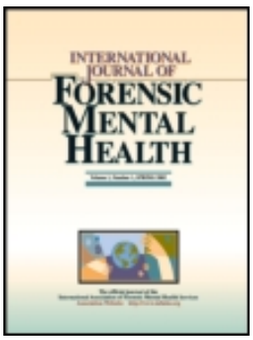

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Research Priorities in Mental Health, Justice, and Safety: A Multidisciplinary Stakeholder Report

Anne G. Crocker

Department of Psychiatry, McGill University and Douglas Mental Health University Institute Research Center, Montreal, Quebec, Canada

Tonia L. Nicholls

Department of Psychiatry, University of British Columbia and BC Mental Health and Substance Use Services, Coquitlam, British Columbia, Canada

Michael C. Seto

Royal Ottawa Health Care Group, Brockville, Ontario, Canada

Laurence Roy

School of Physical and Occupational Therapy, McGill University, Montreal, Quebec, Canada; Douglas Mental Health University Institute Research Center, Montreal, Quebec, Canada

Marichelle C. Leclair

Douglas Mental Health University Institute Research Center, Montreal, Quebec, Canada

Johann Brink

Forensic Psychiatric Services Commission, BC Mental Health and Substance Use Services, Coquitlam, British Columbia, Canada

Alexander I. F. Simpson

Centre for Addiction and Mental Health, Complex Mental Illness, Forensic Division, Toronto, Quebec, Canada; Department of Psychiatry, University of Toronto, Quebec, Canada

Gilles Côté

Department of Psychology, Université du Québec à Trois-Rivières, Trois-Rivières Québec, Canada; Philippe-Pinel Institute, Research Center, Montreal, Quebec, Canada

This paper is based on the report following the National Research Agenda Meeting on Mental Health, Justice, and Safety held in Montreal on November 19, 2014, which convened academics; health, social, and legal professionals; and people with lived experience of mental illness from across Canada. The goal was to identify research priorities addressing relevant knowledge gaps and research strategies that can translate into public policy action and improvements in evidence-based services.

Address correspondence to Anne G. Crocker, Douglas Mental Health University Institute Research Center, 6875 LaSalle Blvd., Montreal, Quebec, H4H 1R3 Canada. E-mail: anne.crocker@mcgill.ca

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Participants identified key challenges: (1) inadequate identification and response to needs by civil mental health services and frontline law enforcement, (2) limited specialized resources in forensic and correctional settings, (3) fragmented care and gaps between systems, (4) limited resources for adequate community reintegration, and (5) poor knowledge transfer strategies as obstacles to evidence-based policies. Knowledge gaps were identified in epidemiology and risk reduction, frontline training and programs, forensic and correctional practices, organizations and institutions, knowledge transfer, and rehabilitation. Finally, participants identified potential sources of support to conduct real time research with regard to data collection and sharing. The findings represent a roadmap for how forensic mental health systems can best proceed to address current challenges through research and practice initiatives, drawing from lived, clinical and research experiences of a multidisciplinary group of experts.

Keywords: forensic mental health, corrections, knowledge transfer, risk, research priorities

BACKGROUND

Few mental health issues stir public and media interest, and generate as much controversy as events involving persons with a mental illness who come into contact with the justice system. Whether through tragic events involving police interactions with mentally ill individuals, or such verdicts as Not Criminally Responsible on account of Mental Disorder (NCRMD; *Criminal Code of Canada*, 1985) – or Not guilty by reason of insanity, depending on jurisdictions – mentally ill individuals tend to become highly visible in rare but dramatic events which can often lead to misperceptions and misconceptions about mental illness (Whitley & Berry, 2013) as well as reactive policy making.

The genesis of the National Research Agenda Meeting on Mental Health, Justice, and Safety and this ensuing report stemmed from the need to identify research priorities to address relevant knowledge gaps and research strategies that can translate into support for policy making and changes in practice. A major spark for this meeting was the reaction of the scientific community and of mental health and legal stakeholders when the Canadian federal government introduced the Not Criminally Responsible Reform Act (formerly introduced as Bill C-14 and C-54, 2013). Some elements of the Act, particularly the "high-risk" designation and dispositions, run counter to the scientific evidence on the trajectories of Canadian individuals found NCRMD (see papers from the National Trajectory Project, which are available at https://ntp-ptn.org in open access, as part of a special issue of *Canadian Journal of Psychiatry*: Charette et al., 2015; Crocker, Nicholls, Seto, Charette et al., 2015a; Crocker, Nicholls, Seto, Charette et al., 2015b; Crocker, Nicholls, Seto, & Côté, 2015; Nicholls et al., 2015; see also Crocker, Nicholls, Charette, & Seto, 2014; Salem et al., 2015; Wilson, Crocker, Nicholls, Charette, & Seto, 2015).

