.lawnow.org/looking-at-mental-health-courts-should-alberta-pursue-them/

[16] Provincial Court of Alberta. (2020). *Mental health court.* https://albertacourts.ca/pc/areas-of-law/criminal/mental-health-court

[17] Provincial Court of British Columbia. (2020). *Specialized courts.* https://www.provincialcourt.bc.ca/about-the-court/specialized-courts#VictoriaIntegratedCourt

[18] Dupuis, T., McKay, R., & Nicol, J. (2013). *Current issues in mental health in Canada: Mental health and the criminal justice system: Background paper* (Publication No. 2013-88-E). Library of Parliament. https://lop.parl.ca/sites/PublicWebsite/default/en_CA/ResearchPublications/201388E

[19] Baba, S. (2018, February 6). Canadian developments in alternative sentencing: Mental health courts (Part 2) [Blog]. *McGill Journal of Law and Health*. https://mjlh.mcgill.ca/2018/02/06/canadian-developments-in-alternative-sentencing-mental-health-courts-part-2/

[20] Slinger, E., & Roesch, R. (2010). Problem-solving courts in Canada: A review and a call for empirically-based evaluation methods. *International Journal of Law and Psychiatry, 33*, 258-264. https://doi.org/10.1016/j.ijlp.2010.06.008

[21] Ontario Ministry of Health and Long-Term Care. (2006). *A program framework for: Mental health diversion/court support services.* http://www.health.gov.on.ca/en/common/ministry/publications/reports/mentalhealth/mentalhealth.aspx#reports

[22] Hall, N., & Weaver, C. (2008). *A framework for diversion of persons with a mental disorder in BC*. https://cmha.bc.ca/wp-content/uploads/2016/07/DiversionFramework.pdf

[23] Alberta Health Services. (2018). *Provincial mental health diversion program: Service operating requirements.* https://www.albertahealthservices.ca/assets/info/amh/if-amh-pmhdp-service-operating-requirements.pdf

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

[25] Chaimowitz, G. (2012). *The criminalization of people with mental illness.*

[26] Dupuis, et al. (2013). *Current issues in mental health in Canada: Mental health and the criminal justice system: Background paper.*

[27] Delveaux, K., MacDonald, C., McConnell, A., Bradley, S., Crawford, A. & Tse, F. (2017). *Evaluation of CSC's health services* (File No. 394-2-96). Correctional Service Canada. https://www.csc-scc.gc.ca/publications/005007-2017-eng.shtml

[28] Correctional Service Canada. (2019). *Health services.*

[29] Correctional Service Canada. (2019). *Health services.*

[30] Correctional Service Canada. (2019). *Health services.*

[31] Correctional Service Canada. (2019). *Mental health strategy.* https://www.csc-scc.gc.ca/publications/005007-3043-en.shtml

[32] Department of Justice Canada. (2018). *Aboriginal justice strategy.* https://www.justice.gc.ca/eng/rp-pr/aj-ja/fs09-fi09.html

[33] Office of the Correctional Investigator. (2020, January 21). *Indigenous people in federal custody surpasses 30%: Correctional investigator issues statement and challenge* [Press release]. https://www.oci-bec.gc.ca/cnt/comm/press/press20200121-eng.aspx

[34] Mental Health Commission of Canada. (2012). *Changing directions, changing lives: The mental health strategy for Canada*. https://www.mentalhealthcommission.ca/sites/default/files/MHStrategy_Strategy_ENG.pdf

[35] Mental Health Commission of Canada. (2016). *Advancing the mental health strategy for Canada: A framework for action (2017-2022).* https://www.mentalhealthcommission.ca/sites/default/files/2016-08/advancing_the_mental_health_strategy_for_canada_a_framework_for_action.pdf

[36] Alberta Health. (2017). *Valuing mental health: Next steps.* https://open.alberta.ca/dataset/25812976-049c-43c9-9494-77526c6f6ddd/resource/684600a3-a0ea-440c-a053-38a4cef83de9/download/alberta-mental-health-review-next-steps-2017.pdf

[37] Stockdale Winder, F. (2014). *Working together for change: A 10-year mental health and addictions action plan for Saskatchewan.* Saskatchewan Health Authority. https://pubsaskdev.blob.core.windows.net/pubsask-prod/99244/99244-Mental_Health_and_Addictions_Action_Plan_Full_Report.pdf

[38] Government of Ontario. (2011). *Open minds, healthy minds: Ontario's comprehensive mental health and addictions strategy.* http://www.health.gov.on.ca/en/common/ministry/publications/reports/mental_health2011/mentalhealth_rep2011.pdf

[39] Alberta Health. (2017). *Valuing mental health: Next steps.*

[40] Government of Manitoba. (2011). *Rising to the challenge: A strategic plan for the mental health and well-being of Manitobans.* https://www.gov.mb.ca/health/mh/docs/challenge.Pdf

[41] Government of Newfoundland and Labrador. (2017). *The way forward — Towards recovery: The mental health and addictions action plan for Newfoundland and Labrador.* https://www.health.gov.nl.ca/health/mentalhealth_committee/mentalhealth/pdf/mentalhealth_addictions_plan.pdf

[42] Nova Scotia Department of Health and Wellness. (2017). *Together we can: The plan to improve mental health and addictions care for Nova Scotians.* https://novascotia.ca/dhw/mental-health/reports/Mental-Health-and-Addictions-Strategy-Together-We-Can.pdf

[43] Yukon Health and Social Services. (2016). *Forward together: Yukon mental wellness strategy 2016-2026*. http://www.hss.gov.yk.ca/pdf/mentalwellnessstrategy.pdf http://www.hss.gov.yk.ca/forwardtogether.php

[44] First Nations Health Authority, British Columbia Ministry of Health, & Health Canada. (2013). *A path forward: BC First Nations and Aboriginal people's mental wellness and substance use – 10 year plan.* https://www.fnha.ca/Documents/FNHA_MWSU.pdf

[45] Government of Manitoba. (2011). *Rising to the challenge: A strategic plan for the mental health and well-being of Manitobans.*

[46] Government of New Brunswick. (2017). *New Brunswick family plan: Supporting those with addictions and mental health challenges*. http://www2.gnb.ca/content/dam/gnb/Departments/eco-bce/Promo/family_plan/mentalhealth.pdf

[47] Government of Prince Edward Island. (2016). *Moving forward together: Mental health and addiction strategy.* https://www.princeedwardisland.ca/sites/default/files/publications/peimentalhealthaddictionsstrategy_moving_forward.pdf

[48] Government of Manitoba. (2011). *Rising to the challenge.*

[49] Mental Health Commission of Canada. (2016). *Advancing the mental health strategy for Canada: A framework for action (2017-2022).*

[50] Alberta Health. (2017). *Valuing mental health.*

[51] Stockdale Winder, F. (2014). *Working together for change: A 10-year mental health and addictions action plan for Saskatchewan.*

[52] Government of Newfoundland and Labrador. (2017). *The way forward — Towards recovery: The mental health and addictions action plan for Newfoundland and Labrador*

[53] Ministère de la Santé et des Services sociaux. (2017). *Plan d'action en santé mentale 2015-2020 – Faire ensemble et autrement.* https://publications.msss.gouv.qc.ca/msss/document-001319/

[54] Government of Manitoba. (2011). *Rising to the challenge.*

[55] Government of Prince Edward Island. (2016). *Moving forward together: Mental health and addiction strategy.*

[56] Stockdale Winder. (2014).

[57] Government of Manitoba. (2011). *Rising to the challenge.*

[58] Correctional Service Canada. (2019). *Mental health strategy.*

[59] Dupuis, et al. (2013).

[60] Schneider, R. D. (2010). Mental health courts and diversion programs: A global survey. *International Journal of Law and Psychiatry 33,* 201-206. https://doi.org/10.1016/j.ijlp.2010.07.001

[61] Ferrazzi, P., & Krupa, T. (2016). Re: Mental health rehabilitation in therapeutic jurisprudence: Theoretical improvements. *International Journal of Law and Psychiatry, 46,* 42-49. https://doi.org/10.1016/j.ijlp.2016.02.028

[62] Sapers, H. (2012). *Annual report of the office of correctional investigator, 2011-2012.* Correctional Investigator of Canada. https://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20112012-eng.pdf

[63] Canadian Institute for Health Information. (2008). *Mental health, delinquency and criminal activity.* https://secure.cihi.ca/free_products/mh_crime_full_report_apr11_08_e.pdf

[64] Kouyoumdjian, F. G., Schuler, A., Hwang, S. W., & Matheson, F. I. (2015). Research on the health of people who experience detention or incarceration in Canada: A scoping review. *BMC Public Health*, *15*, Article 419, 1-8.

[65] Hiday, V. A., & Wales, H. W. (2013). Mental illness and the law. In C. S. Aneshensel, J. C. Phelan, & A. Bierman (Eds.), *Handbook of the sociology of mental health* (2nd ed., pp. 563-582). Springer.

[66] Sapers, H. (2011). *Annual report of the office of correctional investigator, 2010-2011.* Correctional Investigator of Canada. https://www.oci-bec.gc.ca/cnt/rpt/annrpt/annrpt20102011-eng.aspx

[67] Brown, G. P., Hirdes, J. P., & Fries, B. E. (2015). Measuring the prevalence of current, severe symptoms of mental health problems in a Canadian correctional population: Implications for delivery of mental health services for inmates. *International Journal of Offender Therapy and Comparative Criminology*, *59*, 27-50. https://doi.org/10.1177/0306624X13507040

[68] Zinger, I. (2012, June 18). *Mental health in federal corrections* [Conference presentation]. Canadian Association of Statutory Human Rights Agencies Annual Conference, Winnipeg, Manitoba. https://www.oci-bec.gc.ca/cnt/comm/pdf/presentations/presentations20120618-eng.pdf

[69] Khan, S., Chiu, M., Simpson, A. I. F., Guttmann, A., Jembere, N., & Kurdyak, P. (2016). Use of mental health services by youths and young adults before and during correctional custody: A population-based study. *Psychiatric Services*, *67*, 790-793. https://doi.org/10.1176/appi.ps.201500085

[70] Kouyoumdjian, F., Schuler, A., Matheson, F. I., & Hwang, S. W. (2016). Health status of prisoners in Canada: Narrative review. *Canadian Family Physician*, *62*, 215-222

[71] Sapers, H. (2014). *Annual report of the office of correctional investigator, 2013-2014.* Correctional Investigator of Canada. https://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20132014-eng.pdf

