



LE PROTECTEUR DU CITOYEN

Assemblée nationale
Québec

REPORT BY THE QUÉBEC OMBUDSMAN
**TOWARD SERVICES THAT ARE BETTER
ADJUSTED TO DETAINEES WITH MENTAL DISORDERS**

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The masculine gender is used for easy reading purposes and includes the feminine.

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ABSTRACT

The Québec Ombudsman is Québec's correctional ombudsman. It maintains regular contact with the personnel and management of the detention facilities under Québec's jurisdiction, to solve a variety of problems that are brought to its attention either through direct exchanges with detainees, their representatives and correctional network employees, or during its visits to the facilities.

In this report, the Québec Ombudsman examines the specific situation of detainees with mental health disorders. It notes that they need care and services adjusted to their condition, to increase their chances of returning successfully to society after serving their sentence. The individual interests of detainees and their families, as well as the collective interest of society are at stake.

The report addresses the entire process, from the initial police intervention through the detention period to re-entry into society. The Québec Ombudsman presents a number of observations and potential solutions and makes recommendations to the government departments concerned for effective interventions conducive to successful social reintegration, which has been shown to help reduce repeat offender rates.

A BRIEF PROFILE OF DETAINEES WITH MENTAL HEALTH DISORDERS

- There are more people with mental health disorders in detention facilities than in the general population, and the prevalence of severe and persistent mental health disorders is much higher in prisons than in the general population.
- The data do not show any significant difference between the main categories of crimes committed by detainees who have been screened or diagnosed with mental health disorders and other detainees.
- However, the data do show that there are more multiple probations and prior detentions among people with mental health disorders. In all, 28.6% of detainees with mental health disorders had multiple probations in their records (compared to 9.9% of other detainees), and 81% had previously been detained (compared to 58.2% of other detainees). It is important to mention that studies have not documented linkages between mental disorders and criminality. Other factors such as age, sex, socioeconomic background, educational level and residential location are more correlated with criminality⁴⁻⁶.

OBSERVATIONS CONCERNING POLICE INTERVENTIONS

Police officers are frequently called upon to intervene as front-line resources in situations involving people with mental health disorders. There are a number of specialist community organizations, as well as the health and social service network's crisis centres, available to support and complement their efforts to deal with psychosocial or psychiatric crises. However, **the extent to which these services are used varies significantly** from one region to another and from one police officer to another. At the same time, there is **a need for initial and continuous police training** on the subject of specialist interventions with people who have mental health disorders or concurrent problems such as addiction and homelessness.

OBSERVATIONS CONCERNING POTENTIAL SOLUTIONS FOR POLICE INTERVENTIONS

- **The need in each region** for assistance with the management of psychosocial and psychiatric crises must be identified, and the **missing services must be developed** in priority order, so that appropriate support is made available to police officers in every region.
- The policing techniques program offered by Québec's colleges must include **a sufficient number of hours of training** on the subject of interventions involving people with mental health disorders.
- With regard to initial and continuous police training, dispensed principally by the École nationale de police, the need for training on different problem factors (mental health, homelessness, addiction) must first be assessed, and **an integrated training plan** must be produced and implemented to enrich police expertise in dealing with these people.

OBSERVATIONS CONCERNING INITIATIVES OFFERING ALTERNATIVES TO JUDICIAL INTERVENTION (DEJUDICIARIZATION)

A **social services referral** is often the most appropriate solution for people with mental health disorders who commit minor offences, since it meets their needs with due respect for public safety requirements. However, **current resources**, including emergency shelters for people in crisis or suffering from concurrent disorders, **are not sufficient**.

There are a number of means available in the judicial process to help people with mental health disorders. One example is the specialist mental health program pilot project currently underway in Montreal's municipal court. A number of other measures also exist to adjust regular court action to the needs of people with mental health disorders, with support from psychosocial teams. The effectiveness of measures such as these depends on the quality of the available **community treatment programs**. However, good quality programs are still not available to meet the needs of all Québec's regions.

OBSERVATIONS CONCERNING POTENTIAL SOLUTIONS FOR INITIATIVES OFFERING ALTERNATIVES TO JUDICIAL INTERVENTION

- Social service **needs must be assessed**, and target client groups must have **sufficient, fair access** to places in shelters, certified addiction resources and supervised apartments. The number of places required in each type of resource must be assessed for each region, and **a realistic timeframe for the provision of places to fill the shortfall** should be established.
- The Québec Ombudsman recommends a prudent approach to the development of specialist mental health courts. There is no evidence to show that such courts are effective, and there is a real risk of stigmatization for the people who are tried in them. It would be more appropriate to focus on **adapting regular courts** to address the specific needs of people with mental health disorders.
- To do this, **community treatment programs** that meet the conditions for success are required, along with an implementation plan for regions that are less well-served.
- At the same time, **the people involved in the legal process must be made aware of the existence of these programs**, the conditions for access and the target client groups, so that they can make more use of this type of measure as an alternative to incarceration. A variety of information and training initiatives must therefore be prepared, for judges and lawyers in particular.

OBSERVATIONS CONCERNING THE DETENTION PERIOD

A number of deficiencies were observed with regard to the detention of people with mental health disorders.

