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An Investigation into the Feasibility of Collecting Data on the Involvement of Adults and Youth with Mental Health Issues in the Criminal Justice System

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Canada owes the success of its statistical system to a long-standing partnership between Statistics Canada, the citizens of Canada, its businesses, governments and other institutions. Accurate and timely statistical information could not be produced without their continued cooperation and goodwill.

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Executive summary

At the request of the National Justice Statistics Initiative, the Canadian Centre for Justice Statistics (CCJS) examined the feasibility of collecting data on the involvement of adults and youths with mental health issues in the criminal justice system. The results of the feasibility study will help guide future consideration of the development of ongoing data collection to gather information on the nature and extent of the involvement of individuals with mental illness in the criminal justice system.

The feasibility study has three main goals:

1. to provide an overview of the history of societal and legislative treatment of mental illness in Canada and studies on the relationship between individuals with mental illness and the criminal justice system;
2. to consult criminal justice stakeholders on their information priorities, data collection, barriers to data collection, and the feasibility of collecting data on the contact of individuals with mental health issues in the criminal justice system; and
3. to propose viable options for data collection involving police, courts, and corrections.

The following report is divided into two parts. Section A addresses the first goal of the feasibility study by examining the background of the mental health issue. Section B addresses the remaining goals of the feasibility study in presenting the results of the consultations and proposed options for future data collection.

In response to a demand from the justice community, this current report focuses on issues related to mentally ill individuals who come into contact with the criminal justice system through calls for service to the police, or as accused or offenders in the criminal court and correctional systems. It does not examine issues involving persons with mental illness who are victims of crime.

Section A

Section A discusses the societal shifts in views on mental illness, definitional challenges regarding mental illness, criminal justice system processes, and previous studies on the prevalence of individuals with mental illness in the criminal justice system, and the relationship between mental illness and the justice system.

The perception and treatment of persons with mental illness has changed over time, including key developments in the criminal justice system. Since 1992, amendments to the *Criminal Code* have increased the rights of offenders found not criminally responsible by moving away from the prerogative to hold persons for an indeterminate period of time.

Each criminal justice sector approaches the issue of mental illness based on their particular roles and their legislated obligations. As such, there are often

differences in the way mental illness is defined, ranging from observational and reportable behaviours to official diagnoses. For an accused person, contact in the criminal justice system may involve all three levels of the criminal justice system, namely police, courts and corrections, or contact may be limited to one or two levels of the justice system.

Determining the prevalence of mental illness within these sectors has been attempted by a number of researchers, but these studies have been generally restricted to samples that were not nationally representative. Researchers' explanation of the relationships between mental health and the criminal justice system is presented in Section A, including two leading explanations: the increasing visibility of mentally ill individuals, as well as the increased risk to commit crime under aggravating circumstances.

Section B

Section B discusses the results of the consultations, including general objectives of data collection, definition of mental health and mental illness, information needs and priorities, data availability, a proposed data collection approach involving police, and other options for data collection.

Objectives for data collection

Those consulted were presented with five possible objectives for collecting data on persons with mental health issues in the criminal justice system and were asked to rank them in terms of importance. The five objectives presented to the stakeholders were:

- Improve public awareness regarding the issue;
- Assist those in the field and in policy to make information-based decisions regarding responses to the issue, including program development;
- Measure workload, performance and outcomes;
- Establish baseline information; and,
- Work toward consistent data recording practices.

Stakeholders often indicated that these objectives could not be viewed as mutually exclusive but would be overlapping.

Definitional issues

One of the main challenges to gathering consistent data on the involvement of individuals with mental illness in the criminal justice system is a precise and common definition. To assist with developing data collection, the consultation document (Appendix 3) asked stakeholders to consider what types of behaviours or disorders should be included when defining persons with mental health issues.

The results of the consultations reveal variations in definitions across the sectors. These differences in defining mental illness stem from differences in the operational demands and distinct roles of police, courts, Review Boards, and corrections. For instance, as the first tier of the criminal justice system, police must take immediate action on calls involving a variety of individuals, whether or not they have committed

a criminal offence and whether or not a clinical assessment has taken place. This is unlike the traditional criminal courts that strictly deal with individuals who have been charged with an offence and judge the accused persons based on the evidence. Typically, mental illness is raised in court when there is a question of fitness to stand trial or when the accused is believed to be not responsible for the crime on account of mental disorder. An assessment is required in these cases.

Some stakeholders argued that given the differing roles and expectations, a definition should be customized for each sector. On the other hand, a few argued for a more uniform conceptualization of mental health issues across all criminal justice sectors. This discussion examines the definitional issues based on the viewpoints of justice stakeholders.

Priority issues and information needs

As part of the discussion surrounding data needs, those who participated in the consultation were asked to identify the priority issues in their jurisdiction with respect to youth and adults with mental health issues. These priority issues covered the areas of police, courts/Review Boards and corrections. In this report, data needs related to the identified issues are listed directly following their description. Across the sectors, a few key issues were repeatedly mentioned. These issues are outlined below.

1. Lack of mental health resources

It was argued that a lack of mental health services and resources in Canadian communities for persons with mental illness was a significant contributor to the growth in the number of persons with mental health issues entering the criminal justice system. In the absence of sufficient services, many mentioned that the criminal justice system was being used as a primary mechanism for delivering service and healthcare to persons with mental health issues. These issues were particularly pronounced for rural areas and northern communities.

The corresponding data needs for the resource issues include:

- Prevalence, demographic, and mental health characteristics of persons with mental health issues in the criminal justice system; and,
- Number of persons with mental illness in the community who are not receiving services.

2. Relationship between mental illness and involvement in the criminal justice system

There was also some interest in the etiological link between mental illness and contact with the criminal justice system. This interest stemmed from a concern of the impact of limited access to social services in the community (such as housing, employment, and education opportunities) on those individuals with mental illness. The corresponding data needs relating to risk and protective factors on the involvement in the criminal justice system were identified as:

- Social determinants of mental health and contact with the criminal justice system (e.g., homelessness, education level, substance abuse, lack of employment opportunities);
- Offender's history of victimization; and,

- Type of mental illness that contributed to the offence.

3. Sharing of information and collaboration between service sectors

Many stakeholders also expressed the opinion that perceived system inefficiencies were rooted in restrictions on the sharing of information, including privacy legislation and the need for informed consent by clients, and a need for more collaboration between justice sectors and between justice sectors and the health sector. Barriers to information sharing affected the continuity of services to individuals with mental illness. To inform this issue, the following data needs were identified:

- Information on barriers to sharing information; and,
- Data on relationships between different sectors.

Data availability

To determine the data that are currently being collected or have ever been collected on persons with mental health issues and the criminal justice system, participants were asked about their organization's current and past data activities. These activities include systematic, on-going tracking of information or one-time studies. Within the three criminal justice sectors, namely police, courts/Review Boards, and corrections, it was revealed that there is little standardization in the types of data collected and the method of data collection and storage.

Among the different police services, information on the involvement of persons with suspected mental health issues may be captured on a regular or one-time basis. In all, eight types of data collection approaches related to mental health were identified through the consultation process. The majority of these data are stored electronically.

For the courts, data collection occurs within traditional criminal courts, specialized mental health courts, and Review Boards. The majority of provinces and territories collect information on fitness hearings and decisions of "not criminally responsible on account of mental disorder". These data are reported through the Integrated Criminal Court Survey (ICCS), which is managed by the Canadian Centre for Justice Statistics. Very little detail on specialized mental health courts is available through the ICCS, due to difficulties in distinguishing mental health courts from other criminal courts. Review Boards, which monitor cases where individuals have been found unfit to stand trial or not criminally responsible on account of mental disorder, record information within individual case files. This information is often not aggregated and is stored in paper format. In jurisdictions with larger caseloads, electronic databases are maintained.

At the corrections level, some standardization exists with the Integrated Correctional Services Survey (ICSS), which is managed by the Canadian Centre for Justice Statistics. However, this survey is limited in its application to the issue of mental illness. Only one ICSS data element contains information on mental illness and it is restricted to security concerns, namely it is limited to inmates with mental illnesses who are displaying coping problems within the prison environment. Data are also collected independently by provincial/territorial and federal governments. Correctional Service of Canada (CSC), which is responsible for federally sentenced offenders, has two data collection approaches that contain indicators of mental health status.

Feasibility of data collection involving the police

Part of the consultation focused on the policing community and the feasibility of a specific data collection approach. All stakeholders who felt in a position to comment on the policing sector were asked about the feasibility of conducting a survey with a sample of police services. It was proposed that the study would be conducted for a period of time during the year, whereby the sample of police services would be asked to complete a one-page survey on incidents involving persons with mental health issues.

Challenges to the specific approach were expressed (e.g., burden upon police services to take part, accuracy of the information that would be collected, etc.) as well as suggestions for modifying the approach.

Options for data collection

Section B concludes with a set of options for data collection involving police, courts/ Review Boards, and corrections. These options are based on the results from the consultations.

Household survey on contact with police and courts

An option to include questions on contact with police and courts should be considered if a general household survey on the mental health and well-being of Canadians is conducted in the future.

Police

One option is for police services currently using "Emotionally Disturbed Persons" forms to collaborate to standardize the data collection tool, as well as data capture and storage systems. Once standardized, police services using the EDP forms could make this form available to other police services to assist with increasing the collection of standardized data.

Courts

Options that could be considered are improvements to the Integrated Criminal Court Survey (ICCS) data, which is managed by the Canadian Centre for Justice Statistics (CCJS). This could be done by promoting consistency in reporting across jurisdictions, increasing survey coverage and identifying specialized mental health courts.

Promote consistency

Work undertaken to develop standards for capturing and storing mental health data, particularly as it relates to appearance types (fitness hearings) and appearance results (fit or not fit to stand trial), would be an important addition to the ICCS.

Survey coverage and coverage for mental health variables

Working towards full implementation of the ICCS, including participation from Quebec adult court and Saskatchewan courts, would increase survey coverage and would generate national level data.

Working with courts in Quebec (youth) and the Yukon to report the acquittal on account of mental disorder code value for the "type of decision"

(DECISION) variable would add to available information on the defence of not criminally responsible on account of mental disorder.

Working with Manitoba courts to report data on court-ordered medical/ psychological/ psychiatric reports (MPREPORT) would increase information on clinical assessments of accused persons.

Identify mental health courts

Working with jurisdictions that currently have mental health courts to identify courtroom numbers would be useful in distinguishing mental health courts from traditional criminal courts.

Review Boards

Justice Canada to repeat their 2006 study and expand the number of provincial/ territorial Review Boards included in the study.

Corrections

Federal, provincial and territorial correctional systems consider collaboration to identify standardized questions regarding mental health and methods to collect and store the data in an electronic format that would be in accordance with each jurisdiction's privacy legislation.

Section A

Overview of issues - Mental health and the criminal justice system

Introduction

Mental illness is a worldwide health problem that in 2001 was estimated to impact over 450 million individuals (World Health Organization, 2001a). It is further projected that the problem will continue to grow and the World Health Organization (2001b) predicts that by the year 2020 mental and behavioural disorders will account for 15% of the global burden of disease, up from 11% in 1990. In Canada in 2002, approximately 2.6 million individuals (or 10%) reported symptoms consistent with mental health disorders, including major depression, "mania disorder",[1] panic disorder, social phobia and agoraphobia,[2] as well as alcohol and illicit drug dependence (Statistics Canada, 2003). In addition, it is estimated that approximately 1% of the general population has schizophrenia (Health Canada, 2002). While many individuals may be able to cope with their mental illness or compromised mental health in the community, some may display an inability to cope and require more extensive treatment in a hospitalized setting, while others may come into conflict with the law.

While mental illness is not a new concern for the criminal justice system, there has been a growing consideration about the issue of mental illness in general and about the prevalence of individuals with mental health issues and their contact with the criminal justice system. Most notably, the Standing Senate Committee on Social Affairs, Science and Technology, as part of its ongoing study on general health and health care in Canada, formed a roundtable on mental health and mental illness in 2001. A national action plan, including analysis and recommendations relating to the criminal justice system, was developed based on consultations from various stakeholders including federal and provincial departments, non-governmental organizations as well as professionals and individuals. The Committee found that Canada currently lacks national data on the status of mental health in Canada in key areas, including the criminal justice system. While the involvement of persons with mental illness in the criminal justice system has been identified as an issue, it is equally important to recognize that many individuals with mental illness do not come into contact with the criminal justice system (Public Health Agency of Canada, 2006).

Before undertaking an assessment of the possible directions in data collection regarding persons with mental health issues in the criminal justice system, this report will provide some context to the issue. This present part of the report provides a brief overview of changes in societal views of mental illness; changes in the

Criminal Code's approach to mental illness; a discussion of definitional issues; an overview of key criminal justice processes involving individuals with mental illness, and; a brief summary of previous studies on the prevalence of the involvement of individuals with mental illness within the criminal justice system and the relationship between individuals with mental illness and their contact with the system.

Societal views of mental illness over time

Over time, various models have been used to explain mental illness, including those based on moral or religious beliefs and health perspectives. Prior to the late 17th century, Western countries, which were largely dominated by a Christian worldview, viewed individuals with mental illnesses as moral or spiritual deviants (Robb, 1934:235**;** Porter, 2002; Horwitz, 1977; McLachlin, 2004). As a result, the legal and religious authorities would often punish, exclude or eliminate individuals suffering from mental illness, regardless of whether they contravened laws (Szasz, 1970; Horwitz, 1977).[3]

The Western shift to a medical model of mental illness and a wide movement of institutionalization emerged in the 1700s, with a proliferation of mental institutions in the 18th and 19th century (Porter, 2002; Szasz, 1994, Fakhoury and Priebe, 2007). The first Canadian asylum was built in 1714 in Quebec City for female patients (Robb et. al., 1934). This was later followed by the construction of numerous mental asylums throughout Canada (Robb, 1934). A distinction in detention was also made between criminal offenders and offenders with mental conditions. In 1856, a Criminal Lunatic Asylum opened in Rockwood, Kingston, housing "the criminally insane" who were previously kept in the Kingston penitentiary.

In Canada, the deinstitutionalization model generally emerged in the 1960s as a result of issues related to the forcible confinement of individuals deemed mentally ill; the growing criticisms of psychiatric practices as dehumanizing and stigmatizing; and the emergence of the psychopharmacological treatment model[4] (Horwitz, 1977; Szasz, 1970; Krieg, 2001; Porter, 2002). Deinstitutionalization refers to a concerted effort by the mental health system to find community-based alternatives to psychiatric hospitalization. Treatments for mental illness were seen as possible in the community through alternative care and with appropriate medication (Hartford et al, 2003; Fakhoury and Priebe, 2007; Szasz, 1994).

However, it has also been argued that the deinstitutionalization movement has not led to adequate growth in community resources for individuals with mental illness (Sealy and Whitehead, 2004; Roesch, 1997). According to some researchers, many mentally ill persons lack supervision, access to adequate medication and services, and guidance to acquire basic skills for daily activities (Fakhoury and Priebe, 2007; McEwan, 2001).

The *Criminal Code* and mental illness

Along with a shift in the approach to treating the mentally ill in the general population, the *Criminal Code* treatment of individuals with mental illness has recently evolved. From 1892 to 1992, the provisions of the *Criminal Code* related to Mentally Disordered Accused gave powers to the Lieutenant Governor for the detention of persons found not guilty by reason of insanity. Persons could be held for an unspecified period of time.

Changes to this Lieutenant Governor's Warrant system were precipitated by the review of the Law Reform Commission of Canada in the mid-1970s, the findings of the Mental Disorder Project, and the Supreme Court of Canada ruling in R. v. Swain. The Law Reform Commission review found that persons who had been found "not guilty by reason of insanity" could be detained for a longer period of time than were persons found guilty (Law Reform Commission of Canada, 1976). The Mental Disorder Project, initiated by the Department of Justice in response to the review, stated in 1985 that the mental disorder provisions of the *Criminal Code* were in conflict with the *Charter of Rights and Freedoms*. Draft code amendments were circulated in 1986 (Pilon, 2001).

This Charter finding was confirmed with the Supreme Court of Canada ruling in R. v. Swain in 1991, which declared that the automatic detention of persons found not guilty by reason of insanity without a hearing to determine dangerousness or an appropriate disposition, was in conflict with the Charter. The government was given six months to pass remedial legislation.

Bill C-30 was subsequently proclaimed in 1992 to end the Lieutenant Governor's Warrant system and to change the verdict of "not guilty by reason of insanity" to "not criminally responsible on account of mental disorder" (NCRMD). Review Boards were also created as legal bodies to oversee persons found to be NCRMD, as well as persons found unfit to stand trial (UST).

In 1999, the Supreme Court of Canada clarified when detention was warranted in the case of R. v Winko. The Court found that detention was only warranted if the accused presented a significant threat to the public that is criminal in nature. If the person is not considered a threat, then an absolute discharge must be issued.

In 2005, further *Criminal Code* amendments were introduced with Bill C-10 following the Standing Committee on Justice and Human Rights' review of the mental disorder provisions of the *Criminal Code*. These amendments included a number of reforms, such as expanding the powers of Review Boards, allowing victim impact statements to be read by the victim at Review Board hearings, authorizing courts under certain conditions to order a stay of proceedings for accused deemed UST, and repealing unproclaimed provisions from the 1992 reforms (Department of Justice, News Release, May 19, 2005). This represented the last set of legislative amendments relating NCRMD and UST.

Definitional issues

Defining what constitutes mental illness is a significant challenge. Substantial variation exists on which behaviours and conditions should fall under the umbrella of mental illness, depending on the disciplines and mandates of the respective organizations or agencies. This is especially true within the criminal justice system.

Although no consistent definition exists across police services, the Canadian National Committee for Police/Mental Health Liaison (CNCPMHL), a subcommittee of the Canadian Association of Chiefs of Police, takes a broad view of mental illness. According to this group, individuals suffering from mental illness "refer to individuals who are out of touch with reality and who may need help to keep themselves or others safe" (CNCPMHL, Accessed June 16, 2008). Since the police are often the first responders to situations involving individuals with mental illness

and must react to situations, their own observations as well as observations and information from family, friends and neighbours are often used, rather than official psychiatric assessments or diagnosis. Policing decisions, however, must be in keeping with the *Criminal Code* and the relevant provincial/territorial mental health acts.

