Speaking Notes for Dr A I F Simpson

Chief of Forensic Psychiatry and Head, Division of Forensic Psychiatry
Centre for Addiction and Mental Health and University of Toronto

Appearing on behalf of the Canadian Academy of Psychiatry and the Law and the Canadian Psychiatric Association

STANDING SENATE COMMITTEE ON SOCIAL AFFAIRS, SCIENCE AND TECHNOLOGY

Regarding Bill S-208
An Act to establish the Canadian Commission on Mental Health and Justice

March 26, 2015

Thank you for the opportunity to appear before this Committee to provide response to Bill S-208.

The Canadian Academy of Psychiatry and the Law, of which I am the Vice President, represents psychiatrists practicing in the area of forensic mental health which includes courts, correctional settings, both remand and sentenced, and forensic hospitals and a community teams. All our professional lives are spent working at the interface of mental health and justice.

We welcome this Bill and support its objectives. I, and many members of CAPL and the CPA, work in and with correctional authorities to strive to provide good care for prisoners with mental health problems. We work in the Courts and in forensic hospitals and community locations assessing, treating and assisting in the recovery of people with serious mental illness who have offended or may be at risk of offending including those found unfit to stand trial or not criminally responsible (NCR) on the grounds of mental disorder. The problems set out in the preamble to the legislation are all matters of major concern to CAPL, to which we would also add concern about the still small but important population of persons with youth forensic mental health need. We welcome the explicit inclusion of the needs of victims of crime. Many of us have contributed to the research and academic understandings of the nature of these problems. So it is that we welcome the Senate turning its attention to these issues and seeking means to focus public policy initiatives in this area.

Public Policy Priorities

It is our view that there are a series of major public policy concerns in this area that we believe are not being adequately addressed and that a Commission might well bring focus on. These are:

1. Failing the most vulnerable. Many policies at federal and provincial levels fail to provide adequate care for people with serious mental illness in the community. This includes poor mental health services, poor housing, homelessness, and poverty through lack of supported or available benefits and work opportunities. Living in poor areas with unstable housing and prevalent substances of misuse and in poverty all increase the risk of victimization and perpetration of criminal offending for vulnerable people such as those with serious mental illness.

2. Civil commitment laws that are excessively legalistic may cause delay in access to necessary treatment or shorten it to inadequate time periods for the proper addressing of a person's needs, increasing their chance of criminal justice intervention.

3. Making services to those with SMI recovery focused. This approach involves a partnership with and responsibility by the person-in-recovery to take charge of their lives and live well, safely and securely in the community. Recovery principles must extend to how compulsory care is delivered, because persisting negative feelings about compulsory care can drive people from services and increase the likelihood of criminal justice involvement. Such an approach to compulsory care, both inpatient and community, has been referred to as a therapeutic jurisprudential model of mental health law.

4. Much positive work has occurred in the area of police involvement with and approaches to persons with serious mental illness. Local police areas, and work commissioned by the Mental Health Commission of Canada, has been valuable. A provincial and national strategy to assist police implement evidence based approaches to this problem is timely.

5. Should someone with a serious mental illness be brought before the courts, there needs to be the availability of rapid assessment and diversion services especially for those with less serious offending, frequently managed by a 'mental health' court. Despite their widespread popularity, there is no overarching framework for specialist mental health courts, nor careful evaluation of which mental health courts are most effective. All acknowledge that the diversion of persons with serious mental illness away from the criminal justice system and into the mental health system is vital. Yet this area has been little evaluated. We know little about how good access to these types of programs is across the country, especially in more remote settings. Diversion requires, of course, an effective and responsive

recovery oriented mental health system to be diverted into, issues noted in points 1-3 above.

6. Services for persons in correctional settings are a source of major concern and provincial and federal areas. I note the evidence already provided to this Committee by the Office of the Correctional Investigator. In general it is our view that mental health services to mentally ill prisoners should be the responsibility of the health sector, not the correctional system. This principle is common in other Commonwealth countries [Australia, New Zealand, the United Kingdom] and has been instituted in some provincial correctional systems in Canada. Health run correctional mental health care has less professional isolation than correctionally run services, is likely to be effectively benchmarked against community standards of practice and can provide better opportunities for engagement and follow up by health authorities upon release from prison.

7. Criminal justice and correctional legislation, policies and procedures need to be informed by their impact on vulnerable populations, particularly those with serious mental illness. Public safety is rarely enhanced by more punitive policies or approaches. Public safety is better enhanced through better care, treatment, rehabilitation housing and social integration.

8. Barriers to accessing mental health services for persons on community corrections orders must be addressed. Too commonly, mentally ill parolees find major problems accessing mental health care after release from custody, increasing their risk of re-incarceration.

Particular populations

There are two very important and rising groups in the federal correctional settings of major concern. Whilst overall incarceration rates in Canada are largely static, the proportion of that population that are of First Nations, Inuit, Metis (FNIM) ethnicity is rising rapidly, both for male and female inmates. This suggests that at least in part, the 8 points listed above may well be acting disproportionately for FNIM Canadians. Treatment responses must therefore be closely linked to and supported by FNIM communities to assist them in engaging with care appropriately tailored to their needs.

The second rising group with higher prevalence of serious mental illness is that of female inmates. Again whilst a small proportion of all inmates, their number is rising and they have a higher prevalence of mental disorder than male inmates. There is less known about their needs, as much of the research is based on male inmates, so much work is needed to better understand and respond to their needs.

Mechanisms: a new Commission?

Public policy in this area is complex, with federal and provincial jurisdictions, and spanning the health, justice, correctional and social service areas of public policy. Bringing the type of cross departmental and jurisdictional focus on these areas is necessarily complex.

In CAPL's opinion, there is much merit in the proposal for a Canadian Commission on Mental Health and Justice. We agree with the scope proposed in the legislation, with the addition of consideration for the youth forensic population. Whilst youth offenders are fewer in numbers, successful models to address their needs and prevention of migration to becoming adult offenders have a strong evidence base and should be promoted.

Obviously, there is already a Mental Health Commission of Canada. It has done good work in this area, particularly in the areas of homelessness, police involvement of persons with serious mental illness and to promote research into the NCR population. Its brief was much broader than the mental health and justice interface, and some of the issues noted above (points 1-8) have not been addressed by the MHCC. Further, the Law and Mental Health Advisory Committee of the MHCC has been wound up, as have the MHCC's other advisory committees. The mandate for the MHCC runs out in 2017. Whilst we hear rumours of its continuance, this is by no means certain. CAPL and the CPA both support the extension of its mandate.

As a matter of public policy it does not make sense to duplicate existing structures, but we are by no means assured of the continuance of the MHCC. Further, we are not clear that without explicit direction the issues of concern noted above will be addressed in a generic mental health commission. We support the explicit mandate that a Commission must address the particular concerns at the interface of mental health and justice, and therefore welcome the Bill and the directions that it proposes.