[72] Standing Committee on Public Safety and National Security. (2010). *Mental health and drug and alcohol addiction in the federal correctional system*. https://www.ourcommons.ca/Content/Committee/403/SECU/Reports/RP4864852/securp04/securp04-e.pdf

[73] Correctional Service Canada. (2018). *Prevalence of mental disorder among federal women offenders: Intake and in-custody* (Document No. R-420) [Research brief]. https://www.csc-scc.gc.ca/005/008/092/r-420-en.pdf

[74] Correctional Service Canada. (2017). *Rates of current mental disorders among women offenders in custody in CSC* (Document No. ERR-16-23). https://www.csc-scc.gc.ca/research/err-16-23-eng.shtml

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

[76] Sapers, H. (2009). *Annual report of the office of correctional investigator, 2008-2009.* Correctional Investigator of Canada. https://www.oci-bec.gc.ca/cnt/rpt/annrpt/annrpt20082009-eng.aspx

[77] Sittner Hartshorn, K. J., Whitbeck, L. B., & Prentice, P. (2015). Substance use disorders, comorbidity, and arrest among Indigenous adolescents. *Crime and Delinquency*, *61*, 1311-1332. https://doi.org/10.1177/0011128712466372

[78] Correctional Service Canada. (2015). *National prevalence of mental disorders among incoming federally-sentenced men* (Document No. R-357) [Research brief]. https://www.csc-scc.gc.ca/005/008/092/005008-0357-eng.pdf

[79] Correctional Service Canada. (2013). *Prevalence of mental health disorders among incoming federal offenders: Atlantic, Ontario, and Pacific regions* (Document No. ERR-13-3). https://www.csc-scc.gc.ca/005/008/092/err13-3-eng.pdf

[80] Correctional Service Canada. (2013). *Prevalence of mental health disorders among incoming federal offenders: Atlantic, Ontario, and Pacific regions.*

[81] Correctional Service Canada. (2018). *National prevalence of mental disorders among federally sentenced women offenders: In custody sample* (Document No. R-406) [Research brief]. https://www.csc-scc.gc.ca/research/092/R-406-en.pdf

[82] Zinger, I. (2012, June 18). *Mental health in federal corrections* [Conference presentation].

[83] Standing Committee on Public Safety and National Security. (2010). *Mental health and drug and alcohol addiction in the federal correctional system*.

[84] Sapers, H. (2009). *Annual report of the office of correctional investigator, 2008-2009.*

[85] Peters, Y. (2003). *Federally sentenced women with mental disabilities: A dark corner in Canadian human rights*. Disabled Women's Action Network (DAWN). https://www.caefs.ca/wp-content/uploads/2013/05/dawn1.pdf

[86] Kouyoumdjian, Schuler, et al. (2016). Health status of prisoners in Canada: Narrative review.

[87] Lafortune, D. (2010). Prevalence and screening of mental disorders in short-term correctional facilities. *International Journal of Law and Psychiatry*, *33*, 94-100. https://doi.org/10.1016/j.ijlp.2009.12.004

[88] Guebert, A. F., & Olver, M. E. (2014). An examination of criminogenic needs, mental health concerns, and recidivism in a sample of violent young offenders: Implications for risk, need, and responsivity. *International Journal of Forensic Mental Health*, *13*, 295-310. https://doi.org/10.1080/14999013.2014.955220

[89] Kouyoumdjian, Schuler, et al. (2016).

[90] Gretton, H. M., & Clift, R. J. (2011). The mental health needs of incarcerated youth in British Columbia, Canada. *International Journal of Law and Psychiatry*, *34*, 109-115. https://doi.org/10.1016/j.ijlp.2011.02.004

[91] Simpson, et al. (2013).

[92] Canadian Institute for Health Information. (2008). *Mental health, delinquency and criminal activity.*

[93] Almond, K., Simeonov, D., Dunn, M., & Gatson, J. (2014). *Stranded without personal belongings: Putting offenders with mental health issues at risk* [Webinar]. Human Services and Justice Coordinating Committee. https://hsjcc.on.ca/stranded-without-personal-belongings-putting-offenders-with-mental-health-issues-at-risk/

[94] Correctional Service Canada. (2017). *Rates of current mental disorders among women offenders in custody in CSC* (Document No. ERR-16-23).

[95] Simpson, et al. (2013).

[96] Brown, G. P., Stewart, L. A., Rabinowitz, T., Boudreau, H., & Wright, A. J. (2018). Approved and off-label use of prescribed psychotropic medications among federal Canadian inmates. *Canadian Journal of Psychiatry*, *63*, 683-691. https://doi.org/10.1177/0706743718773734

[97] Standing Committee on Public Safety and National Security. (2010).

[98] Correctional Service Canada. (2018). *Prevalence of mental disorder among federal women offenders: Intake and in-custody* (Document No. R-420).

[99] Beaudette & Stewart. (2016). National prevalence of mental disorders among incoming Canadian male offenders.

[100] Correctional Service Canada. (2015). National prevalence of mental disorders among incoming federally-sentenced men (Document No. R-357).

[101] Correctional Service Canada. (2013). Prevalence of mental health disorders among incoming federal offenders: Atlantic, Ontario, and Pacific regions.

[102] Patten, S. B., Wang, J. L., Williams, J. V. A., Currie, S., Beck, C. A., Maxwell, C. J., & El-Guebaly, N. (2006). Descriptive epidemiology of major depression in Canada. *Canadian Journal of Psychiatry, 51*, 84-90. https://doi.org/10.1177/070674370605100204

[103] Statistics Canada. (2020). *Mental health indicators* (Table 13-10-0465-01). https://doi.org/10.25318/1310046501-eng

[104] Zinger. (2012, June 18).

[105] Correctional Service Canada. (2013). Prevalence of mental health disorders among incoming federal offenders: Atlantic, Ontario, and Pacific regions.

[106] Correctional Service Canada. (2018). *National prevalence of mental disorders among federally sentenced women offenders: In custody sample* (Document No. R-406).

[107] Beaudette & Stewart. (2016).

[108] Green, S., Foran, J. & Kouyoumdjian, F. G. (2016). Access to primary care in adults in a provincial correctional facility in Ontario. *BMC Research Notes, 9,* Article 461. https://doi.org/10.1186/s13104-016-1935-4

[109] Sapers, H. (2014). *Annual report of the office of correctional investigator, 2013-2014.*

[110] Brown, et al. (2018). Approved and off-label use of prescribed psychotropic medications among federal Canadian inmates.

[111] Kilty, J. M. (2012). “It’s like they don’t want you to get better”: Psy control of women in the carceral context. *Feminism and Psychology*, *22*, 162-182. https://doi.org/10.1177/0959353512439188

[112] Matheson, F. I., Brazil, A., Doherty, S., & Forrester, P. (2015). A call for help: Women offenders' reflections on trauma care. *Women and Criminal Justice*, *25*, 241-255. https://doi.org/10.1080/08974454.2014.909760

[113] *Corrections in Ontario: Directions for reform: Independent review of Ontario corrections*. (2017). https://www.mcscs.jus.gov.on.ca/english/Corrections/IndependentReviewOntarioCorrections/IndependentReviewOntarioCorrectionsDirectionsReform.html

[114] Kennedy, S. C., Tripodi, S. J., & Pettus-Davis, C. (2013). The relationship between childhood abuse and psychosis for women prisoners: Assessing the importance of frequency and type of victimization. *Psychiatric Quarterly*, *84*, 439-453. https://doi.org/10.1007/s11126-013-9258-2

[115] Correctional Service Canada. (2012). *Comparing the mental health treatment and abuse histories of Aboriginal and non-Aboriginal participants of the methadone maintenance treatment program (MMTP)* (Document No. RS-12-08) [Research brief]. https://www.csc-scc.gc.ca/005/008/092/rs12-08-eng.pdf

[116] Penner, E. K., Roesch, R., & Viljoen, J. L. (2011). Young offenders in custody: An international comparison of mental health services. *International Journal of Forensic Mental Health*, *10*, 215-232 https://doi.org/10.1080/14999013.2011.598427.

[117] Rankin, J., Winsa, P., & Ng, H. (2013, March 13). Unequal justice: Aboriginal and Black inmates disproportionately fill Ontario jails. *Toronto Star.* https://www.thestar.com/news/insight/2013/03/01/unequal_justice_aboriginal_and_black_inmates_disproportionately_fill_ontario_jails.html

[118] Green, et al. (2016). Access to primary care in adults in a provincial correctional facility in Ontario.

[119] Gottfried, E. D., & Christopher, S. C. (2017). Mental disorders among criminal offenders: A review of the literature. *Journal of Correctional Health Care*, *23*, 336-346. https://doi.org/10.1177/1078345817716180

[120] Smith H. P., Sitren, A. H., & King, S. (2019). "A call to action": mental illness and self-injurious behavior occurring in jails and prisons. *Journal of Health and Human Services Administration*, *14*(4) 16-44.

[121] Sapers, H. (2015). *Annual report of the office of correctional investigator, 2014-2015.* Correctional Investigator of Canada. https://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20142015-eng.pdf

[122] Zinger, I. (2018). *Annual report of the office of correctional investigator, 2017-2018.* Correctional Investigator of Canada. https://www.oci-bec.gc.ca/cnt/rpt/annrpt/annrpt20172018-eng.aspx

[123] Smith, et al. (2019). "A call to action": mental illness and self-injurious behavior occurring in jails and prisons.

[124] Kouyoumdjian, Schuler, et al. (2016).

[125] Simpson, et al. (2013).

[126] Stall, N. (2013, February 19). Agony behind bars [News article]. *CMAJ, 185*, 202-204. https://doi.org/10.1503/cmaj.109-4391

[127] *Corrections in Ontario: Directions for reform: Independent review of Ontario corrections*. (2017).

[128] Canadian Institute for Health Information. (2008).

[129] Zinger. (2012, June 18).

[130] Tam, K., & Derkzen, D. (2014). *Exposure to trauma among women offenders: A review of the literature* (Report No. R-333). Correctional Service Canada. https://www.publicsafety.gc.ca/lbrr/archives/cn35599-eng.pdf

[131] Martin, M. S., Dorken, S. K., Colman, I., McKenzie, K., & Simpson, A. I. F. (2014). The incidence and prediction of self-injury among sentenced prisoners. *Canadian Journal of Psychiatry*, *59*, 259-267. https://doi.org/10.1177/070674371405900505

[132] Dixon-Gordon, K., Harrison, N., & Roesch, R. (2012). Non-suicidal self-injury within offender populations: A systematic review. *International Journal of Forensic Mental Health*, *11*, 33-50. https://doi.org/10.1080/14999013.2012.667513

[133] Cesaroni, C., & Peterson-Badali, M. (2017). Ashley Smith and incarcerated young women: Marginalized at any age. *Canadian Journal of Law and Society*, *32*, 249-267. https://doi.org/10.1017/cls.2017.11

[134] Canadian Institute for Health Information. (2008).