At the court level, non-specialized criminal courts rely on the provisions within the *Criminal Code of Canada* relating to fitness to stand trial and not criminally responsible on account of mental disorder (NCRMD), which view mental disorder as a "disease of the mind". An offender is declared unfit to stand trial when it is determined by the court that he or she is:

> unable on account of mental disorder to conduct a defence at any stage of proceedings before a verdict is rendered or to instruct counsel to do so, and, in particular, unable on account of mental disorder to (a) understand the nature or object of the proceedings, (b) understand the possible consequences of the proceedings, or (c) communicate with counsel. (*Criminal Code,* Section 2)

A verdict of NCRMD is based on psychiatric assessment by a court expert. There must be a mental abnormality causing impairment. This excludes voluntary intoxication or fleeting mental conditions, such as a concussion (Hucker, 2005). The individual must also not be able to appreciate the criminal act. Case law has found that the presence of mental disorder does not always result in a determination of NCRMD. For instance, criminal offences stemming from compulsive urges, such as sexual paraphilias or atypical sexual interests, will often not be considered NCRMD (Hucker, 2005).

At the correctional level, custodial facilities and community services view mental illness in terms of protection of self and others, re-offending and treatment needs. The determination of an offender's mental illness may be based on psychiatric assessments or diagnosis. For long-term offenders under the responsibility of the Correctional Service of Canada, the definition of mental illness is on the basis of the requirement to provide essential health care and "reasonable access to non-essential mental health care that will contribute to the inmate's rehabilitation and successful reintegration into the community" (*Corrections and Conditional Release Act*).

Similarly, provincial/territorial correctional services, which are responsible for accused persons remanded to custody, offenders sentenced to custody for less than 2 years and offenders sentenced to the community or conditionally released into the community, approach the mental health of individuals based on risks and needs. Forensic assessments to determine risks of re-offending and treatment needs of the offender are conducted in collaboration with forensic experts, mental health courts, community mental health services and substance abuse programs. Mental health needs are then addressed within the programs of offender rehabilitation and reintegration into community.

From a health perspective, there is some agreement that mental illness can be defined as a behavioural, psychological or biological dysfunction that impairs the person's ability to function with the everyday demands of life (Davidson & Manion, 2008; provincial mental health acts of Prince Edward Island, Nova Scotia, New Brunswick, Saskatchewan, Alberta, British Columbia). However, the extent of impairment varies widely depending on the type of mental illness, as well as on the individual's social support network and socio-economic situation (Public Health

Agency of Canada, 2006). In Canada, the classification of mental illnesses is based on the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD) Mental Health Section. DSM is developed and published by the American Psychiatric Association and covers the diagnostic criteria for all mental disorders, while the ICD is published by the World Health Organization and is the international diagnostic classification for diseases and health problems.

While defining the term mental illness is critical to understanding the relationship between mental illness and criminal justice system involvement, it is equally important to recognize that many individuals with mental illness do not come into contact with the criminal justice system and are able to cope with the illness with treatment and appropriate supports (Canadian Mental Health Association, 2004). Individuals with appropriate treatment for their mental illness who do not display any symptoms would often be considered in good mental health. Mental health is defined by the World Health Organization as a "state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (World Health Organization, Accessed June 19, 2008).

Key criminal justice processes involving individuals with mental illness

An individual with mental illness may come into contact with police (for either a criminal or non-criminal incident), courts or corrections as an accused, victim or witness to a crime. As an accused, the person may move through the three levels of the criminal justice system, namely police, courts, and corrections, or they may only enter one or two levels of the justice system. The process for adults and youth may be lengthy and complex. The following section highlights the key processes for police, courts, and corrections.

Police

Police respond to a variety of incidents, both criminal and non-criminal. When an incident involves a person with suspected mental health issues, the options for police often depend on whether a federal (including the *Criminal Code)*, provincial/territorial, or municipal statute has been violated (See Appendix 1, Diagram 1). If no violation is suspected, the police will decide on an appropriate course of action that may include apprehending the mentally ill individual according to the provincial/territorial mental health acts, referring the individual to community or family resources, or taking no further action.

When it is suspected that an offence has occurred, the police may choose to charge or informally divert the individual out of the criminal justice system. It has been suggested that an officer may be more likely to charge if violence has occurred, if the individual has been arrested before, or if there is an outstanding warrant due to the person's failure to appear in court for another offence (Alderman, 2003). Police may sometimes charge the individual with the offence if resources in the community cannot be found (Wilson-Bates, 2008; Arboleda-Florez and Holley 1988; Hartford et. al, 2005). However, even once charged, the accused can still be informally diverted, diverted to mental health intervention, or sent for psychiatric

assessment. In other cases, charged individuals will proceed to court, with or without pre-trial detention (e.g., remand).

Courts

Like any accused, when an adult or youth with mental illness is charged, a bail hearing will take place. The accused can either be released on bail or detained in either custody or a mental health facility for assessment.

Recently, mental health courts have emerged to address the issue of accused with mental health issues. These specialized courts involve mental health and legal professionals to accommodate the needs of people with mental illness charged with minor criminal offences. By integrating traditional criminal justice principles and the philosophy of providing treatment and help, the overarching goal is to minimize offenders' re-contact with the criminal justice system (McGuire, 2000). This is accomplished by making use of psychiatric, legal and community resources, notably diversion programs. For example, upon discharge into the community, these courts provide accused persons with information and contacts to facilitate access to accommodations, community psychiatric facilities, social assistance, and clothing (Ontario Court of Justice, 2006).

If fitness to stand trial is raised during court proceedings in traditional criminal courts or specialized mental health courts, a fitness hearing will be held. An accused may be found unfit to stand trial (UST) when it is recognized that he or she is not fully capable of instructing counsel or is not capable of understanding the nature and consequences of a trial (Steller, 2003). If the person is fit to stand trial and is found guilty, but mental illness is raised as a possible criminal defence, then the court must determine if the accused is not criminally responsible on account of a mental disorder (NCRMD). The two criminal court considerations, fitness to stand trial and not criminally responsible on account of mental disorder, are described below (Also see Appendix 1, Diagram 2).

Fitness to stand trial[5]

Where the accused is found UST, the judge can issue a disposition for either detention in hospital or conditional discharge.[6] An absolute discharge can not be issued. However, as of 2006, a stay of proceedings can be issued if the accused is not likely to become fit, the accused does not pose a significant threat to public safety and a stay is in the interests of the administration of justice.[7] If a stay of proceedings is not authorized by the court, the accused is assessed for fitness within 45 days by a forensic expert. In some cases, the accused may return to court once they are determined to be fit (e.g., with proper treatment or medication, they are able to understand the court proceedings and instruct their counsel). If the accused remains unfit after 90 days, the accused appears before a Review Board for assessment and disposition.

If the accused is still UST after the initial 90 days, the Review Board reviews the case on an annual basis. In these circumstances, the prosecutor is required to prove that there is enough evidence to bring the case to trial *(*referred to as prima facie) every two years for adults and every year for youths, and at any time the accused requests the proceeding. In cases where the court determines that there is no longer sufficient evidence to prosecute the accused, the case is dropped and an acquittal is entered.

When the accused is found to be fit, the trial may resume. The accused may be found UST again at any point before the verdict is reached.

Not criminally responsible on account of a mental disorder[8]

If the trial resumes, mental illness may be raised as an issue for defence, whether or not a fitness to stand trial was raised. According to the *Criminal Code*, the accused had to be suffering from a "disease of the mind" that prevented the accused from understanding the consequences of his or her actions at the time of the offence or of knowing they were wrong.

A verdict of not criminally responsible on account of mental disorder (NCRMD) is established through an assessment ordered by the court. The issue can only be raised by the prosecution after it has been established that the accused did commit the crime or after the accused has raised his or her mental capacity as an issue.

A verdict of NCRMD is not synonymous with a finding of guilt or a conviction. Rather, the verdict means that the court has ruled that the accused was not criminally responsible for his or her actions at the time the offence was committed.

After a verdict of NCRMD, the court may either give a disposition or defer the action to a Review Board. However, if either the prosecutor or the accused apply for the court to give the disposition itself, and if the court is able to do so, it must comply. The court may give the following dispositions:

- Detention in-hospital;
- Conditional discharge; and,
- Absolute discharge.

In cases where no disposition is made by the court, the accused person is referred to the provincial or territorial Review Board, where the Board will give a disposition within 45 days of the verdict. Dispositions given by the court, with the exception of absolute discharge, are reviewed by the Review Boards within 90 days and may be altered at that juncture.

For accused who receive dispositions for detention in-hospital, they are not required to submit to treatment while in-hospital. The disposition is intended to detain the accused in an environment where appropriate medical and psychiatric care is available to them. However, in cases where the accused refuses treatment that may be necessary to maintain good mental health, treatment may be deemed necessary. In these cases, treatment is administered in accordance with respective provincial/territorial mental health acts.

Consideration of mental illness at sentencing

Even when the accused person is found fit to stand trial and is found criminally responsible for the criminal incident, the courts may consider their mental health condition during sentencing. For both adults and youths, conditions can be attached to a non-custodial sanction, such as probation and for youth, intensive support and supervision orders. One of these conditions can be to attend a mental health treatment program.

In addition, under the *Youth Criminal Justice Act (YCJA)*, courts can sentence serious violent young offenders suffering from mental or psychological disorders to

a specialized custodial sanction. Known as the Intensive Rehabilitative Custody and Supervision order (IRCS), the court must also ensure that an individualized treatment plan has been developed for the young person.

Corrections

Correctional services include both custody and community services. Adult offenders as probation and conditional sentences, are the responsibility of the provinces and territories. In addition, provinces and territories are responsible for adults who are ordered to be held in custody before or during their trial (i.e., remand, or pre-trial detention) and other forms of temporary detention (e.g., immigration holds).

Youth correctional supervision programs include sentenced custody (both secure and open), remand (pre-trial detention) and community supervision, which are administered under the authority of the provincial/territorial agencies responsible for youth corrections.

When an accused with mental illness is admitted to custody, the provincial/territorial or federal facility will determine if the offender needs special accommodation, such as a treatment centre or unit, and if the individual needs psychiatric care, such as psycho-tropic medication and ongoing one-on-one psychiatric treatment (See Appendix 1, Diagram 3). Recently, the Correctional Service of Canada, which is responsible for federally incarcerated offenders, has adopted a number of strategies to improve the assessment of an offender's mental health upon admission. Assessments are undertaken to "establish treatment plans, facility placement, and data collection for future planning" and to provide successful transfer of care upon releasing offenders (Standing Senate Committee on Social Affairs, Science and Technology, 2006).

Previous studies on the prevalence of individuals with mental illness in the criminal justice system

Measuring the prevalence and nature of the criminal justice contact of individuals with mental illness is challenging given differences in definitions of mental illness and variations in data collection techniques (e.g., interviews, administrative records, etc.) across and even within criminal justice sectors. The lack of conformity in definitions and data collection instruments prevents comparison between studies.

This section highlights key Canadian studies that have attempted to document the extent and nature of mental illness in the criminal justice system. These studies are examined by the criminal justice sector, namely police, courts/Review Boards, and corrections. To date, most studies have focused on the corrections sector.

Police

In general, studies on the interaction between individuals with mental illness and the police have examined the frequency and nature of these interactions. While the approaches have varied, the most common data collection tool has been specially designed survey tools, as opposed to existing and ongoing data collection methods.

Most recently, Crocker et al analyzed six years of administrative data from the London Police Service and examined the rates, patterns, and types of police contacts among men and women with and without serious mental illness (Crocker et al,

2009). The study used a specially designed algorithm to extract records based from the police service's records management system. The algorithm extracted records based on police caution flags, addresses and key words indicative of mental illness. The study found that men and women with a serious mental illness represented less than 1% of individuals who had contact with the police service, but that they were involved in 3% of interactions. Individuals with serious mental illness were more likely than those without mental illness to be in contact with police as suspected offenders, to have a greater number of offences, to reoffend more quickly, and to be formally charged for a suspected offence.

The Vancouver Police Department conducted a prevalence study on patrol officers' contact with persons exhibiting mental health issues (Wilson-Bates, 2008). Over a sixteen-day period, two police officers from each squad were asked to complete a card to indicate calls where poor mental health was considered a factor in the call. Of the 1,154 calls, police identified 31% of all persons to be displaying poor mental health. These calls may include non-criminal activities.

Re-contact has also been examined. One study using administrative police records showed that persons with mental illness were twice as likely to be at risk of re-involvement with the criminal justice system compared to other offenders (Hartford et al, 2005).

Finally, a few studies have considered the nature of police criminal contact with mentally ill persons. A 1984 study in southern Alberta examined the socio-demographic, offending and incarceration characteristics of offenders displaying mild to severe disturbed behaviour (e.g., incoherent speech, delusions) and offenders not displaying abnormal behaviour (Arboleda-Florez and Holley, 1988). Using a survey form designed by the police, police officers scored the level of disturbing behaviour on a scale of 1 to 7. The results of the study showed that disturbed mentally ill persons did not have greater number of serious crimes than offenders with no mental health problems. No significant differences existed between the groups with respect to demographic characteristics, employment, alcohol/drug use, number of prior offences, rate of detention and length of stay in custody.

Canadian studies on the policing sector have suggested that police work often involves encounters with individuals with mental illness. However, these interactions are not necessarily criminal in nature and when they are criminal, they do not differ in seriousness from interactions with accused persons with no mental illness.

Courts and Review Boards

Available Canadian studies on the criminal courts tend to focus on fitness hearings and cases involving individuals not criminally responsible on account of mental disorder, rather than the number of individuals with symptoms of mental illness who have appeared in criminal courts. As indicated earlier, not all individuals with mental illness would be found unfit to stand trial or not criminally responsible on account of mental disorder.

Review Boards were created in 1992 to oversee individuals who were not criminally responsible on account of their mental disorder or were found unfit to stand trial. A Department of Justice study of administrative Review Board files from seven provinces and territories found that the rate of court cases referred to Review Boards increased 50% between 1994/1995 and 2003/2004 (Latimer and

Lawrence, 2006). This report indicated that this increase in admissions to Review Boards "is clearly not the result of more accused appearing in adult criminal court. Rather it is an indication that the courts were more likely to find an accused NCRMD/UST or that the issue of mental disorder was raised more often in court" (Latimer, and Lawrence, 2006). The study also indicated that 57% of those admitted for NCRMD/UST had prior criminal convictions.

Corrections

Much of the research on the prevalence of mental illness among correctional populations has focused on adult offenders in custody (Canadian Institute on Health Information, 2008).

A study of Alberta's provincial correctional population was based on clinical interviews using the Diagnostic and Statistical Manual of Mental Disorders-II-R (DSM-III-R) and data from legal, criminological and medical records of inmates admitted to Calgary Remand and Detention Centre (CRDC) (Arboleda-Florez et al., 1995). The 1995 study found a higher prevalence of mental illness among remanded persons than in the general non-incarcerated population. Other findings included a higher prevalence among men and Aboriginal people, as well as differences in types of mental illness depending on the offender's age.

The Correctional Service of Canada collects information on the mental health of federally incarcerated inmates. This information is captured at the point of admission. According to the "Corrections and Conditional Release Statistical Overview", 10% of the federal inmates in 2006/2007 were diagnosed as having mental illness at time of admission (Public Safety Canada Portfolio Corrections Statistics Committee, 2007). The report also shows an increase in the proportion of offenders using prescribed medication for mental health issues, from 10% to 21% between 1997/1998 and 2006/2007.

There is some evidence to suggest that the prevalence of mental illness among federally incarcerated offenders has increased since the 1960s, the decade when deinstitutionalization commenced. In the final report of the Standing Senate Committee on Social Affairs, Science and Technology (2006), Howard Sapers, the Correctional Investigator of Canada, noted that the number of offenders with mental disorders admitted to federal institutions in 2004 was 60% higher compared to 1967 (57% for men and 65% for women). When substance abuse was included, the total increase was 84%.

Criminal histories between mentally ill incarcerated offenders and non-mentally ill incarcerated offenders have been examined. One national study found that both mentally ill individuals and those without mental illness in long-term custody such as federal prisons have "equivalent criminal history" outside and inside their current institutions (Porporino and Motiuk, 1995). This research included a sample of 72 Canadian federal inmates in long-term custody and data were collected from various sources of the Correctional Services of Canada (CSC) and the Canadian Police Information Center. One group (36 inmates) consisted of mentally disordered offenders. The other group comprised non-disordered offenders with matching characteristics, including age at the time of survey, type of offence and length of sentence. The study showed that 67% of the "disordered-offender" group and 64% of those without any disorder were "first time federal offenders" (Porporino, 1995, p. 35).

Evaluation studies have also been conducted on the effect of the change in legislation regarding mentally disordered offenders on correctional services (Roesch et. al, 1997; Laberge et al. 1995). Based on administrative data from British Columbia between 1992/1993 and 1993/1994, researchers found that the Canadian *Criminal Code* changes had a direct impact on the number of mentally disordered individuals sent to remand (Roesch et. al, 1997). The findings suggest an increase in the number of people remanded for pre-trial evaluation for such cases.

With respect to mental health issues among youth in custody, two Canadian studies examining populations in British Columbia and Toronto have looked at prevalence (The McCreary Centre Society, 2005; Ulzen and Hamilton, 1998). The studies provide prevalence rates for disorders such as depression, attention deficit hyperactivity, substance abuse, fetal alcohol spectrum disorder, post-traumatic stress disorder and schizophrenia. In their analysis, the Canadian Institute for Health Information (2005) suggests that prevalence of these disorders may be higher among incarcerated youth than in the general population.

Relationship between mental illness and the criminal justice system

Research literature offers some suggestions on the relationship between individuals with mental illness and their contact with the criminal justice, including the increased visibility of individuals with mental illness in the community, and; mental illness as a risk factor for criminal involvement.

