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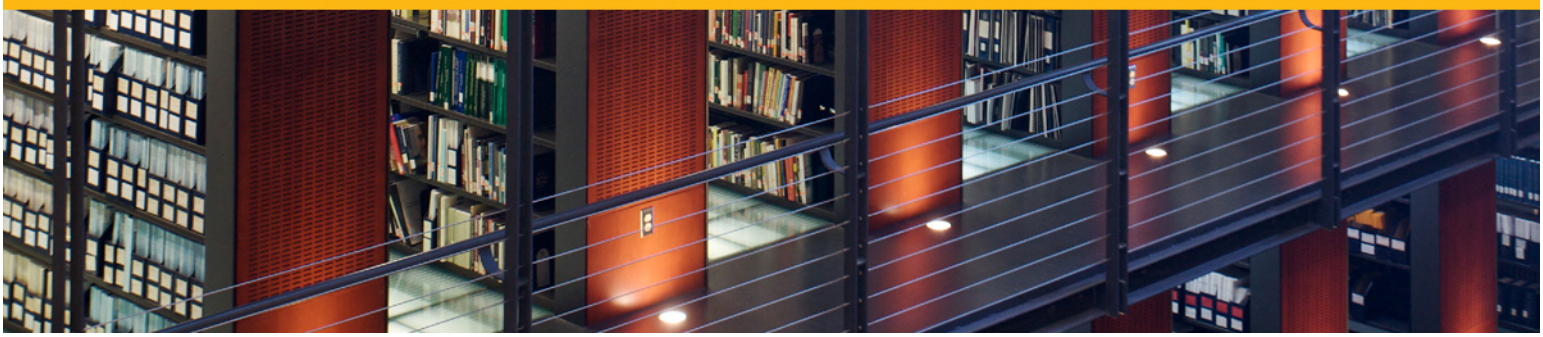

Current Issues in Mental Health in Canada: Mental Health and the Criminal Justice System

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Current Issues in Mental Health in Canada:
Mental Health and the Criminal Justice System
(Background Paper)

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CURRENT ISSUES IN MENTAL HEALTH IN CANADA: MENTAL HEALTH AND THE CRIMINAL JUSTICE SYSTEM

1 INTRODUCTION

Individuals living with mental health problems or illnesses are highly over-represented in the criminal justice system.[1] Mental disorders among inmates in the federal correctional system are up to three times as common as in the Canadian population at large.[2]

This paper describes the procedural and legal framework governing people with mental health problems once they are involved in the criminal justice system.[3] It should be noted, however, that individuals living with mental health problems and illnesses are more likely to be victims of violence than perpetrators of it. Most do not come into contact with the criminal justice system at all during their lifetimes.[4]

The paper begins with a brief overview of the common law origins of the legal treatment of individuals living with mental health problems or illnesses who are alleged to have committed an offence. This treatment is reflected in the current legal position in Canada:

> 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.[5]

Everyone, however, is presumed not to suffer from a mental disorder that would exempt them from criminal responsibility, unless they can prove the contrary on the balance of probabilities.[6]

The paper also examines the various directions in which a case involving an accused person living with a mental health problem or illness may proceed, including pre- and post-charge diversion, a finding that the person is unfit to stand trial, a finding of not criminally responsible on account of mental disorder, diversion to a mental health court, and treatment once incarcerated in the federal correctional system.[7]

2 HISTORICAL OVERVIEW

Holding people criminally responsible only when they can be seen to be morally responsible is a legal tenet which has been part of many legal systems since time immemorial. The Latin legal maxim *actus non facit reum, nisi mens sit rea* ("the act is not culpable unless the mind is guilty") expresses the idea that an act should not be punished legally unless it is committed by a person who has the capacity to recognize the act as being wrong and then freely chooses to do it.