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

[136] Colins, O., Vermeiren, R., Vreugdenhil, C., van den Brink, W., Doreleijers, T., & Broekaert, E. (2010). Psychiatric disorders in detained male adolescents: A systematic literature review. *Canadian Journal of Psychiatry*, *55*, 255-263. https://doi.org/10.1177/070674371005500409

[137] Gottfried & Christopher. (2017). Mental disorders among criminal offenders: A review of the literature.

[138] Stoliker, B. E., & Galli, P. M. (2019). An examination of mental health and psychiatric care among older prisoners in the United States. *Victims and Offenders*, *14*, 480-509. https://doi.org/10.1080/15564886.2019.1608883

[139] Moyes, H. C. A., Heath, J. J., & Dean, L. V. (2016). What can be done to improve outcomes for prisoners with a dual diagnosis? *Advances in Dual Diagnosis*, *9*, 14-25. https://doi.org/10.1108/ADD-07-2015-0016

[140] James, D. J., & Glaze, L. E. (2006). Mental health problems of prison and jail inmates. *Bureau of Justice Statistics Special Report.* https://www.bjs.gov/content/pub/pdf/mhppji.pdf

[141] Gottfried & Christopher. (2017).

[142] Gottfried & Christopher. (2017).

[143] Moyes, et al. (2016). What can be done to improve outcomes for prisoners with a dual diagnosis?

[144] 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

[145] Dean, et al. (2013). *The justice system and mental health: A review of the literature.*

[146] Fazel, S., Ramesh, T., & Hawton, K. (2017). Suicide in prisons: An international study of prevalence and contributory factors. *Lancet Psychiatry*, *4*, 946-952. https://doi.org/10.1016/S2215-0366(17)30430-3

[147] McLachlin, B. (2010). Medicine and the law: The challenges of mental illness. *Dalhousie Law Journal*, *33*, 15-33.

[148] Chaimowitz. (2012).

[149] Chaimowitz. (2012).

[150] Kolodziejczak, O., & Sinclair, S. J. (2018). Barriers and facilitators to effective mental health care in correctional settings. *Journal of Correctional Health Care*, *24*, 253-263. https://doi.org/10.1177/1078345818781566

[151] Kolodziejczak & Sinclair. (2018). Barriers and facilitators to effective mental health care in correctional settings.

[152] Medicine and the law: The challenges of mental illness.

[153] McLachlin, B. (2010). Medicine and the law: The challenges of mental illness.

[154] McLachlin. (2010).

[155] McLachlin. (2010).

[156] Coalition on Community Safety, Health, and Well-Being. (2009). *Youth mental health and justice: Strengthening integration and coordination* [Conference report]. https://www.publicsafety.gc.ca/lbrr/archives/cnmcs-plcng/cn31430-eng.pdf

[157] McLachlin. (2010).

[158] Coalition on Community Safety, Health, and Well-Being. (2009). *Youth mental health and justice: Strengthening integration and coordination*.

[159] Brink, J., Livingston, J., Desmarais, S., Greaves, C., Maxwell, V., Michalak, E., Parent, R., Verdun-Jones, S., & Weaver, C. (2011). *A study of how people with mental illness perceive and interact with the police*. Mental Health Commission of Canada. https://www.mentalhealthcommission.ca/sites/default/files/Law_How_People_with_Mental_Illness_Perceive_Interact_Police_Study_ENG_1_0_1.pdf

[160] Brink, et al. (2011). *A study of how people with mental illness perceive and interact with the police*.

[161] Wilson, A. B., Bonfine, N., Farkas, K. J., & Duda-Banwar, J. (2017). Translating interventions that target criminogenic risk factors for use in community based mental health settings. *Community Mental Health Journal*, *53*, 893-900. https://doi.org/10.1007/s10597-017-0119-6

[162] Wilson, et al. (2017). Translating interventions that target criminogenic risk factors for use in community based mental health settings.

[163] Vogel, L. (2010). Pan-Canadian strategy being developed to tackle mental health in prisons [News article]. *CMAJ, 182*, E819-820. https://doi.org/10.1503/cmaj.109-3722

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

[165] Hiday, V. A., & Burns, P. J. (2010). Mental illness and the criminal justice system. In Brown, T. N., & Scheid, T. L. (Eds.), *A handbook for the study of mental health: Social contexts, theories, and systems* (2nd ed., pp. 478-498). Cambridge University Press. https://doi.org/10.1017/9781316471289

[166] Canadian Institute for Health Information. (2008).

[167] Sinha, M. (2009). *An investigation into the feasibility of collecting data on the involvement of adults and youth with mental health issues in the criminal justice system* [Cat. No. 85-561-M-no. 16]. Statistics Canada. https://www150.statcan.gc.ca/n1/pub/85-561-m/2009016/section-a-eng.htm

[168] Sinha, M. (2009). *An investigation into the feasibility of collecting data on the involvement of adults and youth with mental health issues in the criminal justice system.*

[169] Canadian Institute for Health Information. (2008).

[170] Sinha. (2009).

[171] Roy, L., Crocker, A. G., Nicholls, T. L., Latimer, E., Gozdzik, A., O'Campo, P., & Rae, J. (2016). Profiles of criminal justice system involvement of mentally ill homeless adults. *International Journal of Law and Psychiatry*, *45*, 75-88.

[172] Canadian Institute for Health Information. (2008).

[173] Canadian Institute for Health Information. (2008).

[174] Kennedy, et al. (2013). The relationship between childhood abuse and psychosis for women prisoners: Assessing the importance of frequency and type of victimization.

[175] Sinha. (2009).

[176] Peterson, J. K., Skeem, J. L., Hart, E., Vidal, S., & Keith, F. (2010). Analyzing offense patterns as a function of mental illness to test the criminalization process. *Psychiatric Services*, *61*, 1217-1222. https://doi.org/10.1176/ps.2010.61.12.1217

[177] Haney, C. (2017). "Madness" and penal confinement: Some observations on mental illness and prison pain. *Punishment and Society*, *19*, 310-326. https://doi.org/10.1177/1462474517705389

[178] Simpson, et al. (2013).

[179] Peterson, J., & Heinz, K. (2016). Understanding offenders with serious mental illness in the criminal justice system. *Mitchell Hamline Law Review, 42*, 538-563. http://open.mitchellhamline.edu/mhlr/vol42/iss2/3

[180] Simpson, et al. (2013).

[181] Desai, A. (2013). *Towards an integrated network*: *Working together to avoid criminalization of people with mental health problems* (2nd ed.). St. Leonard's Society of Canada. http://www.stleonards.ca/wp-content/uploads/2013/05/Towards-an-Integrated-Network-Second-Edition_2013.pdf

[182] Redlich, A. D., & Cusack, K. J. (2010). Mental health treatment in criminal justice settings. In B. L. Levin, K. D. Hennessy, & J. Petrila (Eds.), *Mental health services: A public health perspective* (3rd ed., pp. 421-440). Oxford University Press.

[183] Copeland, W. E., Miller-Johnson, S., Keeler, G., Angold, A., & Costello, E. J. (2007). Childhood psychiatric disorders and young adult crime: A prospective, population-based study. *American Journal of Psychiatry*, *164*, 1668-1675. https://doi.org/10.1176/appi.ajp.2007.06122026

[184] John Howard Society of Ontario. (2015). *Unlocking change: Decriminalizing mental health issues in Ontario.* http://www.johnhoward.on.ca/wp-content/uploads/2015/07/Unlocking-Change-Final-August-2015.pdf

[185] Simpson, et al. (2013).

[186] Roy, et al. (2016). Profiles of criminal justice system involvement of mentally ill homeless adults.

[187] Penner, et al. (2011). Young offenders in custody: An international comparison of mental health services.

[188] Copeland, et al. (2007). Childhood psychiatric disorders and young adult crime: A prospective, population-based study.

[189] Dean, et al. (2013).

[190] Hiday, V. A. (1995). The social context of mental illness and violence. *Journal of Health and Social Behavior*, *36*(2), 122-137

[191] Tomlinson, M. F. (2018). A theoretical and empirical review of dialectical behavior therapy within forensic psychiatric and correctional settings worldwide. *International Journal of Forensic Mental Health*, *17*, 72-95. https://doi.org/10.1080/14999013.2017.1416003

[192] Dumais, A., Côté, G., Larue, C., Goulet, M. H., & Pelletier, J.-F. (2014). Clinical characteristics and service use of incarcerated males with severe mental disorders: A comparative case-control study with patients found not criminally responsible. *Issues in Mental Health Nursing, 35*, 597-603. https://doi.org/10.3109/01612840.2013.861885

[193] Galanek, J. D. (2013). The cultural construction of mental illness in prison: A perfect storm of pathology. *Culture, Medicine, and Psychiatry*, *37*, 195-225. https://doi.org/10.1007/s11013-012-9295-6

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

[195] Galanek, J. D. (2013). The cultural construction of mental illness in prison: A perfect storm of pathology.

[196] Roy, et al. (2016).

[197] Wilton & Stewart. (2017). Outcomes of offenders with co-occurring substance use disorders and mental disorders.

[198] Wilton & Stewart. (2017).

[199] Roy, et al. (2016).

[200] Correctional Service Canada. (2015). *Resilience factors related to success on release for offenders with mental disorders* (Document No. R-336) [Research brief]. https://www.csc-scc.gc.ca/research/092/005008-r336-eng.pdf

[201] Raphael, D. (2016). Social determinants of health: Key issues and themes. In D. Raphael (Ed.), *Social determinants of health: Canadian perspectives* (3rd ed., pp. 3-31). Canadian Scholars Press.

[202] Mikkonen, J., & Raphael, D. (2010). *Social determinants of health: The Canadian facts*. https://www.thecanadianfacts.org/The_Canadian_Facts.pdf

[203] Mikkonen, J., & Raphael, D. (2010). *Social determinants of health: The Canadian facts*.

[204] Paradies, Y. (2006). A systematic review of empirical research of self-reported racism and health. *International Journal of Epidemiology, 35*, 888-901. https://doi.org/10.1093/ije/dyl056

[205] Mikkonen & Raphael. (2010).

[206] Mikkonen & Raphael. (2010).

[207] Kouyoumdjian, Schuler, et al. (2016).