Increased visibility of individuals with mental illness

One school of thought suggests that the increased visibility of mentally ill persons outside the mental health care system has manifested itself in increased interaction with the criminal justice system (Holley & Arboleda-Florez, 1988; Adler, 1986; Menzies, 1987; Teplin, 1984). In other words, the argument made is that there are no predisposing factors of mental illness that inherently increase the propensity for criminal activity. The argument stems from the position that "insufficient and under-funded local mental health services" in the wake of the deinstitutionalization policy have contributed to the excessive visibility of persons with mental illness in the community, and thus to their increasing interaction with the police (Hartford et al, 2005, p. 8; Riordan, 2004, Canadian Mental Health Association, 2004).

The Canadian Mental Health Association (2004) further argues that persons with mental illness are susceptible "to detection and arrest for nuisance offences (e.g. trespassing, disorderly conduct)" and "more likely to be remanded in custody for these minor offences". A similar pattern in criminal justice system contact has been also been noted by Canadian and American researchers (Porporino, 1995; Adler 1986; Teplin, 1984; Teplin, 1990).

It has been argued that stigma and discrimination tend to increase the visibility of mentally ill persons, as it can cause difficulties in accessing accommodations, treatment and services (Link and Stueve, 1995). A report by the Public Health Agency of Canada (2006) states that "stigma and discrimination attached to mental illnesses are among the most tragic realities facing people with mental illness in Canada…[promoting] stereotyping, fear, embarrassment, anger and avoidance behaviours" (p. 21).

One indicator of the visibility argument for the association between persons with mental illness and the criminal justice system is the co-existence of homelessness and mental health problems. According to a 1998 study within the City of Toronto, "approximately 66% of homeless persons have a lifetime diagnosis of mental illness. This is 2-3 times the rate in the general population" (Riordan, 2004; see also Canadian Institute for Health Information, 2007). In light of this, some researchers argue that mentally ill persons who are also homeless tend to have greater visibility and are more likely to "be arrested at a disproportionately higher rate compared to non-mentally disturbed offenders" (Arboleda-Florez et. al, 1996, p. 19-21) and are more frequently sent to remand due to inability to pay bail or find legal representation (Davis, 1992).

Many argue that persons with mental illness who offend enter a cycle of criminalization where they are more likely to return to the criminal justice system than those who are not mentally ill. Specifically, the 2006 final report of the Standing Senate Committee on Social Affairs, Science and Technology reports that a cycle is perpetuated by the absence of an adequate transition from correctional services to community-based treatment or support programs. It was stated that the "lack of continuity" often puts offenders, particularly released offenders, at risk of experiencing a number of problems. According to the report, not only do many released offenders with mental disorder come into (re) contact with the criminal justice system, they also tend to look for other means to alleviate their problems, such as self-medication with illegal drugs. This is particularly the case in the absence of sufficient treatment and adequate access to community support and constant stigma and discrimination.

Mental illness as a risk factor for criminal involvement

Other researchers have suggested that individuals with mental illness are at higher risk of committing crime and violence than individuals in the general population (Modestin, 1998; Paterson et. al, 2004). As a whole, the body of academic literature tends to support some type of association between mental illness and violence; however, the argument of an association is tempered by the following:

- the association is often significant but small;
- the co-morbidity with substance abuse increases the risk;
- socio-demographic factors play a role in the association;
- active symptoms are more important than a diagnosis; and,
- the direction of causality is not fully understood (Mulvey, 1997).

In general, researchers have relied on four methodological approaches to test an association between mental illness and criminality. These methods have included examining mental illness among the offender population, criminal behaviour among individuals with mental illness, community studies examining mental illness and criminality separately and then analyzing the relationship, and longitudinal birth cohort studies (Modestin, 1998; Paterson et al, 2004).

Proponents of the increased risk of criminality among individuals with mental illness warn that many studies on this topic are flawed in their methodology, sampling and design (Sirotich, 2008; Paterson et. al. 2004, Arboleda-Florez et. al. 1996; Link & Stueve, 1995). It has been argued that studies are often non-comparable and/or inaccurate due to differences in the subjects studied, absence of standardization,

lack of control for confounding variables, and lack of proper techniques to determine whether mental disorder precedes criminality or vice versa (Ibid.).

Conclusion

The involvement of individuals with mental illness in the criminal justice system is receiving increasing attention, coinciding with a larger movement to study and respond to the mental health of Canadians. In 2003, the Standing Senate Committee on Social Affairs, Science and Technology under the leadership of Senator Michael Kirby, undertook a national study of mental health, mental illness and addiction. The results of this study were a set of recommendations, including the creation of the Mental Health Commission of Canada in March 2007.

In response to a demand from the justice community, this current report has focused on issues related to mentally ill individuals who come into contact with the criminal justice system through calls for service to the police, or as accused or offenders in the criminal court and correctional systems. It does not examine issues involving persons with mental illness who are victims of crime.

The perception and treatment of persons with mental illness has changed over time, including key developments in the criminal justice system. Since 1992, amendments to the *Criminal Code* have increased the rights of offenders found not criminally responsible by moving away from the prerogative to hold persons for an indeterminate period of time.

Each criminal justice sector approaches the issue of mental illness based on their particular roles and their legislated obligations. As such, there are often differences in the way mental illness is defined, ranging from observational and reportable behaviours to official diagnoses. For an accused person, contact in the criminal justice system may involve all three levels of the criminal justice system, namely police, courts and corrections, or contact may be limited to one or two levels of the justice system.

Assessing the prevalence of mental illness within these sectors has been attempted by a number of researchers, but these studies have been generally restricted to samples that were not nationally representative. Researchers' explanation of the relationships between mental health and the criminal justice system was also discussed in this report, including two leading explanations: the increasing visibility of mentally ill individuals, as well as the heightened propensity to commit crime.

Section B

Results of consultations and options for future data collection

Introduction

The issue of individuals with mental health issues in the criminal justice system is attracting increased interest and concern in Canada. While there have been pockets of studies and data collection activities trying to quantify the issue at the police, courts and corrections levels, there is presently a lack of comparative and comprehensive data to understand the extent of the problem, to inform decision-making regarding policy and action, and to measure outcomes of current initiatives and processes.

As a result, the Canadian Centre for Justice Statistics (CCJS), at the request of the National Justice Statistics Initiative, examined the feasibility of collecting data on the involvement of adults and youth with mental health issues in the criminal justice system.

Section B addresses two of the three main goals of the feasibility study:

1. to consult criminal justice stakeholders on their information priorities, data collection, barriers to data collection, and the feasibility of collecting data on the contact of individuals with mental health issues in the criminal justice system; and
2. to propose viable options for data collection involving police, courts, and corrections.

Method

The information contained in this document provides a summary of the consultations that were held between September 2007 and June 2008. The scope of the study encompasses all sectors of the criminal justice system, including police, courts, Review Boards and corrections. Consequently, a number of stakeholders were contacted to participate in the consultation process, including the following:

- Policing services;
- Courts – both traditional criminal courts and specialized mental health courts;
- Review Boards;
- Correctional services;
- Mental health organizations;

- Academics and researchers; and,
- Non-governmental organizations.

In total, over 100 individuals participated in the consultations by phone, in-person, or in writing (Appendix 4). Representatives from each sector were able to participate in the consultation. Some who were contacted for the consultations were unable to participate. While a large number of individuals from across Canada were involved in the consultations, the information presented in this report should not be considered representative of all viewpoints on the collection of mental health data in the criminal justice system.

Section B of the report is divided according to criminal justice sectors, namely police, courts/Review Boards, and corrections. Each section presents the stakeholders' views on general objectives of data collection, definition of mental health and mental illness, information needs and priorities, and data availability. Options that could be considered for future data collection are described for each sector of the criminal justice system.

Police

Objectives for data collection

Among police services, the most commonly identified objectives for data collection on persons with mental health issues in the criminal justice were 1) to facilitate information-based policy and programming decisions regarding responses to the issue and 2) to measure workload, performance and outcomes.

While only one police service ranked the need for consistent data recording practices as the most important objective among the five presented, most recognized this objective as worthwhile. Additional objectives were also mentioned, including the need to determine gaps in community resources and training and education needs of police and other criminal justice workers.

Definitional issues

In defining and responding to the issue of mental illness, there was a consensus that police must rely on observable behaviours and the environment to determine the presence or possibility of mental health issues. Diagnosed mental health conditions based on medical assessments are often not readily available or are only accessible as a result of police prior contact with the individual or information obtained from family or friends.

When asked which specific types of behaviours or conditions should be included in a definition of mental illness, the Canadian National Police Mental Health Liaison Committee,[9] a subcommittee of the Canadian Association of Chiefs of Police, argued that the clinical diagnostic criteria within the "Diagnostic and Statistical Manual for Mental Health Disorders" (DSM-IV-TR) can be useful. However, they argued that personality disorders that are criminogenic by nature, such as anti-social personality disorders, should be excluded in a definition of mental illness. In addition, many police services indicated that along with severe mental illness, such as schizophrenia, other conditions such as permanent brain injury/damage (e.g., Fetal Alcohol Spectrum Disorder) and substance abuse (due to evidence of co-morbidity with mental illness) should be included within the definition of mental illness.

At the operational level, a definition has been developed by some urban police services. Specifically, police services, such as the Ottawa Police Service and the Toronto Police Service, reported using the definition of "emotionally disturbed persons" when dealing with individuals they suspect as suffering from mental illness. This type of definition overcomes the difficulties in assessment and distinguishing between different types of mental disorders. It relies on visual cues and does not compel the officer to make a diagnostic assessment of the individual.

An observational definition, however, can pose some problems when applied to the issue of persons with mental health issues, including the following:

a. not all people who are emotionally disturbed are mentally ill;
b. the behaviour of an individual can be situational or fleeting as a result of a stressful situation;
c. it may be difficult to distinguish mental illness from substance use; and,
d. observations may be considered subjective.

Priority issues and information needs

A range of stakeholders, including police, provincial/territorial departments responsible for justice matters, academics, and non-government organizations, provided feedback on the issues relating to police contact with youth and adults with mental health issues. These issues, along with the corresponding data needs, are outlined below.

Overall, those consulted indicated that it would be ideal to have data at all geographic levels, including municipal, provincial, regional and national. Various arguments were presented in support of collecting and analysing data at different geographic levels, including legislative jurisdiction and budget allocation.

1. Workload of police

By far, police workload in responding to persons with mental health issues was identified as a leading priority issue. Police contact with persons with mental illness can include criminal and non-criminal contacts and can be the result of pro-active policing or call for service.

Consultation participants, including police and academics who have conducted research in the area, reported that there has been an increase in the number of police contacts with individuals with mental illness. It was said that in many cases, these interactions are associated with relatively minor offences, such as disturbances of the public peace, or non-criminal activities. For example, two major municipal police services, Regina and Vancouver police, reported that about half of their service calls involve non-criminal activities by individuals with a mental illness.

In addition, many participants reported that repeat contact involving the same individuals accounts for a substantial proportion of cases. This revolving door of individuals with mental illness was often attributed by participants to a lack of mental health monitoring and an absence of community resources.

It was also reported that the time taken to deal with a situation involving a youth or adult with mental illness is generally longer than a situation with no indication of mental illness. One academic consulted advised that results of an urban police study showed the average contact time was three times longer for mental health cases.

Consultation participants pointed to a number of reasons for the greater time spent on mental health calls. In non-criminal cases, the process to apprehend an individual under the provincial/territorial mental health act can involve a number of prolonged steps, depending on the proximity to hospitals.[10] The police officer is required to accompany and provide security at the local hospital while the individual waits for evaluation by a physician. In remote and northern communities, this process can be even longer, as a 2-person police escort must transport the individual to the nearest hospital setting, which can sometimes be located in the southern region of provinces.

Even when an apprehension under the mental health act is not undertaken and the incident is minor, participants indicated that locating appropriate resources in the community for diversion can be an onerous and lengthy task. In some cases, police may advise the individual with mental illness to voluntarily attend the hospital emergency room. This avoids an official apprehension under the mental health act and therefore eliminates wait times at the hospital and reduces the amount of paperwork.

In addition to police workload involved in apprehension, police are also responsible for transporting individuals who were charged and found not criminally responsible on account of a mental disorder. Depending on the location of the closest available forensic institution, which can vary based on the forensic bed capacity, police may be required to travel outside the jurisdiction of their local police service.

Measuring the workload of police with respect to mental health issues was seen as important to assessing the extent of the problem and to determining the policing costs and allocation of human resources. Through the consultations, the following workload indicators were identified as important:

- Number of contacts between police and individuals with mental health issues;
- Nature of contact: non-criminal or criminal. If criminal, type of crime (minor or violent crimes);
- Characteristics of individuals with mental illness, such as age, sex, occupation, medication use;
- Number of repeat contacts between police and individuals with mental health issues;
- Average length of time spent during interactions with mentally ill individuals;
- Identification of areas with higher incidence of mental illness within policing boundaries;
- Criteria used by police in making decisions on appropriate actions;
- Action taken (e.g., no action, charge, divert to social services, apprehend under mental health act);
- Number of apprehensions under the provincial/territorial mental health acts;
- Number of individuals with mental illness brought to hospital and average wait time at the hospital; and,
- Outcome from hospital visit (e.g., admission, discharge).

In most cases, stakeholders suggested the use of comparison groups (i.e., mentally ill contacts versus non-mentally ill contacts) in the collection and analysis of data.

2. Absence of community resources

Closely related to the issue of police workload was the availability of resources in the community. Consultations indicated that the suspected increase in mental health calls may be linked to an absence of adequate mental health services in the community and the subsequent reliance on police as the access point for services. In addition, the lack of resources was said to limit the non-charging options for police.

Along with a stated scarcity of readily accessible mental health treatment programs, it was reported that the absence of social supports, such as appropriate housing and drug treatment programs, is seen to exacerbate mental health co-morbidity issues. A lack of adequate resources to address compromised social well-being, such as homelessness, and to address addictions was viewed as contributors to police contact.

When police involvement is initiated with individuals suffering from mental illnesses, consultation results indicated that police participants believed they have limited options in providing appropriate responses. Diversion for minor offences or referrals was seen as difficult to manage in an environment with a perceived absence of or an actual lack of community resources. A need for greater education and awareness on alternatives to charging was seen as critical to limiting individuals' involvement in courts and corrections. The absence of community resources was also linked to the issue of police re-contact, as the likelihood of re-involvement was argued to increase with a lack of adequate health care plan for those with mental illness, combined with limited access to services.

For youth, consultation participants commented that while the *Youth Criminal Justice Act (YCJA)* contains provisions to assist police with mental illness cases, it was felt that there was a lack of services or protocols to put these provisions into practice. Participants also stated a difficulty in addressing service needs of older adolescents aged 16 to 17 years.

To inform the community resource issues, stakeholders have indicated the following data needs:

- Identify community resources that can and would be willing to provide services to individuals with mental illness that come into contact with police;
- Number and percentage of cases where the police would have diverted/ referred the individual with mental illness to community service, if services were available;
- Number of individuals with mental illness who come into contact with the police who previously accessed mental health services and/or who were on prescribed medications;
- Type of treatment needs among mental health contacts; and,
- Measurement or assessment of the effectiveness of mental health services in decreasing future involvement in the criminal justice system.

3. Assessment of mental illness and training issues

While police participants viewed mental health issues as a priority, many participants expressed the view that police are not always equipped to assess mental illness, particularly the specific type of mental illness or diagnosis. As visual cues are the primary tools used by police during an incident, it was thought that basic education on symptoms and even myth-busting would be useful.

Some stakeholders argued that the lack of recognition of mental illness could be due to minimal police training on mental illness. As a result, there was an identified need for properly trained police to deal with mental health cases. At the same time, it was also noted that in some larger police services, crisis intervention teams, comprised of a police officer and health worker, are specially trained to deal with individuals presenting symptoms of mental illness. These teams are dispatched to suspected mental health calls and attempt to keep individuals with mental health issues out of the court system, either by referral, pre-charge or post-charge diversion.

To address the information priority surrounding assessment and training/ qualifications, consultation results reveal the following data needs:

- Information on available responses based on specific mental health condition;
- Number of calls for specialized mental health crisis intervention teams; and,
- Action taken by police services with mental health crisis intervention teams.

4. Information sharing

Consultation participants said that one of the difficulties in easily identifying and responding to persons with mental illness is the challenge of information sharing between police and health authorities. While recognizing and respecting that privacy legislation is necessary to protect individual's privacy rights, the question of privacy and confidentiality was identified as a barrier to sharing client information for the purpose of coordinating and improving service.

In addition, in some jurisdictions, mental health files are legislated for deletion after a set period of time. This introduces issues for long-term tracking and monitoring of individuals.

To address this information priority, stakeholders have proposed:

- Data that would integrate police and health information for research and operational purposes.

5. Nature of interactions between police and persons with mental illness

Due to the complex nature and dynamics of the interactions between police and persons with mental illness, police participants commented that it was important to track both positive and negative encounters with individuals presenting mental illness. An example of a positive police encounter includes outreach with the homeless population who are mentally ill, while the use of force against individuals with mental illness represents an example of a negative encounter. The element of officer safety in incidents involving individuals with mental illness was also raised as an important issue.

The data needs for documenting these interactions include the following:

- Recording and reporting on positive interactions between police and persons with mental illnesses;
- Number of complaints against the police regarding persons with mental illness, including use of force and deaths in police custody (suicide and deaths by officers); and,
- Data on officer safety involving individuals with mental illness.

Data availability

Consultations revealed that information on police contact with individuals with mental health issues is being collected by some police services. The purpose of capturing these data, however, is varied and includes legal requirements relating to the mental health acts, operational needs (e.g., safety of attending officer) and data analysis. Given the differing goals underlying data capture, there is no standardization in the methodology or in the type of information captured. In all, eight types of data collection approaches related to mental health were identified as current methods of data collection. These included mental health act calls, calls for service, involuntary admission of an individual to a mental hospital, activity reporting systems, use of force reports, specialized data collection tools for emotionally disturbed persons, cross-sectional studies and the homicide survey. The majority of these data are stored electronically.

