



TOWARDS AN INTEGRATED NETWORK

Avoiding the criminalization of people who have
mental health problems

The Montreal Forum

report prepared by
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for
The Canadian Criminal Justice Association

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Acknowledgements

Several studies (Sinha, 2009; Szasz, 1970; Horwitz, 1977) have shown that either through legal or religious authority, we have always wanted to punish, exclude or eliminate individuals who suffer from mental illness and break the law. These are bothersome individuals, seen as undesirable in our increasingly perfection- and performance-oriented societies. Even today, in spite of ongoing efforts, the road to the best possible options for this clientele remains long and windy, but promising none the less. In 2007, the St-Leonard's Society of Canada and the Canadian Criminal Justice Association undertook to identify some of the more promising practices implemented in various other Canadian cities (Halifax, Kingston, Calgary and Vancouver). Following this initiative, we continued this work in Montreal in 2009.

None of this would have been possible without the support of the Canadian Criminal Justice Association and, in particular, Mr. Irving Kulik, who piloted this project. We would nonetheless also like to underscore the fact that this guide would never have seen the light of day without the participation of our speakers, Dr. Jocelyn Aubut; Suzanne Carrière; Anne Crocker; Gilles Côté; Pierre Gendron; Dr. Mimi Israël; Jean-Jacques Leclerc, and the rich debates that followed each of their presentations. All share a common concern: to prevent the criminalization of people with mental health problems to the greatest extent possible, and to find new initiatives and alternatives.

Finally we would like to especially thank the Department of Public Safety Canada whose on-going financial support has allowed us to bring together all the key professionals and volunteers who dedicate their careers and lives for a safer and healthier society.

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Introduction

Before 1960, people with mental health problems found themselves disadvantaged by the ineffective and inappropriate options available to them. There were two “options” back then, the prison or the asylum. Then the idea of deinstitutionalization emerged. It was born of the best intentions for more effective and personalized healthcare delivery, but what was good in theory never materialized in practice due to a lack of support and funds. This is why, following deinstitutionalization, another ‘option’ became available to people with mental health problems (panhandling and living on the street) which had replaced the asylums. In 1970, the Institut Philippe-Pinel de Montreal (IPPM) appeared on the scene, and then it was after the 1990’s that the effects of the legal shift would begin to take effect within the world of psychiatry (through the hospital door and into the world of psychiatry). Amendments to the Canadian criminal code made it possible for the court to designate a hospital center for the detention, treatment and assessment of an accused person who has received a ruling, an assessment or a placement order. Review boards were also set up at this time.

The findings of several empirical studies brought the harmful effects of deinstitutionalization to light (Keely, 2004; Brink, Doherty & Boer, 2001). Admission to health and justice systems, which tends to make this population even more stigmatized and discriminated against, is still the only means of obtaining support and services for people with mental health problems. Indeed, the system has a tendency to criminalize situations that should not always be criminalized and where alternative measures could be taken. Prison is not an adequate environment in which to receive mental health treatment, but then, what is? Are hospitals any better? Generally speaking, those supplying the services are not necessarily sufficiently equipped and financed to receive these individuals (Kelly, 2004). It should also be pointed out that, on the one hand, there are not enough services to handle a growing demand and, on the other, professionals are not well-enough trained to adequately provide for this population (Kaiser, 2007).

The study conducted by Stuart and Arboleda-Flòrez in 2001 on the perception of people with mental health problems demonstrates that the public sees these people as dangerous. The media is in part responsible for this false perception and contributes to the stigmatization and discrimination to which this clientele is subjected. Moreover, “members of the public react to the effect of crime and disorderly conduct on their lives. It is irrelevant to them whether the conduct is criminal or non-criminal. The public expects the police to step in, regardless of the nature of the behaviour.” (BC Justice Review Task Forces, 2005: 29). We believe it is important to begin by recalling the context of the Montreal mental health initiative by taking a brief look at the body of literature and the research conducted within this framework. We will then provide examples of mental health initiatives in Montreal. This will be followed by conclusions drawn from the Montreal context, along with a series of future recommendations.

I. Overview of literature and research on the criminalization of people with mental health problems

We will begin by taking a brief look at the existing literature and making several general points that will help the reader better understand the mental health situation. We will then move to Dr. Mimi Israël's presentation, which takes a critical look at the current situation in Montreal, particularly access to services for psychiatric and justice clientele. Finally, we will observe the current state of research through the respective presentations of Mr. Côté and Ms. Crocker.

A) *Brief overview of literature, a few general points*

1) Some important statistics...

The World Health Organization revealed in 2001 that mental health affects almost 450 million individuals and as such is a global concern (Statistics Canada, 2009). Canada assessed approximately 2,6 million individuals in 2002, almost 10% of the Canadian population, who had reported mental health symptoms including major depression, "mania disorder", panic attack, social anxiety disorder and fear of public places (agoraphobia), as well as concurrent drug- and alcohol-use problems (Statistics Canada, 2003). Health Canada estimates that in 2002 roughly 1% of the general public was suffering from schizophrenia. A more recent study conducted by Rush and his collaborators in 2008, found that 2% of the Canadian adult population had mental health problems, as well as substance abuse problems. Effectively, people struggling with mental health problems (in Quebec, for example) are more vulnerable to illegal substance abuse (Kairouz et al., 2008). Perreault and associates (2009) have been able to ascertain with respect to this that substance abuse can accentuate mental health problems, mask symptoms, produce an appearance of well-being, or reduce the effectiveness of a medication or be taken in place of it.

2) Lack of consensus on an appropriate definition for mental health and legislative changes.