[208] Kouyoumdjian, Schuler, et al. (2016).

[209] Kouyoumdjian, Schuler, et al. (2016).

[210] Roy, et al. (2016).

[211] Correctional Service Canada. (2018). *Mental health needs of veterans in the Canadian correctional system: A brief review.* (Document No. R-409) [Research brief]. https://www.csc-scc.gc.ca/005/008/092/r-409-en.pdf

[212] Chaimowitz. (2012).

[213] Chaimowitz. (2012).

[214] Butler, A. (2014). *Mental illness and the criminal justice system: A review of global perspectives and promising practices*. International Centre for Criminal Law Reform and Criminal Justice Policy. https://icclr.org/wp-content/uploads/2019/06/Mental-Illness-and-the-Criminal-Justice-System_Butler_ICCLR_0.pdf?x37853

[215] McLachlin. (2010).

[216] Butler, A. (2014). *Mental illness and the criminal justice system: A review of global perspectives and promising practices*.

[217] Livingston, J. D. (2016). Criminal justice responses to people with mental illnesses. In J. V. Roberts & M. G. Grossman (Eds.), *Criminal justice in Canada: A reader* (5th ed., pp. 199-210). Nelson Education.

[218] McLeod, K. E., & Martin, R. E. (2018). Health in correctional facilities is health in our communities [Commentary]. *CMAJ, 190*, e274-e275. https://doi.org/10.1503/cmaj.171357

[219] Mikkonen & Raphael. (2010).

[220] Bakken, N. W., & Visher, C. A. (2018). Successful reintegration and mental health: An examination of gender differences among reentering offenders. *Criminal Justice and Behavior*, 45, 1121-1135. https://doi.org/10.1177/0093854818774384

[221] 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*, 39-55. https://doi.org/10.1177/0004865815620703

[222] Sapers, H. (2013). *Annual report of the office of correctional investigator, 2012-2013.* Correctional Investigator of Canada. https://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20122013-eng.pdf

[223] de Vogel, V., & Nicholls, T. L. (2016). Gender matters: An introduction to the special issues on women and girls. *International Journal of Forensic Mental Health*, *15*, 1-25. https://doi.org/10.1080/14999013.2016.1141439

[224] Reitmanova, S., & Henderson, R. (2016). Aboriginal women and the Canadian criminal justice system. *Critical Social Work, 17*(2), 1-19. https://doi.org/10.22329/csw.v17i2.5899

[225] Reitmanova & Henderson. (2016). Aboriginal women and the Canadian criminal justice system.

[226] Cross, L. E., Morrison, W., Peterson, P., & Domene, J. F. (2012). Investigating positive psychology approaches in case management and residential programming with incarcerated youth. *Canadian Journal of Counselling and Psychotherapy*, *46*, 63-84.

[227] Cross, et al. (2012). Investigating positive psychology approaches in case management and residential programming with incarcerated youth.

[228] Coalition on Community Safety, Health, and Well-Being. (2009).

[229] Coalition on Community Safety, Health, and Well-Being. (2009).

[230] Coalition on Community Safety, Health, and Well-Being. (2009).

[231] Office of the Correctional Investigator. (2020, January 21). *Indigenous people in federal custody surpasses 30%: Correctional investigator issues statement and challenge*.

[232] Roy, et al. (2016).

[233] Roy, et al. (2016).

[234] Rankin, et al. (2013, March 13). Unequal justice: Aboriginal and Black inmates disproportionately fill Ontario jails.

[235] Coalition on Community Safety, Health, and Well-Being. (2009).

[236] Gutierrez, L., Chadwick, N., & Wanamaker, K. A. (2018). Culturally relevant programming versus the status quo: A meta-analytic review of the effectiveness of treatment of Indigenous offenders. *Canadian Journal of Criminology and Criminal Justice*, *60*, 321-353. https://doi.org/10.3138/cjccj.2017-0020.r2

[237] de Vogel & Nicholls. (2016). Gender matters: An introduction to the special issues on women and girls.

[238] McLeod-Shabogesic, D., & Kruger, L. A. (2015, November 17). *Meeting the needs of Aboriginal women in Ontario corrections through programs and services* [Presentation]. Toronto, Ontario. Human Services and Justice Coordinating Committee. https://hsjcc.on.ca/wp-content/uploads/Meeting-the-Needs-of-Aboriginal-Women-in-Ontario-Corrections-Through-Programs-and-Services-2015-11-17.pdf

[239] Kouyoumdjian, Schuler, et al. (2016).

[240] Kouyoumdjian, Schuler, et al. (2016).

[241] Hiday & Wales. (2013). Mental illness and the law.

[242] Hiday & Wales. (2013).

[243] Kouyoumdjian, et al. (2015). Research on the health of people who experience detention or incarceration in Canada: A scoping review.

[244] Lafortune, D. (2010). Prevalence and screening of mental disorders in short-term correctional facilities.

[245] Martin, M. S., Hynes, K., Hatcher, S., & Colman, I. (2016). Diagnostic error in correctional mental health: Prevalence, causes, and consequences. *Journal of Correctional Health Care*, *22*(2), 109-117. https://doi.org/10.1177/1078345816634327

[246] Martin, et al. (2016). Diagnostic error in correctional mental health: Prevalence, causes, and consequences.

[247] Martin, et al. (2016).

[248] John Howard Society of Ontario. (2015). *Unlocking change: Decriminalizing mental health issues in Ontario.*

[249] Simpson, et al. (2013).

[250] John Howard Society of Ontario. (2015).

[251] Olley, M. C., Nicholls, T. L., & Brink, J. (2009). Mentally ill individuals in limbo: Obstacles and opportunities for providing psychiatric services to corrections inmates with mental illness. *Behavioral Sciences and the Law*, *27*, 811-831.

[252] Moore, K. E., Folk, J. B., Boren, E. A., Tangney, J. P., Fischer, S., & Schrader, S. W. (2018). Pilot study of a brief dialectical behavior therapy skills group for jail inmates. *Psychological Services*, *15*(1), 98.

[253] Oliffe, J. L., Hanberg, D., Hannan-Leith, M. N., Bergen, C., & Martin, R. E. (2018). “Do you want to go forward or do you want to go under?”: Men’s mental health in and out of prison. *American Journal of Men's Health*, *12*(5), 1235-1246.

[254] Malakieh, J. (2019). Adult and youth correctional statistics in Canada, 2017/2018 (Cat. No. 85-002-X). *Juristat*. Statistics Canada. https://www150.statcan.gc.ca/n1/en/pub/85-002-x/2019001/article/00010-eng.pdf?st=U-MBOKWt

[255] John Howard Society of Ontario. (2015).

[256] John Howard Society of Ontario. (2016). *Fractured care: Public health opportunities in Ontario’s correctional institutions.* https://johnhoward.on.ca/wp-content/uploads/2016/04/Fractured-Care-Final.pdf

[257] Simpson, et al. (2013).

[258] *Corrections in Ontario: Directions for reform: Independent review of Ontario corrections*. (2017).

[259] Mikkonen & Raphael. (2010).

[260] John Howard Society of Ontario. (2015).

[261] John Howard Society of Ontario. (2015).

[262] Trach & Mardon. (2016, October 27). Looking at mental health courts: Should Alberta pursue them?

[263] Bursac, R., Raffa, L., Solimo, A., Bell, C., & Ford, E. (2018). Boundary-spanning care: Reducing psychiatric rehospitalization and self-injury in a jail population. *Journal of Correctional Health Care*, *24*, 365-370. https://doi.org/10.1177/1078345818792055

[264] Zinger, I. (2018). *Annual report of the office of correctional investigator, 2017-2018.*

[265] Bursac, et al. (2018). Boundary-spanning care: Reducing psychiatric rehospitalization and self-injury in a jail population.

[266] Oliffe, et al. (2018). “Do you want to go forward or do you want to go under?”: Men’s mental health in and out of prison.

[267] Simpson, et al. (2013).

[268] Canadian Institute for Health Information. (2008).

[269] Bakken & Visher. (2018). Successful reintegration and mental health: An examination of gender differences among reentering offenders.

[270] 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.

[271] Housing, Health, and Justice Community of Interest. (2019). *Closed quarters: Challenges and opportunities in stabilizing housing and mental health across the justice sector.* Evidence Exchange Network. https://www.eenet.ca/sites/default/files/2018/Housing%20Health%20and%20Justice%20COI%20Report-%20Final%20-%20Feb%2014%202019_0.pdf

[272] John Howard Society of Ontario. (2017). *The counter point*, *Issue 8*. https://johnhoward.on.ca/wp-content/uploads/2017/03/Counterpoint-Health-Care.pdf

[273] Møllerhøj, J., & Stølen, L. O. (2018). "First and foremost a human being . . .": User perspectives on mental health services from 50 mentally disordered offenders. *Nordic Journal of Psychiatry, 72*, 593-598. https://doi.org/10.1080/08039488.2018.1502352

[274] Mental Health Commission of Canada. (2014). *National final report: Cross-site At Home/Chez Soi project*. https://www.mentalhealthcommission.ca/sites/default/files/mhcc_at_home_report_national_cross-site_eng_2_0.pdf

[275] Housing, Health, and Justice Community of Interest. (2019). *Closed quarters: Challenges and opportunities in stabilizing housing and mental health across the justice sector.*

[276] Housing, Health, and Justice Community of Interest. (2019).

[277] 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*, e153-e161. https://doi.org/10.9778/cmajo.20150098

[278] Dean, et al. (2013).

[279] Denton, et al. (2017).

[280] John Howard Society of Ontario. (2017). *The counter point*, *Issue 8*.

[281] Kouyoumdjian, Kiefer, et al. (2016). Mortality over 12 years of follow-up in people admitted to provincial custody in Ontario: A retrospective cohort study.

[282] Shantz, L. R., & Frigon, S. (2009). Aging, women and health: From the pains of imprisonment to the pains of reintegration. *International Journal of Prisoner Health, 5*, 3-15. https://doi.org/10.1080/17449200802692045

[283] Chaimowitz. (2012).

[284] Peters, Y. (2003). *Federally sentenced women with mental disabilities: A dark corner in Canadian human rights*.

[285] Martin, M. S., Potter, B. K., Crocker, A. G., Wells, G. A., Grace, R. M., & Colman, I. (2018). Mental health treatment patterns following screening at intake to prison. *Journal of Consulting and Clinical Psychology*, *86*, 15-23. https://doi.org/10.1037/ccp0000259

[286] John Howard Society of Ontario. (2015).