This controversy, in addition to "tough on crime" legislative policy trends in Canada (Cook & Roesch, 2012) that are likely to have significant effects on vulnerable populations such as individuals living with a mental illness (Barbaree et al., 2012; Simpson, McMaster, & Cohen, 2013), also brought to the forefront a discussion about significant innovations in mental health, criminal justice, policing, corrections, social, and forensic services in recent decades. Clearly, these issues (e.g., funding of community mental health resources, public concerns about safety) are relevant to other countries besides Canada. For example, "tough on crime" trends such as the "three strikes" approaches have failed in terms of crime reduction (Dvoskin et al., 2012). In the United States, there are now more people with a mental illness in prisons and jails than in psychiatric hospitals (Torrey et al., 2010).

These observations highlighted the need to raise awareness and identify research priorities that would lead to enhanced mental health, justice, and safety through evidence-informed mental health and legislative policies. The objective is to position stakeholders to be able to respond effectively and pre-emptively to support the adoption of scientifically evaluated and rigorous policies and practice and conversely to actively prevent stigmatizing policies and practices, when necessary, by ensuring that the necessary knowledge and data are readily available.

The research team conducting the National Trajectory Project of individuals found NCRMD (see https://ntp-ptn.org) brought together diverse stakeholders at the intersection of mental health, justice, and safety to discuss current research needs and principles through a research planning grant from the Canadian Institutes of Health Research. The objective of the meeting was threefold: (1) to identify research priorities that need to be addressed in Canada at the mental health, criminal justice, and public safety interface; (2) to target existing and potential data platforms for research, clinical, and administrative purposes; (3) to build a Canadian network on mental health, justice, and safety.

PROCEDURE

A one-day, intensive meeting was hosted based on a participatory research approach and consisted of three distinct parts. In the first part, five experts in the field of mental health, justice, and safety in Canada provided brief presentations on current issues and recent research results. In the second part, the participants broke into small group

discussions for most of the day and identified key challenges, key knowledge gaps, and potential supports for research and knowledge transfer pertaining to mental health, justice, and safety. Groups were designed to include a variety of stakeholders and organizations, including corrections and forensic experts, clinicians, decision-makers (medical directors, Review Board chairs), researchers, persons with lived experience of mental illness, and advocates from NGOs in order to facilitate the identification of systemic and intersystemic challenges. The third component of the meeting was a large group discussion moderated by an expert facilitator to identify consensus areas from each of the breakout groups.

Members of the planning team thus first identified crucial research evidence that arose in the last five years pertaining to the interfaces between mental health, justice, and safety.

Increased Demands for Forensic Mental Health Services

Michael Seto reviewed national and international data showing increasing demands for forensic mental health services, particularly for persons found Not Criminally Responsible on Account of Mental Disorder or the comparable legal status in other jurisdictions. There are inverse relationships between forensic and civil mental health demands, and between forensic and correctional mental health demands, not only in Canada but elsewhere (Jansman-Hart et al., 2011). This suggests that individuals who might have traditionally gone into the civil psychiatric services directly or to the correctional systems may recently have been moving into the forensic mental health system instead. Hence, it seems that people living with mental illness are being criminalized.

Highlights from the National Trajectory Project (NTP)

Anne Crocker presented highlights from the National Trajectory Project of individuals found Not Criminally Responsible on Account of Mental Disorder. This study was carried out in the three largest provinces of Canada (British Columbia, Ontario and Quebec) and followed 1,800 individuals through the provincial Review Board systems (Charette et al., 2015; Crocker et al., 2015a; Crocker et al., 2015b; Crocker et al. 2015c; Crocker et al., 2015d; Nicholls et al., 2015; see also Crocker et al., 2014; Salem et al., 2015; Wilson et al., 2015). The NTP results provided several essential insights into the population served by forensic psychiatric services:

- The NCRMD population is quite diverse in terms of criminal patterns, psychopathology, and psychosocial needs.
- The diversity of profiles and needs may not be currently recognized in the organization of services.
- Unlike what is currently portrayed in the media, serious violent offenses represent a small proportion of offenses leading to a NCRMD verdict (less than 10%).
- Recidivism rates of individuals found NCRMD are quite low (less than 20%), and are lower than those of individuals with a mental illness released from prison and those of the general incarcerated population. In particular, serious violent recidivism was exceedingly rare (<1%) within a three-year follow-up.
- Rates of recidivism are lowest for individuals who were found NCRMD following a serious violent offense, which does not support the Not Criminally Responsible Reform Act's high-risk accused designation.
- Nearly three-quarters of individuals found NCRMD were known by mental health services prior to the NCRMD finding; thus suggesting that prevention strategies could be targeted at the level of general mental health care.
- Results also show that supported housing plays an important role in reducing recidivism and re-hospitalization.
- Finally, there is a need to reduce the gap between current evidence and knowledge on risk assessment and management and practice in the processing of individuals found NCRMD through the forensic and Review Board system.