- There is **no systematic screening** for mental health problems (other than suicide risk) upon admission. If these problems are not identified through screening, the people concerned have little chance of receiving the necessary services.
- The **large number of inter-facility transfers** and the ensuing information exchange problems are especially likely to affect people with mental health problems.
- For example, inter-facility transfers may cause **problems with access to prescribed medication**. Interruptions in medication may compromise mental stability and even lead to withdrawal symptoms and their associated undesirable effects.
- **Confidentiality** is a complex issue in the sharing medical information between the medical care team and the correctional team. Conflicts arise, and there are **significant inter-facility differences** in the practices applied. The rules are not clear.

- In addition, **legal representatives**, including the **Public Curator**, are not always informed **immediately** of situations that require their input.
- **Detention facility personnel do not receive much support when working with people in crisis.** The use of isolation and restraint may be their only choice in such situations, and they do not always have access to assistance and advice from medical care personnel.
- Detainees usually have access to basic medical, pharmaceutical and nursing services. However, **it is rare for them to have access to certain services, including rehabilitation and psychosocial follow-up. There are also problems with access to psychiatric consultation services.** The supply of services is therefore fragmented, and does not address all the person's needs.

The combined effect of all these factors means that detainees with mental health disorders are unable to obtain the socio-sanitary services they need. This complicates case management during detention, makes it more difficult to achieve correctional goals, and hinders the post-detention social reintegration process.

POTENTIAL SOLUTIONS FOR THE DETENTION PERIOD

A clear division of responsibility and effective collaboration

At the present time, the Ministère de la Sécurité publique is responsible for providing all services in detention facilities. For the last few years, it has maintained a memorandum of understanding with the Ministère de la Santé et des Services sociaux concerning the division of responsibility for socio-sanitary services in prisons. However, due to poor coordination of the various partners, the supply of services is still incomplete.

The Ministère de la Santé et des Services sociaux and its network have all the levers required to provide preventive, curative and social integration services following release from a detention facility. The Québec Ombudsman therefore recommends that, as from April 1, 2012, it should be responsible for delivering socio-sanitary services to people with mental health disorders in detention facilities.

During the **transfer of responsibility**, a clear distinction should be drawn between the respective roles and responsibilities of, and the resources to be provided by, the health and social service network and the correctional service network. In addition, the **Ministère de la Santé et des Services sociaux and the health and social services agencies must clarify their**

supply of services to meet the needs of the prison population, and must incorporate that supply into their policies and action plans.

A COHERENT CLINICAL VISION

The **health and social service needs of people with mental health disorders are complex and variable**. For example, service duration and intensity requirements will differ from one individual to the next. A coherent clinical vision is therefore needed to provide a sufficiently effective supply of health services and social services during the detention period. The health and social service network has developed a number of tools used to prepare a clinical project designed to meet the needs of all the territory's inhabitants. The needs of the detained population could easily be included in this project, giving it **timely access to the required level of service**. The clinical vision should focus on the following eight goals:

1. Introduce **systematic screening for mental health disorders** immediately upon admission to a detention facility.
2. Allow for **effective sharing of relevant information** between health workers and correctional workers, in compliance with the rules of confidentiality.
3. Ensure **adequate and ongoing case management** during detention.
4. Provide immediate **access to appropriate medication and pharmaceutical care**, and encourage compliance with pharmacological treatment.
5. **Manage transfers more effectively**, with due regard for the special needs of people with mental health disorders.
6. Provide **better support for personnel dealing with crisis situations**.
7. Provide **adapted training** for correctional services officers on the subject of interventions involving people with mental health disorders.
8. Develop **innovative methods to foster service access**, such as the use of telepsychiatry.

A fundamental aspect of this process will be to ensure better coordination of the goals of medical care teams and correctional personnel. This could be achieved by forming multidisciplinary teams responsible for preparing integrated intervention plans designed to address socio-sanitary and correctional goals.

OBSERVATIONS CONCERNING RE-ENTRY INTO SOCIETY

Generally speaking, the Québec Ombudsman notes that all detainees, and particularly accused detainees¹, are **poorly prepared to re-enter society**. In addition, people are often **left to their own devices** upon being returned to the community, and are not put into contact with resources that could help them. For people with mental health disorders, **the gains made through the mental health services obtained during detention will evaporate quickly if they are forced to start over upon being released and find a new source of treatment in the community.**

In its Annual Reports since 2006-2007, the Québec Ombudsman has submitted a certain number of concerns to the government and recommended a **social reintegration action plan** for all detainees. The Ministère de la Sécurité publique published such a plan in December 2010. The new plan addresses all the relevant aspects and should produce positive results if the announced measures are supported by coherent action in the field.

POTENTIAL SOLUTIONS FOR RE-ENTRY INTO SOCIETY

A number of interministerial initiatives have been announced in recent years, in addition to the social reintegration action plan. Some of the measures in the initiatives address issues relating to the social reintegration of detainees with mental health disorders. However, there is a need for **better coordination between the various government departments concerned**, as well as **rigorous follow-up**, including targets that can be used to measure the impact of the measures in terms of improving individual health and reducing repeat offender rates.

Continuous, individualized services are needed, in a relatively stable environment and in a context where the person's vital needs are met. The goal is for every person with a mental health disorder to have an integrated, coherent plan coordinated by a case manager familiar with the person's needs, providing services that are sufficiently assertive, along with the resources required to achieve the plan's objectives.