The basis for what is called the "defence of mental disorder" in the current *Criminal Code* is the 1843 United Kingdom case involving Daniel McNaughton (or "M'Naghten") who attempted to assassinate British Prime Minister Robert Peel but

ended up killing his secretary, Edward Drummond. While McNaughton was acquitted and committed to a hospital for people living with mental health problems or illnesses, the House of Lords was asked five questions concerning the insanity defence. In its answers, the House of Lords stated:

> In all cases of this kind the jurors ought to be told that every man is to be presumed to be sane, and to possess a sufficient degree of reason to be responsible for his crimes, until the contrary be proved to their satisfaction; and that to establish a defence on the ground of insanity, it must be clearly proved that at the time of committing the act the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or as not to know that what he was doing was wrong.[8]

This test makes it clear that "mental disorder" (the term that has replaced "insanity" in Canada's modern *Criminal Code*) is a legal concept, not a psychiatric concept of mental illness. An accused person may be diagnosed with a mental illness but still be held legally responsible for committing a criminal offence. It is only when a court determines that the mental disorder interfered with the person's ability to determine right from wrong at the time of the offence that a defence of "not criminally responsible by reason of mental disorder" can be made.

2.1 PART XX.1 OF THE *CRIMINAL CODE*

Section 2 of the *Criminal Code* defines "mental disorder" as a "disease of the mind." Legally, it has been interpreted to mean an illness, disorder or abnormal condition which impairs the human mind from its proper functioning. It excludes self-induced states caused by alcohol or drug consumption, as well as what is known to be a transitory state, such as a concussion or hysteria.[9]

Part XX.1 of the *Criminal Code* establishes the statutory framework that governs the treatment of accused persons who are deemed to be unfit to stand trial or not criminally responsible on account of mental disorder. It is an independent branch of the criminal justice system which was codified in 1992 with the passage of Bill C-30.[10]

The vast majority of criminal cases are not dealt with under Part XX.1,[11] but those that are can be contentious. The cases are not only complex but peppered with legal issues, including principles of equality, justice and fairness:

> Reconciling the goals of public safety and fair treatment of individuals who commit offences while suffering from a mental disorder is one of the most important and difficult challenges for our criminal justice system. The issues are complex. Courts must grapple with questions of statutory interpretation and constitutional rights. They must take account of medical as well as legal considerations.[12]

Since the regime began, few statistics have been gathered on the provisions of Part XX.1 of the *Criminal Code*. In June 2002, in its report entitled *Review of the Mental Disorder Provisions of the Criminal Code*, the House of Commons Standing Committee on Justice and Human Rights pointed out the lack of data on the numbers

of accused declared unfit to stand trial or not criminally responsible on account of mental disorder. The Committee's report stressed the need to improve research and data gathering.[13] To fill this gap, in 2006, the Department of Justice introduced a data collection strategy in cooperation with the Review Boards – specialized tribunals that assess accused with mental problems or illnesses – in seven provinces and territories. The resulting report provided information on the nature of the cases that had been processed through the Review Board systems between 1992 and 2004.[14] Moreover, a report submitted to the Research and Statistics Division of Justice Canada in 2013 analyzed the cases of individuals found not criminally responsible on account of mental disorder who had been accused of serious offences involving violence.[15]

2.1.1 Fitness to Stand Trial

When a person is charged and brought before a court, one of the parties or the court itself may question whether the accused is fit to stand trial.[16] This issue may be raised at any stage of the legal proceedings, although it is generally brought forth at the time of first appearance or at the bail hearing.

There is a presumption that the accused is fit, unless the court is satisfied to the contrary on a balance of probabilities. Consequently, a court may order an assessment of the mental condition of the accused when it has reasonable grounds to believe that it is necessary in order to determine whether the accused is fit to stand trial. From this point on, the accused is assessed by medical experts in the mental health system. The court and the parties will be kept apprised of the mental condition of the accused throughout the process.

> [W]hen an accused is found unfit to stand trial, it has significant implications for all involved. The Criminal proceedings are held in abeyance while the accused remains under some form of liberty curtailment until he or she returns to a fit state and the criminal proceedings can begin anew.[17]

If the accused is declared to be fit, his or her legal proceedings continue as though the issue had never been raised.

2.1.2 Not Criminally Responsible

An accused who has been deemed fit to stand trial may nevertheless be held not criminally responsible on account of mental disorder where the jury or the judge finds that the accused committed the act but was at the time of the offence suffering from a mental disorder so as to be exempt from criminal responsibility (under section 16(1) of the *Criminal Code*).[18] It should be noted that a verdict of not criminally responsible on account of mental disorder implies neither an acquittal nor a finding of guilt. Where such a verdict is rendered, a disposition hearing must be held in order to determine what is to be done with the accused. The disposition ultimately ordered must be the least onerous and least restrictive to the accused, while taking into consideration the need to ensure public safety, as well as the needs and mental condition of the accused, including his or her reintegration into society.