Overview of Preliminary Results from the At Home/*Chez Soi* Study

Tonia Nicholls provided an overview of preliminary results from the At Home/*Chez Soi* study, focusing on criminal justice and victimization. In recent years, there has been considerable growth in public interest and concern over the increasing number of criminal justice contacts among individuals living with mental illness (Crocker, Hartford, & Heslop, 2009; Roy, Crocker, Nicholls, Latimer, & Reyes-Ayllon, 2014; Sinha, 2009). Considerably less attention has been focused on the victimization of mentally ill individuals. The At Home/*Chez Soi* project was a multi-site, randomized controlled trial of a Housing First intervention (Tsemberis, 1999; Tsemberis & Eisenberg, 2000; Tsemberis, Gulcur, & Nakae, 2004) for homeless individuals living with mental illness in five Canadian cities (Montreal, Toronto, Moncton, Winnipeg, and Vancouver). Housing First has been shown to be effective in reducing homelessness and hospitalizations as well as other positive outcomes such as well-being (Larimer et al., 2009; Nelson, Aubry, & Lafrance, 2007) in the United States and is being implemented and evaluated in France (Goering et al., 2012).

As hypothesized, criminal victimization in the At Home/Chez Soi sample far exceeded that of the general population. As is found in the general population, being young and Aboriginal was a risk factor for being the victim of a violent crime. Unexpectedly, in contrast to what we see in the general population, male gender was not a risk factor in

this sample of individuals who were mentally ill and homeless. In fact, homeless and mentally ill women reported significantly higher rates of threats, physical assaults, and sexual assaults than their male counterparts. Given the severity and prevalence of victimization experiences and the known sequelae, the findings suggest that gender, ethnicity, and trauma are essential components of any systematic effort to serve this highly marginalized and high-needs population.

As would be expected, the sample also had high rates of arrests and other contacts with the criminal justice system, and continued involvement over the duration of the two-year study was the most common trajectory (Crocker, Nicholls, Roy et al., 2014; Roy, Crocker, Nicholls, Latimer, & Reyes-Aylion, 2014). This suggests that housing and traditional services need to be supplemented with interventions that address criminogenic needs. However, the results demonstrated that this is a group for whom criminal justice system involvement is characterized by poverty-related offenses, and few violent or serious crimes (Roy, Crocker, Nicholls, Latimer, Grozdzik et al., 2014).

Prevalence Rate of Mental Disorders in Correctional Settings

Gilles Côté discussed the difficulties in establishing a definitive prevalence rate of mental disorders in correctional settings as well as discrepancies between different attempts to do so (Côté et al., 2013; Kirby & Keon, 2006; Office of the Correctional Investigator, 2010). A decrease in the rates of major mental disorders has been observed in Quebec since the 1988 study (Hodgins & Côté, 1990) among federal inmates (in Canada, those serving sentences of two years or longer). But prevalence rates for provincial inmates (sentences less than two years) in two Quebec prisons are identical to those observed 25 years ago (Daigle & Côté, 2003). Important differences exist between provinces, which could be partially explained by the use of the NCRMD defense, as lawyers may tend to use it more frequently for offenses that could result in a longer sentence. Accordingly, the substantial decrease in inmates with severe and persistent mental illnesses in the Quebec penitentiaries can possibly be attributed, at least partly, to the changes made to the Canadian Criminal Code in 1992 regarding Part XX.1 that resulted in a significant increase in the use of the NCRMD defense (Jansman-Hart et al., 2011; Latimer & Lawrence, 2006; Schneider, Forestell, & MacGarvie, 2002).

Other changes in legislation, including the recently enacted Not Criminally Responsible Reform Act (see below), might also have an impact on the future prevalence rates observed. The status of "high-risk accused," which results in increased restrictions, could potentially discourage the use of the NCRMD defense, consequently increasing the number of mentally ill offenders in both provincial and federal correctional facilities. Dr. Côté also highlighted several knowledge gaps, such as the specificities of prevalence rates according to gender, regions, and within the aboriginal population.