Effective **assertive community treatment programs** must be developed and made available **throughout Québec**. There is also a need for **continuity of service between detention facilities and the community**. In other words, a health professional should provide seamless service to the person's release, until another is appointed to take over.

¹ **Accused detainee:** "A person incarcerated in a detention facility in Québec, either to await the outcome of judicial proceedings against him or her [...], or to await transfer to a prison, or for any other reason as a result of which the person cannot be considered to have been found guilty."

CONCLUSION

The costs and benefits of the proposed approach must be examined seriously, from an economic standpoint. In addition, it would be wrong not to consider the **highly positive impact of successful social reintegration in reducing repeat offences**, particularly when taking into account their considerable financial, human and social costs.

The Québec Ombudsman is convinced that it is vital, in the interests of the individuals concerned and in the collective interest of society, to provide proper access to appropriate services. This will not only improve the well-being of the citizens themselves, but will also help to build a sustainable sense of safety for their families and for society in general.

1 Introduction

1.1 The Québec Ombudsman's mission

The Québec Ombudsman ensures that individual citizens' rights are upheld by intervening with Québec Government departments and agencies, and with health and social service network institutions, to recommend corrections to prejudicial situations. The Ombudsperson is appointed by and accountable to the members of the National Assembly, and acts both independently and impartially, either in response to complaints received or on its own initiative.

The Québec Ombudsman is also Québec's Correctional Ombudsman. In overseeing the activities of the province's correctional services in general, and its detention facilities in particular, it must deal rigorously and diligently with complaints made by detainees or their relatives. This task involves regular visits to detention facilities, preventive and corrective interventions, and active monitoring of the sector.

In its 2006-2007 Annual Report, the Québec Ombudsman expressed concern regarding the management of detainees with mental health disorders detention facilities, and in 2008-2009 it noted a number of problems with general access to health services in detention facilities.

In its 2006-2007 Annual Report, the Québec Ombudsman expressed concern regarding the management of detainees with mental health disorders.

Based on its experience, the Québec Ombudsman notes that the criminalization of the mentally ill, and their subsequent incarceration in detention facilities, is both real and widespread. It also notes that clinical management is a challenge for the facilities, hence the decision to proceed with this initiative, in addition to its regular interventions to solve individual situations.

1.2 The purpose of this initiative

The Québec Ombudsman's goals in proceeding with this initiative are:

- To understand the extent to which people with mental health disorders are incarcerated, by preparing a profile of the situation in detention facilities administered by Québec;
- To check whether the conditions in detention facilities allow these people to obtain the health services and social services they need as a result of their mental state;
- To identify and recommend solutions that will reconcile individual health-related interests with the interests of collective rehabilitation and public safety.

With regard to this latter goal, the Québec Ombudsman believes that **incarceration and the need for care are not in opposition. On the contrary, the goal of administering fair**

The goal of administering fair punishment for a criminal act is entirely compatible with the goal of long-term rehabilitation for the offender, in order to obtain the best possible guarantee that he or she will no longer be a threat to public safety by the end of the period of incarceration.

punishment for a criminal act is entirely compatible with the goal of long-term rehabilitation for the offender, in order to obtain the best possible guarantee that he or she will no longer be a threat to public safety by the end of the period of incarceration. It is from this perspective that the Québec Ombudsman analyzed the problem, all the while making sure, in its capacity of Correctional Ombudsman, that the rights of incarcerated citizens suffering from mental health problems were respected.

2 The sources of information used for this report ⁱⁱ

2.1 *Complaints received*

The Québec Ombudsman has drawn on its own experience by incorporating relevant elements from its investigations in detention facilities, and has carried out an in-depth analysis of the complaints received.

In the last three years, in the complaints received from detainees with mental health disordersⁱⁱⁱ:

- 70.5% of the grounds for complaint concerned access to medication;
- 27.5% of the grounds for complaint concerned transfers between detention facilities and their negative consequences;
- 6% of the grounds for complaint concerned access to care (medical care personnel or hospitalization);
- 2.5% of the grounds for complaint concerned the use of isolation for mental health disorders^{iv}.

2.2 *Visits to detention facilities*

The Québec Ombudsman makes regular visits to detention facilities, and uses standardized indicators to collect information on infrastructures, detention conditions and basic services, including the infirmary and isolation cells. It also hears testimony from detainees, correctional services officers and other stakeholders. The health care indicators include management of medical information, medical follow-up during admission, respect for confidentiality, and coordination between the health service and the inter-facility transportation service.

ⁱⁱ In this text, explanatory notes are designated by Roman numerals and appear at the bottom of the page. Bibliographical references are designated by Arabic numerals and refer to entries in the bibliography presented at the end of the report.

ⁱⁱⁱ The total may exceed 100%, because some complaints contain more than one ground for dissatisfaction.

^{iv} It is important to distinguish the reason for the use of isolation, since it may also be used as a form of punishment.

2.3 A profile of detention facility inmates, documented by scientific research and focus groups

In addition to its own expertise, the Québec Ombudsman also asked the Centre International de Criminologie Comparée (CICC) at the Université de Montréal to research the following questions:

- How prevalent are mental health disorders in detention facilities?
- What is the criminal profile of the people concerned?
- What resources do the detention facilities have to manage these people?
- What kind of expertise is available, and what clinical and social reintegration approaches are used by the facilities, given that their primary mission is not to act as health and social service institutions?