1. Calls for service – Apprehensions under the *Mental Health Act*

In general, provincial and territorial mental health acts provide powers to police to apprehend a person when the officer has reasonable and probable cause to believe that the person is a threat to him/herself, a threat to others, or shows a lack of competence to care for him/herself. The action of compelling a physician's assessment and possible involuntary admission to hospital legally requires police to complete a mental health act apprehension form. These forms are submitted by officers to their respective police detachment.

Mental health act calls can also be recorded on the police service's Computer Aided Dispatch (CAD) system and the Records Management System (RMS). The RCMP specifically uses the Police Reporting and Occurrence System (PROS) to score mental health act calls for service as "Mental Health Act Non-Criminal" and "Mental Health Act - other activities". This reporting, which is recorded electronically, includes all mental health act calls for both adults and youth. This information is then used to track the specific time requirements and workload issues. Known as the Police Resourcing Methodology, the RCMP and OPP use the system to indicate the prevalence of mental health act events per detachment and zone, as well as time spent on the call.

2. Flagging calls for services as mental health

For some police services, when calls are received through emergency dispatchers, the dispatcher may enter a mental health flag in the Computer Aided Dispatch (CAD) system and for some police services, this information is automatically transferred into the Records Management System (RMS). The primary objective is to alert attending officers of the nature of the current incident, as well as any future incidents involving the same individual. This operational type of information, however, has its limitations for data analysis in terms of the type of data capturing system and the way in which the mental health flag is maintained.

Within the CAD system, a number of calls can be entered for a single incident. For example, separate individuals can place calls into the police station for the same incident, all of which can be recorded by the dispatcher. This could lead to an exaggeration of the volume of mental health flags. The CAD system, however, has the advantage of capturing all calls for services, including non-criminal activities. This may help to inform police workload issues.

In terms of reporting mental health flags, there is an absence of consistent reporting across jurisdictions and by individual dispatchers and officers. This prevents a reliable assessment on the actual prevalence of mental illness among all calls for service. Furthermore, the flag often does not undergo updates based on the outcome of the call. It may not be removed if it is determined that the incident was unrelated to mental health issues and alternatively, a mental health flag may not be added when a mental health issue is determined after police appearance and investigation on the scene. Depending on the police service, this absence of updates may be due to the authorization level required for modifications. Specifically, for some police services, individual officers cannot make changes to the records and can only be modified by the records manager.

3. Involuntary admission to a mental hospital

Information on involuntary admissions to mental hospitals is forwarded to the Canadian Centre for Justice Statistics (CCJS) as part of the Incident-based Uniform Crime Reporting Survey (UCR2). Police services are mandated by the *Statistics Act* to report if an accused person is not available for prosecution because: a) they are in a mental institution without the hope of early release or b) as per conditions set by the court or Review Board under C.C. 672.54(b).

4. Activity reporting system

Information on mental health may also be recorded in the activity reporting system, which describes the activities of an officer during the course of his or her shift. A duty code related to mental health, however, it is not consistently reported. Also, if an offence occurred, the offence code takes precedence over the mental health code. A secondary code of mental disorder will not be captured.

5. Use of force reports

All police services are required to complete a "use of force" form when force is used by officers against a suspect. This form includes information on persons designated as emotionally disturbed. This data source for individuals with mental illness is limited to a small number of cases and would not serve as an indicator of prevalence.

6. Specialized data capture for mental health calls

Among police services consulted, some indicated that data on mental health cases are maintained on a regular basis. An "emotionally disturbed persons" (EDP) form was the most common data collection tool. Although there are variations in the form depending on the police service, the form typically contains observational information on the incident and the individual, the individual's thinking (e.g., displaying disorganized thinking, abnormal speech, and odd beliefs), the type of behaviour exhibited, dwelling information, and substance use. In addition to differences in the type of information collected, police services also vary in when EDP forms are completed. For some, the forms are completed for all interactions involving persons with a suspected mental illness. Others only complete the form when the police officer is apprehending the individual under the mental health act or when the officer is referring the individual to specialized crisis intervention teams, which are teams comprised of police officers and health workers.

Besides EDP forms, a few police services reported tools for capturing information on the mental health of contacts. Again, the type of information is based on observations, as opposed to mental health diagnosis. One division of the RCMP currently uses a standardized Police Template that provides physicians/nurses with data from mental health calls for service.

7. Cross-sectional studies on police contact involving individuals with mental illness

In addition to ongoing data collection, some police services have undertaken special one-time studies to determine the extent of police contact with individuals suffering from mental illnesses. For example, the Vancouver police service conducted a 16-day prevalence study with a sample of police officers. Using a paper-based system, officers indicated whether the incident, both criminal and non-criminal, was related to an individual's mental health condition. This type of study captured the prevalence but did not examine characteristics of the incident or individual.

8. The Homicide Survey administered by the Canadian Centre for Justice Statistics

The Canadian Centre for Justice Statistics manages the annual Homicide Survey, which collects information on all homicides in Canada. All police services are mandated to provide incident, victim and accused information on homicides. Within the accused questionnaire, police services must indicate if the suspect was suffering from a mental or developmental disorder at the time of the homicide. The variable is based on the investigating officer's assessment and does not need to be based on an assessment or diagnosis of a medical professional. In addition, the information is not subject to release under the *Access to Information Act*.

This type of status information on the mental health of the offender is not currently captured with the Incident-based Uniform Crime Reporting Survey. This police-based survey, which is also managed by the Canadian Centre for Justice Statistics, records a variety of detailed accused, victim and incident information for all crimes reported to police and substantiated through police investigation.

Feasibility of data collection involving the police

Those consulted were asked to provide feedback on a possible approach to gathering information on police contacts involving individuals with mental health issues. Specifically, all participants, including police and experts who felt they were in a position to comment on the policing sector, were asked about the feasibility of conducting a survey with a sample of police services. It was proposed that the study would be conducted for a period of time during the year, whereby the sample of police services would be asked to complete a one-page paper survey on incidents involving persons with mental health issues.

While stakeholders expressed a number of challenges with the proposed data collection, nearly all participants indicated that some type of data collection involving the police would be feasible. Their views differed on the actual approach. The challenges and suggested modification to the approach are presented below.

Challenges in proposed approach

The most frequently expressed concerns of any form of data collection were related to respondent burden and defining mental illness. Participants indicated that front-line officers are already over-burdened with calls for services and work within limited resources. A few stakeholders further indicated that police are over-studied. Some police services were apprehensive that an additional survey would duplicate existing data collection efforts.

It was also expressed that completing a survey on mental health contacts would be time consuming and would heighten officers' workload. As a result, individual officers may be unwilling to participate. Integrating the survey within existing records management systems was identified as a possible way to reduce respondent burden and to monitor changes in mental health contacts over time. Specifically, it was suggested that a drop-down mental health template screen be added to Record Management System (RMS). This would ensure standardization across all police services.

Determining a practical and reliable definition of mental illness was seen as critical for successful data collection. For some stakeholders this also meant providing training for officers, such as training in diagnostic tools. Among academic stakeholders, it was felt that researchers should accompany police officers, while for police stakeholders, partnering between police and health workers was seen as most beneficial to collecting data on individuals with mental health issues.

Any new data component would have to be simple and reflect the expertise of police personnel, namely questions based on observational/visual cues. A few of those consulted noted that mandating data collection would increase reliability of the data; that is, requiring completion of the survey under the authority of the *Statistics Act*.

To further ensure quality data capturing, many stakeholders recommended proper monitoring of data collection and follow-up, particularly at the initial stages of implementation. This data quality step could be done by researchers or the records management team. The importance of accurate and appropriate data analysis was also stressed during consultations.

It was also proposed that a police mental health survey should be representative of urban and rural police services, as well as police services with and without specialized mental health crisis teams. The challenges for these latter police services, such as access to community resources and action taken would be different. Others mentioned the importance of data capture at different times of day and during the year to account for variations.

Other concerns for data collection included consistency of reporting in larger detachments, as well as between individual officers with differences in experience and training.

Modified data collection approach by the police

Based on the consultations, it was determined that a data collection strategy relying on a paper-based survey would result in a high respondent burden, especially if implementation involved all police services in Canada. Such an approach would also require site management of paper forms prior to processing by the Canadian

Centre for Justice Statistics. This would be particularly challenging for police services without specialized crisis intervention teams.

Consultation participants' feedback suggests that future data collection should look toward a long-term solution by integrating questions within a standardized and existing crime survey. Realizing this vision would essentially require working within the records management systems and modifying the existing Incident-based Uniform Crime Reporting Survey (UCR2). In doing so, data on prevalence of incidents involving emotionally disturbed persons in Canada would be available on an annual basis, along with data on the detailed characteristics of the incident, victim and accused.

The disadvantage of using the UCR2 survey would be the inevitable exclusion of non-criminal incidents, since the UCR2 program is not mandated to record other non-criminal calls for service. In other words, a crime must have occurred for any information to be recorded.

While the integrated approach would seemingly have less respondent burden for the police, previous UCR2 data elements that relied on police observations and interpretation have been plagued by reporting problems and questions of data quality. For example, earlier versions of the UCR2 survey contained a data element on alcohol/drug consumption to understand the prevalence of drug and/or alcohol consumption by accused persons. The criterion for police completing this information for the UCR2 Survey was police observations of apparent alcohol or drug consumption prior to the time of the incident. Despite an identified need for this information, this variable was rarely completed by officers for two reasons. First, the police were not always able to determine through observation if the accused had consumed drugs, alcohol or both. Second, there was concern among officers that the information based on observation could subsequently be used or challenged in a subsequent court case. The problems led to the eventual removal of this data element from the UCR2 survey.

Considering the observation-based similarity between alcohol/drug consumption and emotionally disturbed persons, it is likely that introducing a variable to measure emotional disturbance and indicators of possible mental health issues could suffer the same data quality issues. In addition, to accurately document the indicators of emotionally disturbed persons, a new observation-based data element on the UCR2 would require numerous data fields relating to appearance, thinking, mood, behaviour, dwelling/housing and personal hygiene. This is because a range of indicators, interpreted as a whole, are needed to ensure the accuracy of the accused status as emotionally disturbed. The number of required data fields would be substantially higher than any current data element on the UCR2 survey. This would further heighten the possibility of incomplete data.

Moreover, in some police services, the information that is entered on Records Management Systems is actually completed by records management personnel who review narratives written by the attending officers and then complete the required UCR2 data fields. As such, for these police services, the scoring of a UCR2 variable on emotional disturbance would require the interpretation of the records management personnel and, depending on the depth of the narrative taken by police, may not include the details necessary to accurately score such a variable. Again, this runs the risk of incomplete data or compromised data quality.

Therefore, notwithstanding the desire for integration within the existing RMS, the feasibility of successful implementation within the UCR2 is questionable. In other words, the UCR2 does not appear to be the appropriate tool for future data collection on individuals with emotional disturbance or possible compromised mental health and their contact with police.

Possible options for future data collection

1. Option for data collection by police

To successfully implement a future data collection tool by the police, it is key to consider current approaches that have been developed, tested and implemented. To date, police services that have been systematically collecting mental health data rely on "Emotionally Disturbed Persons" (EDP) forms. This tool can include both criminal and non-criminal contacts with police. While EDP forms are similar in design across police services, their development has been specific to the needs of particular police services and the community. There are variations in the types of information collected and the way in which the information is collected and stored.

Facilitating questionnaire standardization across police services that currently use EDP forms could be a short-term goal, which could be accomplished through collaboration between the participating services. Such collaboration could examine possibilities for consistent methods of data capture and storage, which in turn could lead to comparable data. In the end, standardization in questionnaire design and data storage may permit comparison of police contact with emotionally disturbed persons across police services and over time.

Collaborating police services may also consider options for sharing EDP data publicly to provide stakeholders, including other members of the justice community, governments, the health sector and the general public with information on the prevalence and nature of police contacts with emotionally disturbed persons. In the long-term, extending expertise and knowledge on data collection with other police services, namely those with an interest in mental health data collection could be considered.

One option is for police services currently using "Emotionally Disturbed Persons" forms to collaborate to standardize the data collection tool, as well as data capture and storage systems.

Once standardized, police services using the EDP forms could make this form available to other police services to assist with increasing the collection of standardized data.

2. Option for data collection using a household survey

A household survey of the general Canadian population would facilitate an examination of the mental health status of Canadians, juxtaposed with their previous contact with the criminal justice system, including the police. It could also capture both criminal and non-criminal contacts with police. Ideally, the household survey would be developed based on an existing survey tool that has already been tested and implemented in the field. One common limitation of household surveys is the exclusion of the homeless population and the population in institutions, such as prisons and hospitals.

In 2002, Statistics Canada as part of its Canadian Community Health Survey (CCHS) conducted a cycle devoted to aspects linked to the mental health of Canadians. Cycle 1.2 named the "Canadian Community Health Survey-Mental Health and Well-being" interviewed Canadians aged 15 years and older living in private occupied dwellings in the ten provinces, representing approximately 98% of the population aged 15 and older in the provinces. The homeless and institutionalized population were excluded from the survey. One of the primary objectives of the CCHS Mental Health and Well-being survey was to provide cross-sectional estimates of mental health determinants, mental health status and mental health system utilization across Canada. For the first time, this survey was able to provide provincial level estimates of past 12-month and lifetime prevalence of mental disorders in the population, as well as information on the utilization of mental health services.

Given this survey's demonstrated ability to capture the extent and nature of selected mental disorders in Canada, developing and integrating questions on previous contact with the criminal justice system within such a survey would enable an understanding of both criminal and non-criminal contacts of mentally ill individuals with the criminal justice system. Indeed, such an approach would require examining the feasibility of adding new questions to the survey without unduly increasing the respondent burden, as well as assessing the necessity of existing survey questions on non-mental health measures. That said, it is expected that adding a module on the criminal justice system to such a survey would only require the addition of key questions on previous contact with different components of the system.

Specifically, new questions on criminal justice contact could be modelled on questions contained in another household survey, namely the General Social Survey (GSS) on Victimization. The GSS asks a series of questions on criminal justice system contact in relation to individuals' views of the system. For a future mental health survey, these contact questions could be asked and then analyzed alongside the mental health status of respondents. The following police contact questions from the GSS could be considered.[11]

During the past 12 months, did you come into contact with police:
…for a public information session

During the past 12 months, did you come into contact with police:
…for a traffic violation

During the past 12 months, did you come into contact with police:
…by being arrested

During the past 12 months, did you come into contact with police:
…as a victim of crime

During the past 12 months, did you come into contact with police:
…as a witness of crime

During the past 12 months, did you come into contact with police:
…for any other reason?

Other, please specify.

These questions could be posed regardless of whether the person had a profile consistent with mental illness. By doing so, comparisons of police contact could be made between individuals with mental illness in the last 12 months and those without any mental illness over the same time period.

For a mental health survey similar to cycle 1.2 of the CCHS to provide provincially representative data on the prevalence of police contact among Canadians with and without profiles consistent with mental illness, the size of the sample to be surveyed would need to quite large. If the sample size is too small, the size of the sampling error would be substantial and would, therefore, make the estimates too unreliable to publish. (The sampling error is the difference between an estimate derived from the sample and the one that would have been obtained from a census that used the same procedures to collect data from every person in the population.)

Consideration of the sample size is critical given that findings from the 2004 General Social Survey on Victimization with a sample size of approximately 24,000 showed that a small proportion of all respondents were arrested by police (1%). The size would decrease when the data are analysed by mental health status and when examining individuals who proceed to court.

Therefore, in order to produce national level estimates for mental illness and contact with the criminal justice system, it would be necessary to conduct a mental health survey with a large sample size, greater than the previous sample of 37,000 for cycle 1.2 (mental health and wellbeing) of the CCHS. This would improve the possibility of obtaining reliable estimates with low levels of sampling errors.

Another limitation to conducting such a survey to improve our understanding of the rate of contact with the criminal justice system among people with a profile consistent with mental illness is that the homeless and populations in institutions would be excluded due to operational and financial constraints.

It is recommended that, if a household survey on the mental health and wellbeing of Canadians is conducted in the future, questions on contact with police be considered for inclusion.

Criminal Courts and Review Boards

Objectives for data collection

According to participants from criminal court areas, including traditional courts and specialized mental health courts, as well as Review Boards, three objectives for mental health data collection were considered most important: 1) the need for greater public awareness on mental illness and the criminal justice system; 2) information-based policy and programming decisions; and 3) measuring workload and performance outcomes.

While similar to the goal of making information-based decisions, the chair of one provincial Review Board expressed the importance of evaluating legislation, notably the *Criminal Code* as it relates to mentally disordered offenders. Another Review Board chair indicated that data collection should aim to improve an understanding of mental health and the role of the Review Board among those working in the criminal justice system. Finally, some stakeholders from courts and Review Boards indicated that the issue of assessing resources in the community should be a separate objective of data collection.

Definitional issues

With respect to data collection at the court level, most stakeholders representing the criminal courts and Review Boards indicated that a definition of mental illness should be based on section 2 of the *Criminal Code* which defines "mental disorder" as a disease of the mind. This broad understanding of mental disorder is further refined in the court's consideration of mental disorder within the context of the *Criminal Code* provisions on fitness to stand trial and criminal responsibility.

It was argued that the legal test for fitness to stand trial and the defence of mental disorder differs from determining if the accused person is suffering from a mental illness. That is, not all persons who are mentally ill will are found unfit to stand trial or not criminally responsible on account of mental disorder. The legal determination of fitness and criminal responsibility is based on the results of an expert health assessment and diagnosis, rather than observational or experiential knowledge of the court. Furthermore, beyond a finding of mental illness, fitness assessments must indicate if the accused is not fully capable of instructing counsel or is not capable of understanding the nature and consequences of the trial. For criminal responsibility, the assessment must indicate if the person was incapable of appreciating the nature and quality of the act or omission or of knowing it was wrong.

Other stakeholders specifically listed behaviours or mental health conditions, such as cognitive disorders, addictions, and depression that should be used to determine mental illness. This broader application of mental disorder is often used following a court decision to inform sentencing and conditions. It may be used when considering pre-sentencing reports, the use of stays and withdrawals, court-sponsored diversion programs, and Review Board orders (e.g., addiction treatment). The mental health conditions tend to be less severe than the thresholds used to determine fitness to stand trial and the finding of not criminally responsible on account of mental disorder.