Overview of the Not Criminally Responsible Reform Act

Finally, Johann Brink provided an overview of the new Not Criminally Responsible Reform Act, which amended the Mental Disorder provisions of the Criminal Code, specifically concerning those persons who have been found NCRMD. The Act, which came into law in July 2014, aimed to renew emphasis on public safety as the paramount concern in decision making regarding NCRMD accused persons; a new definition of "significant risk"; the creation of a "high-risk accused" category within the regime; and greater recognition and accommodation of victims in the Review Board process. The impact of this reform may be far reaching, such that several areas in need of research are emerging, including the changes in prevalence rates of severe mental illness in correctional as compared to forensic psychiatric settings (as the NCRMD defense may be less attractive to those living with mental illness and who may be designated as a high-risk accused); the impact of the Not Criminally Responsible Reform Act on victim engagement; the prevalence of repeat offense rates across NCRMD, high-risk accused, and mentally disordered offending populations; and the sociopolitical impact of the reform on Canada's status internationally as a safe, fair, and just society.

QUESTION 1: WHAT ARE THE KEY CHALLENGES FOR CONSTITUENTS?

First Challenge: Keeping People out of the Criminal Justice System – The Importance of Civil Mental Health Services and Frontline Law Enforcement Services

Participants noted that many persons whose mental illness or associated precarious living conditions are the main contributing factors to their coming into contact with the criminal justice system are not being appropriately diverted.

Civil Mental Health Services as Entry into the Judicial System

Participants expressed concern about the lack of adequate resources for families who care for a loved one whose mental illness contributes to criminal behavior. The attending experts note that families are often faced with the impossible choice to remain in their current situation (e.g.,

in fear of their ill relative's behavior and with insufficient support from mental health services) or to press charges against their loved ones. Both of these choices come with an array of negative consequences. In the case of families choosing the status quo, the absence of sufficient services may result in their loved one further deteriorating or in an escalation of problematic behavior that could put family members at risk of victimization. Alternatively, family members who choose to press charges criminalize their loved one and create a criminal or forensic label that may result in long-term ramifications and may also strain their relationship with their relative living with mental illness. This might challenge family reunification and community reintegration when the mental health crisis is resolved.

The group observed that many forensic psychiatric patients have had prior contact with civil psychiatric services; however, civil mental health services are often poorly equipped to deal with aggressive and violent behavior. Very few interventions outside of correctional systems address criminogenic needs in a way that is congruent with evidence-based approaches such as the Risk-Needs-Responsivity model (Bonta & Andrews, 2007) or the Good Lives model (Ward & Fortune, 2014).

Civil mental health services are also poorly equipped in terms of their use and uptake of empirically based assessment strategies on risk evaluation and management. The group identifies current knowledge exchange initiatives as insufficient to allow for a systematic use of empirically based assessment methods; it is only through a collaborative process of elaboration and implementation of these tools (i.e., a bottom-up approach) that they will be widely implemented and used.

This lack of adequate intervention and assessment methods for patients who display aggressive or violent behavior in civil mental health settings sometimes results in a misuse of the criminal justice system, for instance when minor incidents between staff and patients result in police calls.

The group noted that some studies show an increased use of the criminal system resulting from decreased or inappropriate use of civil commitment.

When patients are discharged from correctional or forensic services, time-limited involvement of mental health services, and few controls and resources upon release are believed to contribute to the probability of a re-occurrence of a mental health or legal crisis.

Frontline Law Enforcement Work as Entry into the Judicial System

Participants pointed out the need for law enforcement personnel to receive appropriate training on how to interact with persons who have a mental illness. This training should include persons with lived experience of mental illness, be as tailored as much as possible to officers' needs, and include a focus on de-escalation of mental health crises.

Information sharing was also seen as a key challenge for frontline law enforcement agencies.

Questions and Directions for Research.

1. How could we better structure resources within the civil mental health system, including for patients with aggressive or violent behaviors? What is the best mix of mental health service models, resourcing, and laws to prevent criminal justice involvement of people with serious mental illness?
2. What are the best community reintegration/transition models of service?
3. Are current diversion programs being evaluated?
4. Could long-term involvement and supervision of patients leaving forensic services, coupled with provision of appropriate social and rehabilitation services, enhance community reintegration?
5. What training programs for law enforcement personnel on interactions with persons living with mental illness should be implemented and evaluated?
6. How could we best enhance interprofessional work between law enforcement personnel and social services? Examples include crisis intervention teams, police, and social service patrol teams.