In 2006-2007, a sample of 671 case records entered in the DACOR (Dossier Administratif Correctionnel or Correctional Administrative Record) system maintained by the Ministère de la Sécurité publique was selected and then compared with matching records held by the Régie de l'assurance maladie du Québec (RAMQ). This produced a profile of mental health disorders among inmates in detention facilities, and the types of offences they committed.

The CICC, with support from Correctional Services, then inventoried the health services available in the detention facilities. The study included data collection through interviews with the people concerned, both inside the correctional facilities (correctional officers, managers, nurses) and outside (mostly professionals from the health and social service sector). All these people gave their perceptions of the problems and the means available.

Prior to this, although a certain amount of work had been done in Québec, there was no specific descriptive study of detention conditions for people with mental health disorders in Québec. Elements from the CICC study have been used to support the Québec Ombudsman's observations in this report. In addition, the next section, which presents a profile of prison inmates with mental health disorders, is based directly on the CICC study.

The Québec Ombudsman also organized a number of focus groups composed of people with acknowledged expertise and experience in the justice, correctional services, health and social service sectors, along with people from community agencies and organizations. The focus group participants were asked to propose solutions they felt were urgently needed, realistic and effective.

2.4 A critical analysis of published evidence on initiatives offering alternatives to judicial intervention (dejudiciarization), the organization of mental health services and social reintegration

The Québec Ombudsman critically examined the scientific literature^V on issues relating to:

- Substitutes to incarceration through initiatives offering substitutes to judicial intervention;
- the organization of mental health services in detention facilities;
- social reintegration programs.

The critical analysis was structured to assess the strengths and weaknesses of interventions:

- prior to incarceration: police interventions and initiatives offering alternatives to judicial intervention;
- during incarceration: access to care and services;
- after incarceration: re-entry into the community and social reintegration, to avoid repeat offences.

^V In the scientific literature, the problem is addressed from two standpoints, the first relating to public safety and the second to treatment. The Québec Ombudsman examined the scientific literature relating to justice and public safety first, followed by that relating to health and social services.

3 A brief profile of detention facility inmates

Québec has 19 detention facilities under its jurisdiction. At the time of the study, in 2006-2007, a daily average of 4,192 people (96.6% of whom were male) were incarcerated in those facilities. Of these, 47% were accused detainees and 53% were convicted inmates^{vi}. In 2009-2010, the Ministère de la Sécurité publique reported a capacity of 4,814 actual places and 4,681 places available in detention facilities, including 48% for accused detainees and 52% for convicted inmates. There were also 46 additional places in Percé for sex crimes.

How prevalent are mental health disorders in detention facilities?

Using the diagnostic codes¹ obtained from the Régie d'assurance maladie's database, the study found that 61% of detainees in Québec's detention facilities had at least one diagnosis in their records in the previous five years for a mental health disorder and/or a problem relating to drug or alcohol addiction. The percentage of people suffering from mental health disorders during detention was somewhat lower because some types of disorder were temporary and of limited duration.

The number of people who underwent recurrent medical treatment for mental health disorders in the five years preceding the study can be used as a basis to identify chronic problems. The study's findings revealed that 25% of detainees had undergone recurrent medical treatment.

In all, 1,545 diagnoses were made^{vii} for detainees, with an average of 2.3 diagnoses per person. They can be grouped under four main headings:

- less serious disorders, including but not limited to personality disorders, adjustment disorders and anxiety, which dominated this category;
- severe and persistent mental disorders, including but not limited to schizophrenia, bipolar disease, paranoid states and depression, which dominated this category;

^{vi} **Accused detainee:** "A person incarcerated in a detention facility in Québec, either to await the outcome of judicial proceedings against him or her [...], or to await transfer to a prison, or for any other reason as a result of which the person cannot be considered to have been found guilty."

Convicted inmate: "A person sentenced to a penalty of less than two years of detention or to several prison sentences the total duration of which is less than two years at the time they are imposed."

(<http://www.securitepublique.gouv.qc.ca/index.php?id=450>, free translation from the French.

To avoid confusion, the term "detainee" is used in this report to refer to both the above categories, and the term "offender" is used to refer to people who break laws, regardless of whether or not they are incarcerated.

^{vii} A person may be given more than one diagnosis – for example, a nervous disorder combined with drug addiction (comorbidity).

- addiction, including but not limited to alcohol and/or drug use, alcoholic psychosis and poisoning;
- other diagnoses of psychosomatic diseases or neurological problems.

To illustrate the profile of mental health disorders, the most common diagnoses were identified, and principal diagnosis rates were then calculated and compared with medical treatments administered before and after incarceration. The relative percentages for each diagnosis and treatment are shown in the table below.

Diagnosis Category	Principal Diagnosis (%)	Medical Treatment Before Incarceration (%)	Medical Treatment After Incarceration (%)
Less serious mental disorders	48,2 %	48,3 %	43,7 %
Severe and persistent mental disorders	17,4 %	22,5 %	29,2 %
Addiction	32,5 %	27,2 %	22,0 %
<i>Other diagnoses</i>	1,9 %	2,0 %	5,1 %
<i>Total</i>	100,0 %	100,0 %	100,0 %

There are therefore more people with mental health disorders in prisons, and the prevalence of severe and persistent mental health disorders is much higher in prisons than in the general population.