To begin, one of the main challenges is to come up with a precise and common definition of mental health by considering, for example, which types of behaviours or disorders we would take into account in order to characterize people with mental health problems (Statistics Canada, 2009). Variations on the definition depend upon the discipline, (e.g. Justice, Health). A common definition is all the more important since the police must respond immediately to calls involving a variety of individuals, who may or may not have committed a criminal act and who may or may not have had a clinical assessment (Statistics Canada, 2009). Moreover, we were able to ascertain that each justice system has a different approach to mental illness. The importance of the relationship between mental illness and the criminal justice system can be mainly explained by two factors: first, increased visibility of individuals with mental health problems and, second, the fact that these latter are at greater risk of committing crimes in the face of aggravating circumstances (Statistics Canada, 2009).

A series of legislative and other reforms have been made over the past 17 years in an attempt “to clarify” the situation. In brief, bill C-30, enacted in 1992 at the end of the Lieutenant Governor Warrant’s regime, changed the verdict of “not guilty by reason of insanity” to “not criminally responsible by reason of mental disorder” (NCRMD). A review board acting as a legal body was created with the goal of monitoring people deemed NCRMD and those found unfit to stand trial. The amendments to the 1992 Criminal Code also increased the rights of people not deemed criminally responsible. Since the 1999 R. v Winko case, the Supreme Court of Canada has clarified the protections against detention. Detention would henceforth be used only if the accused represents a significant threat to the public. Finally, in 2005, several amendments to the Criminal Code gave rise to bill C-10 along with a series of reforms primarily concerning the power of review boards and victims’ rights (Statistics Canada, 2009).

3) Treatment

In the domains of treatment and prevention, studies indicate that the most effective interventions are those that integrate several sectors (Perreault and his collaborators, 2009: 91). It has indeed been demonstrated that treatments available through substance abuse or mental health services for people suffering from serious mental health problems were not only ineffective, but generated poor results (Perreault et al., 2009: 95).

This is why, in the case of concurrent disorders, Perreault and associates (2009) proposed the integrated treatment model (ITM) as one of the best practices. They draw several conclusions regarding best practices for concurrent disorders:

- Concurrent disorders are characterized by great heterogeneity;
- Studies on the effectiveness of treatment demonstrate the need for better-defined program components and evaluation of their differential effects;
- Further development and validation of meaningful existing data using more exacting methods is needed;
- It is important to overcome bias introduced by the selection of experimental methods by adopting best practices;
- It would be opportune to consider that best practices for prevention are equally important to those for treatment.
- Over and above the availability of best practices, how to implement them is in itself a challenge.

4) Recommendations

The 2009 Statistics Canada study conducted among adults and youth with mental health problems in the criminal justice system produced three main observations:

The lack of mental health resources tends to significantly increase the number of people with mental health problems entering the justice system. Likewise, the justice system becomes the main mechanism able to offer healthcare and services to people with mental health problems;

The relationship between mental illness and contact with the criminal justice system. This interest flows from concerns over limited access to social services within communities;

The sharing of information and collaboration among the services. The inefficiency of the system is due to a restricted sharing of information among services, reflecting privacy laws and a need for clear client consent and greater collaboration among the justice sectors and between the justice sectors and the health sector. These barriers affect the continuity of services offered to individuals with mental health problems.

Also according to the Statistics Canada study, the strategic priorities identified by the justice system and the review board are:

- Give priority to those accused who have mental health problems;
- Develop legal expertise by increasing the number of specialists and psychiatrists, thus also reducing wait times for the expert's assessment;
- Increase community services and social support so that people suffering from mental health problems receive appropriate treatment quickly, that is supported within the community;
- Consider court decisions concerning the release on bail of people with mental health problems. Due to lack of community or family support, these people have an increased tendency to breach their conditions and return to prison to await their hearings; this is particularly true among youth;
- Encourage specialized mental health courts;
- Share information between the different sectors through a collaborative approach to mitigate, in certain cases, the privacy act and confidentiality policy.

Finally, current priorities for correctional services should be:

- that this population requires correctional services and has specific needs. Substance abuse is the most common problem concurrent with mental health problems;
- that an appropriate form of imprisonment is required. There is a lack of psychiatric units;
- the standardization of provincial and federal programs;
- encouraging correctional services to become more knowledgeable about this problem; to be able to recognize symptoms and avoid false diagnoses or failure to identify people with mental health problems;
- continuity of mental health care prior to and following detention.

According to Kirby et Keon (2006: 336), even though continuity of care is the intended goal, the lack of required mental health services means that few federal offenders are receiving the care they need.

B) A critical look at the current situation in Montreal

Dr. Mimi Israël's presentation entitled "L'accès aux services pour la clientèle de psychiatrie et justice : l'hôpital, la prison ou la rue ?" (access to services, psychiatric and legal aid clients: hospital, prison or the street?)

Following the shift in mental health care by the Federal Government of Canada and within a sectoral framework, Ministerial Order 2005-013, August 25, 2005, designated 14 centres to which the judiciary can refer people with mental health problems on the Island of Montreal. Indeed, no distinction is made among psychiatric hospitals, e.g. there is no means of prioritizing the severity of the pathology or the risk level (dangerousness) of the individual. This means we do not take into consideration whether or not the Hospital has the specific human and material resources required for proper treatment of the patient. Furthermore, Bill 83 in 2004 entrusted the organization of local mental health services to health and social services centres (CSSS), which are responsible for the health of a given territory's population. Thirteen of these centers designated by ministerial order are qualified to appear in court and have the right to assess and treat the referred individual.