Currently, a court that chooses to make a disposition in respect of an accused, or a Review Board to which the matter has been referred, can make one of the three following dispositions:

- the accused may be discharged absolutely if, in the opinion of the court or the Review Board, the accused is not a significant threat to the safety of the public;
- the accused may be discharged subject to such conditions as the court or Review Board considers appropriate; or
- the accused may be detained in custody in a hospital, subject to such conditions as the court or Review Board considers appropriate.[19]

2.2 Diversion and Mental Health Courts

Aside from the formal procedure set out in Part XX.1 of the *Criminal Code*, diversion of individuals living with mental health problems or illnesses can occur at various points within the criminal justice process. Either in the absence of a charge or once a charge has been laid, police officers, Crown counsel and the criminal courts can help guide the individual towards appropriate community services or medical treatment. The overall objective of diversion is to address the root causes of crime through early intervention.

Not all persons living with mental health problems or illnesses will qualify for diversion of their cases at the beginning of the criminal process. These accused will, therefore, need to be brought before the courts. In Canada, special courts, known as mental health courts (MHC), have been set up, and they favour a holistic approach to dealing with persons living with mental health problems and illnesses.[20] Within this judicial setting, the accused is referred to the appropriate mental health services and supports. The admissibility criteria for each MHC in Canada vary. That being said, police officers, bail court justices, probation officers, duty counsel, defence counsel and Crown prosecutors can refer an accused living with a mental health problem or illness to an MHC.

The goal of an MHC is to provide specialized care to those living with a mental health problem or illness by diverting them from the regular justice system to a special stream in which they can receive treatment. Mental health courts are also equipped to meet the complex needs of accused persons appearing before them, including those living with mental health problems or illnesses (such as schizophrenia, bipolar disorder, depression and complex anxiety disorders) and developmental delays that are significant enough to have an impact upon the fitness to stand trial or the criminal responsibility of the accused.

Depending on the severity of the criminal offence involved, an MHC may offer pre-trial diversion to the individual in question. The MHC favours a therapeutic approach to sentencing; some offenders may be allowed to complete medical treatment before being sentenced. Where a more serious offence has been committed, an MHC may tailor the sentence to the needs of the offender by opting to place the offender in treatment rather than imposing a sentence of a jail term.

3 MENTAL HEALTH AND INCARCERATION IN A FEDERAL PENITENTIARY

Many individuals who end up being incarcerated are living with significant mental health problems and illnesses. The sheer scale of the mental health needs of those held in federal penitentiaries has been highlighted repeatedly by the Office of the Correctional Investigator.[21] Thirteen percent of male inmates and 29% of female inmates in federal institutions have been identified at admission as presenting mental health problems. In addition, 30% of women offenders and 14.5% of male offenders have previously been hospitalized for psychiatric reasons. Federal offenders diagnosed with a mental illness are also typically afflicted by more than one disorder. This often includes a substance abuse problem, which affects four out of five offenders in federal custody.[22]

While many offenders who enter the federal system arrive with mental health problems or illness, some develop such issues as a result of imprisonment. Prison is a high stress environment, particularly where overcrowding is an issue, and separation from social networks can be a factor contributing to such difficulties as well.

Some inmates living with mental health problems and illnesses react with violence, self-harm, disruptive behaviour or an inability or unwillingness to follow institutional rules. This, in turn, often leads to disciplinary consequences and time in segregation, as the mental health needs are treated as security or behavioural issues, which may further exacerbate mental health problems.[23] Staff do not always have the training required to deal with the complex mental health needs of inmates and to de-escalate situations.[24] In addition, addressing mental health issues in a carceral environment requires a delicate balancing of safety and treatment needs that is not easily achieved as those needs may be at odds.[25]

Addressing the various mental health requirements of federal offenders in such a context and with scarce resources has proven to be quite challenging, as noted in numerous reports by parliamentary committees and the Office of the Correctional Investigator.[26] Most recently, the coroner's jury in the inquest into the death of Ashley Smith provided a number of recommendations as to how to improve mental health care in the correctional system.[27]