As a comparison, 20% of the general population will develop a mental health disorder during their lifetime, and between 1% and 3% will develop severe and persistent disorders. There are therefore more people with mental health disorders in prisons, and the prevalence of severe and persistent mental health disorders is much higher in prisons than in the general population².

Profile of crimes

The CICC study also collected information on criminality^{viii}, although it only provides information on the most serious current offences and current offence categories. The

^{viii} There are different categories of crimes and different levels of severity. Generally speaking, crimes against the person are considered to be the most serious. According to the classification used by the Ministère de la Sécurité publique³ to establish its statistics, the offences against the person entered in the sample records used for the study were, in decreasing order of frequency: assault (14.5%), robbery (7%), sexual assault, sexual contact or child corruption (2.7%), conspiracy, actual or attempted aiding and abetting, kidnapping and threats (2.2%), homicide, manslaughter or attempted murder (0.4%), and other offences (2.2%). For crimes against property, the offences, in decreasing order of importance, were: breaking and entering (7.9%), theft, possession of stolen goods, mischief, extortion or possession for the purposes (9.3%), other offences (3.5%). Other categories of offences were, in decreasing order of importance: possession, traffic or production of narcotics (9.7%), driving offences (4%: driving under the influence, dangerous driving, municipal offences), violation of a probation order or respite order, or failure to comply with a condition (3.5%), falsification of

findings are likely to be more accurate for convicted inmates because their records were more complete than those of accused detainees.

If the data are grouped together under the four main headings used by the Ministère de la Sécurité publique, the charges brought against detainees with mental health disorders can be classified as follows:

- 29 % for offences against the person;
- 20.7 % for offences against property;
- 9.7 % for drug-related offences;
- 10.6 % for other offences;
- Data were missing from 30 % of the records.

Although not necessarily exhaustive, these data show that there are more multiple probations and prior detentions among people with mental health disorders. In all, 28.6% of people with mental health disorders had three or more probationary measures in their records, and 81% had previously been detained^{ix}, compared to 9.9% and 58.2% respectively for other detainees. This difference highlights the importance of introducing better management models to reduce the high rate of repeat contacts with the justice system among detainees with mental health disorders.

These data show that there are more multiple probations and prior detentions among people with mental health disorders.

It is important to mention that studies have not documented linkages between mental disorders and criminality. Other factors such as age, sex, socioeconomic background, educational level and residential location are more correlated with criminality⁴⁻⁶.

documents, counterfeiting, speculation, fraud, corruption, confidence racket, possession of a firearm and ammunition (2.2%), offences related to policing, obstruction of justice, violations of other Québec legislation or municipal by-laws (0.9%).

^{ix} The total is more than 100% because some records contained both probationary measures and prior detentions.

4 Continuity of service

4.1 Prior to incarceration: police interventions and initiatives offering alternatives to judicial intervention

Two aspects of the period prior to incarceration attracted the Québec Ombudsman's attention during the data collection process:

- Police interventions involving people with mental health disorders;
- Initiatives offering alternatives to judicial intervention for people with mental health disorders.

4.1.1 Police interventions

Police officers are frequently called upon to intervene in situations involving people with mental health disorders⁴⁻¹². They are usually the first to be called in crisis situations^X or to deal with people whose behaviour deviates significantly from expected social standards and disturbs the public order. In such cases, police officers may act under penal legislation such as the Criminal Code, or under an Act that is applicable in exceptional circumstances only, namely the Act respecting the protection of persons whose mental state presents a threat to the self or to others¹³ (P-38.001), which sets out the conditions in which police officers may take a person against his or her will to an institution providing care, at the request of a crisis centre worker or on their own initiative. In practice, the person is usually taken to a hospital emergency room.

Police officers are frequently called upon to intervene in situations involving people with mental health disorders.

The most common reasons for which police officers are asked to intervene in situations involving people with mental health disorders are as follows:

- Suicide threats;
- People who harm themselves or pose a threat to their own physical integrity, and must therefore be protected from themselves;
- Requests for police assistance from relatives of people in crisis, who may be afraid for their own safety;
- Discovery, by the police, of a person who is alone and unable to obtain the services he or she needs;

^X In psychiatry, the term “disorganization” is used to refer to psychological reactions to “traumas” that trigger psychological disorders of varying persistence and severity, depending on the person and the situation concerned. The term “decompensation” is also used to refer to a crisis.

- Reports from third parties regarding abnormal behaviour;
- Victims of alleged offences who appear to suffer from mental health disorders;
- People behaving abnormally who commit offences;
- Provocation by people in crisis.

The police response to each of these situations will vary according to the cause of the behaviour and the context in which the intervention takes place. Police officers have discretionary powers when performing their duties. However, the use of these powers, while not limited to minor offences^{XI}, must nevertheless be justified by the seriousness of the alleged acts, and must be in the public interest. In some cases no charges will be brought; the officers will simply refer the person to an appropriate health or social service resource. Some researchers, mainly outside Québec, have concluded that the police officer's decision to send the person into the judicial system or into the health and social service network will have a significant impact on case management and the likelihood of repeat offences. In the heat of the action, however, it may be difficult for the officer to choose the right response^{4-5, 7-10, 15-24}.