These are:

1. Douglas Institut
2. Hôpital Louis-H. Lafontaine
3. Hôpital Maisonneuve-Rosemont
4. Hôpital Sacré-Coeur de Montréal
5. Centre hospitalier de l'Université de Montréal
6. McGill University Health Centre
7. St. Mary's Hospital Centre
8. SMBD Jewish General Hospital
9. West Island CSSS - Lakeshore General Hospital
10. Coeur-de-l'île CSSS (Jean-Talon HC)
11. Ahuntsic et Montréal-Nord CSSS (Fleury HC)
12. Hôpital Rivière des Prairies
13. Sainte-Justine Hospital

Only one of the 14 designated centres, the Institut Philippe-Pinel, admits individuals deemed dangerous and has a mandate to assess criminal responsibility.

It is important to note that this does not mean that because the patient comes from the legal system that he or she necessarily receives specialized care. In fact, no psychiatry department other than Pinel has professional or medical resources specialized in forensic psychiatry.

In practice, in most cases, the patient is admitted:

- to a short-term care unit for an unestablished length of stay that normally lasts no more than 21 days for a varied and vulnerable clientele, which encourages rapid discharge to avoid bottlenecking the system. It's a question of resources;
- with no recourse to security mechanisms, if required, which leads to a lack of control over patients and which increases the risks to those around them;
- by a care team having no knowledge of the legal system or any expertise in substance abuse, criminology or risk assessment and management. This lack of tools

with this type of patient engenders feelings of discomfort, powerlessness and mistrust.

Complexity is the word that best sums up the current mental health system: complexity for the client who finds himself dealing with three ministries, 12 CSSS's, 14 hospitals and numerous community resources, as well as complexity for those professionals in charge of people with Axis I mental health problems (schizophrenia, depression etc.), and/or Axis II (e.g. antisocial personality disorder), and/or substance abuse, and/or social deprivation. Actually, the same client can have a combination of these different disorders. For example, the same person can have a problem within Axis I, be an addict and suffer from social deprivation. This is what makes this clientele so complex; this clientele is more difficult to treat due to a concurrency of disorders, but sometimes also more dangerous, less motivated, and at a greater risk of not sticking to the treatment.

Faced with the same problem, the two worlds collide; in spite of the fact that only by working together will progress be possible. On the one hand is the world of justice and public security, which enacts the law and sees itself as rigid, clear and requiring control in order to protect the public and if necessary to counter, punish and monitor individuals who break the law. On the other hand is the world of health and social services, which, contrary to that of justice and public security, desires better practices that inevitably necessitate flexibility, a measure of uncertainty and negotiations, with the idea of protecting their patients so that these latter can be cured or at least become socially re-established and/or motivated to move in new directions.

It boils down to two worlds each operating in a traditional silo structure and thus lacking global vision and refusing to recognize the various professionals and their roles; both consequently end up with service coordination problems and either failing or almost failing to recognize the special needs of this group. This silo effect is frustrating for both worlds, each being wary of the other, not sharing information, failing to recognize the other system, and finding it difficult to follow or become accustomed to each other's rules.

The complexity of the system is also due to the fact that the entry point of people with mental health problems is unpredictable. Indeed, whether the first contact is with the legal system or the health system, in both cases the client will experience the revolving door syndrome, e.g. he is discharged quickly and just as quickly returns to the hospital, and in addition, will certainly be stigmatized. When a mental health problem is detected, the client will have speedier access to certain types of resources, but once released his access is restricted and engenders the revolving door syndrome as well as stigmatization. When the mental health problem goes undetected, he will most likely be in and out of the system without ever being diagnosed and prone to relapse and victimization. In addition, there is a lack of resources and expertise for people at risk who have not yet committed a criminal act, as well as a shortage or even an absence, of pertinent resources for people having antecedents of violence and behaviour problems.

All the problems mentioned above have the effect of increasing the number of psychiatric cases before the courts. Indeed, we observe that as a result of deinstitutionalization, patients in the community are at higher risk of committing offences. We also observe that

since the amendment to the criminal code, complex patients have not been receiving pertinent care. We have also observed a general increase in the use of narcotics.

This report offers several observations regarding the mental health system on the island of Montreal:

- Resources and budgets are not aligned with the clientele.
- There has been an increase in cases.
- A lack of resources.
- Misuse of existing resources.
- Problems moving clients through the justice and public safety sector.
- Accessibility problems with respect to psychiatric and medical treatments, rehabilitation services for addicts, and housing.
- Accidental deaths that could have been avoided.
- Poor use of the judicial and health systems increases their respective costs.

Dr. Israël's suggestions for the future: Create a vision aimed at prevention, screening, destigmatization and specialization. To make this happen, the following must occur:

- Prevent prosecution to the extent possible
- Avoid 'psychiatrization' to the extent possible
- Reduce the time it takes to move through the justice network for those who would be better served by the mental health network and vice versa
- Meet the specific needs of this population
- Concentrate the expertise and reduce the number of players
- Invest in liaising and coordination
- Create a justice-health-substance abuse network

Comments Made Following Dr. Israël's Presentation:

- It is not merely a question of willingness, but of INVESTMENT
- Problems are often concurrent; appropriate services that meet the particular needs must be available
- Nurses have no training in forensic psychiatry
- Problems of stigma and discrimination
- The problem is Canada-wide
- The root problem is that health is in the hands of the provinces
- General guidelines are needed
- Substance abuse must be included in the mental health problematic
- By influencing structures, it will be possible to integrate better practices.

C) What is the state of research in the field?

Presentation by **Mr. Gilles Côté**, entitled: *“Évolution de la recherche dans le système de justice pénale” (the evolution of research within the penal justice system)*

In the prison environment, mental health problems are considerable and varied. Drugs play a paramount role given that that substance abuse of any kind can cause psychoses. Epidemiology findings in the 80's demonstrated a higher degree of mental disorders among incarcerated offenders. Indeed, several eloquent examples may be used to illustrate this:

- Schizophrenic disorders, for example, are almost four times higher among incarcerated individuals as among members of the general public (1.70%), and over four times higher in penitentiaries.
- Major depression affects close to 5% of the general public and is a bit more than 17% in prisons, and a bit less than 17% in penitentiaries.
- Drugs are by far the most telling example. Basically, 6.10% of the general public consumes drugs yet drugs are involved in 65.70% of prison cases and 49.40% of penitentiary cases.