Second Challenge: Limited Specialized Resources in Forensic and Correctional Settings

Some participants noted that the current hospital-based forensic system creates a bottleneck as a result of the shortage of well-trained professionals, particularly forensic psychologists and psychiatrists. Lack of psychiatrists with forensic training may lead to a build-up of cases and significant delays in the judicial process, long waitlists for people needing involuntary care (who are kept in segregation in the meantime), lack of appropriate assessment and follow-up, and deterioration pre/post assessment/treatment.

Furthermore, some participants remarked that having psychologists conduct fitness assessments would lessen the demand on psychiatry. From that point of view, policy and legislation should optimize the scope of practice.

The organization of mental health services in correctional systems was also noted to be problematic. In Canada, criminal law is Federal, but health and the administration of justice are provincial. Furthermore, there are Federal (sentence of two years or more) and provincial correctional facilities (sentences of less than two years). Thus, health and corrections vary across provinces even though the same criminal code applies. With the exception of Ontario and British Columbia, which have adopted the Jail Screening Assessment Tool (Nicholls et al., 2005) across all pretrial centers, there is no standardized approach to identifying people living with mental illness in many provincial and federal institutions. Mental health professionals

in correctional institutions spend most of their time focused on individuals with substance abuse, adjustment problems or suicide risk, at the expense of assessment and treatment of other mental illnesses.

Segregation as a solution to mental health crises is inappropriate, yet is often used due to the (perceived) lack of alternatives. For example, some provincial forensic hospitals/clinical settings will not take on patients from correctional institutions because of a lack of dedicated beds and expertise.

Questions and Directions for Research

1. What measurement tools are needed at the time of intake into forensic and correctional services (e.g., Should questions of medication history and adherence, comorbid substance misuse, and existing/past diagnoses be included?)?
2. What safe and effective alternatives to segregation in institutional settings could be implemented and evaluated?
3. How are the current organizations of services in forensic and correctional settings acting as systemic facilitators or obstacles to accessible, safe and effective services for individuals living with mental illness?

Third Challenge: Gaps Between Systems

Participants noted that care planning is fragmented and that discharge planning does not effectively address community integration. It was argued that fragmented care is a result of fundamental differences in culture between community corrections and community-based mental health services, such as the contrast between punitive and rehabilitative approaches, even when the presenting condition is similar. Fragmented care was also noted to result in poor sharing of mental health information at both the federal and provincial levels, between services (police departments, corrections, forensics, mental health teams, and social service providers), between researchers and non-health/social services (particularly corrections and police), and within agencies such as corrections (e.g., between clinical and security staff).

Questions and Directions for Research

1. What are the most effective models for planning discharge from institutions?
2. What services are needed to optimize community reintegration and reduce re-institutionalization and recidivism?

Fourth Challenge: Adequate and Optimal Reintegration

Community Mental Health Services

Participants noted that a forensic label can be an exclusion criterion for provision of community mental health services. In Ontario and British Columbia, for instance, the civil health care system may refuse to treat a forensic patient. Instead, the patient must stay at the forensic psychiatric hospital, occupying a bed that is needed by someone else who requires involuntary psychiatric treatment.

Housing

The consistent and endemic lack of access to safe and affordable housing for persons living with mental illness is a significant challenge to social stability and community reentry after involvement with forensic or correctional services. This also creates a delay in discharge from forensic services when individuals are ready for absolute discharge, but have nowhere to go. There is also a lack of specific housing resources for forensic patients. Furthermore, once they get housing, some patients lack the appropriate supports to maintain their housing and prevent breach of conditions. Fitting the proper admission conditions to the person's housing needs is thus critical.

Other Social Services

Although an essential contributing factor to long-term community integration, discharge planning from institutions (forensic, civil psychiatric, corrections, and youth corrections) is often inadequate. Patients need access to basic income (preferably through employment), primary care, identification, transportation, and other essential resources.

Probation (from corrections) and conditional release (from psychiatric settings) are an opportunity to connect people to the social and community mental health services that they require in order to successfully transition back into the community. Probation officers, however, experience high and complex caseloads, in addition to limited access to resources and training options. A liaison person who specializes in the transitions between systems could facilitate the access to appropriate services. Probation services should be tailored to the patients' individual needs (e.g., in light of the Risk-Needs-Responsivity principles), which could be achieved via inreach programs and improved communication between systems (e.g., health services, courts, correctional, community resources, etc.).

Questions and Directions for Research

1. How effective are inreach programs for soon-to-be-released patients? Different programs should be tested across Canadian communities. Probation

officers could be part of teams with outside liaison officers to facilitate transition/release.
2. How can we think "outside of the box" to improve outcomes in the community? It is essential to explore the potential of rehabilitation services that focus on housing and vocation (i.e., both education and employment).
3. How could we follow the person through the systems? Cross-system transitions need to be the focus of more research to achieve a better understanding of the mechanisms involved and to identify best practices.
4. How can we best address mental health challenges and relapse prevention post-release? What are the barriers to putting effective practices in place?