[287] Frank, R. G., & McGuire, T. G. (2010). Mental health treatment and criminal justice outcomes. In P. J. Cook, J. Ludwig, & J. McCrary (Eds.), *Controlling crime: Strategies and tradeoffs* (pp. 167-207). University of Chicago Press.

[288] Møllerhøj & Stølen. (2018). "First and foremost a human being . . .": User perspectives on mental health services from 50 mentally disordered offenders.

[289] Martin, et al. (2018). Mental health treatment patterns following screening at intake to prison.

[290] Nordberg, A. (2015). Liminality and mental health court diversion: An interpretative phenomenological analysis of offender experiences. *British Journal of Social Work, 45*, 2441-2457. https://doi.org/10.1093/bjsw/bcu104

[291] Nordberg, A. (2015). Liminality and mental health court diversion: An interpretative phenomenological analysis of offender experiences.

[292] Martin, et al. (2018).

[293] Redlich, A. D., Steadman, H. J. Robbins, P. C., & Swanson, J. W. (2006). Use of the criminal justice system to leverage mental health treatment: Effects on treatment adherence and satisfaction. *Journal of the American Academy of Psychiatry and the Law, 34*, 292-299. http://jaapl.org/content/jaapl/34/3/292.full.pdf

[294] Monahan, J., Redlich, A. D., Robbins, P. C., Swanson, J., Appelbaum, P. S., Petrila, J. D., Steadman, H. J., Swartz, M., Angell, B., & McNiel, D. E. (2005). Use of leverage to improve adherence to psychiatric treatment in the community. *Psychiatric Services, 56,* 37-44. https://doi.org/10.1176/appi.ps.56.1.37

[295] Monahan, et al. (2005). Use of leverage to improve adherence to psychiatric treatment in the community.

[296] Hiday, V. A. (1995). The social context of mental illness and violence.

[297] Burns, T., Yeeles, K., Molodynski, A., Nightingale, H., Vazquez-Montes, M., Sheehan, K., & Linsell, L. (2011). Pressures to adhere to treatment ("leverage") in English mental healthcare. *British Journal of Psychiatry, 199,* 145-150. https://doi.org/10.1192/bjp.bp.110.086827

[298] McNiel, D. E., Gormley, B., & Binder, R. L. (2013). Leverage, the treatment relationships, and treatment participation. *Psychiatric Services, 64*(5), 431-436.

[299] 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 (British Columbia). https://cmha.bc.ca/wp-content/uploads/2016/07/DiversionBestPractices.pdf

[300] Frank & McGuire. (2010). *Mental health treatment and criminal justice outcomes.*

[301] Frank & McGuire. (2010).

[302] Nordberg, A. (2015). Liminality and mental health court diversion: An interpretative phenomenological analysis of offender experiences.

[303] Munetz, M. R., Ritter, C., Teller, J. L. S., & Bonfine, N. (2014). Mental health court and assisted outpatient treatment: Perceived coercion, procedural justice, and program impact. *Psychiatric Services, 65*, 352-358. https://doi.org/10.1176/appi.ps.002642012

[304] Munetz, et al. (2014). Mental health court and assisted outpatient treatment: Perceived coercion, procedural justice, and program impact.

[305] Galanek. (2013).

[306] Archambault, K., Joubert, D., & Brown, G. (2013). Gender, psychiatric symptomatology, problem behaviors and mental health treatment in a Canadian provincial correctional population: Disentangling the associations between care and institutional control. *International Journal of Forensic Mental Health, 12*, 93-106. https://doi.org/10.1080/14999013.2013.787560

[307] Archambault, et al. (2013). Gender, psychiatric symptomatology, problem behaviors and mental health treatment in a Canadian provincial correctional population: Disentangling the associations between care and institutional control.

[308] Brown, et al. (2018).

[309] Shantz & Frigon. (2009). Aging, women and health: From the pains of imprisonment to the pains of reintegration.

[310] Martin, et al. (2018).

[311] Cesaroni & Peterson-Badali. (2017). Ashley Smith and incarcerated young women: Marginalized at any age.

[312] Cross, et al. (2012).

[313] Sapers, H. (2012). *Annual report of the office of correctional investigator, 2011-2012.*

[314] Stall, N. (2013, February 19). Agony behind bars.

[315] Haney, C. (2017). "Madness" and penal confinement: Some observations on mental illness and prison pain.

[316] Kelsall, D. (2014). Cruel and usual punishment: Solitary confinement in Canadian prisons [Editorial]. *CMAJ, 186*, 1345. https://doi.org/10.1503/cmaj.141419

[317] Webster, P. (2015, January 6). Controls over solitary confinement needed [News article]. *CMAJ, 187*, e3-e4. https://doi.org/10.1503/cmaj.109-4943

[318] Webster, P. (2019). Canadian prisons face new legal challenges over mental health. *Lancet Psychiatry, 6*, 567-569. https://doi.org/10.1016/S2215-0366(19)30228-7

[319] Sapers, H. (2011). *Annual report of the office of correctional investigator, 2010-2011.*

[320] Olley, et al. (2009). Mentally ill individuals in limbo: Obstacles and opportunities for providing psychiatric services to corrections inmates with mental illness.

[321] Iftene, A. (2016). Unlocking the doors to Canadian older inmate mental health data: Rates and potential legal responses. *International Journal of Law and Psychiatry, 47*, 36-44. https://doi.org/10.1016/j.ijlp.2016.02.032

[322] Haney. (2017).

[323] Kolodziejczak & Sinclair. (2018).

[324] *Corrections in Ontario: Directions for reform: Independent review of Ontario corrections*. (2017).

[325] *Corrections in Ontario: Directions for reform: Independent review of Ontario corrections*. (2017).

[326] Chaimowitz. (2012).

[327] Canadian Institute for Health Information. (2008).

[328] John Howard Society of Ontario. (2017).

[329] Haney. (2017).

[330] Haney. (2017).

[331] Dubé, P. (2017). *Out of oversight, out of mind.* Ombudsman Ontario. https://www.ombudsman.on.ca/Media/ombudsman/ombudsman/resources/Reports-on-Investigations/Out_of_Oversight-with_appendices-EN-accessible.pdf

[332] Sapers, H. (2013). *Annual report of the office of correctional investigator, 2012-2013.*

[333] Iftene, A. (2016). Unlocking the doors to Canadian older inmate mental health data: Rates and potential legal responses.

[334] Correctional Service Canada. (2017). *Comorbid mental disorders: Prevalence and impact on institutional outcomes* (Document No. R-379) [Research brief]. https://www.csc-scc.gc.ca/005/008/092/r-379-eng.pdf

[335] *Corrections in Ontario: Directions for reform: Independent review of Ontario corrections*. (2017).

[336] Redlich & Cusack. (2010). Mental health treatment in criminal justice settings.

[337] Webster, P. (2019). Canadian prisons face new legal challenges over mental health.

[338] Sapers. (2011).

[339] Olley, et al. (2009).

[340] Sapers. (2011).

[341] Sapers. (2011).

[342] Sapers. (2011).

[343] de Vogel & Nicholls. (2016).

[344] *Corrections in Ontario: Directions for reform: Independent review of Ontario corrections*. (2017).

[345] Iftene. (2016).

[346] Iftene. (2016).

[347] Bromwich, R. & Kilty, J. M. (2017). Law, vulnerability, and segregation: What have we learned from Ashley Smith's carceral death? *Canadian Journal of Law and Society, 32*, 157-164. https://doi.org/10.1017/cls.2017.10

[348] Kaiser-Derrick, E. (2017). Intensifying the incarceration of the vulnerable legal subject: Correctional treatment of Ashley Smith as a source of legal norms. *Canadian Journal of Law and Society*, *32*, 229-248. https://doi.org/10.1017/cls.2017.7

[349] Office of the New Brunswick Ombudsman and Child and Youth Advocate. (2008). *The Ashley Smith Report.* https://www.ombudnb.ca/site/images/PDFs/AshleySmith-e.pdf

[350] Kaiser-Derrick, E. (2017). Intensifying the incarceration of the vulnerable legal subject: Correctional treatment of Ashley Smith as a source of legal norms.

[351] Kaiser-Derrick. (2017).

[352] Kelsall, D. (2014). Cruel and usual punishment: Solitary confinement in Canadian prisons.

[353] Dubé, P. (2017). *Out of oversight, out of mind.*

[354] Webster, P. (2015). Controls over solitary confinement needed.

[355] Correctional Service Canada. (2017). *Comorbid mental disorders: Prevalence and impact on institutional outcomes.*

[356] Schizophrenia Society of Ontario. (2012).

[357] John Howard Society of Ontario. (2017).

[358] Simpson, et al. (2013).

[359] Dubé. (2017).

[360] Sapers. (2012).

[361] Dubé. (2017).

[362] Chaimowitz. (2012).

[363] McLeod & Martin. (2018). Health in correctional facilities is health in our communities.

[364] Tait, C. L., Mela, M., Boothman, G., & Stoops, M. A. (2017). The lived experience of paroled offenders with fetal alcohol spectrum disorder and comorbid psychiatric disorder. *Transcultural Psychiatry, 54*, 107-124. https://doi.org/10.1177/1363461516689216

[365] Redlich & Cusack. (2010).

[366] Sinha. (2009).

[367] McLachlin. (2010).

[368] Coalition on Community Safety, Health, and Well-Being. (2009).

[369] Redlich & Cusack. (2010).

[370] Manjunath, A., Gillham, R., Semele, C., Taylor, P. J. (2018). Serving a community sentence with a mental health treatment requirement: Offenders' perspectives. *Criminal Behaviour and Mental Health, 28*, 492-502. https://doi.org/10.1002/cbm.2096

[371] Derrick, A. (2010). "We shall not cease from exploration": Narratives from the Hyde inquiry about mental health and criminal justice. *Dalhousie Law Journal, 33*, 35-62.

[372] Manjunath, et al. (2018). Serving a community sentence with a mental health treatment requirement: Offenders' perspectives.

[373] Martin, et al. (2018).

[374] Peterson & Heinz. (2016). Understanding offenders with serious mental illness in the criminal justice system.

[375] Power, J., Usher, A. M., & Beaudette, J. N. (2015). Non-suicidal self-injury in male offenders: Initiation, motivations, emotions, and precipitating events. *International Journal of Forensic Mental Health, 14*, 147-160. https://doi.org/10.1080/14999013.2015.1073196

[376] Power, Usher, & Beaudette. (2015). Non-suicidal self-injury in male offenders: Initiation, motivations, emotions, and precipitating events.

[377] Simpson, et al. (2013).