Priority issues and information needs

A range of stakeholders, including courts, provincial/territorial Review Boards, provincial/territorial and federal departments responsible for justice matters, academics, and non-government associations provided feedback on the issues affecting courts with respect to youth and adults with mental health issues. In most cases, these stakeholders indicated that the data would be most useful at the provincial level, followed by intra-provincial regions and the national level.

1. Prevalence of accused with mental illness in the court system

Some court stakeholders indicated that based on their own observations, they had witnessed an increase in the number of accused with mental health problems appearing in court. It was suggested that along with a growth in the number of fitness hearings and applications for the defence of not criminally responsible, there had been an increase in the volume of accused persons who were mentally ill but did not reach the legal threshold for unfit to stand trial or not criminally responsible.

To quantify this assumption of an increase, stakeholders identified the following data needs:

- Prevalence of fitness to stand trial and not criminally responsible on account of mental disorder, including calculating rates per 1,000 population;

- Number of accused persons with mental illness appearing in court over time;
- Number of accused persons with mental illness found guilty and their sentence type;
- Types of mental illnesses among accused persons with mental health problems; and,
- Number of accused persons on mood-altering drugs.

2. Forensic assessments

The reliance on court-ordered assessments, as opposed to visual or experiential knowledge was the key reason for the identification of forensic assessments as a priority issue for courts and Review Boards. Consultation participants argued that there are limited resources for forensic assessments. Specifically, a lack of forensic specialists and psychiatrists to adequately deal with the current caseload for assessments was linked to longer wait times for assessments and subsequent longer lengths of remand for accused waiting to be assessed. In addition, it was argued that there are unacceptable delays in getting accused into hospital for court-ordered assessments and treatment. This was attributed to under-resourcing of 'designated hospitals', as defined in Part XX.1 of the *Criminal Code*.

The consequences of assessment delays can be far-reaching. Participants indicated that delays can lengthen the elapsed time of case processing, reducing the overall efficiency of the criminal court system and impacting the right of the accused to have their case processed through the court system in a timely manner. It was suggested that data could help inform decision-making on this matter.

Some stakeholders expressed the view that there had been an increase in the volume of referrals for forensic assessments, which has had an effect on the costs of administering the court system. The perceived increasing volume of forensic assessments is also seen as an issue for non-forensic community-based assessment. Court-ordered referrals for assessments were felt to pre-empt assessments for individuals in the community who are not in contact with the criminal justice system.

In terms of informing the issue of court-ordered forensic assessments, stakeholders indicated the following data needs:

- Number and type of court-ordered forensic assessments for adults and youth over time;
- Percentage of forensic assessments that are false positive (e.g., an accused person is deemed unfit to stand trial through an assessment but in fact, the assessment is incorrect and they are fit);
- Number of times an accused person is sent for forensic assessments; and,
- Number of forensic assessments ordered before and after the 1992 *Criminal Code* amendments.[12]

3. Community resources and social supports

Among stakeholders, there was the suggestion that a gap in community services and social supports can be linked to a greater number of adults and youth with mental illnesses appearing in court. In other words, it was argued that individuals suffering with mental illnesses may not receive proper treatment and support in the

community, which brings them in conflict with the law. Stakeholders expressed concern that once in contact with police, individuals who could have been diverted away from the criminal justice system are often charged and appear before court, especially in cases where police do not feel comfortable releasing mentally ill individuals back into the community and are unable to locate suitable community alternatives.

The perceived absence of community resources, including mental health treatment, housing and social supports, also extends to supports following court appearances. Some of those consulted expressed the need for better follow-up and community support after court release, such as in the case of absolute discharge, to limit re-contact with the criminal justice system. There was a sense among participants that services dwindle following the persons' involvement in the criminal justice system.

At the Review Board level, a leading priority issue involved access and availability of resources to support the Review Board mandate. Appropriate treatment and care for mental health conditions were identified as challenges given a perceived under-staffing of psychologists and case managers to work with forensic patients. Consultation participants further suggested that the scarcity of forensic resources also requires Review Board clients and their families to travel long distances. Moreover, the remote location of some psychiatric facilities was argued to contribute to difficulties in accessibility.

As with the court system, social and housing supports is a concern for the Review Boards. According to stakeholders, there are often difficulties in community placements for forensic patients. This was explained by the fact that special care homes are owned privately and in turn, it can be difficult for patients to pay accommodation costs.

To address these priority issues, stakeholders identified the following data needs:

- Proportion of accused before courts and Review Boards who had previous contact with community resources;
- Social determinants of mental health, including homelessness, education, substance abuse, lack of employment opportunities;
- Socio-demographic and offence differences between individuals under Review Board supervision who lack mental health treatment and those who refuse mental health treatment; and,
- Outcomes after Review Board discharge, such as progress and repeat contact/recidivism.

4. Court decisions on bail for persons with mental illness

As with all accused persons, criminal courts must consider whether an accused person with mental illness should be held in custody while awaiting further court appearances or be released in the community on bail or their own recognizance. Those consulted indicated that mentally ill individuals may be more likely than other accused to be remanded into custody. The perceived higher likelihood of remand was attributed to waiting times for assessments and forensic beds. That is, accused persons with mental health problems may be held in remand while awaiting psychiatric resources. Some stakeholders indicated that this is particularly an issue

for youth accused. Depending on the waiting times for services, the time spent in remand can be lengthy.

In addition, participants felt that accused with mental illness often do not have sufficient community, social and/or family supports. With an absence of supervised bail programs, stakeholders indicated that accused persons with mental health illnesses are denied bail and are remanded to custody. They are deemed flight risks.

To inform the issue of the perceived over-use of remand for mentally ill accused, stakeholders indicated the following data needs:

- Number of accused persons with mental health issues remanded to custody, compared to accused persons with no mental health issues.

5. Structure of traditional criminal courts and mental health courts

Stakeholders identified differing priority issues for traditional criminal courts and specialized mental health courts. Many times, the priority concerns related to traditional criminal courts were non-issues for mental health courts, since these same issues were specifically addressed in the development of the specialized courts. In other words, mental health courts are designed to address the unique needs of accused with mental illnesses and therefore, do not always face the same challenges as other criminal courts.

Non-criminal court stakeholders expressed the view that traditional criminal courts are not well informed about the mental health services available in the accused persons' community. This appears to contrast the operations of mental health courts. For example, mental health court workers stated that Crown prosecutors with the Ontario mental health courts are responsible for finding a physician in the community to treat the accused with mental illness.

Another example of a priority issue affecting traditional courts that did not seem to affect the specialized courts is legal representation. Some stakeholders indicated that the refusal of legal aid for accused with mental illnesses clogs the traditional court system, making it inefficient. Mental health courts, on the other hand, are often tasked with finding a lawyer to represent the accused with mental health issues; thereby making it a non-issue. However, some consultation participants argued that the ability of the mental health courts to provide these additional services can be difficult with insufficient funding and inadequate staffing.

Both types of courts are also limited to the parameters of the *Criminal Code* and the *Youth Criminal Justice Act (YCJA)*. For example, one stakeholder argued that the *YCJA* places limits on sentencing for youth with mental health issues, as sentences must be offence-based not risk-based.

To better understand the benefits and limitations associated with traditional criminal courts and specialized mental health courts, the following data needs were suggested:

- Need for evaluation of mental health courts;
- Identification of components of mental health courts that are successful (e.g., greater access to forensic beds, more resources, operation structure); and,
- Outcomes of traditional criminal courts and specialized mental health courts for accused with mental health problems.

6. Information sharing between sectors

To properly coordinate services and resources for accused persons with mental health problems, stakeholders consistently stated the need for a collaborative approach involving all relevant sectors. This is not strictly limited to justice sectors but also encompasses the education and social systems. The primary barrier to information sharing was related to privacy legislation and policies regarding confidentiality.

No data needs were identified for this priority issue.

7. Forensic patients under the authority of the Review Boards

Specific to the provincial/territorial Review Boards, priority issues centered on forensic patients' legal representation, their time spent under the authority of the Review Board and issues related to the severity of their offence.

Some Review Board chairs were concerned that the courts were referring too many individuals involved in minor criminal offences to the Review Board. It was felt that these accused persons might be better dealt with diversion and/or other programs. It was also argued that it was important to know the characteristics of individuals under the authority of the Review Board, such as the accused person's Aboriginal and immigrant status to fully understand the clientele and their needs.

The following data needs were identified as priority issues related to forensic patients under the authority of the Review Boards:

- Number of admissions to provincial/territorial Review Boards;
- Average time forensic patients spend under Review Board supervision; and,
- Types of offences and demographic information on forensic patients (e.g., sex, Aboriginal status, immigrant status, country of origin).

Data availability

An examination of data availability for the courts and Review Boards must consider the data collection activities of traditional criminal courts, specialized mental health courts and Review Boards. For traditional criminal courts, the Integrated Criminal Court Survey (ICCS) provides standardization in the type of information captured.[13] No such national data collection tool is specifically available for mental health courts and Review Boards.

1. Traditional criminal courts – Integrated Criminal Court Survey

Among the traditional criminal courts, those consulted indicated that very little information is currently collected on the mental health condition of accused persons, including both youth and adults. Most often, data on fitness hearings and the outcome of "not criminally responsible on account of mental disorder" are the two data elements that are recorded by the criminal courts. This information is then forwarded to the Canadian Centre for Justice Statistics as part of the Integrated Criminal Court Survey (ICCS). However, not all jurisdictions report these variables in the same way, and some jurisdictions do not submit complete data.

The ICCS, managed by the Canadian Centre for Justice Statistics, is a micro-data survey that collects detailed information pertaining to adults and youth who are processed through the criminal courts in Canada. At this time, coverage of the

ICCS includes most jurisdictions, with the exception of Quebec adult courts and Saskatchewan courts.

1.a. Fitness to stand trial

The ICCS contains two data fields dealing with the accused person's fitness to stand trial: 1) the type of appearance and 2) the appearance result. The first variable, appearance type, indicates the reason for the court appearance (i.e., fitness hearing). This data element has the benefit of indicating how often the issue of fitness is raised during court proceedings. Reporting on this variable to the ICCS is high, as only Quebec youth court does not currently report when the code value is a fitness hearing.

However, there are issues of consistency in reporting on the "appearance type" variable. First, there is a possibility that courts may not submit data on fitness hearings if during the hearing, the accused person is found fit to stand trial. Second, not all jurisdictions will report fitness hearings if there was more than one reason for the appearance. Some jurisdictions do not have the capacity to report multiple reasons for an appearance. Finally, some jurisdictions report the scheduled reasons for an appearance, while others report the actual reason. These reasons can differ.

The ICCS appearance result variable indicates the result of the court appearance. In the case of fitness to stand trial, there are two code values: decision to find the accused fit and the decision to find the accused unfit. The results may not be considered final since an accused may be initially found unfit to stand trial but with medication to treat the mental illness, the same accused person can be later determined fit. The decision of "unfit to stand trial" is more consistently reported than "fit to stand trial". In particular, nine jurisdictions report the code value of unfit to stand trial, while only four jurisdictions report data on the code value for fit to stand trial. The remaining jurisdictions either do not report any data on these code values or report information as a residual value code under another data field (i.e., "other" code value under Decision variable), making it analytically unusable.

The main explanations for the inconsistency in reporting across jurisdictions are due to variations in data capturing systems and the identified data collection priorities. The data capturing systems were originally developed by jurisdictions for operational purposes prior to their participation in the ICCS and as such, the systems are not always setup to capture all ICCS variables. Furthermore, despite a variable being listed as an ICCS national data requirement, the jurisdictions must first identify this type of information as a priority before the courts will take steps to collect the data. In some cases, mental health variables are not considered priorities for the day-to-day operations of the court. For example, for the appearance decision of "fit to stand trial", there is often a lack of willingness to collect the information, since operationally, the courts are only concerned if the case can proceed.

1.b. Defence of not criminally responsible on account of mental disorder

Another set of data elements on the ICCS deals with the defence of not criminally responsible. As with fitness hearings, there is an indicator when the defence of not criminally responsible is raised during court proceedings. Under the data field "appearance type", the courts can indicate if an application for the mentally disorder defence was submitted to the court. However, all applications, including those for mentally disordered offender, dangerous offender status and publication bans, are

not yet released as individual appearance types. The consistency in reporting application values within the appearance type data field has to be evaluated and better understood.

Another variable, "type of decision", has better quality information on the defence of mental disorder. Nearly all jurisdictions, with the exception of Quebec youth court and Yukon courts, report whether the decision was an acquittal on account of mental disorder. With this variable, it is possible to determine the volume of decisions of not criminally responsible along with the number of not criminally responsible offenders sent to provincial/territorial Review Boards. Case characteristics, such as the offence type, age and sex, can be analyzed alongside the decision of not criminally responsible.

1.c. Other ICCS variables on mental disorder

In addition to fitness hearings and the mental disorder decision, the ICCS contains a variable relating to medical/psychological/psychiatric reports ordered by the courts. This variable can be considered a strong indicator of the volume of court-ordered assessments. Most jurisdictions comply with reporting requirements on this variable, with the exception of Manitoba. Beyond the data collected by the ICCS, some jurisdictions indicated that they collect and internally retain data on pre-sentencing reports, which may contain information on programming recommendations for offenders who are suffering from mental health conditions.

Following a conviction, an offender with mental health issues may receive a sentence other than custody, probation, fine, restitution/compensation, conditional type sentences, discharge, and suspected sentence. Under the ICCS data field "other sentence type", courts can indicate if the offender was issued a hospital order. However, the majority of jurisdictions do not report any data on this code value.

A final ICCS mental health variable strictly deals with youth. Under the *Youth Criminal Justice Act (YCJA)*, courts can sentence serious violent young offenders suffering from a mental or psychological disorder to a specialized custodial sanction. Known as the Intensive Rehabilitative Custody and Supervision order (IRCS), this custodial sanction is currently captured under the ICCS. Only one jurisdiction, Saskatchewan, does not report any data on this decision, since Saskatchewan youth courts do not currently report to ICCS.[14]

2. Specialized mental health courts

When data beyond fitness hearings and criminal responsibility outcomes are collected by mental health courts, most stakeholders indicated that they record the number of cases heard and the number of court appearances in the specialized court. Some mental health courts collect additional data on the outcome of court proceedings, diagnosis, diversion (if any), and residence before and after court appearance.

The main data collection challenge for mental health courts is accurately distinguishing mental health courts from other criminal courts. This is because mental health courts are not always dedicated facilities. Similar to other specialized courts, mental health courts take place in courtrooms with multiple uses and are therefore difficult to identify. Multi-use courtrooms also prevent analysis of differences in appearances and outcomes within the Integrated Criminal Court Survey (ICCS). While the ICCS currently allows jurisdictions to indicate individual courtroom

numbers that can then be mapped to the type of specialized court, no jurisdictions currently provide this information.

During consultations, it was indicated that at least one jurisdiction was conducting its own evaluation of mental health courts and trying to overcome the identification challenge.

3. Review Boards

Provincial and territorial Review Boards do not have a standardized approach to data collection for individuals with mental health issues. Variations exist in the type of data collected and the method of data collection and storage. Review Boards with small caseloads tend to keep paper-based administrative files or transcripts of proceedings for each individual case. This information is retained by Review Board members until the forensic patients are discharged. More comprehensive data on forensic patients are sometimes retained by forensic hospital facilities. For example, the forensic facility in Nova Scotia has a database on all unfit to stand trial cases, as well as cases of not criminally responsible on account of mental disorder.

Among Review Boards with larger caseloads, such as British Columbia and Ontario, electronic stand-alone case management databases are maintained. Some of the data fields contained within the British Columbia database include: number of active cases, number of cases closed, caseload by verdict (not criminally responsible on account of mental disorder and unfit to stand trial), reasons for case closures (absolute discharge, sent out of province, appeal verdict, death), number of hearings, and demographic information.

Privacy and confidentiality were raised as possible issues for sharing information with the Canadian Centre for Justice Statistics.

A new standardized survey of Review Boards could address the different reporting practices across Review Boards. This administrative survey could be completed for each Review Board hearing and could include hearings for all persons admitted prior to and during the start of data collection. This approach would allow for the production of both admission and count data. Administrative forms would be completed by Review Board members.

Despite the benefit of this approach in providing ongoing data for the examination of trends in prevalence and case characteristics, it does not seem feasible in the immediate future. When consulted regarding the feasibility of this data collection approach, Review Board members perceived the research design as too onerous, since it was felt that Review Board members, as opposed to other staff members, would need to complete the survey to ensure accuracy. Review Board members indicated that they are unable to add any additional tasks to their regular workload.

In order to make the approach possible, there would be a need for ongoing funding to employ a trained researcher for each review board. These researchers would be responsible for data collection and submission to the Canadian Centre for Justice Statistics (CCJS). Ongoing funding would also be needed for CCJS to process, analyse and disseminate the data. There are currently no funding sources for a data collection endeavour of this magnitude.

The National Trajectory Project (NTP) is a project currently underway and funded through the Mental Health Commission of Canada and aims to examine the

operation of current criminal justice provisions for individuals declared not criminally responsible on account of mental disorders (NCRMD) who are under the authority of a provincial or territorial review board. It will examine the antecedents and course of accused who end up in the Review Board System. The study will include the three largest provinces (Ontario, Quebec and British Columbia), which comprise the majority of NCRMD cases. The project is based on an ongoing study in Québec funded by the Fonds de recherche en santé du Québec.