Fifth Challenge: Poor Knowledge Transfer Strategies Get in the Way of Evidence-Based Policies

Participants strongly emphasized that public discourse and media coverage of mental illness indicate a lack of knowledge, understanding, and compassion towards mentally ill persons. This is, in part, fuelled by the ambiguous terminology used by academics, politicians, and policy makers alike (e.g., there is confusion over terms like "mental disorders," "mental illness," "mental stress/distress," "severe and persistent," "personality disorders," and "personality traits").

Poor recognition and understanding of mental illness as a risk factor for violence also contributes to stigmatizing public and media discourse. Fine distinctions between timing of the offense in relationship to onset of mental illness might help to clarify these issues for the public.

These explanations must also encompass the broader problems of criminalization as a result of poverty, poor housing, victimization, substance misuse, and other factors that create vulnerability inflicted upon those with severe mental illness in our communities.

Participants also stated that the risk-averse nature of contemporary society plays a role in the stigmatization of persons living with mental illness who engage in criminal behavior. This often translates into an emphasis on the biomedical model of mental illness, with a focus on linear relationships between criminal behavior and mental illness. Far less public and media attention is devoted to the resilience and recovery models, which promote rehabilitation and community integration as end outcomes. Participants asserted that dualistic thinking between concepts of recovery and public safety run counter to the current evidence suggesting that punitive approaches actually increase recidivism, thus leading to decreased public safety. Current legislation is at odds with its own intended outcome of increasing public safety and is also inconsistent with the rationale behind the NCRMD regime as one of a melding of therapeutic and public safety needs. Examples include the Not Criminally Responsible Reform Act, as well as federal legislation fettering the discretion of judges with mandatory minimum sentences.

Participants noted that these worrying trends in public discourse, media coverage, and policy making, indicate the failure of effective knowledge transfer from the experts in the field to decision makers and the public, alike.

Barriers to effective knowledge transfer include lack of public communication skills and training among experts, the duty of discretion for experts in some organizations (particularly in correctional/forensic settings), and lack of intersectoral communication and collaboration. Many participants observed that lack of intersectoral communication results from the fact that different systems are a product of various ministries operating with different budgets.

Questions and Directions for Research

1. What are the most effective ways of educating the public and policy makers about mentally ill persons who engage in criminal behavior?
2. Would it be more effective to have strategies focusing on subgroups of individuals with particular characteristics? What are the different profiles of persons leaving with mental illness who engage in criminal behavior? Do they differ in trajectories and in outcomes, such as re-hospitalization, recidivism, and community reintegration?
3. What is the most effective model for interministerial and intersectoral communication and collaboration? Health and criminal justice are different ministries; sectors, on the other hand, can be within the same ministry but function independently (such as mental health and intellectual disability sectors, for example).
4. What are the effects of the current legislation on services and outcomes for the NCRMD population?

QUESTION 2: WHAT ARE THE KEY KNOWLEDGE GAPS?

First Knowledge Gap: Epidemiology and Risk Reduction

At the level of individual offenders, participants noted lack of knowledge associated with:

- the exact timing of offending in relation to the onset and the evolution of mental illness and psychiatric symptoms;
- risk and protective factors for offending in children and youth living with mental illness;

- the population of re-offenders, including their typical profiles and their association with personal and environmental factors;
- suicide rates among persons living with mental illness who come into contact with the law.

At the level of systems, the group commented on:

- a lack of longitudinal and interprovincial data on the prevalence and profiles of mental illness encompassing all settings of judicial contact (prison, jail, community corrections, and NCRMD);
- poor understanding of factors that explain the different recidivism rates between correctional services and forensic services and the characteristics of access to mental health services in those two settings;
- poor understanding of the active ingredients for promoting recovery and community integration.

Second Knowledge Gap: Frontline Training and Programs

- Participants noted that while some police departments have implemented training on interactions with persons living with mental illness, there is a lack of knowledge on the effectiveness of this training and of the collaborative initiatives between mental health workers and police. This is an important gap to close since the high victimization rate of people living with mental illness is also at stake, and the reporting process may accentuate the "revolving doors" problem.
- There is also a need to document the prevalence of mental illness in fatal or near-fatal interactions with police.
- Finally, participants reported concerns that the factors contributing to police use of force in interactions with people living with mental illness are not documented.