Due to the prevalence of depression, psychosis and dependency in the 1990s, there was a general feeling that it was urgent to move on the mental health front, as much on the corrections side, as on the hospital side of things. Among the homeless population for instance, 42.1 per cent were suffering from dependencies and 59 per cent had prison records. Given the increased rate of incarceration, risk assessment tools were developed towards the end of the 1990s and during the 2000s in order to provide better adapted services to this population. In fact, prior to this, clinicians' ability to assess dangerousness was limited, which had the potential of leading to difficult situations. However, more effort is needed. For instance, it should be noted that according to the Correctional Investigator's Office (2005: 13) : *“...the proportion of federal offenders with mental health problems has more than doubled in the last ten years”*. In spite of this, there are still too few resources and services available.

Mrs. Anne Crocker's presentation, entitled: *“La clientèle à l'interface des systèmes de santé mentale et judiciaire : une question de psychodiversité légale et de coordination des services” (Clientele at the interface of the mental health and justice systems: a question of legal psychodiversity and coordination of services)*

Interactions between people with mental disorders and the police and criminal justice system have been the subject of much debate. Indeed, research shows that deinstitutionalization and legislative changes are responsible for the fact that persons with mental health problems are more likely to be involved with the criminal justice system. In 1984, Teplin had already observed that the level of involvement between police and people having mental health problems was higher than for the general public. On the other hand, Engel and Silve (2001) noted that police are three times less likely to proceed with an arrest if the individual has serious mental disorders. In Canada, there are still few studies on the interaction of people with mental disorders and police services. In addition, we observe that little attention is given to the differences between the sexes.

A London (Ontario) study showed that men and women with serious mental disorders represent a small percentage of all contact between citizens and police services. This small percentage, however, becomes exaggerated in the mind of the general public. They are often approached by police during routine patrols or in responding to a complaint. In the event of a crime, people with serious mental disorders are more often suspect and more susceptible to police involvement. One out of three men and one out of five women having a serious mental health disorder is suspected of being a violent offender. This kind of interaction not only impacts public perception but also that of police. People with serious mental disorders are more likely to have formal charges brought against them than are members of the general public. The London study researchers asked themselves whether mental health disorder is a significant influence on the relationship between violence and gender? They concluded that mental health disorder is probably a greater risk factor for crime (and violence) for women than for men. Nonetheless, men are more susceptible than women to committing criminal acts and displaying violent behaviour. Basically, criminal activity among women is viewed as less of a social problem.

According to Hodgins and his collaborators (1992; 1996) men with serious mental disorders are up to seven times more likely to be violent, and women with mental health disorders up to 27 times more likely, than men and women having no mental health disorder. This major disparity between the sexes is equally due to the fact that clinical assessments predicting the risk of violence among women are less accurate than those for men (Skeem and Al., 2005). Do women have different needs and problems than men? Are interventions taking specific gender-based variables into account needed? For the moment, all we can say is that very little research on women exists.

Following this brief exposé, let us point out the factors influencing outcome:

- incident severity
- source of the complaint
- attitude towards the police
- drugs and alcohol
- homelessness

A study similar to the one in London is currently underway in Montreal. Conducted by Charette, Crocker and Billette, it concerns police interventions with people who appear to have mental health problems.

II. Mental Health Initiatives in Montreal, a few examples

A) *The Intersectoral Table on Forensic Psychiatry*

Presentation by Mr. Pierre Gendron entitled "Table intersectorielle de psychiatrie légale"

The Intersectoral Table on Psychiatry is first and foremost an innovative project that its participants fight to keep on an ongoing basis. They also work toward furthering knowledge and identifying the main challenges in mental health in Montréal. Its members do all in their power to improve conditions for people with mental health problems. It is crucial that such initiatives continue and be multiplied across the province and all of Canada.

The development of the Table was for the most part beset with pitfalls from several different sources. Indeed, the first was the psychiatric justice protocol, an influential document written in 1989 but never reviewed or even updated. An inter-departmental committee that should have been established never came into being due to a failure to recognize the government's lack of global vision. Secondly, this Table led to numerous reorganizations of policy as well as of the structures themselves. Thirdly, there was a lack of knowledge or interest by the Montreal forensic psychiatry agency. Fourthly and finally, Montreal's Pinel Institute has a national mandate but finds itself being managed within a regional framework.

These different sources of problems ensured the Table was created and then restructured during four distinct periods.

The Table came into being in the middle of the 1980's. The first period stretched from the middle of the 1980's to the middle of the 1990's. Its members were people coming from different backgrounds: the Agency (Régie régionale), the Department of Public Safety (Justice), social services centres (CSS), attorneys and solicitors, the Pinel Institute (IPPM), and the Louis-H. Lafontaine hospital. It was led by André Cimon from the Agency and Marcel Courtemanche of the IPPM. This endeavour consisted of analyzing the difficulties associated with the psychiatric justice clientele, such as the revolving door syndrome, uncooperative clients, access to services or even judiciarization. The analysis resulted in the establishment of the Centre de psychiatrie légale de Montréal (CPLM) where appointed partners (Justice, social service centres, Pinel Institute) geared their programs towards clients with sexual problems. Emergency beds were also added to avoid detention at "Entre-Toit," a group home specializing in forensic psychiatry. In 1994, the Table closed down in favour of the establishment of the Psycho-Social-Justice Emergency, better known by the diminutive UPS-Justice, which has a mandate to prevent prosecution and incarceration of individuals with a severe and persistent mental health problem.