[378] Correctional Service Canada. (2013). Prevalence of mental health disorders among incoming federal offenders: Atlantic, Ontario, and Pacific regions.

[379] Mental Health Commission of Canada. (2014).

[380] Mental Health Commission of Canada. (2014).

[381] 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*, 1-12. https://doi.org/10.1080/14999013.2017.1405123

[382] Crocker, et al. (2015).

[383] Sirotich, F., Durbin, A., Suttor, G., Um, S., & Fang, L. (2018). Seeking supportive housing: Characteristics, needs and outcomes of applicants to the Access Point. Access Point. http://www.wellesleyinstitute.com/wp-content/uploads/2018/04/The-Access-Point-Waiting-List-Analysis-Full-Report.pdf

[384] Denton, et al. (2017).

[385] Denton, et al. (2017).

[386] Simpson, A. I. F., & Jones, R. M. (2018). Two challenges affecting access to care for inmates with serious mental illness: Detecting illness and acceptable services. *Canadian Journal of Psychiatry, 63*, 648-650. https://doi.org/10.1177/0706743718792844

[387] Tam, L. (2017). Agitation and sudden death: Containing Black detainee affect. *American Quarterly, 69*, 339-345. https://doi.org/10.1353/aq.2017.0030

[388] Martin, et al. (2018).

[389] Redlich & Cusack. (2010).

[390] Sirotich, et al. (2018). Seeking supportive housing: Characteristics, needs and outcomes of applicants to the Access Point.

[391] Cesaroni & Peterson-Badali. (2017).

[392] Beaudette, J., Power, J., & Ritchie, M. (2018). A culturally-informed and culturally-safe exploration of self-injury desistance in Aboriginal offenders: Perspectives of staff and offenders. *Canadian Journal of Native Studies*, *38*(2), 1-23.

[393] Sapers, H. (2015). *Annual report of the office of correctional investigator, 2014-2015.*

[394] Sapers. (2015).

[395] Sapers. (2015).

[396] Khan, et al. (2016). Use of mental health services by youths and young adults before and during correctional custody: A population-based study.

[397] Sapers. (2015).

[398] Shaw, M. (2000). Women, violence and disorder in prison. In: K.Hannah-Moffat & M. Shaw (Eds.), *An Ideal prison? Critical essays on Women's Imprisonment in Canada* (pp. 61-70). Fernwood Publishing.

[399] Usher, A., Power, J., & Wilton, G. (2010). *Assessment, intervention and prevention of self-injurious behaviour in correctional environments* (Document No. 2010-no. R-220). Correctional Service Canada. https://www.csc-scc.gc.ca/research/005008-0220-01-eng.shtml

[400] Iftene. (2016).

[401] Sapers. (2015).

[402] Sapers. (2015).

[403] Sapers. (2015).

[404] McLachlin. (2010).

[405] Hiday & Wales. (2013).

[406] Sapers. (2015).

[407] Sapers. (2015).

[408] Hiday & Wales. (2013).

[409] Ferrazzi & Krupa. (2016). Re: Mental health rehabilitation in therapeutic jurisprudence: Theoretical improvements.

[410] Ferrazzi & Krupa. (2016).

[411] Sapers. (2009).

[412] Dumais, et al. (2014). Clinical characteristics and service use of incarcerated males with severe mental disorders: A comparative case-control study with patients found not criminally responsible.

[413] Campbell, M. A., Adams, N., Ennis, A., & Canales, D. (2015). *Prospective evaluation of the Nova Scotia mental health court: An examination of short term outcomes.* University of New Brunswick Centre for Criminal Justice Studies. https://www.courts.ns.ca/provincial_court/NSPC_documents/Evaluation_Report_NS_MHC_15_04_16.pdf

[414] Durbin, A., Sirotich, F., & Durbin, J. (2014). Predictors of unmet need for medical care among justice-involved persons with mental illness. *Psychiatric Services, 65*, 826-829. https://doi.org/10.1176/appi.ps.201300301

[415] Peterson & Heinz. (2016).

[416] Nordberg, A. (2016). Therapeutic governmentality and biopower in a Canadian mental health court. *Biosocieties, 11*, 240-261. https://doi.org/10.1057/biosoc.2015.36

[417] Kaiser-Derrick. (2017).

[418] Redlich & Cusack. (2010).

[419] Frank & McGuire. (2010).

[420] Watts, J., & Weinrath, M. (2017). The Winnipeg mental health court: Preliminary findings on program implementation and criminal justice outcomes. *Canadian Journal of Community Mental Health, 36*, 67-82. https://doi.org/10.7870/cjcmh-2017-005

[421] Dean, et al. (2013).

[422] Canadian Mental Health Association (Ontario). (2019). *Racialized populations and mental health court diversion.* http://ontario.cmha.ca/wp-content/uploads/2019/05/Racialized-Populations-and-MH-Court-Diversion-May-2019.pdf

[423] Penner, et al. (2011).

[424] Sirotich, et al. (2018).

[425] Livingston, J. D. (2009). *Mental health and substance use services in correctional settings: A review of minimum standards and best practices*. International Centre for Criminal Law Reform and Criminal Justice Policy. https://icclr.org/wp-content/uploads/2019/06/Mental_Health.pdf?x37853

[426] Dean, et al. (2013).

[427] Kolodziejczak & Sinclair. (2018).

[428] Haney. (2017).

[429] Besney, J. D., Angel, C., Pyne, D., Martell, R., Keenan, L., & Ahmed, R. (2018). Addressing women's unmet health care needs in a Canadian remand centre: Catalyst for improved health? *Journal of Correctional Health Care, 24*, 276-294. https://doi.org/10.1177/1078345818780731

[430] Tamburello, A. C., & Ferguson, E. (2016). Better prescribing in correctional facilities. *Journal of Health Care for the Poor and Underserved, 27*, 29-33. https://doi.org/10.1353/hpu.2016.0055

[431] John Howard Society of Ontario. (2016). *Fractured care: Public health opportunities in Ontario's correctional institutions.*

[432] Michalski, J. H. (2017). Mental health issues and the Canadian criminal justice system.

[433] Dupuis, et al. (2013).

[434] Crocker, et al. (2015).

[435] Hiday & Wales. (2013).

[436] Iftene. (2016).

[437] Haesen, S., Merkt, H., Imber, A., Elger, B., & Wangmo, T. (2019). Substance use and other mental health disorders among older prisoners. *International Journal of Law and Psychiatry, 62*(1), 20-31. https://doi.org/10.1016/j.ijlp.2018.10.004

[438] Zinger. (2018).

[439] Sapers. (2014).

[440] Khan, et al. (2016).

[441] Cossy, L. S., & Miller, L. T. (2013). A descriptive study of primary health care practices in Ontario's youth custody facilities. *Paediatrics and Child Health, 18*, 523-528. https://doi.org/10.1093/pch/18.10.523

[442] Brown, et al. (2018).

[443] Archambault, et al. (2013).

[444] Oliffe, et al. (2018).

[445] Redlich & Cusack. (2010).

[446] Sapers. (2011).

[447] Besney, et al. (2018). Addressing women's unmet health care needs in a Canadian remand centre: Catalyst for improved health?

[448] Dupuis, et al. (2013).

[449] Sapers. (2014).

[450] Correctional Service Canada. (2018). *Health and service access challenges for correctional offenders with mental health and substance use problems in transition from incarceration to community: A literature review* (Document No. R-398) [Research brief]. https://www.csc-scc.gc.ca/research/r-398-en.shtml

[451] Dumais, et al. (2014).

[452] Michalski. (2017).

[453] Kouyoumdjian, et al. (2015).

[454] Shantz & Frigon. (2009).

[455] Correctional Service Canada. (2018). *Health and service access challenges for correctional offenders with mental health and substance use problems in transition from incarceration to community: A literature review*.

[456] Sapers, H. (2014).

[457] Livingston, J. D., Chu, K., Milne, T., & Brink, J. (2015). Probationers mandated to receive forensic mental health services in Canada: Risks/needs, service delivery, and intermediate outcomes. *Psychology, Public Policy, and Law*, 21, 72-84. https://doi.org/10.1037/law0000031

[458] Tam, L. (2017). Agitation and sudden death: Containing Black detainee affect.

[459] Livingston, et al. (2008). *Criminal justice diversion for persons with mental disorders: A review of best practices*.

[460] Sirotich, F. (2009). The criminal justice outcomes of jail diversion programs for persons with mental illness: A review of the evidence. *Journal of the American Academy of Psychiatry and the Law, 37*, 461-472. http://jaapl.org/content/37/4/461

[461] Butler, A. (2014).

[462] Desai, A. (2013). *Towards an integrated network*: *Working together to avoid criminalization of people with mental health problems.*

[463] Redlich & Cusack. (2010).

[464] Schneider, R. D. (2010). Mental health courts and diversion programs: A global survey.

[465] Schneider. (2010).

[466] Schneider. (2010).

[467] Campbell, M. A., Canales, D. D., Wei, R., Totten, A. E., Macaulay, W. A. C., & Wershler, J. L. (2015). Multidimensional evaluation of a mental health court: Adherence to the risk-need-responsivity model. *Law and Human Behavior*, 489-502. https://doi.org/10.1037/lhb0000135

[468] Michalski. (2017).

[469] Canadian Institute for Health Information. (2008).

[470] Canadian Institute for Health Information. (2008).

[471] Schneider. (2010).

[472] Canadian Institute for Health Information. (2008).

[473] Watts & Weinrath. (2017). The Winnipeg mental health court: Preliminary findings on program implementation and criminal justice outcomes.

[474] Watts & Weinrath. (2017).

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

[476] Canadian Institute for Health Information (2008).