The project is comprised of three arms: a quantitative arm, a qualitative arm and a legislative review. The objectives of the quantitative arm of the National Trajectory Project are to: 1) Explore the demographic, psychosocial, and criminological profile of people declared NCRMD in Canada, as a function of geographic region and type of institution of detention; 2) Evaluate the importance and systematization of assessments of risk of violence presented to the Review Boards; 3) Report the rationale for decisions made by the Review Boards as a function of the disposition rendered (absolute discharge, conditional discharge, or custody); 4) Establish rates of criminal recidivism and psychiatric rehospitalization of discharged offenders as well as track positive outcomes; 5) Examine the migration trajectories or sedentary patterns of people declared NCRMD; 6) Identify the individual and organizational factors associated with these trajectories; 7) Determine the use and predictors of mental health services by this clientele prior to the NCRMD verdict, during the jurisdiction of the Review Board, and following discharge. An overarching objective will be to examine each of these findings with respect to culture and gender of NCRMD individuals. To do so, a file-based trajectory study of individuals declared NCRMD (examining mental health services received and criminality prior to being declared NCRMD, during NCRMD tenure and following absolute discharge from the provincial review board) is ongoing in Quebec. The study is currently being put in place in British Columbia and is being developed in Ontario. Based on the results, qualitative interviews with key stakeholders in the NCRMD and mental health services provision (e.g. persons declared NCR, caregivers, victims, family, review board members, psychiatrists and lawyers who have NCR clients, hospital administrators) will be carried out in order to contextualize the quantitative arm as well as report on current practices in various jurisdictions. Finally, a legislative review committee on the Part XX.1 provisions of the *Criminal Code* will be established. Legislative review of the history, development, implementation and consequences of the 1992 reforms to the mental disorder provisions of the *Criminal Code* will be done by legal experts familiar with these developments. The objective is to ensure that the National Trajectory Project maintains a practical focus on the operation of the current law.

Possible options for future data collection

Based on the consultations, it would be advantageous to improve the consistency and coverage of the data being reported to the existing national micro-data survey - the Integrated Criminal Court Survey (ICCS). For Review Boards, one data collection option could fulfill some of the key data gaps. Finally, a household survey on mental illness and contact with the courts could provide information on accused persons with mental health issues, regardless of whether or not they were found unfit to stand trial or not criminally responsible on account of mental disorder.

1. Opportunities for improvements to Integrated Criminal Court Survey data

In considering adult and youth traditional criminal courts, the stated data need to determine the prevalence of individuals with mental health issues in the court system can be partly addressed with improvements to data that are reported to the Integrated Criminal Court Survey (ICCS). It is recognized that the full extent of the issue of mental illness in the courts cannot be solely based on fitness hearings, findings of not criminally responsible, hospital sentencing orders, and youth Intensive Rehabilitative Custody and Supervision orders. However, these court actions relating to mental illness can be useful indicators of court and Review Board workload issues.

While the ICCS has the capacity to measure the above indicators of mental illness, there is significant jurisdictional disparity in the way ICCS data are captured and stored. In addition, there are coverage limitations. Therefore, there is a need to promote consistency in ICCS reporting across jurisdictions and to increase overall survey coverage and coverage for ICCS variables relating to mental illness.

1.a. Promote consistency

Work undertaken to develop standards for capturing and storing mental health data, particularly as it relates to appearance types (fitness hearings) and appearance results (fit or not fit to stand trial), would be an important addition to the ICCS.

1.b. Survey coverage and coverage for mental health variables

Working towards full implementation of the ICCS, including participation from Quebec adult court and Saskatchewan courts, would increase survey coverage and would generate national level data.

Working with courts in Quebec (youth) and the Yukon to report the acquittal on account of mental disorder code value for the "type of decision" (DECISION) variable would add to available information on the defence of not criminally responsible on account of mental disorder.

Working with Manitoba courts to report data on court-ordered medical/ psychological/ psychiatric reports (MPREPORT) would increase information on clinical assessments of accused persons.

Consultation results also revealed that data specific to mental health courts are not collected in a standardized manner. This is not surprising given the relatively recent emergence of specialized courts. To overcome the lack of standardization and allow for the possibility of comparison of court proceedings and outcomes between mental health courts and traditional criminal courts, it is important to consider the capabilities of the Integrated Criminal Court Survey (ICCS). As with any specialized courts, such as family violence courts and drug courts, ICCS allows jurisdictions to indicate a courtroom number associated with the specialized court.

> Working with jurisdictions that currently have mental health courts to identify courtroom numbers would be useful in distinguishing mental health courts from traditional criminal courts.

2. Options for data collection involving Review Boards

The data collection gaps regarding individuals subject to the jurisdiction of a provincial or territorial review board suggest a need to consider data collection tools that could address the information needs expressed by consultation participants. Some of these key data needs include the number of admissions to Review Boards and the characteristics of offences and accused persons.

Based on the consultations, the following is a viable option for future data collection involving the Review Boards. The advantages and disadvantages of this option are described below.

Justice Canada to repeat their 2006 study and expand the number of provincial/territorial Review Boards included in the study

In the previous Justice Canada study, data were compiled on a one-time basis through manual extraction of administrative Review Board files from seven provinces and territories.[15] A data collection form was used to collect information on a number of different fields, such as current criminal offence, criminal history, mental disorder and treatment information. Additional provinces and territories could be added to the study to ensure representation across Canada. Funding for the project would need to be secured.

The advantages of such an approach include:

- The possibility of comparing results with previous findings;
- The tools for data collection have been developed; and,
- The Review Boards' endorsement of a trained researcher studying case files,[16] rather than Review Board members collecting information.

The disadvantages of the approach relate to the fact that the one-time study would not fulfil the need for ongoing data on the prevalence and nature of individuals under the authority of the Review Boards. In addition, the previous Justice Canada study did not include all provinces and territories. The lack of involvement from Review Boards in the Prairie Provinces precluded a complete understanding of Aboriginal issues. This could be addressed with an expansion in the number of participating Review Boards.

3. Option for data collection on courts using a household survey

With an adequate sample size, a general household survey on mental illness with questions on respondents' contact with the criminal court system might address limitations of the proposed data approaches involving the courts and Review Boards. These limitations relate to the inability of the Integrated Criminal Courts Survey (ICCS) and a questionnaire for the Review Boards to capture data on accused persons who were never sent for a forensic assessment, as well as those accused whose fitness or criminal responsibility was never questioned. The inclusion of questions to measure contact with criminal courts to a household survey on mental illness could make it possible to examine the prevalence of mental illness among all persons who came into contact with the courts. An example of such a survey, Statistics Canada's Cycle 1.2 of the Canadian Community Health Survey (CCHS), is provided in the section on police. While the inclusion of court-related questions in a household survey on mental illness may fill a data need not currently filled by the ICCS, a possible limitation is that populations who are in institutions or who are homeless are usually excluded due to operational and financial constraints.

As with the questions on police contact, new questions on criminal court contact could be modeled on questions contained in Statistics Canada's General Social Survey (GSS) on Victimization. Responses to these questions could be analyzed according to the mental health status of respondents. The following screening question on criminal court contact modeled on a GSS question could be included in a future mental health household survey.[17]

> Have you had contact with the Canadian Criminal courts within the last 12 months?

If respondents answer 'yes' to this question, a follow-up question, which does not currently appear on the GSS, would be asked to understand the nature of the court contact. The question would ask:

> Was this contact because: (check all that apply)
>
> …you were on jury duty
>
> …you were charged with a crime
>
> …you were a victim of a crime
>
> …you were a witness to a crime
>
> …your friends or family members were charged with a crime, were witnesses to a crime, or were victims of a crime
>
> …other reason (specify)

These questions could be posed regardless of whether the person had a profile consistent with mental illness. By doing so, comparisons of court contact could be made between individuals with mental illness in the last 12 months and those without any mental illness over the same time period.

With an adequate sample size, results of a mental health survey similar to cycle 1.2 of the CCHS, with questions on criminal justice contacts, might provide provincially representative data on the prevalence of court contact among Canadians with a profile consistent with mental illness and those without.

A significant limitation to this approach, however, is that it would be necessary to conduct such a mental health survey with a very large sample size to produce reliable estimates of contact with criminal courts among Canadians with a profile consistent with mental illness. This is because a small proportion of individuals overall are arrested and proceed to court (see section on police for full discussion). In addition, this data collection tool would exclude the institutionalized and homeless populations due to operational and financial constraints.

It is recommended that, if a general household survey on the mental health and wellbeing of Canadians is conducted in the future, questions on contact with the criminal courts be considered.

Correctional System

Objectives for data collection

As with other sectors of the criminal justice system, correctional service respondents were asked to provide comments on objectives for data collection relating to mental illness. Nearly all provincial, territorial, and federal correctional respondents indicated

that data collection on mental health should primarily aim to assist those in the field and in policy to make information-based decisions regarding responses to the mental health issue, including program development. Specifically, those consulted indicated that data can inform treatment, rehabilitation and correctional intervention programs.

Also of interest were data that can help plan and allocate resources for correctional institution medical and psychiatric services. Less commonly expressed objectives were to improve public awareness regarding the issue of mental illness and to measure workload, performance and outcomes.

Definitional issues

Provincial/territorial and federal correctional system participants tend to prefer a broad definition of mental illness. For this group, a definition of compromised mental health or mental illness should include depression, suicide ideation, substance abuse, emotional disturbance, behavioural disorders, cognitive disorders, personality disorders, and permanent brain damage (e.g., Fetal Alcohol Spectrum Disorder).

However, stakeholders consulted disagreed on whether the definition should be strictly based on an actual health assessment/diagnosis or one based on observable or reportable behaviours. Proponents of a diagnostic definition of mental illness view the need for complete accuracy in assessing and treating mental illness. Relying on medical and psychiatric reports was argued to reduce the likelihood of over-predicting the incidence of mental illness in the correctional population.

On the other hand, most argued that the observation-based definition of mental illness overcomes the need for psychiatrists and forensic experts, which are often costly and not readily accessible to all offenders. Several participants commented that mental health treatment is based on symptom reduction irrespective of the actual diagnosis. For instance, not all people with schizophrenia experience the same symptoms and therefore, the treatment is not identical and will not necessarily be based on the diagnosis of schizophrenia. It was further argued that this observation-based definition better ensures that offender's mental health needs and problems are addressed in the correctional setting. Under this definition, self-injurious behaviour and isolation can also be captured.

Priority issues and information needs

Provincial/territorial and federal correctional systems, provincial/territorial and federal departments responsible for justice matters, researchers, academics, and non-government association participants suggested that in consideration of the structure of corrections in Canada, data would be most useful at the provincial/territorial and federal levels. The specific data needs and priority issues are described below.

1. Prevalence of mental illness among offenders

One of the leading priority issues for corrections pertained to an increasing number of adults and youth with mental health issues entering the correctional system. Respondents indicated that the growing prevalence, combined with the changing types of mental illnesses has required correctional services to take measures to meet the needs of this population.

In particular, those who participated in the consultation expressed concern over the number of individuals in correctional services with cognitive or brain

disorders, notably Fetal Alcohol Spectrum Disorder, and challenges with respect to their rehabilitation. Individuals with dual diagnoses or co-morbidity issues were also identified as a challenge in terms of treatment, since, as it was argued, multiple mental health issues must be treated at the same time. Failing to address all mental health conditions was connected to a higher risk of re-contact with corrections. The most commonly identified co-existing mental health condition was substance abuse. Participants explained this association by a tendency for offenders to self-medicate the initial mental illness, especially when resources are unavailable in the community.

The following data were suggested as good indicators of the prevalence of mental illness in the correctional system, particularly at the provincial/territorial level:

- Number of youth and adults with mental illness in correctional systems and by type (s) of mental illness;
- Number of suicide incidents, attempted and completed;
- Number of offenders with substance abuse issues; and,
- Number of repeat contacts of offenders with mental illnesses.

2. Appropriate type of custody for individuals with mental illness

The appropriateness of different types of correctional placement for individuals with mental illness was raised as a priority issue during consultations. This issue was identified for both adult and youth offenders with mental health issues.

Aside from remanding individuals to await future court appearances, the additional reasons for remanding individuals with mental illnesses raised concerns among stakeholders. In particular, the practice of remanding offenders while waiting for diagnostic assessments or the availability of forensic beds was seen as problematic. It was conveyed that the special needs of the individuals with mental illnesses cannot be met while remanded because of the actual absence of treatment or the inability to provide treatment due to the accused person's indeterminate period of custody. A few stakeholders further commented that there has been an increase in the number of individuals with mental illness who have been admitted to remand custody.

For non-remand custody, it was reported that the lack of psychiatric units results in segregation of offenders with mental illness away from the general population. A few participants communicated concern that this isolation may further exacerbate existing mental health conditions. Others expressed concerns about the use of secure custody for young offenders with mental health issues in the absence of appropriate specialized forensic youth facilities. A greater co-ordination with children and youth services was seen as a possible solution.

To inform the custodial placement issue, consultation participants stressed the importance of the following data needs:

- Number of individuals with mental health issues in corrections, including remand and sentenced custody;
- Length of remand for individuals with mental illness; and,
- Location of remanded accused persons with mental illness – hospital versus custodial setting.

3. Mental health services in corrections

Closely related to the appropriate placement of individuals with mental illnesses was the overwhelming concern of participants with the level of mental health services

in corrections, principally in provincial/territorial community and custodial corrections. Since each province and territory develops its own approach to address the needs of offenders with mental health problems, there are provincial/territorial differences in the delivery of programming and treatment. One academic argued that the lack of consistency in mental health services is especially pronounced between provincial/territorial and federal offenders. He attributed the lack of program standardization to provincial/territorial mental health acts, which do not set medical parameters for correctional institutions, as they do for hospitals.

Several consultation participants reported that offenders with mental health problems have a willingness to participate in treatment programs but unlike the hospital setting, the appropriate therapy is not always available in provincial/territorial corrections. The lack of mental health resources in custody was seen as creating problems with case management and planning, as well as an ability to prevent re-offending and return to corrections. A few stakeholders suggested that another consequence of the absence of sufficient services is the use of medication to control rather than treat offenders in custody. For young offenders in smaller provinces, it was mentioned that the absence of in-patient treatment programs results in referrals to services outside the youth's home province.

At the community corrections level, some consultation participants suggested better management of offenders with compromised mental health. The concern was primarily rooted in long wait times for treatment in the community and the refusal of non-voluntary referrals by mental health and addiction services in the community. It was felt that offenders on probation and parole were unable to receive timely and proper treatment, including diagnostic assessments. This was said to impact case management and planning.

Consultation participants wanted the following data to inform the issue of mental health services in corrections:

- Type of mental health and nursing services in correctional facilities compared to the community;
- Number of users of mental health services within corrections;
- Programming differences in provincial/territorial custody and federal custody;
- Identification of characteristics of offenders that increase probability of success in programming; and,
- Outcomes for offenders who received mental health programming.

4. Knowledge of mental illness by correctional services

Effective treatment of offenders with mental illnesses requires proper recognition of symptoms and problems. During consultations, it was argued that mental health disorders can be unidentified or misdiagnosed. This challenge in assessing and treating offenders was associated with an insufficient number of mental health experts within corrections, a lack of access to assessments, and lack of diagnostic procedures. There was a stated need to train corrections staff on mental illness and to determine indicators of mental health issues for both youth and adults, which would in turn, ensure more appropriate delivery of services.

To inform the issue, the following data need was expressed:

- Differences in persons receiving diagnosis in prison versus those diagnosed upon admission.

5. Continuity of mental health care before correctional admission and after discharge

The flow into and out of corrections and its impact on offenders' mental health treatment was raised. In cases where offenders were receiving support in the community, there was some concern that this same level of care did not always continue upon admission into the correctional system. Some academic researchers stressed that the mental health condition of offenders should not worsen while in corrections because of an inability to continue treatment while in custody.

Monitoring and providing treatment also extends to offenders' release from the correctional system. Many consultation participants argued that there is a lack of continuity of mental health care from the correctional system to the community, since the access to community services can be limited for individuals with criminal records. In addition, a lack of transportation to and from services, as well as proper housing was argued to impede the ability and willingness of offenders to participate in programming outside of corrections.

Many discussed the need for quality discharge planning, which would connect youth and adults to resources in the community. While a need for correctional services to work outside of institutions was identified, it was acknowledged that correctional services are not obligated or permitted to provide follow-up when offenders are released from correctional supervision.

To address the issue of continuity of mental health care, stakeholders identified the following data needs:

- Information on the state of the offenders' mental health before and after admission to corrections;
- Comparison of treatment before and after incarceration for both youth and adults; and,
- Presence of discharge planning and quality of support.

Data availability

The majority of data collection undertaken by correctional services occurs upon intake or soon afterwards. While the point of data collection is similar across all jurisdictions, wide variations exist in the type of information collected and the method of collection and storage. Some standardization exists with the Integrated Correctional Services Survey, which is managed by the Canadian Centre for Justice Statistics. This survey, however, is limited in its application to the issue of mental illness, since there are no strong indicators of the overall prevalence and characteristics of those with mental illness in corrections. A description of the variables within this survey, along with data collection conducted by the provinces/territories and the Correctional Service of Canada is described below.

1. Integrated Correctional Services Survey, Canadian Centre for Justice Statistics

The Integrated Correctional Services Survey (ICSS), managed by the Canadian Centre for Justice Statistics (CCJS), is a micro-data survey that collects detailed

information pertaining to those who fall under the supervision of the youth and adult correctional systems. At this time, coverage of the ICSS includes six jurisdictions: Newfoundland and Labrador, Nova Scotia, New Brunswick, Ontario, Saskatchewan (adults only), and Alberta (community corrections only). Therefore, the results are not nationally representative of offenders with mental illness.

Within the data element "security concern", which identifies security or supervision concerns with respect to a specific inmate, correctional systems can indicate whether the offender was suffering from a mental illness and could not function in the general prison population. This data element is limited to inmates with mental illnesses who are displaying coping problems within the prison environment and not those inmates with mental illness who are not experiencing any outward adjustment problems. Also within the data element of "security concern", corrections can indicate symptoms not necessarily directly related to mental illness, namely suicidal tendencies and substance abuse. Substance abuse responses also appear in numerous other ICSS data elements, including needs assessment, conditions of sentence, and event type (attending treatment).[18]

2. Data within provincial/territorial information systems

Aside from the ICSS, provincial/territorial correctional systems collect their own information on mental health of offenders. Generally speaking, information on community corrections is collected by probation officers or case managers. This information is primarily used to assess individual offender's programming requirements and is stored in case files. Aggregate data are not consistently compiled and analysed.