3.1 THE CORRECTIONAL SERVICE OF CANADA'S MENTAL HEALTH OBLIGATIONS

The Correctional Service of Canada (CSC) has a duty to provide inmates with essential health care and to ensure reasonable access to non-essential mental health care in the interests of rehabilitation and reintegration into the community.[28] CSC also has an obligation to ensure that services meet professionally acceptable standards.[29]

The provinces are generally responsible for health care, which makes it challenging to ensure continuity of care (medication, counselling personnel, etc.), as an offender may lose access to provincial mental health services upon incarceration in a federal penitentiary, transition to CSC services during incarceration and then return to provincial services upon release. As a result, offenders with mental health problems

have been caught in what has been described as a “revolving door” between the community, provincial/territorial and federal correctional facilities.[30]

3.2 Mental Health Services for Federal Offenders

The CSC Mental Health Strategy, first announced in 2004, outlines the main priorities for mental health services for federal offenders. Since 2004, there has been an increase in funding for and focus on mental health.

3.2.1 Mental Health Screening and Assessment Upon Admission

One of the goals of the Institutional Mental Health Initiative (IMHI), which was launched in 2007, was to improve mental health screening and assessment. In 2008, permanent funding for this priority was secured. According to this initiative, an offender should have the opportunity to be evaluated at least four times within 14 days of his or her admission:

- An immediate needs interview is to be held within 24 hours of admission.
- Offenders are to be offered an intake Health Status Assessment within 24 hours of admission.
- Offenders are to be offered a comprehensive nursing assessment within 14 days of admission.
- Offenders are to be offered a Computerized Mental Health Intake Screening System assessment between three and 14 days after admission.

A 2012 review found that the timeline for the first interview and assessment were generally respected,[31] but that the time period for the other two assessments met the targets only approximately half of the time.[32]

3.2.2 Primary Mental Health Care in All Institutions

Where an offender is identified in screening or at a later time as having mental health care needs that are less acute or severe, he or she may receive primary care in the penitentiary, such as counselling, support and treatment. This level of care is part of the IMHI and has permanent funding. Generally, offenders receive services in a timely manner once a referral has been made, though some challenges to timely treatment remain, such as vacancies in nursing and psychologist positions in some regions.[33]

3.2.3 Intermediate Mental Health Care Units

Upon entering the penitentiary or during their sentence, some offenders may require intermediate care. These offenders are unable to cope in a regular institution and need specialized services, interventions and/or environments. Such care would assist these offenders in respecting their correctional plans, in staying out of segregation and limiting emotional crises.[34]

Intermediate care is not yet universally funded and has been identified by the Office of the Correctional Investigator as one of the most urgent needs in the mental health system for federal offenders.[35] There have been pilot projects for male inmates in some institutions. There are also Structured Living Environments in each of the five women's institutions for minimum and medium security female inmates, which provide forms of intermediate care for individuals who require greater levels of support.[36] However, many inmates do not benefit from the limited spaces in those programs and do not meet the criteria for a regional treatment centre (outlined below), which can result in difficulty receiving the services they are entitled to under the *Corrections and Conditional Release Act*.

The lack of comprehensive intermediate care also puts a strain on primary care services and has been said to lead to the use of segregation to manage offenders who would be candidates for intermediate care.[37]

3.2.4 Regional Treatment Centres

Where a male offender is suffering from an acute illness such as psychosis, has a chronic mental illness or cognitive deficits, is an older offender suffering from an illness such as dementia or is in crisis, he may be sent to one of the regional treatment centres (RTCs, which are both a penitentiary and a psychiatric institution) for treatment, or to certain provincial institutions that have agreements with CSC.[38] Certain other facilities provide services for women in similar circumstances: the Regional Psychiatric Centre in Saskatoon has beds for female offenders, as does the Institut Philippe-Pinel in Montréal, which is a psychiatric hospital with which CSC has an agreement for services. Once stabilized, offenders are returned to the general inmate population.