Third Knowledge Gap: Forensic and Correctional Practices

- The absence of gold standards in assessment and treatment models was noted in both forensic and correctional practice, especially for patients who misuse substances or who have personality disorders.
- Participants also noted that there is no documented evidence of alternatives to segregation for mentally ill offenders in correctional settings.
- Although some organizations have implemented training on interactions with persons living with mental illness for correctional officers, there is a lack of knowledge on the effectiveness of this training across various outcomes.
- The same applies to probation officers, as well as to any inreach of collaborative work between community-based probation and mental health services.
- There is also a need to evaluate the effectiveness of training community mental health service providers on Risk-Needs-Responsivity principles and interventions.
- At the systems level, participants remarked that there is little knowledge of factors involved in the observed discrepancies in mental health services for offenders between provinces.

Fourth Knowledge Gap: Organizations and Institutions

- There is an urgent need for gathering of timely knowledge on the effects of legislative changes over time on individual and systems outcomes.
- There is also limited knowledge on the efficacy and cost-effectiveness of Canadian policies and protocols in the field of mental health, justice, and safety, as well as in Mental Health Courts across Canada. Replication of existing American studies in these areas is warranted.
- In light of the recent legislative changes regarding victims' involvement, participants expressed an absence of knowledge on the best strategies to involve victims in processes while addressing victim re-traumatization and enhancing restitution.

Fifth Knowledge Gap: Knowledge Transfer and Exchange

- Participants noted that there is very limited knowledge on good knowledge transfer and translation practice in the area of mental health and justice.
- Since knowledge transfer and exchange (KTE) efforts are not reaching the public and the right stakeholders, there is a need to know what KTE strategies are most efficient to increase public awareness of all key challenges discussed in this report.
- People with lived experience, their families, and victims need to be involved in the production, exchange and transfer of knowledge.

Sixth Knowledge Gap: Rehabilitation

Recovery and Public Safety

- Participants noted that the concept of recovery in a forensic setting should be clarified.
- How do people living with mental illness and involved in the forensic system experience recovery?
- How do we measure and evaluate recovery orientation of services?

- Does recovery enhance public safety? How is it associated with public safety and to what extent (end outcomes)?
- To what extent are organizational barriers (referral mechanisms, access to services, and lack of synergy between the criminal justice organizations and the communities and community plans) getting in the way of recovery (including employment, education, and housing)?

Best Housing Models

- What are the most effective housing models (e.g., supervised housing, rent subsidies, Housing First) for people at different levels of security?
- What is the impact of geographic location and relative access to housing and mental health resources in the community on outcomes?
- What inreach models are best supported by existing evidence? What would the outcomes be for the forensic population in Canada, i.e., what would be the results of a rigorous large-scale evaluation of inreach services?

QUESTION 3: WHAT ARE THE POTENTIAL SOURCES OF SUPPORT & PLATFORMS TO CONDUCT RESEARCH IN REAL TIME?

Data Collection

Participants identified a need to pool national data on statistically rare issues. Too often research on low base rate characteristics (e.g., transgender persons) or events (e.g., completed suicide) is not possible locally due to small sample sizes and the resulting low statistical power.

Some police services are increasingly open to collecting data, but need help knowing what data to collect, and what questions to add to the arrest paper or intake interview on mental health and criminal history variables. These could be easily accessible to professionals. There is also a need for minimum/standardized simple data markers (national scoreboard) that should be built into the intake interview/arrest records, but will not require extra work.

If there were small pieces of information to add to the intake sheets, Provincial Review Boards would be happy to participate (if they added minimally to administrative burden). This would enable data collection suitable for clinical, administrative, and research purposes.

There was general consensus that there is a need for standardized toolkits to collect the data throughout systems and organizations.

Data Sharing

In addition to collecting data, data sharing was identified as a challenge for setting a National Research Agenda. Opportunities exist to build platforms for data sharing. For example, an interdisciplinary committee on Mental Health and the Law could produce a document on gathering information. A national database that takes into account interprovincial differences could be set up to be shared and transferred across systems. A national scoreboard could be standardized across provinces to streamline sharing of information. Inventory of previous/ongoing projects to conglomerate common goals and resources as well as interministerial anonymous databases would enhance the research and funding application efforts of academics and would simultaneously support funding and policy directions.

CONCLUSIONS

Key Principles

There was a general consensus among participants that the following key principles guided the discussion regarding key knowledge gaps, research priorities, and opportunities.