The second period began at the end of the 1990's under the leadership of the Agency's Léo Fortin. Participants were fewer in number, only including members from the Agency (Régie régionale), the Louis-H. Lafontaine hospital, the Pinel Institute, and housing resources. This second period was mainly concerned with the housing initiatives, such as the opening of "Le Jalon" resource providing forensic psychiatry services for women. Equal opportunity for

housing resources, such as the Comité d'Orientation Clinique – COC and the Comité d'Accès au Réseau – CAR were created. But this period was marked by feelings of powerlessness among the members, or as a 'depressing' period, and by the departure of Léo Fortin.

The third period extended from 2001 to 2004. The Table resumed its work under leadership of Mrs. Bibiane Dutil and new participants: UPS-Justice, Montreal police force (SPVM), and the community sector. The main files preoccupying the Table during this period were Bill 38, an exceptional law for use when all other recourse is precluded. Its implementation was complicated by the fact, among others, that it contravenes the Charter of Human Rights and Freedoms. Bill P-38 applies when a person's mental state poses a severe and imminent danger to himself or others. The financial framework of intermediate resources was reorganized during this period, leading to the closing of a care unit at Montreal's Pinel Institute. This period was marked equally by the closer involvement of the Montreal police service (SPVM) and lawyers Brousseau and Brouillette in problem resolution. The Spring of 2004 welcomed several major events, such as the "reorganization" of the Agency, the abolition of programs, as well as the abolition of sectoral tables.

The fourth period.: Following demands from within the Agency for the return of the Table's 2004 standard, work began anew in 2005. It was renamed the Intersectoral Forensic Psychiatry Table and was under leadership of Bibiane Dutil and Chantal Despatie. Representation was dramatically broadened. The Table benefited from this by updating the links between the partners, its collaborations and offers of service, and initiating a service organization model. In November of 2007, a forensic psychiatry symposium, during which the service organization model project was presented, was held at the IPPM. Mr. Levine was hired that same month. The day after his engagement was announced however, the Table received word of its dissolution. In spite this, the members decided to proceed under the leadership of Sylvie Quenneville of the Department of Public Safety.

Mr. Gendron offers several proposals for the future:

- the need for a national organization of forensic psychiatry services
- a coherent and consistent definition of the role and place of the Institut Philippe-Pinel de Montréal
- a definition of the role and place of regional forensic psychiatry units
- a definition of the links and interactions between psychiatric hospitals and the psychiatric departments of general hospitals
- the Institut Philippe-Pinel de Montréal must be under national (Quebec) jurisdiction rather than that of the Montreal region for: coherent organization of services, budget, interaction between the Justice and Public Safety departments, and for planning as well as research.

Comments following Mr. Gendron's presentation:

- Lack of a front-line medical services representative
- Table should be permanent
- Many obstacles remain
- Organization of Montreal forensic psychiatry is chaotic

- Lack of network coordination. This problem must become a government priority, e.g. not one that requires a crisis for action to be taken
- All services are plagued by the same problems, caused by organizational flaws, etc. Solidarity among certain services would make things move along more quickly.
- Nothing is structurally in place, but one must have 'faith.'

B) Institut Philippe-Pinel de Montréal (IPPM)

Presentation by **Dr. Jocelyn Aubut**, entitled: "*Forum en santé mentale : initiatives nouvelles et anciennes*". Voir site internet de l'IPPM : www.pinel.qc.ca/ (*mental health forum: old and new initiatives*)

The IPPM has existed for 40 years now. This institute is a psychiatric, supraregional, teaching and forensic psychiatry hospital specialized in the assessment, treatment and management of patients presenting a risk of violent behaviour, making it a globally unique model. Essentially, it brings together all facets of forensic psychiatry. The Institute is affiliated with the Université de Montréal and works in concert with teaching institutions and other universities in Canada and around the world.

The Institut Philippe-Pinel de Montréal has the following mission:

- To assess a person's mental state and risk of violence and to provide suitable treatment;
- To teach residents in psychiatry and students in different fields of health sciences and to offer continued education to mental health professionals;
- To carry out research on biological, sociological and psychological aspects related to violence and dangerousness and on the effectiveness of treatment programs;
- To prevent violence by applying specific programs and by sharing its expertise with its partners in collaboration with Fondation Docteur Philippe-Pinel.

Several groups of professionals are involved in the different phases of the treatment plan. Among these professionals are psychiatrists, psychologists, specialized services in personal development (SSPD), and pastoral care service.

Patients admitted to the Institute are transferred to one of 15 care units that provide care and treatment programs specific to the individual's condition. The Institute has no more than 292 beds. The Institute delivers care and services to a mixed, multiethnic and multicultural clientele, of every legal status (open-door, accused, federal and provincial offender, dangerous offenders or to be monitored, youth under the protection of the Youth Protection Act coming in through Quebecois and Canadian health networks (psychiatric and general hospitals), Justice and Correctional Services (prevention centres, Quebec courts, criminal and penal courts, Quebec detention centres and Quebec penitentiaries, youth centres), rehabilitation centres, as well as halfway houses, group homes, etc. Upon exception, the Institute receives patients from outside of Quebec, referred by institutions lacking the superspecialized resources and security features required for the assessment and treatment of very difficult cases.

The services are offered by various professionals: psychiatrists, nurses, clinicians, psychologists, criminologists and sexologists. Also, a probation officer is involved with the clinical teams.