Most offenders do not meet the requirements to enter an RTC, as they have less serious or acute mental health issues such as personality disorders, anxiety or depression.[39] Reviews by CSC and the Office of the Correctional Investigator have identified a number of challenges in providing all offenders requiring this level of care with the services that are needed.[40]

3.2.5 Enrichment of Mental Health Support in the Community

When an offender is released into the community on conditional release or when the sentence is finished, CSC will consider the mental health needs of the individual in developing a release plan. In addition, CSC provides mental health supports to some offenders in the community through its Community Mental Health Initiative (CMHI), which started in 2005.[41] CSC has found that those who receive community mental health services have a 34% lower risk of suspension and a 59% lower risk of revocation of parole than the comparator group.[42] Though the CMHI is intended to be an important development in mental health services for offenders, ensuring a continuum of care as offenders transition from CSC services to provincial, municipal and/or community services remains a challenge.[43]

4 CONCLUSION

In May 2012, the Mental Health Commission of Canada released Canada's first-ever national mental health strategy.[44] The Commission noted that the over-representation of people living with mental health problems and illnesses in the criminal justice system has increased as the process of de-institutionalization of such persons has taken place, coupled with inadequate re-investment in community-based services. Estimates suggest that rates of serious mental health problems among federal offenders upon admission have increased by 60 to 70% since 1997.[45]

Aside from a focus on preventing mental health problems and illnesses and providing timely access to services, treatments and supports in the community, the Mental Health Commission recommends that diversion programs be the next alternative. These programs can redirect people who are about to enter the criminal justice system into care that will address their mental health needs. In order for this redirection to work, however, services must be in place in the community to support the people who are being diverted. Mental health supports are also required for individuals who end up being incarcerated.[46]

While the Mental Health Commission states that "there continue to be significant shortfalls in meeting the mental health needs of youth and adults in the criminal justice system,"[47] the production of the national mental health strategy, combined with CSC's mental health initiatives for inmates, reflect the increased attention that is being paid to mental health issues both in the criminal justice system and in society more broadly.

NOTES

1. Alison MacPhail and Simon Verdun-Jones, "Mental Illness and The Criminal Justice System," Prepared for *Re-Inventing Criminal Justice: The Fifth National Symposium*, International Centre for Criminal Law Reform and Criminal Justice Policy, Montréal, January 2013, p. 2.
2. House of Commons, Standing Committee on Public Safety and National Security [SECU], *Mental Health and Drug and Alcohol Addiction in the Federal Correctional System*, Fourth Report, 3rd Session, 40th Parliament, December 2010, p. 13.
3. There are many terms used to refer to people who experience mental health issues. This paper uses the expression "people living with mental health problems and illnesses," found in Mental Health Commission of Canada, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*, 2012. The exceptions are where reference is made to the legal concept of "mental disorder," which is the term used in the *Criminal Code* or to "insanity," which was the term used historically in criminal law.
4. Mental Health Commission of Canada (2012), p. 46.
5. *Criminal Code*, R.S.C. 1985, c. C-46, s. 16(1).
6. The balance of probabilities standard of proof requires that something is more likely than not, in contrast to the general criminal law standard, which is beyond a reasonable doubt, a higher standard.

7. This paper deals exclusively with adults in the criminal justice system, as youths have a separate system. It also deals only with incarceration in federal – not provincial or territorial – institutions.

8. *M'Naghten's case*, [1843] UKHL J16 (19 June 1843).

9. *Cooper v. R.*, [1980] 1 S.C.R. 1149.

10. *An Act to amend the Criminal Code (mental disorder) and to make consequential amendments to other Acts*, S.C. 1991, c. 43.

11. Mia Dauvergne, "Adult criminal court statistics in Canada, 2010/2011," *Juristat*, 28 May 2012, p. 10: "1% of cases resulted in another type of decision such as the accused being found not criminally responsible or unfit to stand trial, the court's acceptance of a special plea, or cases that raised Charter arguments."

12. Joan Barrett and Riun Shandler, *Mental Disorder in Canadian Criminal Law*, Thomson Carswell, Toronto, 2006, p. iii (Foreword by Justice J. L. Laskin).

13. House of Commons, Standing Committee on Justice and Human Rights, *Review of the Mental Disorder Provisions of the* Criminal Code, Fourteenth Report, 1st Session, 37th Parliament, June 2002.

14. Department of Justice Canada, *The Review Board Systems in Canada: Overview of Results from the Mentally Disordered Accused Data Collection Study*, January 2006.

15. Anne G. Crocker et al., *Description and processing of individuals found Not Criminally Responsible on Account of Mental Disorder accused of "serious violent offences,"* Final report submitted to the Research and Statistics Division, Department of Justice, March 2013.