Case management is therefore influenced by the types of crisis services offered, their availability at the appropriate time, and the police officers' willingness to use them.

Case management is therefore influenced by the types of crisis services offered, their availability at the appropriate time, and the police officers' willingness to use them.

These problems are not specific to Québec, and it is interesting to consider the responses made by other jurisdictions to similar situations. In North America, police forces use three types of mental health interventions to support their officers^{7, 24-29}:

- liaison and coordination of police force teams with health and social service network professionals;
- training of police officers for specialist interventions;
- hiring of professional staff by police forces, to work with clients suffering from mental health disorders.

Given the context in Québec, the Québec Ombudsman focused on the following aspects of the first two structures:

^{XI} There is no official definition of what constitutes a minor offence or crime. However, a program introduced in Québec some 12 years ago allows for certain crimes committed by adults to be dealt with outside the criminal justice system. In 2009-2010, 8,194 files were treated in this way by counsel in criminal and penal proceedings. Counsel's decision to apply the program or not is therefore extremely important. For assistance, counsel may refer to the criteria set out in Directive NOJ-1, issued by the Director of Criminal and Penal Proceedings, which relate to the circumstances in which the offence takes place. The directive, and its accompanying list of 118 offences, is Québec's best source of reference for what constitutes a minor offence¹⁴.

4.1.2 Liaison and coordination of police force teams with health and social service network professionals

At the present time, police officers in some regions can obtain support from specialist organizations or crisis centres in the health and social service network. Urgence psychosociale-justice (UPS-Justice) and Programme d'encadrement clinique et d'hébergement (PECH) are often cited as models to illustrate this type of support for police officers³⁰⁻³⁴.

UPS-Justice is a Montreal-based organization created 14 years ago to apply alternatives to legal action or, at the very least, to reduce the use of preventive detention for people with mental health disorders. Police officers can call on the team's members 24 hours a day, seven days a week. The team's resource then assesses the person to see whether he or she needs to be taken to hospital. The organization also cooperates with the entire Montreal health and social services network on case management.

In Québec, police officers can call on the PECH to help deal with people exhibiting signs of mental health disorders. A PECH resource is dispatched to the site within half an hour, and is able to assess the person to see whether he or she is dangerous, and to decide whether the police officer should simply leave or take the person to hospital or to the PECH shelter in order to manage the risk. The PECH service is available 24 hours a day, seven days a week.

Despite their availability, the extent to which these services are used varies significantly, depending on the police officers and regions concerned³⁵. Often, they are called only to situations involving the application P-38.001. Generally speaking, overall use of crisis services is fairly low. Although there are many examples of collaboration^{xii} between police forces and crisis service workers, the success of the relationship appears to depend on regional needs and collaborative dynamics^{7,24,26-29}. In this respect, the health and social services agencies have a key role to play in providing a service supply based on the dynamics in their respective regions, and police forces must also ensure that their officers are aware that the service exists. It is not a question of simply reproducing the model used in Montreal or Québec City, but of working together to implement the services that are best suited to the specific needs of each region.

The extent to which these services are used varies significantly, depending on the police officers and regions concerned

RECOMMENDATIONS AIMED AT SUPPORTING POLICE INTERVENTIONS INVOLVING PEOPLE WITH MENTAL HEALTH DISORDERS

Given that police officers must intervene regularly as front-line

^{xii} Regarding police support for problems relating to substance abuse, an interministerial table and committee have been set up to foster joint action. Locally, police forces can join regional tables. The spin-offs in terms of improving police use of resources for people with mental health disorders are still unknown.

resources in situations involving people with mental health disorders;

Given the considerable contribution that can be made by various specialist organizations and crisis centres in the health and social service network to support the work done by police officers in situations involving psychosocial or psychiatric emergencies;

Given that the availability and use of these resources by police officers varies significantly from one region to the next;

The Québec Ombudsman recommends:

1. That the Ministère de la Sécurité publique should work with the Ministère de la Santé et Services sociaux to determine the need, in each region, to support police officers in the management of psychosocial or psychiatric emergencies;

2. That the Ministère de la Santé et des Services sociaux should enter into management agreements with the health and social service agencies to set targets stipulating that the agencies must make available, in a given priority order, the services required to help police officers manage psychosocial and psychiatric emergencies.

That the Ministère de la Sécurité publique and the Ministère de la Santé et des Services sociaux should present the Québec Ombudsman with an action plan and implementation schedule for the measures retained, by March 31, 2012.

4.1.3 Police officer training for specialist interventions

Interventions involving people with mental health disorders are a priority for Québec's École nationale de police (national police training school), along with racial profiling and spousal violence. However, the School does not feel able to demand that the province's colleges should offer training on the subject in their police programs, because this would interfere with their academic independence^{XIII}. This is clearly a problem¹².

The Vocational Development branch of the École nationale de police provides training for working police officers, in partnership with all Québec's police forces. On-the-job training can also be given by police support organizations. However, specific training for

^{XIII} Aspiring police officers who are accepted at the École nationale de police, in Nicolet, have normally taken a specific three-year course at a CÉGEP (general and vocational college) in Québec. People from other academic backgrounds may also be admitted to the École nationale de police, but only in exceptional cases.

interventions involving people with mental health disorders is not given systematically to all Québec's police officers.