1. Prevention: Taking forensic experience upstream (e.g., bring knowledge of assessment and management of risk into civil psychiatric and community mental health organizations and services; target risk factors for early intervention efforts).
2. Recovery Orientation: Incorporating recovery orientation at all levels of clinical care, research, police, and knowledge transfer and exchange.
3. Public Safety: Emphasizing the potentially positive relationship between recovery/rehabilitation and public safety.
   - Break the dualism opposing rehabilitation and "tough on crime", or rehabilitation and public safety, or victim and perpetrator;
   - Seek societally optimal policy;
   - Change the conversation/language around severe mental illness and crime.
4. Holistic Individualized Approach: Following the person across systems (i.e., sharing information between civil psychiatry, forensic psychiatry, and correctional and social services agencies); seeking to fill the gaps when patients/clients are transitioning between systems of care / moving through an individual agency's continuum of care (e.g., it is often when persons are discharged from institutional settings that there is insufficient planning and resources in place to ensure that transportation, medication, housing, etc. are in place to facilitate community integration).
5. Intersectoral Collaborations: Creating more opportunities for cross-ministerial panels in order to promote data consistency, information sharing, transparency, and communication.
6. Inclusion of People with Lived Experience:

- Including persons with lived experience of homelessness, criminal justice involvement, and/or mental illness as partners in research from inception to dissemination and as collaborators in KTE efforts;
- Involving families and victims in the production, exchange and translation of knowledge.

7. Information Sharing and Data Consistency (e.g., through research-friendly administrations).

Knowledge Transfer and Exchange Agenda

A common theme across the discussions was the importance of knowledge transfer and exchange between researchers and practitioners, across sectors, etc. The following principles and considerations were identified.

What?

1. Evidence-based policy making
2. Paradigm of risk reduction, rehabilitation services, and recovery orientation
3. Holistic perspective that includes social determinants of health
4. Thread of recovery message
5. Cost-effectiveness
6. Data access

How?

1. Promote tailored, confident, concise and consistent communication to the public
2. Make use of personal stories, success stories; become positive and proactive rather than reactive and defensive
3. Target media, swing voters, and political leaders to position optimal policy solutions

Top Research Priorities

Following the presentations from the small groups formed for Part Two of the one-day agenda meeting, all participants discussed research priorities in Part Three and agreed that the following were key priorities for an agenda on mental health, criminal justice, and public safety research.

First Contact

1. Evaluation of diversion programs and community supports (e.g., Mental Health Courts in Canada)
2. Examination of contexts and factors related to police-driven fatalities of people living with mental illness
3. Initiation of multi-site cohort studies of early interactions with criminal justice personnel
4. Evaluation of training for frontline service providers on criminal justice, and recovery outcomes
5. Evaluation of longitudinal impacts of legislation or policy change, including on families and suicide rates

Assessment

1. Examination of factors associated with crime and recidivism among people living with mental illness
2. Risk assessment and communication, including shared risk understanding between service user and provider
3. Risk assessment and management: Research on closing the gap between research and practice
   a. Improving the relevance of research and knowledge transfer strategies on risk management and assessment beyond psychometric properties of tools
   b. The role of management and treatment efforts in the moderation of the relationship between risk factors and adverse outcomes

Treatment and Rehabilitation

1. The 3 Rs (Recovery, Recidivism, Research): Evaluation of recovery approaches and recovery-oriented care on recidivism and other outcomes, including future mental health service use, housing, employment, and quality of life
2. Cost-benefit analysis of forensic interventions and legislative practices from a health economics perspective
3. Research transitions and success/failure outcomes to develop best practices
4. Exploratory and pilot research on alternatives to segregation in correctional settings
5. Studies that deconstruct and identify active ingredients of successful programs in terms of lower recidivism

Systems

1. Creation of a national data sharing coalition among researchers in the field
2. Creation of a national database with common indicators (e.g., national scorecard)
3. Edition of a scoping review on international legislation and approaches at the intersection of mental health, justice, and safety
4. Evaluation of best knowledge transfer and exchange strategies to support evidence-based practices and practice-based evidence. Answering the questions and addressing the problems of direct care providers and of those with lived experience

5. Creation of a national research network on mental health, justice, and safety with a strong focus on knowledge transfer and public communication.

SOME FINAL WORDS FROM THE RESEARCH TEAM

This report does not purport to cover all important issues at the intersection between mental health justice and safety, but rather is a reflection of the full one-day discussion with expert stakeholders in this area.

Our hope is that this report can help stimulate discussion; guide and advance research in mental health, justice, and safety; and foster collaborations between academics, persons with lived experience of mental illness, families, direct care providers, policy makers, and various stakeholder groups in order to increase relevance and timeliness of research endeavors for knowledge transfer into evidence-informed policy making and organization of services.

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SUPPLEMENTAL MATERIAL

Supplemental data for the manuscript (a French translation of the article) can be accessed on the publisher's website.

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