[477] Schneider. (2010).
[478] Schneider. (2010).
[479] Schneider. (2010).
[480] Campbell, Adams, et al. (2015). *Prospective evaluation of the Nova Scotia mental health court: An examination of short term outcomes.*
[481] Schneider. (2010).
[482] Redlich & Cusack. (2010).
[483] Kutcher, S. & McDougall, A. (2010). Problems with access to adolescent mental health care can lead to dealings with the criminal justice system. *Paediatrics and Child Health, 14*, 15-18. https://doi.org/10.1093/pch/14.1.15
[484] Schneider. (2010).
[485] Davis, K. M., Peterson-Badali, M., & Skilling, T. A. (2016). A theoretical evaluation of a youth mental health court program model. *International Journal of Law and Psychiatry, 45*, 17-24. https://doi.org/10.1016/j.ijlp.2016.02.003
[486] Davis, et al. (2016). A theoretical evaluation of a youth mental health court program model.
[487] Davis, et al. (2016).
[488] Lange, S., Rehm, J., & Popova, S. (2011). The effectiveness of criminal justice diversion initiatives in North America: A systematic literature review. *International Journal of Forensic Mental Health, 10*, 200-214. https://doi.org/10.1080/14999013.2011.598218
[489] Campbell, Adams, et al. (2015).
[490] Dean, et al. (2013).
[491] Dean, et al. (2013).
[492] Dean, et al. (2013).
[493] Canadian Institute for Health Information. (2008).
[494] Campbell, Canales, et al. (2015). Multidimensional evaluation of a mental health court: Adherence to the risk-need-responsivity model.
[495] Boothroyd, R. A., Polythress, N. G., McGaha, A., & Petrila, J. (2003). The Broward mental health court: Process, outcomes, and service utilization. *International Journal of Law and Psychiatry, 26*, 55-71. https://doi.org/10.1016/s0160-2527(02)00203-0
[496] Broner, N. Lattimore, P. K., Cowell, A. J., & Schlenger, W. E. (2004). Effects of diversion on adults with co-occurring mental illness and substance use: outcomes from a national multi-site study. *Behavioral Science and the Law, 22*, 519-541. https://doi.org/10.1002/bsl.605
[497] Broner, et al. (2004). Effects of diversion on adults with co-occurring mental illness and substance use: Outcomes from a national multi-site study.
[498] MacDonald, S.-A., & Michaud, A.-A. D. (2015). Social exclusion in a Mental Health Court? *Intersectionalities, 4*, 51-75. https://journals.library.mun.ca/ojs/index.php/IJ/article/view/1279/1238
[499] MacDonald & Michaud. (2015). Social exclusion in a Mental Health Court?
[500] Schneider. (2010).
[501] Redlich & Cusack. (2010).
[502] Campbell, Canales, et al. (2015).
[503] Campbell, Canales, et al. (2015).
[504] Denton, et al. (2017).
[505] Kouyoumdjian, et al. (2015).
[506] Campbell, Canales, et al. (2015).
[507] Campbell, Canales, et al. (2015).
[508] Livingston, et al. (2008).

[509] Galietta, M., Fineran, V., Fava, J., & Rosenfeld, B. (2010). Antisocial and psychopathic individuals. In D. McKay, S. Taylor, J. S. Abramawitz, & S. Taylor. (Eds.), *Cognitive-Behavioral therapy for refractory cases: Turning failure into success* (pp. 385-405)*.* American Psychological Association. https://doi.org/10.1037/12070-018

[510] Redlich & Cusack. (2010).

[511] Zinger. (2018).

[512] Zinger. (2018).

[513] Smith, et al. (2019).

[514] Sapers. (2015).

[515] Tomlinson, M. F. (2018). A theoretical and empirical review of dialectical behavior therapy within forensic psychiatric and correctional settings worldwide.

[516] Rotter, M., & Carr, W. A. (2011). Targeting criminal recidivism in mentally ill offenders: Structured clinical approaches. *Community Mental Health Journal*, *47*, 723-726. https://doi.org/10.1007/s10597-011-9391-z

[517] Rotter & Carr. (2011). Targeting criminal recidivism in mentally ill offenders: Structured clinical approaches.

[518] Pardini, J., Scogin, F., Schriver, J., & Domino, M. (2014). Efficacy and process of cognitive bibliotherapy for the treatment of depression in jail and prison inmates. *Psychological Services, 11*, 141-152.

[519] Pardini, et al. (2014). Efficacy and process of cognitive bibliotherapy for the treatment of depression in jail and prison inmates.

[520] Smith, et al. (2019).

[521] Dixon-Gordon, et al. (2012). Non-suicidal self-injury within offender populations: A systematic review.

[522] Martin, et al. (2014). The incidence and prediction of self-injury among sentenced prisoners.

[523] Besney, et al. (2018).

[524] Besney, et al. (2018).

[525] Besney, et al. (2018).

[526] Beaudette, et al. (2018). A culturally-informed and culturally-safe exploration of self-injury desistance in Aboriginal offenders: Perspectives of staff and offenders.

[527] Beaudette, et al. (2018).

[528] Beaudette, et al. (2018).

[529] Dixon-Gordon, et al. (2012).

[530] Mak, V. W. M., Ho, S. M. Y., Kwong, R. W. Y., & Li, W. L. (2018). A gender-responsive treatment facility in correctional services: The development of psychological gymnasium for women offenders. *International Journal of Offender Therapy and Comparative Criminology, 62*, 1062-1079. https://doi.org/10.1177/0306624X16667572

[531] Mak, et al. (2018). A gender-responsive treatment facility in correctional services: The development of psychological gymnasium for women offenders.

[532] Standing Committee on Public Safety and National Security. (2010).

[533] Pillai, K., Rouse, P., McKenna, B., Skipworth, J., Cavney, J., Tapsell, R., Simpson, A., & Madell, D. (2016). From positive screen to engagement in treatment: A preliminary study of the impact of a new model of care for prisoners with serious mental illness. *BMC Psychiatry, 16*, Article 9, 1-7. https://doi.org/10.1186/s12888-016-0711-2

[534] Livingston, J. D. (2009). *Mental health and substance use services in correctional settings: A review of minimum standards and best practices.*

[535] Livingston. (2009).

[536] Livingston. (2009).

[537] Simpson, et al. (2013).

[538] Simpson, et al. (2013).

[539] Livingston. (2009).

[540] Sapers. (2014).

[541] Simpson, et al. (2013).

[542] Vaughan, A. D., Zabkiewicz, D. M., & Verdun-Jones, S. N. (2018). In custody deaths of men related to mental illness and substance use: A cross-sectional analysis of administrative records in Ontario, Canada. *Journal of Forensic and Legal Medicine, 48*, 1-8. https://doi.org/10.1016/j.jflm.2017.03.002

[543] Canadian Institute for Health Information. (2008).

[544] Sapers. (2009).

[545] Sapers. (2009).

[546] Moyes, et al. (2016).

[547] Moyes, et al. (2016).

[548] Canadian Institute for Health Information. (2008).

[549] Zinger. (2012, June 18).

[550] Coalition on Community Safety, Health, and Well-Being. (2009).

[551] Coalition on Community Safety, Health, and Well-Being. (2009).

[552] Forrester, A., Till, A., Simpson, A., & Shaw, J. (2018). Mental illness and the provision of mental health services in prison. *British Medical Bulletin, 127,* 101-109. https://doi.org/10.1093/bmb/ldy027

[553] Forrester, et al. (2018). Mental illness and the provision of mental health services in prison.

[554] McKenna, B., Skipworth, J., Tapsell, R., Pillai, K., Madell, D., Simpson, J., Cavney, C., & Rouse, P. (2018). Impact of an assertive community treatment model of care on the treatment of prisoners with a serious mental illness. *Australasian Psychiatry, 26*, 285-289. https://doi.org/10.1177/1039856217748247

[555] Pillai, et al. (2016). From positive screen to engagement in treatment: A preliminary study of the impact of a new model of care for prisoners with serious mental illness.

[556] Forrester, et al. (2018).

[557] Bonta, J., & Andrews, D. A. (2007). *Risk-need-responsivity model for offender assessment and rehabilitation.* Public Safety Canada. https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/rsk-nd-rspnsvty/index-en.aspx

[558] Hiday & Burns. (2010). Mental illness and the criminal justice system.

[559] Dean, et al. (2013).

[560] Bonta & Andrews. (2007). *Risk-need-responsivity model for offender assessment and rehabilitation.*

[561] Livingston, et al. (2015). Probationers mandated to receive forensic mental health services in Canada: Risks/needs, service delivery, and intermediate outcomes.

[562] Hiday & Burns. (2010).

[563] Tomlinson. (2018).

[564] Dean, et al. (2013).

[565] Simpson, et al. (2013).

[566] Rotter & Carr. (2011).

[567] Dean, et al. (2013).

[568] Rotter & Carr. (2011).

[569] Leutwyler, H., Hubbard, E., & Zahnd, E. (2017). Case management helps prevent criminal justice recidivism for people with serious mental illness. *International Journal of Prisoner Health, 13*, 168-172. https://doi.org/10.1108/IJPH-06-2016-0021

[570] Simpson, et al. (2013).

[571] Babchuk, L. C., Lurigio, A. J., Canada, K. E., & Epperson, M. W. (2012). Responding to probationers with mental illness. *Federal Probation, 76*(2), 41-48. https://www.uscourts.gov/sites/default/files/76_2_8_0.pdf

[572] Babchuk, et al. (2012). Responding to probationers with mental illness.

[573] Babchuk, et al. (2012).

[574] Babchuk, et al. (2012).

[575] Epperson, M., & Lurigio, A. (2016). *Comparative evaluation of court-based responses to offenders with mental illnesses* (NCJRS publication No. 2010-IJ-CX-0033). U.S. Justice Department. https://www.ncjrs.gov/pdffiles1/nij/grants/249894.pdf

[576] Epperson, M. W., Thompson, J. G., Lurigio, A. J., & Kim, S. (2017). Unpacking the relationship between probationers with serious mental illnesses and probation officers: A mixed-methods examination. *Journal of Offender Rehabilitation, 56*, 188-216. https://doi.org/10.1080/10509674.2017.1290005

[577] Epperson, et al. (2017). Unpacking the relationship between probationers with serious mental illnesses and probation officers: A mixed-methods examination.

[578] Skeem, J. L., Manchak, S., & Montoya, L. (2017). Comparing public safety outcomes for traditional probation vs specialty mental health probation. *JAMA Psychiatry, 74*, 942-948. https://doi.org/10.1001/jamapsychiatry.2017.1384

[579] Skeem, et al. (2017). Comparing public safety outcomes for traditional probation vs specialty mental health probation.

[580] Mental Health Commission of Canada. (2014).

[581] Leclair, M. C., Deveaux, F., Roy, L., Goulet, M.-H., Latimer, E. A., & Crocker, A. G. (2019). The impact of Housing First on criminal justice outcomes among homeless people with mental illness: A systematic review. *Canadian Journal of Psychiatry 64*, 525-530. https://doi.org/10.1177/0706743718815902

[582] Correctional Service Canada. (2014). Patterns of release conditions related to mental health among offenders supervised in the community (Document No. RS-14-16) [Research brief]. https://www.csc-scc.gc.ca/005/008/092/005008-rs14-16-eng.pdf

[583] McLeod-Shabogesic & Kruger. (2015, November 17). *Meeting the needs of Aboriginal women in Ontario corrections through programs and services.*

[584] Bamarki, R. (2016). Blocking their path to prison: Song and music as healing methods for Canada's Aboriginal women. *Canadian Journal of Native Studies, 36*(1), 1-27. https://iportal.usask.ca/index.php?sid=750553989&id=61958&t=details

[585] Hiday & Burns. (2010).