Offenders may also have a host of other problems, including addiction, homelessness, mental deficiencies and pervasive developmental disorders, for which additional police training would also be appropriate ^{2, 36-38}. However, every training program has a limited number of hours available, and it is relevant to wonder whether or not it is actually possible to cover every single need that could possibly arise. This is why it is so important for everyone concerned to work together in order to produce integrated training programs³⁹.

RECOMMENDATIONS AIMED AT ENRICHING POLICE TRAINING

Given that needs have been identified at the level of initial training and continuous training for police officers, so that they are better able to deal with people who have mental health disorders;

Given that there is also a need for training in connection with other types of problems, clearly showing the benefits of an integrated training plan;

Given that the Ministère de la Santé et des Services sociaux and its network have the expertise required to help prepare appropriate content for training given by public safety sector partners in order to meet the need for training on various problems relating to mental health, substance abuse and homelessness;

The Québec Ombudsman recommends:

3. That the Ministère de la Sécurité publique should agree with the École nationale de police and the Ministère de l'Éducation, du Loisir et du Sport on a minimum number of college-level training hours for all aspiring police officers on the subject of interventions involving people with mental health disorders, including the related legal aspects, such as the application of P-38.001, and that it should establish a memorandum of understanding to this effect with the colleges;

4. That the Ministère de la Sécurité publique, in conjunction

with the École nationale de police and Québec's police forces, should identify the need for continuous training on the subject of interventions involving people with mental health disorders, including the related legal aspects, and that it should make this training available to working police officers;

5. That the Ministère de la Sécurité publique should work with the École nationale de police and the Ministère de la Santé et des Services sociaux to prepare a coherent, integrated training plan for police officers, covering their basic training and ongoing professional development, and aimed at enriching their expertise so that they are able to work effectively with people suffering from a variety of problems, such as substance abuse and homelessness.

That the Ministère de la Sécurité publique should provide the Québec Ombudsman with a progress report on this issue, along with a schedule for implementation of the chosen measures, by March 31, 2012.

4.2 Initiatives offering alternatives to judicial intervention

Two major aspects need to be considered in connection with such initiatives. The first involves the difficulty of accessing the social service resources required to avoid the need for judicial intervention and the second concerns the possibility of adjusting the penal process to reflect the specific situation of people with mental health disorders^{9, 11, 18-20, 23, 27-34, 40-74}.

4.2.1 The difficulty of accessing appropriate social service resources

In cases where referral to the social services is the most appropriate solution, the current resources are simply not sufficient.

As mentioned earlier, police officers often take people in crisis to hospital emergency rooms^{24, 26-29, 60, 75}. In many cases, however, the subsequent assessment reveals that hospitalization is not necessary^{XIV}.

In cases where referral to the social services is the most appropriate solution (for example, finding accommodation for people in psychosocial emergencies), the current resources are simply not sufficient. There are not

^{XIV} In the Mental Health Action Plan⁷⁶, front-line emergency services are considered to be a priority. In the community, according to PECH statistics, front-line solutions are found for 75% of people who are in violation of the law at the time of the police intervention. The other 25% are taken to hospital.

enough emergency shelters and adapted dwellings for people in crisis or suffering from concurrent disorders^{60, 75, 77-79}. The shortage has been well-documented, especially in the case of the homeless^{xv}.

The Québec Ombudsman⁸⁹ has recommended the development of emergency reception places for these people. The province has recently adopted an interministerial action plan for homelessness³⁷ that recommends the development of places in shelters for vulnerable people. Generally speaking, the measures proposed in the action plan³⁷, along with addiction services, are gradually being implemented throughout Québec. In addition, the interministerial action plan for drug addiction³⁶ provides for emergency support and lodging services that will reduce the need to incarcerate people whose problems are more social than medical or correctional in nature^{xvi}. Support services for police officers, with mobile referral and intervention teams or liaison teams, may also be offered in some regions of Québec.

In the case of minor offences, the shortage of resources limits the possibility of avoiding legal action for people who are not a risk to public safety. Detention facilities are only allowed to turn people away in certain exceptional situations, and are often the only available option. Clearly, prison overcrowding^{xvii} is also likely to complicate the management of people with mental health disorders.

RECOMMENDATIONS AIMED AT IMPROVING ACCESS TO APPROPRIATE SOCIAL SERVICES RESOURCES

Given that a social services referral is the most appropriate solution for many people in psychosocial emergencies;

Given that the current resources, including emergency shelters and

^{xv} A number of studies and reports in Québec have documented the problems that arise when homeless people – who are a major target group for psychiatric interventions via the justice system – are arrested by police officers for minor offences or misdemeanors^{8-10,23,32,36-37,55,79-88}. Ideally, to avoid rupturing the person's social ties, services should be made available upstream, along with social support (at home, at work and at school); case-by-case emergency interventions are not a sustainable solution for the people concerned. Similarly social reintegration and prevention of repeat offences are complex problems that require a set of measures adjusted to each person's specific needs.

^{xvi} Certified drug addiction organizations and shelters cannot meet the need for emergency accommodation in crisis situations. In 2010-2011, a budget of \$1.18 million was made available to support the Ministère de la Santé et des Services sociaux's undertaking to consolidate emergency accommodation places for the homeless, and the health and social service agencies are required to monitor the supply of accommodation services within their respective territories.