16. "Unfit to stand trial" is defined in section 2 of the *Criminal Code* as:

> 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.

17. Barrett and Shandler (2006), p. 3-1.

18. *Criminal Code*, s. 672.34.

19. Ibid., s. 672.54.

20. There are, for example, mental health courts in Ottawa, Montreal and Toronto.

21. See, for example, The Correctional Investigator Canada, *Annual Report of the Office of the Correctional Investigator, 2012–2013*, 2013.

22. Ibid., p. 6.

23. Ibid., pp. 7 and 12; Office of the Correctional Investigator, *Risky Business: An Investigation of the Treatment and Management of Chronic Self-Injury Among Federally Sentenced Women*, 30 September 2013, pp. 20–21, 23 and 28–29.

24. Sylvie Soucy, *Review of Mental Health Screening at Intake*, Internal Audit 378-1-261, Correctional Service of Canada, 23 February 2012; Office of the Correctional Investigator (2012); and Office of the Correctional Investigator, *Risky Business* (2013), p. 32.

25. Canadian Institute for Health Information, *Improving the Health of Canadians 2008: Mental Health, Delinquency and Criminal Activity*, Ottawa, 2008, p. 45. Though offenders in provincial jails or serving their sentence in the community may also have mental health issues, section 3 in this Background Paper focuses on federal offenders, because Parliament's role in corrections is limited largely to the federal corrections system.

26. See, for example, SECU (2010); Senate, Standing Committee on Social Affairs, Science and Technology [SOCI], *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*, Second Report, 1st Session, 39th Parliament, May 2006; Office of the Correctional Investigator (2013); John Service, *Under Warrant: A Review of the Implementation of the Correctional Service of Canada's 'Mental Health Strategy,'* Prepared for the Office of the Correctional Investigator of Canada, September 2010; Office of the Correctional Investigator, "Annual Reports," *Reports*.

27. Chief Coroner, Province of Ontario, *Inquest Touching the Death of Ashley Smith: Jury Verdict and Recommendations,* December 2013. For a summary of events leading to the death of Ashley Smith, see Office of the Correctional Investigator, *Backgrounder: "A Preventable Death."*

28. See *Corrections and Conditional Release Act*, S.C. 1992, c. 20 [CCRA], ss. 85–87. In section 2 of the *Canada Health Act*, "a person serving a term of imprisonment in a penitentiary" is excluded from the definition of "insured person," meaning that provincial health care coverage is not available to such offenders.

29. CCRA, s. 86.

30. Lauren Vogel, "Pan-Canadian strategy being developed to tackle mental health in prisons," *Canadian Medical Association Journal*, Vol. 182, No. 18, 14 December 2010.

31. Soucy (2012).

32. Ibid.

33. Ibid.

34. Service (2010).

35. The Correctional Investigator Canada, *Annual Report of the Office of the Correctional Investigator, 2011–2012*, 2012, p. 7.

36. Correctional Service of Canada, "Intensive Intervention Strategy in Women's Institutions," *Commissioner's Directive 578*, in effect 22 July 2013.

37. Service (2010); SECU (2010), pp. 39 and 53.

38. The Ontario Regional Treatment Centre in Kingston closed in September 2013. Offenders will be provided with temporary accommodation until construction of a permanent space is completed.

39. SECU (2010), pp. 10–11.

40. Service (2010); Sylvie Soucy, *Audit of Regional Treatment Centres and the Regional Psychiatric Centre*, Internal Audit 378-1-252, Correctional Service of Canada, 5 January 2011. Issues that have been identified include insufficient capacity and infrastructure, a lack of sufficient personnel, the need to increase the therapeutic role of correctional officers at regional treatment centres (RTCs) and the need for improved documentation to establish that the RTCs are in compliance with the legal requirements outlined in the CCRA.

41. For an explanation of which offenders receive Correctional Service of Canada services in the community, see SOCI (2006), p. 304.

42. Correctional Service of Canada, *Response of the Correctional Service of Canada to the 39th Annual Report of the Correctional Investigator*.

43. Service (2010).
44. Mental Health Commission of Canada (2012).
45. SECU (2010), p. 13.
46. Mental Health Commission of Canada (2012), p. 47.
47. Ibid.