In most provincial and territorial facilities, information is collected on suicidal risk and risk of re-offending and escape from custody. Depending on the province or territory, this information is either stored on paper files or electronically. Additional information, which may or may not be directly related to mental health, is collected by some provinces/territories and can include previous hospital admissions, level of previous mental health services, type of medications, substance use and abuse, number of assessments ordered, and history of family violence.

Medical units within custody maintain patient mental health records; however, these records are typically not stored electronically. Correctional clinical services also collect information on mental health services but data on the characteristics of offenders with mental health issues are not systematically captured.

3. Data on federally sentenced inmates – Correctional Service of Canada

Consultations revealed that nursing staff at Correctional Service of Canada (CSC) conduct an assessment of mental health indicators during the intake assessment. This information is paper-based. In addition, CSC is developing a computer-based screening tool that will provide indicators of possible areas of mental health concern.

The nursing intake process involves assessment of mental health indicators, which are retained in the inmates' medical files. This information is more comprehensive than the Offender Intake Assessment and includes a set of detailed questions on suicide ideation, mental health history, current mental status, and mental health impression (e.g., physical appearance, mood and behavioural and emotional state). These records are paper-based. In addition to the information collected at the nursing intake process, other indicators of mental health were collected via questions

asked by correctional and parole officers at intake. These data were included in the CSC's offender management system. However, in February 2008, a privacy audit concluded the collection of these data were in contravention of privacy legislation.

In addition, the CSC is developing an individualized assessment tool, known as the Computerized Mental Health Intake Screening System (ComHiss). Implementation began in September 2008 with the intention of implementing the system at all 16 CSC intake assessment sites. The psychological test assesses nine different indicators of psychological problems, such as psychosis and obsessive compulsive disorder, and three global indicators of psychological distress using the Brief Symptom Inventory (BSI). In addition, the Depression, Hopelessness and Suicide (DHS) Scale and the Paulhus Deception Scale are used to screen for dissimulation and life-threatening behaviours. While these indicators will not provide psychiatric diagnoses, they will provide indicators to psychology staff who can then follow up with arriving inmates. The BSI and Paulhus are available to psychologists from test suppliers, and the DHS is available from its authors.

Possible option for future data collection

Consultations with correctional systems revealed that despite numerous data needs, provincial and territorial correctional systems have few reliable, automated indicators of mental illness. The status of data may be due to the provisions of privacy legislation regarding the collection and storage of such information. Generally, the collection of such information must be completed by a qualified professional and access to the data must be restricted. This gap in the collection of mental health information provides an opportunity to underscore the need for the electronic collection of standardized indicators of mental illness which are collected according to the provisions of privacy legislation. A starting point to work toward this goal could be for the provinces and territories and the CSC to share information on the types of data they collect and identify how these data could be stored in an automated fashion that would abide by privacy legislation.

To successfully work toward standard questions to measure mental health issues, the Canadian Centre for Justice Statistics, CSC and the provincial/territorial correctional systems would benefit from collaboration to achieve the following tasks:

1. Share information across the federal, provincial and territorial systems regarding standard questions on mental health issues and discuss their advantages and disadvantages as basic indicators;
2. Identify how data could be collected and stored electronically without contravening privacy legislation.
3. Secure appropriate funding to move forward on automated, standardized data collection.
4. Examine the technical requirements needed to automate the collection of standard information;
5. Determine training requirements for intake assessment personnel.
6. Identify one or more provinces/territories to initiate implementation.
7. Aid the identified provinces/territories and their system vendors with the changes required; and,
8. Determine ways in which final data could be shared with the CCJS or ways in which analysis and findings from the data could be made available to the public and stakeholders in order to fill gaps in information.

Conclusion

Quantifying the issue of the involvement of persons with mental health illness in the criminal justice system presents a significant challenge. A combination of factors ranging from the lack of standard definitions, assessment and resourcing issues, operational requirements of the justice sectors, issues of privacy and confidentiality and challenges with information sharing, and current design of databases, all place challenges on efforts to quantify the issue. Nevertheless, sound statistics provide quality information to governments, the justice community, the health sector and the general public to understand and set priorities, and make policy decisions regarding the involvement of persons with mental illness in the criminal justice system.

Based on the results of this feasibility study, several options for data collection are presented for the criminal justice sectors that have the potential to generate useful and reliable statistics on the issue of mental illness and the criminal justice system. The options varied widely, from emphasizing data co-ordination and collection by policing services to improving data capture for an existing micro-data survey to creating new survey tools to address current data gaps. Implementing proposed options means that funding would have to be secured to move forward and partnerships would have to be developed and strengthened.

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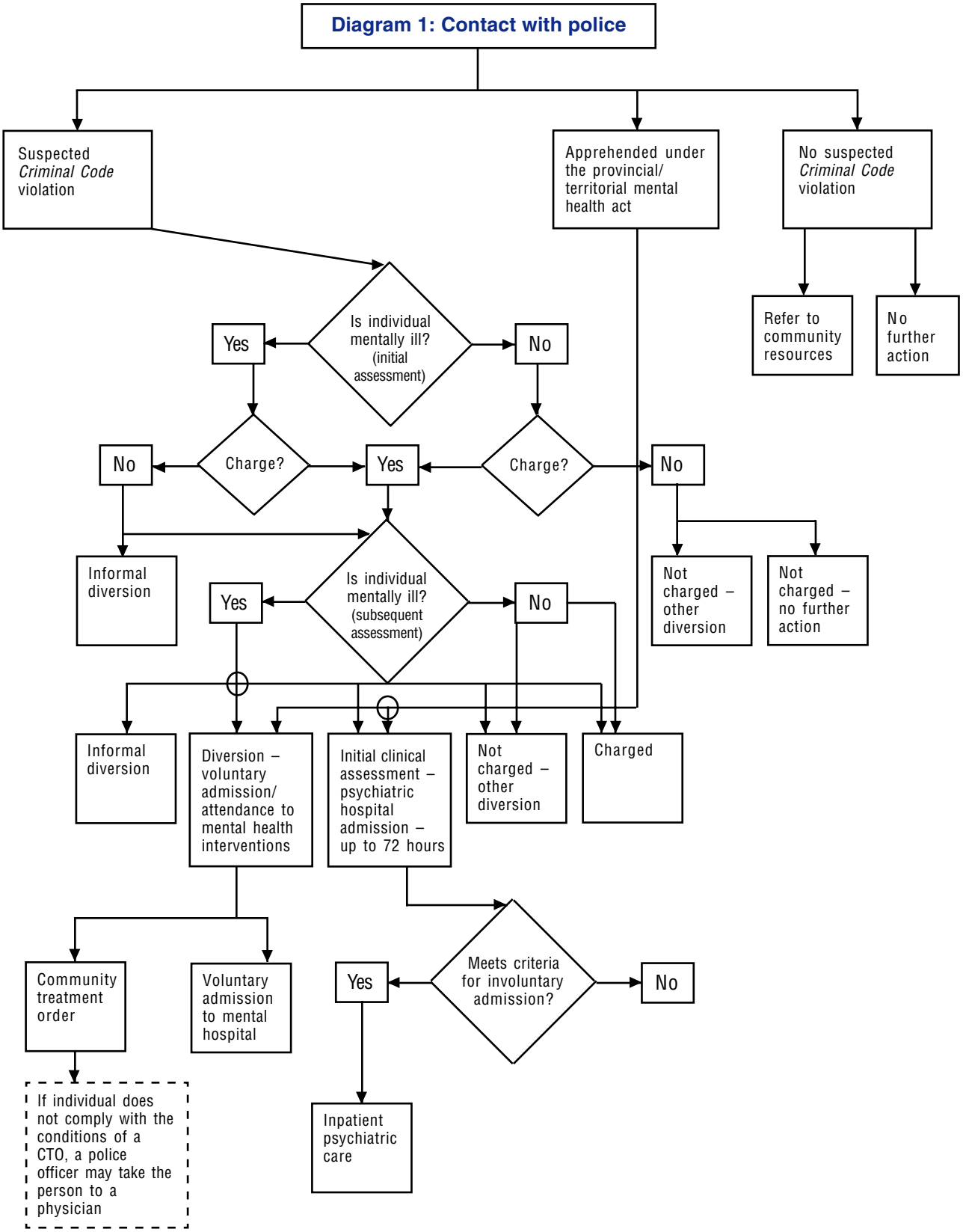
Endnotes

1. The Canadian Community Health Survey - Mental Health and Well-being defines mania as a period of a week or days with exaggerated feelings of well-being, energy, and confidence in which a person can lose touch with reality (Statistics Canada, 2003).
2. The Canadian Community Health Survey - Mental Health and Well-being defines agoraphobia as the fear and avoidance of being in places or situations from which escape might be difficult or in which help may not be available (Statistics Canada, 2003).
3. These views still pervade many parts of the world. According to the World Health Organization (2006), in some cultures mental illness is still perceived as an affliction of an evil spirit. Mentally ill persons are widely neglected, often confined to psychiatric institutions, subjected to "inadequate, degrading and harmful care and treatment as well as unhygienic and inhuman living conditions" (World Health Organization, 2006).
4. Psychopharmacological treatment model refers to the use of medication to modify behaviour.
5. Adapted from Steller, S. 2003. Special Study on Mentally Disordered Accused in the Criminal Justice System. Catalogue no. 85-559-XIE. Ottawa, Canadian Center for Justice Statistics, Statistics Canada.
6. The court or Review Board can direct the accused be discharged subject to conditions as the court or the Review Board considers appropriate (C.C.C. 672.54 (c)).
7. Bill C-10, *An Act to amend the Criminal code (mental disorder) and to make consequential amendments to other Acts,* 1st session, 38th Parliament (assented May 19, 2005), Statutes of Canada 2005, c 22.
8. Adapted from Steller, S. 2003. *Special Study on Mentally Disordered Accused in the Criminal Justice System.* Catalogue no. 85-559-XIE. Ottawa, Canadian Center for Justice Statistics, Statistics Canada.
9. As of November 2008, the Canadian National Committee for Police/Mental Health Liaison has been disbanded.
10. All provinces and territories have versions of mental health acts. These acts provide direction on the treatment of individuals with mental health issues, including provisions relating to apprehension and detention/admission for psychiatric examination.
11. The addition of questions on contact with other criminal justice sectors is addressed in their respective sections.
12. The provisions of the *Criminal Code* that relate to Mentally Disordered Accused changed significantly in 1992 with the proclamation of Bill C-30. Before that time, law and policy regarding persons found not guilty by reason of insanity was not codified and detention was at the discretion of the Lieutenant Governor (Steller, 2003).
13. Within the ICCS, mental health courts are not differentiated from other criminal courts.
14. A small number of youth are sentenced each year to this type of sentence. For example, in 2006/2007, only 5 youth received an IRCS order (excludes Saskatchewan).
15. These seven jurisdictions were Prince Edward Island, Quebec, Ontario, Alberta, British Columbia, Nunavut and the Yukon.
16. Based on consultations with Review Boards
17. The addition of questions on contact with other criminal justice sectors is addressed in their respective sections.
18. The Adult Correctional Services Survey, which is also managed by the Canadian Centre for Justice Statistics, contains aggregate data on correctional systems in Canada. All provinces/territories report to this survey. The survey includes a data element on suicides within and outside of custody.

Appendices

Appendix 1 – Criminal justice processes



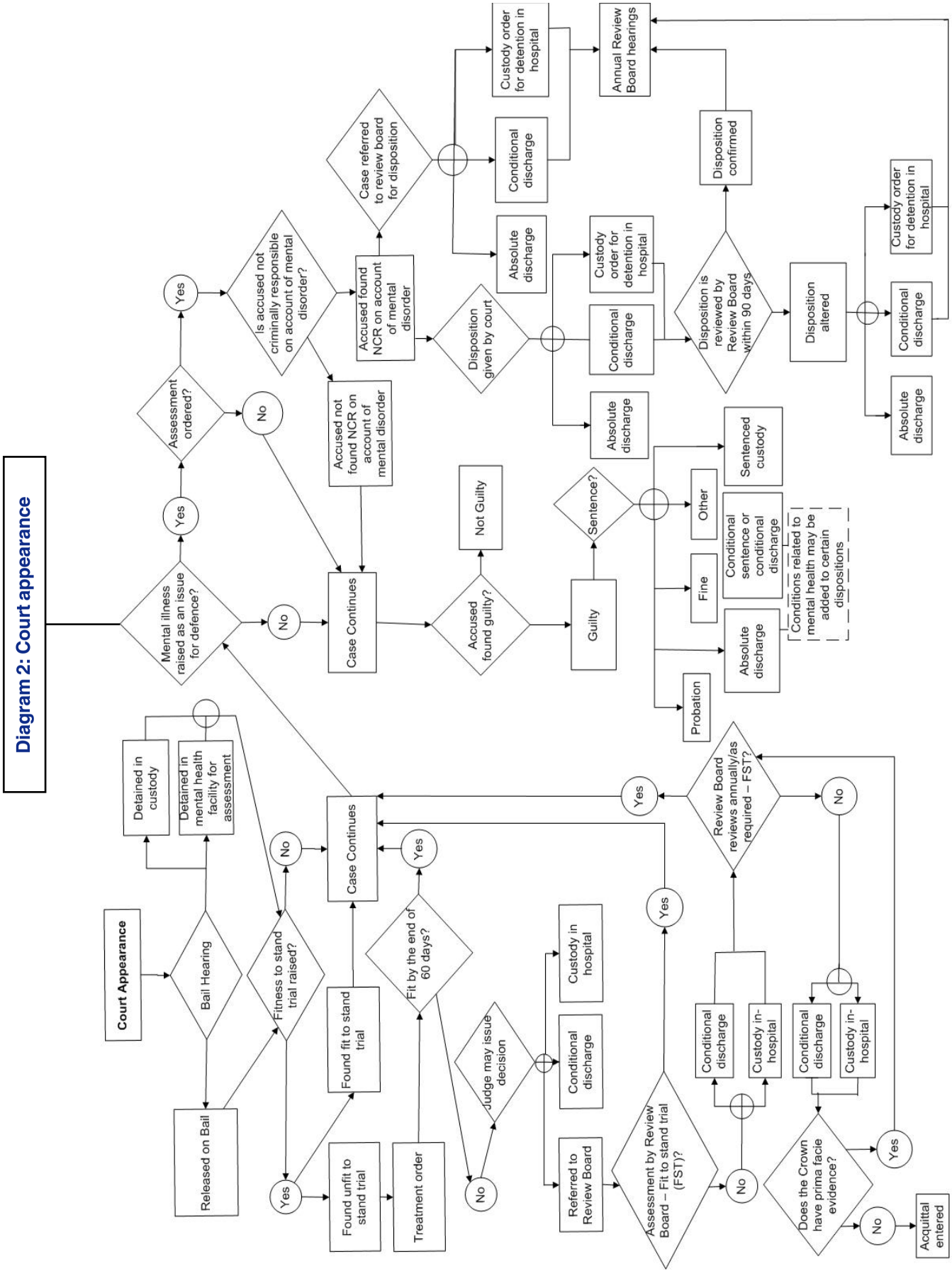
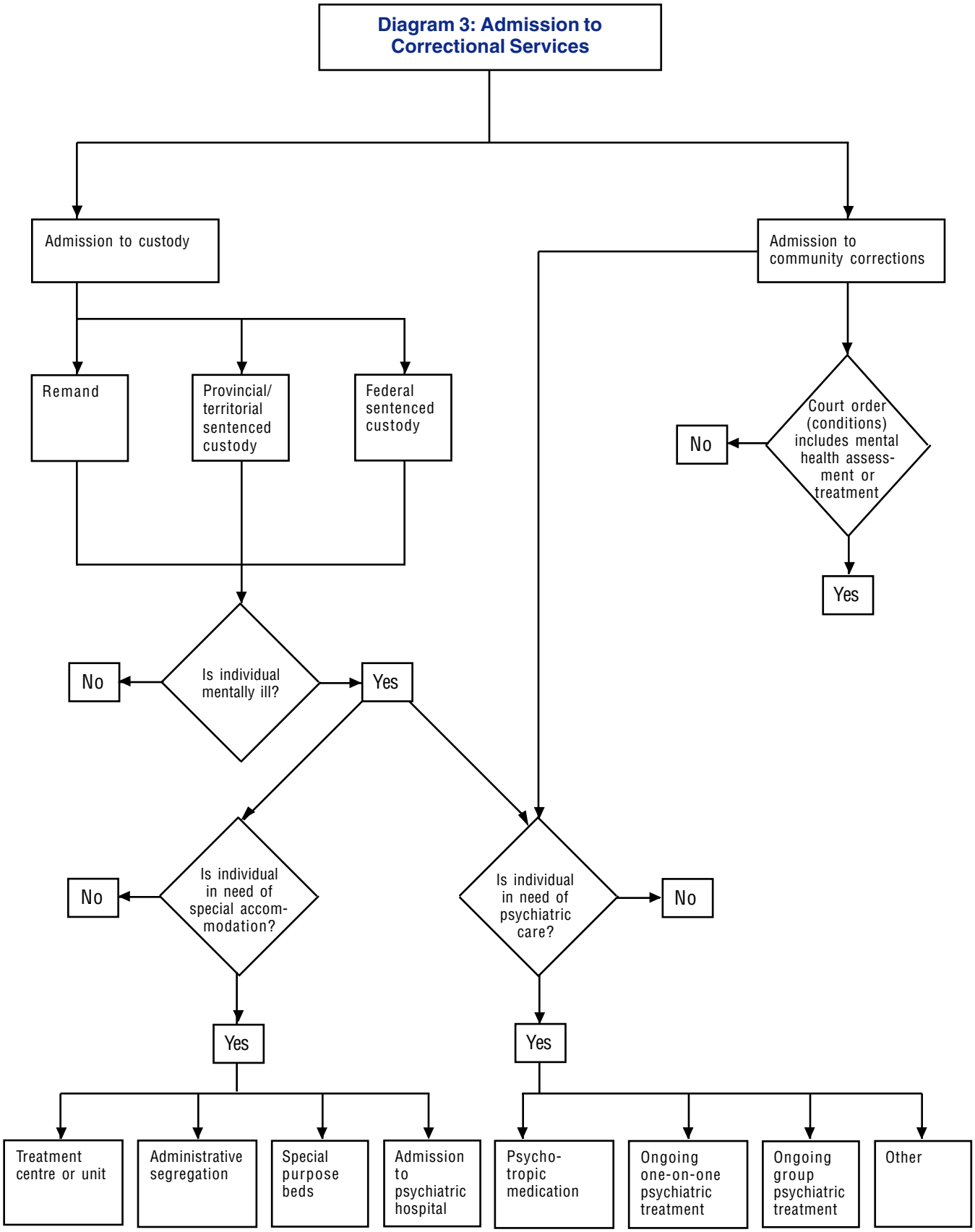