Certain programs are offered on an in-patient basis (expertise, treatment, rehabilitation, adult and adolescent sexual offenders, psychiatric care for women serving a federal sentence, adolescent assessment and treatment), while others are offered on an out-patient basis:

- ✓ Montreal forensic psychiatry centre (Le Centre de Psychiatrie Légale de Montréal)
- ✓ Postcure, which receives almost all patients requiring clinical follow-up and monitoring following hospitalization at Montreal's Pinel Institute.
- ✓ Adult forensic psychiatry
- ✓ Adult sexual offenders (consultation, assessment and treatment)
- ✓ Adolescent sexual offenders (specialized assessment and treatment)
- ✓ The dangerousness clinic provides services to different psychiatry departments in the province
- ✓ Child psychiatry clinic for severe behaviour problems
- ✓ UPS-Justice, which improves the organization and delivery of services to justice-psychiatric clientele in the Centre-Sud region of Montréal.
- ✓ Youth clinic (reorientation, exploration of new approaches, interactions with certain organizations working with street children, integrated multidisciplinary research.

Whether the services are offered on an in-patient or out-patient basis, they are all aimed at the social reintegration of the patient.

For many years, there have been no escapes from Pinel, nor any major 'acting out'. And yet, all non-return patients are subject to a hypermediatization which has the tendency of creating needless panic in the community. This is why the IPPM decided to make itself better known to the Chamber of Commerce and within the community in order to demystify media portrayals.

For the moment, we are observing a mutual lack of awareness among the networks and a lack of awareness regarding the new territory being charted. However, some solutions are emerging, such as National Leaders in Forensic Psychiatry whose objective is to share facts, issues and constraints concerning the organization of forensic psychiatry services in each region of Canada. This recent initiative distinguishes itself from other symposiums in which the accent lies solely on the organization of services.

The transfer of services from the Public Health Ministry to the Department of Health and Social Services may allow for a change of culture. Over and above the operational aspects, however, the main challenge is as follows: How to reduce the prejudices surrounding this clientele in order to ensure equal access to services?

According to Dr. Aubut, despite expanded efforts extended to this clientele over many years, we are observing an increasingly strong evolution toward 'law and order' and a

devaluing of advice from people in the field and experts. Whatever happened to the lobby for “law and order and compassion and rehabilitation?”

Comments following Dr. Aubut’s presentation:

- There are discrepancies in services. We do not always find the right person in the right place;
- Networks are not equipped to receive this clientele;
- Lack of ‘runways’ leading up to and following incarceration;
- Relative absence of housing resources;
- Provide quality of life for patients as well as for the professionals and caregivers in charge of this special-needs clientele;
- Develop initiatives within the local community;
- “Is there a plane and a pilot (financing)?” Almost everything is in place, but government must provide the funding needed for existing and future initiatives.
- Vancouver has an interesting private sector initiative in its creation of an agency offering forensic psychiatry training to nurses.
- A plan for offenders following their release from detention, and not just a subway ticket; Their reintegration must be facilitated.
- Absolute need to emphasize staff training and supervision;
- Need to broaden the definition of forensic psychiatry to avoid creating a vacuum.

C) Residential facilities and social re-integration of the forensic psychiatry clientele at Hôpital Louis-H. Lafontaine de Montreal

Presentation de Mr. Jean-Jacques Leclerc, intitulée: “Hébergement réadaptatif et intégration sociale de la clientèle en psychiatrie légale” (rehabilitative housing and social reintegration of mentally ill persons involved with the justice system)

The Louis-H. Lafontaine hospital has a multi-faceted mission. In effect, it is to facilitate access to care and specialized and ultraspecialized services, but also develop a relevant body of knowledge through research, teaching and assessment, and finally disseminate said knowledge not only to users, providers and professionals, but also to the general public.

This mission is integrated into the 2005-2010 Mental Health Action Plan (MHAP), “The Strength of Links.”

a) Psychosocial Readaptation

The slogan of Hôpital Louis-H. Lafontaine is ‘psychosocial readaptation.’ The preferred model is the T-R-R (Treatment-Readaptation-Rehabilitation) model, which emphasizes interdependence of the intervention methods for a recovering person: The person receiving treatment is central to the model, which aims at getting the person to take a new step in his or her own development by encouraging complete social integration. It aims at skills development in concrete situations for the person through active participation in his or her actual environment. Effectively, we believe that the more independent the person is, the less recourse he or she will need to the mental health network, enhancing at the same time

system flow and client turnover in service delivery. To ensure this, people affected by mental health problems must be prevented from losing their jobs.

With respect to psychosocial readaptation (PSR), certain values must be respected:

- to respect the rights and the users,
- to respond to the needs,
- to develop potential,
- to hope
- to actively participate

Accreditation Canada, in December 2007, brought to light three 'exemplary' practices with regard to psychosocial readaptation. First and foremost, the abolition of structural regulations was overly restrictive in certain regards. This was followed by the implementation of a program for the distribution and administration of drugs within housing resources and social re-integration residences. Finally, a support program for the self-administration of PRN (antipsychotic drugs) in group homes was set up.

b) Housing Resources

There is presently a range of housing resources. We have intermediary resources and family-type resources managed by private organizations with the goal of maintaining the user. We also have group homes, supervised apartments or rooming houses managed for non-profit organizations focused on social re-integration. Finally, we have group homes, individual apartments, halfway housing managed by institutional resources or non-profit organizations focused on providing specialized housing for two-to-three year periods.

Critical mass in these various home-like environments allows for:

- Responding to multiple needs
- Accommodating a mixed clientele in terms of age and clinical profile
- Offering stimulating, encouraging and creative environments
- Offering services that focus on recovery
- Promoting recovery through the social integration of clients and their maintenance in the community, the development of autonomy, working towards a quality of life, and self-development.

The profile of the housed clientele is varied and complex. The majority, 64%, are between age 35 and 64 (note that, among these, 36% of clientele are between age 50 and 64), 23% over age 65, and 13% under age 35.