[586] Rotter & Carr. (2011).

[587] Rotter & Carr. (2011).

[588] Livingston, et al. (2008).

[589] Dean, et al. (2013).

[590] 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*, 371-384. https://doi.org/10.1002/cbm.2005

[591] Correctional Service Canada. (2014). *The impact of the community mental health initiative (CMHI)* (Document No. R-337) [Research brief]. https://www.csc-scc.gc.ca/005/008/092/005008-0337-eng.pdf

[592] Smith, D., Harnett, S., Flanagan, A., Hennessy, S., Gill, P., Quigley, N., Carey, C., McGhee, M., McManus, A., Kennedy, M., Kelly, E., Carey, J., Concannon, A, Kennedy, H. G., & Mohan, D. (2018). Beyond the walls: An evaluation of a pre-release planning (PReP) programme for sentenced mentally disordered offenders. *Frontiers in Psychiatry, 9,* Article 549. https://doi.org/10.3389/fpsyt.2018.00549

[593] B.C. Mental Health and Substance Use Services. (2019, January 30). Community transition teams aim to prevent overdose deaths among people recently released from a correctional facility [Press release]. http://www.bcmhsus.ca/news/Pages/Community-transition-teams-aim-to-prevent-overdose-deaths-among-people-recently-released-from-a-correctional-facility.aspx

[594] Alberta Health Services. (n.d.). *Corrections transition team.* https://www.albertahealthservices.ca/findhealth/service.aspx?Id=1068452

[595] Schizophrenia Society of Ontario. (2012).

[596] Housing, Health, and Justice Community of Interest. (2019).

[597] Chircop, A., Bassett, R., & Taylor, E. (2014). Evidence on how to practice intersectoral collaboration for health equity: A scoping review. *Critical Public Health, 25*, 178-191. https://doi.org/10.1080/09581596.2014.887831

[598] Livingston, et al. (2008).

[599] Courts of Nova Scotia. (2019). *Nova Scotia's wellness courts: Progressing justice.* https://courts.ns.ca/documents/WellnessCourtsReport_Nov5.pdf

[600] Dewa, C. S., Trojanowski, L., Cheng, C., & Sirotich, F. (2012). Lessons from a Canadian province: Examining collaborations between the mental health and justice sectors. *International Journal of Public Health, 57*, 7-14. https://doi.org/10.1007/s00038-011-0268-2

[601] Olley, et al. (2009).

[602] *Corrections in Ontario: Directions for reform: Independent review of Ontario corrections*. (2017).

[603] Sapers. (2015).

[604] Zinger. (2018).

[605] Correctional Service Canada. (2015). *Resilience factors related to success on release for offenders with mental disorders* (Document No. R-336).

[606] McLeod & Martin. (2018).

[607] John Howard Society of Ontario. (2016).

[608] Ontario Ministry of the Attorney General, Criminal Law Division. (2018). *Community justice centres* [Presentation]. Meeting of the Human Services and Justice Coordinating Committee. https://hsjcc.on.ca/wp-content/uploads/NY-HSJCC-Community-Justice-Centres.pdf

[609] McCormick, S., Peterson-Badali, M., & Skilling, T. A. (2015). Mental health and justice system involvement: A conceptual analysis of the literature. *Psychology, Public Policy, and Law*, *21*, 213-225. https://doi.org/10.1037/law0000033

[610] Mental Health Commission of Canada. (2014). *National final report: Cross-site At Home/Chez Soi project*.

[611] Dean, et al. (2013).

[612] Chaimowitz. (2012).

[613] Dean, et al. (2013).

[614] Chaimowitz. (2012).

[615] Sapers. (2011).

[616] Sapers. (2011).

[617] John Howard Society of Ontario. (2015).

[618] Service, J. (2010). *Under warrant: A review of the implementation of the Correctional Service of Canada's "Mental Health Strategy."* Office of the Correctional Investigator. https://www.oci-bec.gc.ca/cnt/rpt/oth-aut/oth-aut20100923-eng.aspx

[619] McLeod & Martin. (2018).

[620] John Howard Society of Ontario. (2016).

[621] John Howard Society of Ontario. (2016).

[622] Awofeso, N. (2010). Preventing suicides in prison settings: The role of mental health promotion policies and programs. *Advances in Mental Health*, *9*, 255-262. https://doi.org/10.5172/jamh.9.3.255

[623] Kolodziejczak & Sinclair. (2018).

[624] Kolodziejczak & Sinclair. (2018).

[625] Smith, et al. (2019).

[626] Smith, et al. (2019).

[627] Smith, et al. (2019).

[628] Schizophrenia Society of Ontario. (2012).

[629] Smith, et al. (2019).

[630] Chaimowitz. (2012).

[631] Chaimowitz. (2012).

[632] Service, J. (2010). *Under warrant: A review of the implementation of the Correctional Service of Canada's "Mental Health Strategy."*

[633] Smith, et al. (2019).

[634] Sapers. (2015).

[635] Zinger. (2018).

[636] Service. (2010).

[637] Smith, et al. (2019).

[638] Zinger, I. (2018, November 20). Comments submitted to meeting 137 of Canada's Public Safety. https://openparliament.ca/committees/public-safety/42-1/137/dr-ivan-zinger-1/

[639] Sapers. (2011).

[640] Webster. (2019).

[641] Webster. (2019).

[642] Carter, I. (2018, November 19). Letter to Hon. John McKay, M.P., chair of the standing committee on public safety and national security — Re: Bill C-83, Corrections and Conditional Release Act amendments. Canadian Bar Association. https://www.cba.org/CMSPages/GetFile.aspx?guid=96b44312-6a63-4e7a-a14f-952217652995

[643] *Corrections in Ontario: Directions for reform: Independent review of Ontario corrections*. (2017).

[644] *Corrections in Ontario: Directions for reform: Independent review of Ontario corrections*. (2017).

[645] Jacobs, L. A., & Giordano, S. N. J. (2018). "It's not like therapy": Patient-inmate perspectives on jail psychiatric services. *Administration and Policy in Mental Health and Mental Health Services Research*, *45*, 265-275. https://doi.org/10.1007/s10488-017-0821-2

[646] Jacobs & Giordano. (2018). "It's not like therapy": Patient-inmate perspectives on jail psychiatric services.

[647] Jacobs & Giordano. (2018).

[648] Penner, et al. (2011).

[649] Hancock, N., Smith-Merry, J., & Mckenzie, K. (2018). Facilitating people living with severe and persistent mental illness to transition from prison to community: A qualitative exploration of staff experiences. *International Journal of Mental Health Systems*, *12*, Article 45, 45-54. https://doi.org/10.1186/s13033-018-0225-z

[650] Khan, et al. (2016).

[651] McLeod & Martin. (2018).

[652] McLeod & Martin. (2018).

[653] Hancock, et al. (2018). Facilitating people living with severe and persistent mental illness to transition from prison to community: A qualitative exploration of staff experiences. *Supra*, note 602

[654] Dean, et al. (2013).

[655] Hancock, et al. (2018).

[656] Dean, et al. (2013).

[657] Penner, et al. (2011).

[658] Hancock, et al. (2018).

[659] Hancock, et al. (2018).

[660] Penner, et al. (2011).

[661] Penner, et al. (2011).

[662] Khan, et al. (2016).

[663] Martin, et al. (2018).

[664] Frank & McGuire. (2010).

[665] Dean, et al. (2013).

[666] Sapers. (2013).
[667] Sapers. (2009).
[668] Sapers. (2013).
[669] Sapers. (2013).
[670] Sapers. (2013).
[671] Sapers. (2013).
[672] Sapers. (2013).
[673] Matheson, et al. (2015). A call for help: Women offenders' reflections on trauma care.
[674] Reitmanova & Henderson. (2016).
[675] Reitmanova & Henderson. (2016).
[676] Matheson, et al. (2015).
[677] Michalski. (2017).
[678] Ferrazzi & Krupa. (2016).
[679] Slade, M., Adams, N., & O'Hagan, M. (2012). Recovery: Past progress and future challenges. *International Review of Psychiatry, 24*, 1-4. https://doi.org/10.3109/09540261.2011.644847
[680] Provincial Court of Alberta. (2020). *Mental health court.* https://albertacourts.ca/pc/areas-of-law/criminal/mental-health-court
[681] Coalition on Community Safety, Health, and Well-Being. (2009).
[682] Ferrazzi & Krupa. (2016).
[683] Ferrazzi & Krupa. (2016).
[684] Ferrazzi & Krupa. (2016).
[685] Crocker, et al. (2015).
[686] Ferrazzi & Krupa. (2016).
[687] Kerr, L. (2017). Sentencing Ashley Smith: How prison conditions relate to the aims of punishment. *Canadian Journal of Law and Society*, *32*, 187-207. https://doi.org/10.1017/cls.2017.14
[688] Schizophrenia Society of Ontario. (2012).
[689] Schneider. (2010).
[690] Sapers. (2012).
[691] Smith, et al. (2019).
[692] Webster. (2019).
[693] Wilton & Stewart. (2017).
[694] Zinger. (2018).
[695] Federal-Provincial-Territorial Working Group in Mental Health. (2012). *Mental health strategy for corrections in Canada*: *A federal-provincial-territorial partnership*. Correctional Service Canada. https://www.csc-scc.gc.ca/health/092/MH-strategy-eng.pdf
[696] Rogan, M. (2018). Human rights approaches to suicide in prison: Implications for policy, practice and research. *Health and Justice*, *6*, Article 15. https://doi.org/10.1186/s40352-018-0075-4
[697] Rogan, M. (2018). Human rights approaches to suicide in prison: Implications for policy, practice and research.
[698] Coalition on Community Safety, Health, and Well-Being. (2009).
[699] Michalski. (2017).
[700] Michalski. (2017).
[701] Simpson, et al. (2013).
[702] Sapers. (2011).
[703] Sapers. (2011).

[704] Simpson, et al. (2013).
[705] Crocker, et al. (2015).
[706] Crocker, et al. (2015).
[707] Redlich & Cusack. (2010).
[708] Crocker, et al. (2015).
[709] Martin, et al. (2018).
[710] Crocker, et al. (2015).
[711] Coalition on Community Safety, Health, and Well-Being. (2009).

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