Diagram 2: Court appearance
Court Appearance
Bail Hearing
Released on Bail
Detained in custody
Detained in mental health facility for assessment
Fitness to stand trial raised?
Found unfit to stand trial
Treatment order
Found fit to stand trial
Fit by the end of 60 days?
Judge may issue decision
Referred to Review Board
Custody in hospital
Conditional discharge
Assessment by Review Board – Fit to stand trial (FST)?
Does the Crown have prima facie evidence?
Acquittal entered
Review Board reviews annually/as required – FST?
Conditional discharge
Custody in-hospital
Conditional discharge
Custody in-hospital
Case Continues
Mental illness raised as an issue for defence?
Assessment ordered?
Is accused not criminally responsible on account of mental disorder?
Accused found NCR on account of mental disorder
Disposition given by court
Absolute discharge
Conditional discharge
Custody order for detention in hospital
Case referred to review board for disposition
Custody order for detention in hospital
Conditional discharge
Absolute discharge
Custody order for detention in hospital
Disposition is reviewed by Review Board within 90 days
Disposition confirmed
Annual Review Board hearings
Disposition altered
Conditional discharge
Absolute discharge
Accused not found NCR on account of mental disorder
Case Continues
Accused found guilty?
Not Guilty
Guilty
Sentence?
Probation
Absolute discharge
Fine
Other
Conditional sentence or conditional discharge
Sentenced custody
Conditions related to mental health may be added to certain dispositions
Yes
No

Diagram 3: Admission to Correctional Services



Appendix 2 – Federal, provincial and territorial legislation

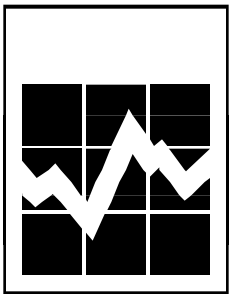
Federal legislation with provisions on mental health

Legislation	Provisions relating to mental health
Criminal Code of Canada (R.S., 1985, c. C-46)	*Fitness to stand trial* 2.0 "Unfit to stand trial" is defined as being unable on account of mental disorder to conduct a defence at any stage of the proceedings before a verdict is rendered or to instruct counsel to do so, and, in particular, unable on account of mental disorder to (a) understand the nature or object of the proceedings, (b) understand the possible consequences of the proceedings, or (c) communicate with counsel; *Not criminally responsible on account of mental disorder* 16. (1) No person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong. (2) Every person is presumed not to suffer from a mental disorder so as to be exempt from criminal responsibility by virtue of subsection (1), until the contrary is proved on the balance of probabilities. (3) The burden of proof that an accused was suffering from a mental disorder so as to be exempt from criminal responsibility is on the party that raises the issue.
Youth Criminal Justice Act (2002, c. 1)	*Court-ordered medical/psychological/psychiatric reports for purposes of sentencing, application for adult sentence, etc.* 34. (1) A youth justice court may, at any stage of proceedings against a young person, by order require that the young person be assessed by a qualified person who is required to report the results in writing to the court, (a) with the consent of the young person and the prosecutor; or (b) on its own motion or on application of the young person or the prosecutor, if the court believes a medical, psychological or psychiatric report in respect of the young person is necessary for a purpose mentioned in paragraphs (2)(a) to (g) and (i) the court has reasonable grounds to believe that the young person may be suffering from a physical or mental illness or disorder, a psychological disorder, an emotional disturbance, a learning disability or a mental disability, (ii) the young person's history indicates a pattern of repeated findings of guilt under this Act or the *Young Offenders Act*, chapter Y-1 of the Revised Statutes of Canada, 1985, or (iii) the young person is alleged to have committed a serious violent offence. *Intensive rehabilitative custody and supervision order* 42. (7) A youth justice court may make an intensive rehabilitative custody and supervision order under paragraph (2)(r) in respect of a young person only if (a) either (i) the young person has been found guilty of an offence under one of the following provisions of the *Criminal Code*, namely, section 231 or 235 (first degree murder or second degree murder within the meaning of section 231), section 239 (attempt to commit murder), section 232, 234 or 236 (manslaughter) or section 273 (aggravated sexual assault), or (ii) the young person has been found guilty of a serious violent offence for which an adult is liable to imprisonment for a term of more than two years, and the young person had previously been found guilty at least twice of a serious violent offence; (b) the young person is suffering from a mental illness or disorder, a psychological disorder or an emotional disturbance; (c) a plan of treatment and intensive supervision has been developed for the young person, and there are reasonable grounds to believe that the plan might reduce the risk of the young person repeating the offence or committing a serious violent offence; and (d) the provincial director has determined that an intensive rehabilitative custody and supervision program is available and that the young person's participation in the program is appropriate.
Corrections and Conditional Release Act (1992, c. 20)	86. (1) The Service shall provide every inmate with (a) essential health care; and (b) reasonable access to non-essential mental health care that will contribute to the inmate's rehabilitation and successful reintegration into the community. 87. The Service shall take into consideration an offender's state of health and health care needs (*a*) in all decisions affecting the offender, including decisions relating to placement, transfer, administrative segregation and disciplinary matters; and (*b*) in the preparation of the offender for release and the supervision of the offender.

Provincial/territorial mental health acts

Legislation	Province/Territory
Mental Health Care and Treatment Act, 2006, c. M 9.1	Newfoundland and Labrador
Mental Health Act, 1994, c.39	Prince Edward Island
Involuntary Psychiatric Assessment Act, 2007	Nova Scotia
Mental Health Act, 1989, c.23	New Brunswick
Loi sur la protection des personnes dont l'état mental présente un danger pour elles-mêmes ou pour autrui, 1997, c. 75	Quebec
Mental Health Act, 1990, c. M.7	Ontario
Mental Health Act, 1998, c. 36	Manitoba
Mental Health Services Act, 1984-85-86, c.M-13.1	Saskatchewan
Mental Health Act, 1988, cM13.1 s12	Alberta
Mental Health Act, RSBC 1996 C 288	British Columbia
Mental Health Act, 1989-90, c.28	Yukon
Mental Health Act, 1988, c. M-10	Northwest Territories
Mental Health Act, 1988, c. M-10	Nunavut

Appendix 3 – Consultation document



Canadian Centre for Justice Statistics

Feasibility study on collecting information on the involvement of adults and youth with mental health issues in the criminal justice system

Consultation Document

September 2007

Statistics Canada Statistique Canada

Canada

Catalogue no. 85-561-M No. 016

Table of contents

Background

For those working in the criminal justice and health sectors, the increased involvement of persons with mental health issues in the criminal justice system has been apparent. While there have been pockets of studies and data collection activities trying to quantify the issue at the police, courts and corrections levels, there is presently a lack of data to understand the extent of the problem, to inform decision-making regarding policy and action, and to measure outcomes of current initiatives and processes.

Purpose of the consultation

At the request of Deputy Ministers responsible for justice matters, the Canadian Centre for Justice Statistics (CCJS) is examining the feasibility of collecting data on the involvement of adults and youth with mental health issues in the criminal justice system. Therefore, the objectives of this consultation are to:

- Consult with key stakeholders to determine **information priorities** regarding the issue, and;
- Determine **what data are currently being collected** on the topic, how they are being collected and any barriers to data collection.

In addition, the study aims to examine issues of confidentiality and privacy regarding data collection, as well as describe strategies, responses, legislation, policies and training that exist with respect to the involvement of persons with mental health issues in the criminal justice system.

The CCJS is looking to consult with stakeholders in the areas of policing, courts, corrections and health, as well as with researcher, academics and non-governmental organizations specializing in this area.

Identification of consultation participant

The following information will help us to compile and analyze the results of the consultation.

Name:

Title:

Organization:

Section:

E-mail:

Phone number:

Fax number:

Date of consultation:

Discussion points

This document is drafted in a general manner to gather feedback with respect to police, courts, corrections and health services. Please respond to the questions as they relate to your specific sector, but if you have comments to make regarding other sectors, please include these as well.

A. General objectives of data collection

Information on adults and youth with mental health issues who are involved in the criminal justice system can serve a number of objectives. These include:

- Improve public awareness regarding the issue.
- Assist those in the field and in policy to make information-based decisions regarding responses to the issue, including program development.
- Measure workload, performance and outcomes.
- Establish baseline information.
- Work toward consistent data recording practices.

Questions:

A1 Are there other objectives for data collection that have not been mentioned above?

A2 Among the objectives listed above and any others that have been suggested, could you identify, in order, the three most important objectives that you see these data serving?

B. Information needs and priorities

To make recommendations on the types of data that should be collected regarding persons with mental health issues in the criminal justice system, it is crucial to understand the current issues and gaps in information.

B1 Without getting caught up in the definition of 'mental health' right now, what are the priority issues facing police, courts, corrections or health services in your jurisdiction with respect to youth and adults with mental health issues? (e.g., Police are spending too much time responding to calls involving non-criminal activities by persons with mental health issues, or; there are few options for police when dealing with persons with mental health issues who have not committed a crime.).

B2 What information do you need to understand and respond to these priority issues (e.g., Information on the number of non-criminal incidents involving mentally ill persons that police respond to. Information on the average length of time for each police intervention, etc.)?

B3 At what geographic level would information be most useful (i.e. municipal, provincial, regional such as Atlantic Region, etc., national)?

B4 Are you aware of any data or potential sources of information either within or outside your organization that could inform these questions or issues?

C. Data availability

C1 Does your organization currently collect or has it ever collected any data regarding persons with mental health issues? Collection means systematic, on-going tracking of information, or a one-time study.

C2 If yes, can you describe the following about the data:

- Types of information collected
- Method of data collection and storage
- Reference period
- Characteristics of the population targeted for data collected (e.g. adults, youth, federal offenders, etc.)?

- Retention period for the data collected
- Are any findings from these data available in a report?

D. Data collection: Police information

This question relates to the policing community. Please continue to Section E if you are not in a position to provide feedback on this section.

One possible way of gathering information on **police** contacts with persons with mental health issues is by conducting a survey with a sample of police services. For instance, for a period of time during the year, a sample of police services could be asked to complete a one-page survey form to provide information on incidents involving persons with mental health issues. These would be returned to the CCJS for processing and analysis.

Questions:

D1 Does this approach seem feasible? What challenges do you foresee in such an option for data collection?

D2 Is there any way of resolving these challenges or can you recommend any other approaches.

D3 Do you have any other concerns about gathering information about contact with police or about the involvement of adults and youth with mental health issues in the criminal justice system in general?

E. Defining mental health

Defining 'mental health issues' or 'mental illness' will be one of the biggest challenges with respect to data collection because of the potentially vast scope of a definition. For instance, from a clinical perspective anything from substance addiction to psychopathic behaviour is included under the *Diagnostic and Statistical Manual for Mental Health Disorders, 4th Edition* (DSM-4). Data collection, however, needs to be feasible and meaningful.

E1 In terms of the issues facing police, courts, corrections, or health services and considering any operational challenges in collecting this kind of information, what types of behaviours or disorders should be included when defining persons with mental health issues?

F. Training, protocols, procedures, policies and legislation

F1 Does your organization have training or other strategies in place to guide employees when dealing with persons with mental health issues?

F2 What are the options for **police** when dealing with someone they suspect has mental health problems (e.g., charge, not charge, referral, etc.)?

F3 Can you describe any protocols, procedure, policies or legislation in effect in your jurisdiction that guide police, court, corrections, health services in responding to persons with mental health issues?

F4 Are there any other protocols, procedures, policies or legislation in your jurisdiction not discussed above that are relevant to the issue of persons with mental health issues in the criminal justice system?

G. Other

G1 Is there anything that has not been covered in this consultation that you want to raise with respect to collecting data on adults and youth with mental health issues involved in the criminal justice system?

H. Additional consultations

H1 An attempt has been made to include as many key stakeholders as possible within the timeframe of this consultation process. Can you suggest anyone else who should be included?

I. Next steps and follow-up

The CCJS will continue to consult with stakeholders until spring 2008. The information gathered will be used to determine the types of information that are needed and to describe the current processes, legislation, etc. for handling persons with mental health issues who come into contact with the criminal justice system. The second part of this project will then be to determine how to collect the information that is needed. To this end, further consultations may be required. A report recommending the types of information to collect and options for data collection will be released by March 2009.

Appendix 4 – Consultation participants by sector

Policing services

- Canadian Association of Chiefs of Police committees:
  - o Canadian National Police Mental Health Liaison Committee (CNPMHLC) – subcommittee of the Human Resources Committee
  - o Police Information and Statistics Committee (POLIS)
- 10 additional police services, representing large urban centres and rural areas

Criminal Courts (9 of 13 provincial/territorial jurisdictions)

- Newfoundland and Labrador
- Prince Edward Island
- New Brunswick
- Ontario
- Saskatchewan
- Alberta
- British Columbia
- Yukon
- Northwest Territories

Review Boards (9 of 13 provincial/territorial Review Boards)

- Newfoundland and Labrador
- Nova Scotia
- New Brunswick
- Ontario
- Manitoba
- Saskatchewan
- British Columbia
- Yukon
- Nunavut

Corrections (10 of 14 provincial/territorial/federal jurisdictions)

- Newfoundland and Labrador
- Prince Edward Island
- Nova Scotia
- New Brunswick
- Ontario
- Saskatchewan
- Alberta
- British Columbia
- Northwest Territories
- Federal, Correctional Services of Canada

Academic/research (5 research institutes/universities)

Mental health organizations and government health departments (7 agencies)

Non-governmental organizations (2 advocacy organizations)

Appendix 5 – Emotionally Disturbed Person (E.D.P.) Form

Example

OFFICER:		OCCURRENCE #:		DATE: (yy/mm/dd)	/ /

GENERAL

Name of Subject:		DOB: (yy/mm/dd): / /
Type of Dispatched Call:		
Who Contacted Police:		
Location:		

APPEARANCE/BEHAVIOUR *Check ALL Boxes that Apply*

GENERAL		HYGIENE		ACTIVITY	
Co-operative w/Police	☐	Dirty	☐	Slow	☐
Rude	☐	Clean	☐	Agitated	☐
Maintain Eye Contact	☐	Body Odour	☐	Restless / Fidgety	☐
Proper Clothing	☐	Malnourished	☐	Abnormal Movements	☐

THINKING

DISORGANIZED THINKING		ABNORMAL SPEECH		ODD BELIEFS		HALLUCINATIONS	
None	☐	Rapid	☐	Paranoid	☐	Voices	☐
Mild	☐	Loud/Spearing	☐	Grandiose	☐	Visions	☐
Moderate	☐	Few Words	☐	Bizarre	☐	Abnormal Sensations	☐
Severe	☐	Other	☐	Other	☐	Other	☐
Describe Other:							

MOOD

Sad	☐	Anxious	☐	Rapid Change of Mood	☐
Happy	☐	Flat	☐	Mood Not Appropriate for Situation	☐
Angry	☐				

ORIENTATION

Ask & Record Responses

Day:	Month:	Year:	Location

DWELLING

Food in Fridge	☐	Clean	☐	Disorganized	☐
Rotten Food	☐	Dirty	☐	Fire Hazard	☐
Comment:					

Developed by the Dufferin-Peel Crisis System Review Committee.

Emotionally Disturbed Person (E.D.P.)

ALCOHOL / DRUG USE

ALCOHOL		DRUG USE					
		ADMITTED			SUSPECTED		
Admitted ☐		Drug Type			Drug Type		
Suspected ☐		Cocaine ☐	Marijuana ☐		Cocaine ☐	Marijuana ☐	
Quantity:		Other:			Other:		
Comment:							

DANGER ISSUES

ACTIVE TO SELF	ACTIVE TO OTHERS	PASSIVE TO SELF
Suicidal Thoughts ☐	Homicidal ☐	Poor Self Care ☐
Self Mutilation ☐	Aggressive ☐	Poor Judgment ☐
Suicidal Act ☐	Weapon(s) Present ☐	Clothing Inappropriate for Weather ☐

MEDICAL INFORMATION

Family Doctor:		
Previous Apprehension MHA:		
Hospital Associated With:		
Psychiatrist:		
Other Professional Agency		
Is Subject on Medication:	Yes ☐	No ☐
Name of Medication:		
Pharmacy Name & Phone:		

ACTION

Follow Up with Professional – Name:		Arrested/Charge ☐
Voluntary – Hospital name		MHA Section 17 ☐
Form		

HOSPITAL INFORMATION

Take to Hospital Known to Subject – if Unknown, Take Subject to Closest Hospital			
SUBJECT DOES NOT CHOOSE THE HOSPITAL			
Hospital Name		Admitted ☐	Arrested/Charge ☐
Doctor Seen:		Discharged ☐	Left Before Decision Was Made ☐
Total Time at the Hospital			

OVERALL COMMENTS

Developed by the Dufferin-Peel Crisis System Review Committee.

Canadian Centre for Justice Statistics

Crime and Justice research paper series

Cumulative Index

The **Canadian Centre for Justice Statistics** (CCJS) was created in 1981 as a division of Statistics Canada. The CCJS is the focal point of a federal-provincial-territorial partnership for the collection of information on the nature and extent of crime and the administration of civil and criminal justice in Canada. This partnership, known as the "National Justice Statistics Initiative", has become the international model of success on how to develop, implement and manage an effective national justice statistics program. Its analytical output appears in the flagship publication *Juristat* (http://www.statcan.ca/english/IPS/Data/85-002-XIE.htm), in various annual and biennieal publications, and in the *Crime and Justice research paper series* (http://www.statcan.ca/english/IPS/Data/85-561-MIE.htm).

Following is a cumulative index of Canadian Centre for Justice Statistics research papers published to date:

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