Youth (under age 35) are in the minority compared to the rest of the clientele; it is nonetheless important to create meaningful links with them. They are sometimes re-integrated too quickly into the adult environment and have a tendency to become mired in criminal environments that quite often lead to detention.

This clientele is, to say the least, complex in the sense that aside from being in a state of continual change, they are also suffering from concurrent problems (substance abuse and dependency, prostitution, homelessness, behavioural problems, loss of autonomy due to aging, physical health, forensic psychiatry). This clientele thus requires ongoing rehabilitation.

Over the past few years, we have observed an increase in the demand for forensic psychiatry and waiting lists continue getting longer. In May of 2009, 78 people suffering from mental health problems were on these lists. The forensic psychiatry roster is full. Excessive wait times carry a dangerous risk for this already fragile clientele, but are just as discouraging for professionals, hence the importance of networking with the regular network. It is important to ensure that these people stay in or return to their natural environment. This situation ensures that the providers and professionals act only in the event of a crisis and with the common goal of getting the person out of the system as quickly as possible.

Comments following Mr. Leclerc's presentation:

- Develop the forensic psychiatry network
- Prioritize the "discharge" of 20 people from the Pinel Institute
- Urgent need for housing and quality social reinsertion within forensic psychiatry (document signed by Aubut and Lemieux) to prevent the cycle of judicialization. It is a most important issue.
- Offer support during the return to a home environment by developing in-house support, by nurturing these people through peer support, make provisions for respite care for the family.
- Unblock funding
- Revise network access mechanisms to make them more unified
- Develop housing resources, but this necessitates deconstructing the old adage, 'not in my neighbourhood.'

D) *The Mental Health Court*

Presentation by Suzanne Carrière, entitled: "Projet pilote à la cour municipale de la Ville de Montréal d'intervention multidisciplinaire pour les contrevenants souffrant de troubles mentaux : Tribunal de la Santé Mentale" (pilot project in Montreal municipal court on multidisciplinary intervention for offenders suffering from mental health problems: mental health court)

What is the Mental Health Court?

The source of this project is a series of meetings. In the Spring of 2006, a first meeting was held among the Department of Justice, the Department of Public Safety, the EJLB foundation, and mental health organizations. In the Fall of 2006, a second meeting was held, this time with the Department of Justice, Department of Health and Social Services (Mental Health), the Montreal Municipal Court, and correctional services. The Montreal Agency became involved in Spring of 2007 to ensure that the project would be launched and Court

activities started in May of 2008. This implementation necessitated the involvement of diverse stakeholders:

- Department of Justice
- Department of Public Safety
- Réseau correctionnel de Montréal (Montreal correctional network)
- Montreal Municipal Court
- Montreal Health and Social Services Agency
- Institut Philippe-Pinel de Montréal
- Jeanne-Mance CSSS (UPS-Justice)
- Centre Dollard-Cormier
- Fondation des maladies mentales (mental illness foundation)
- EJLB Foundation
- Réseau d'aide aux personnes seules et itinérantes de Montréal - RAPSIM (Montreal network for people living alone and the homeless)
- Société québécoise de la schizophrénie - SCS (schizophrenia society of Quebec)

What are the objectives of the Court?

- Avoiding the imprisonment of people who have mental health problems by promoting monitoring, follow-up and supervision within the community.
- Ensuring ongoing monitoring and follow-up of these people so as to reduce the risk of re-offending.
- Improving judicial treatment of this type of offender at the Montreal Municipal Court.
- Permitting more uniform and coherent processing of court records.
- Reduce the detention period required for psychiatric assessments.

Who is the target clientele?

- Adults from the territory of Montreal
- People charged with minor offences (ex: misdemeanours, causing a public disturbance, simple assault, obstructing a police officer)
- People presenting signs of mental health problems that could be concurrent, such as mental health - dependency; mental health - intellectual disability

What is its judicial organization?

- Limited number of judges, crown prosecutors, probation agents
- Physical layout (needs improving)
- Relaxing the rules of operation
- Offering the Justice and Health Support Plan (PAJES)

What is the PAJES (justice and mental health support plan)?

The PAJES has three basic objectives:

- Offering the defendant the possibility of community-based services aimed at stabilizing or improving the state of his or her mental and psychosocial health.
- Offering the defendant the possibility of different and more favourable judicial or criminal measures such as: withdrawal of complaint, exclusion from sentences of imprisonment.
- Enhance links between community and public organizations.

We need to note that the PAJES is a volunteer program, meaning that offenders may default through refusal of or withdrawal from this plan at any time. The participants appointed to the PAJES come from Justice and Public Security (judges, crown prosecutors, probation agent, defence attorney) and Health and Social Services (physicians, UPS-Justice; CSSS teams, psychiatric hospital centres, Centre Dollard-Cormier, intellectual deficiency rehabilitation centres and community organizations). The PAJES strives to offer temporary housing; however, correctional authorities offer only two to three beds that are not really very available to the project, while Health and Social Services has created two places at the maison Ste-Claire and reserved them for the project.

The mental health court is a three-year project (started in May of 2008). Research by the Douglas Mental Health University Institute is aimed at project implementation. A monitoring committee and a multisectoral monitoring committee have been put in place to monitor and also to evaluate the project.

What are the positive aspects of such a project?

- Openness and confidence
- Collaboration among the various partners
- Solid understanding of the problematic
- Integration of dependence problems
- Liaison
- The client

What are the negative aspects of such a project?

- Data collection
- Access to psychiatry
- Mental health team - CSSS
- Confusion over roles and mandates (psychiatry ; forensic psychiatry: attitude and responsibility)
- Housing
- Site management and maintenance

The Mental Health Court pilot project tends to improve the PAJES (justice and mental health support plan project).

Following Mrs. Carrière's presentation, a few suggestions:

- Need for a certain autonomy
- Attention to information management
- Development of alternative resources with respect to non-liability
- In certain cases, file incident reports instead of opening of a criminal record
- Refer to the similar Toronto example, which has already proved itself successful

In order to better visualize a client's path, outlines of our process are available in the appendix.

Conclusions and Future Recommendations

This project will reaffirm that in spite of a willingness and desire among the people in the field to overcome the numerous obstacles surrounding mental health, much more than this is needed. By much more, we mean not only a political willingness with respect to the financing of innovative and effective initiatives, but also for the continued financing of existing initiatives. The debates that followed the presentations were rich in promising ideas for responding to the difficulties surrounding the criminalization of people with mental health problems. It will thus be necessary to follow through with this in future policies and other reforms.

All the recommendations made by Josée Tremblay in her 2008 report “Vers un réseau intégré” (Towards an Integrated Network) are certainly still viable.

The main strategic areas are:

- Accentuating prevention
- Increasing housing resources
- Increasing mental health financing
- Remediating the mental health definition problem
- Working in partnership with the different sectors (Justice, Health and community)
- Adapting treatment to encompass mental health problems that are concurrent with other problems (exclusion, substance abuse, etc.); this implies a more personal, holistic and multidisciplinary approach
- Respecting the dignity of patients, as they are not pawns of the system, but people in their own right.
- Emphasizing rehabilitation
- Educating the general public, opening the doors of mental health, gaining public confidence by demystifying people who have a mental health problem
- Developing professional training in mental health (nurses, specialized correctional agents)
- Transferring knowledge between research and practice

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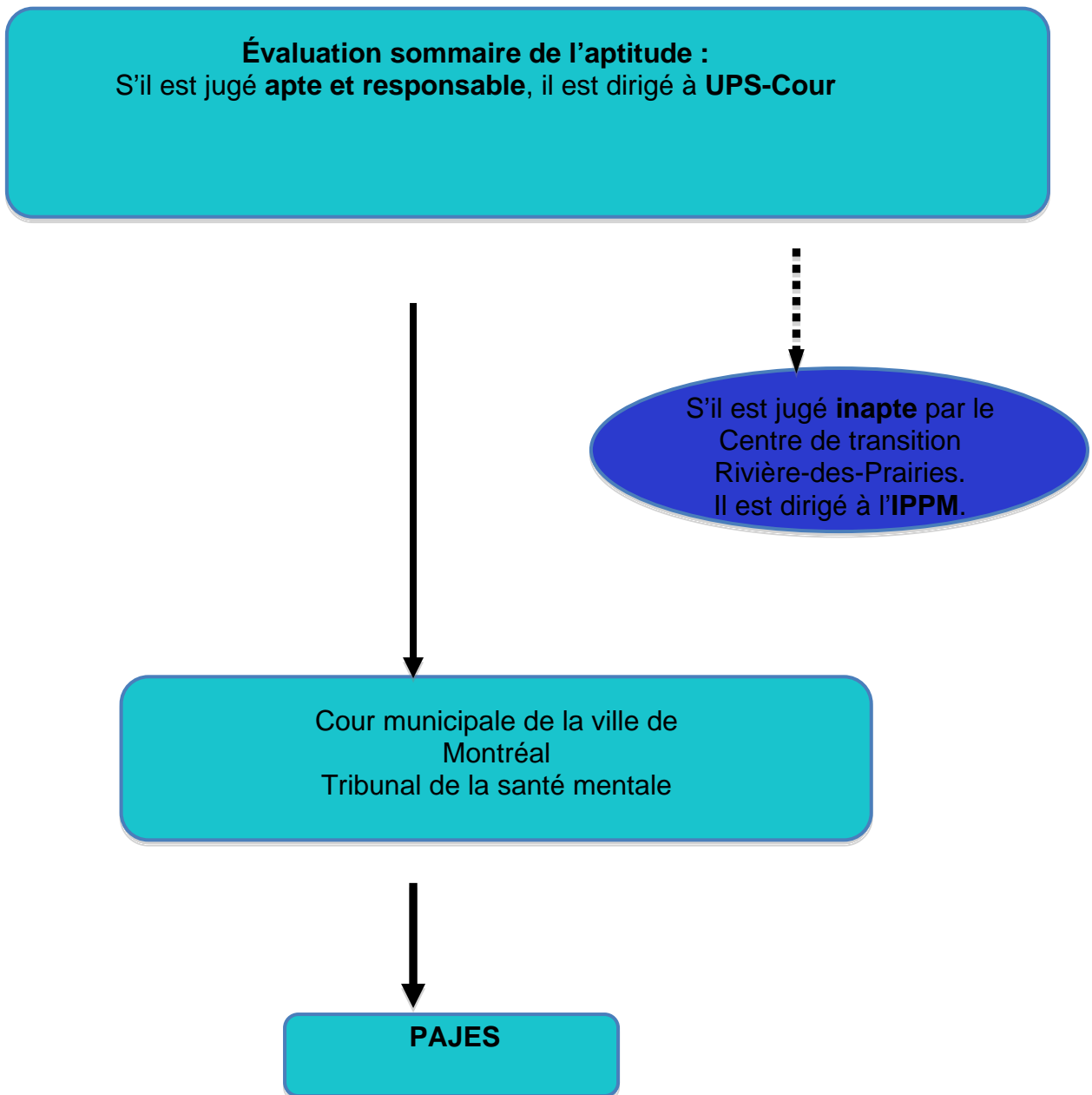
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Schéma 1 - 2 -Trajectoire à la clientèle



PAJES
Engagement de l'accusé à respecter les conditions énoncées
par le Procureur de la Couronne



Si non respect

Retour au tribunal régulier

- Retrait du PAJES
- 810
- Mesures plus clémentes