^{xvii} In its 2006-2007 and 2007-2008 Annual Reports, the Québec Ombudsman expressed concern at this situation, and noted its consequences for inmate services, cleanliness, human dignity and safety. The 2008-2009 annual report of the Ministère de la Sécurité publique observed an overcrowding ratio of 1.19⁹⁰, compared with 1.17 in 2009-2010.

adapted dwellings for people in crisis or suffering from concurrent disorders, are not sufficient;

The Québec Ombudsman recommends:

6. That the Ministère de la Sécurité publique and the Ministère de la Santé et des Services sociaux, in collaboration with the other government partners in the homelessness plan, should ensure that target groups have fair and sufficient access to places in shelters or, where necessary, in drug addiction resources, so that police officers are able to direct people to the places best suited to their needs;

7. That the Ministère de la Santé et des Services sociaux should assess the number of places required in each region for these types of resources, in order to establish a realistic timeframe for their development.

That the Ministère de la Sécurité publique and the Ministère de la Santé et des Services sociaux should submit an action plan and an implementation schedule for the chosen measures to the Québec Ombudsman by March 31, 2012.

4.2.2 Adapting the legal process

Orders for assessment

In February 2011, the interministerial working committee on the provision of forensic psychiatry services set up pursuant to the Criminal Code published a report describing the current situation of forensic psychiatry, identifying the main problems and proposing solutions in the form of twelve recommendations⁹¹. One of the problems identified was the question of where people should be held under orders of assessment. The complaints received by the Québec Ombudsman in this respect are generally from detainees who do not feel an order has been properly applied because the hospital named in the order refused to take them.

Every person accused of a crime may be subjected to an order for assessment. There are two types of orders:

- an assessment of criminal liability – in which case the order is for a period of 30 or 60 days;
- an assessment of fitness for trial – in which case the order is for a period of five days.

These orders for assessment are sometimes accompanied by custodial orders, and it is important for them to be placed in their respective contexts. There are three main points to be made here:

- Judges issue orders for assessment based on specific criminal justice criteria.
- It is rare for the actual assessment to take more than a few hours. The period of validity of an order therefore refers to the time within which the assessment must take place, and not the period for which the person should be placed under observation.
- The notion of fitness for trial and the ability to form criminal intent are not necessarily tied to mental health disorders. The legal criteria for fitness and the criteria used to diagnose mental health disorders are not the same^{xviii}. A person subject to an order for assessment may not necessarily need hospital care. The Criminal Code allows for orders for assessment to be made without a custody or detention order.

Based on these three observations, it is clear that not everyone who is subject to an order for assessment will need to be detained in a hospital. A person who occupies a hospital bed but does not need care will prevent an emergency room patient who does need care from being admitted to a care unit. The fact of being accused of a crime should not create a two-tier system for hospital admission; admission should always depend on the need for care. However, some people who are subject to orders for assessment will in fact need care, and will therefore have to be admitted to hospital.

Not everyone who is subject to an order for assessment will need to be detained in a hospital.

Like the Québec Ombudsman, the interministerial committee believes the principle of “the right person at the right place” must be applied by offering a supply of services within which resources can be allocated in a way that is consistent with the duty to provide care to those who need it, and with the legal obligation to select the location that least deprives the person of his or her freedom. This would mean that assessments could be done on an outpatient basis. To solve problems relating to custody, the interministerial committee recommends that forensic psychiatric services should be ranked, and that service agreements should be entered into by health and social service institutions. Some of the committee’s recommendations are aimed at making better use of court testimony by health professionals, facilitating the transmission of information relevant to the assessment, and informing the Court about the availability of resources. The Québec Ombudsman believes the committee’s recommendations cover a crucial aspect of forensic psychiatry, and will carefully monitor the follow-up action taken by the various government departments concerned.

^{xviii} A person may be unfit for trial due to a change in his or her mental state, without necessarily having a chronic mental health disorder requiring medical follow-up. Another person may be in perfect health or have a physical or mental health disorder that is under control, but still be unable to form criminal intent at the time the acts in question were carried out.

Specialist courts, adjustments to the judicial system and community support.

Special mental health courts have been set up in some cities to address the specific needs of people with mental health disorders^{27,30,48-59,63-67}. There are nearly 200 such courts in North

The critical review of the scientific literature revealed very little real information on which to base the definition of an ideal mental health court.

America. However, the Québec Ombudsman's critical review of the scientific literature revealed very little real information on which to base the definition of an ideal mental health court^{27,48-57,63}.

There has been only one pilot project in Québec, at the Montreal Municipal Court. The experiment began on May 20, 2008, for a three-year period, and is known as the *Programme d'accompagnement Justice-Santé mentale* (Justice-Mental Health Support Program, or PAJ-SM)^{30,63-66}. Originally, the initiative was to be known as the Mental Health Court, but the name was changed to reflect the fact that, when the concept was adjusted to the context in Québec, it moved away from the original notion of a specialist court. The pilot project in Québec differs significantly from the courts that exist in the United States. The name chosen also reflects a desire to avoid the additional stigmatization associated with court appearances for people who are already victims of stigmatization because they suffer from mental health disorders. The Québec Ombudsman is also aware of the stigmatization that may arise from the creation of special courts.

The program itself can be summarized as a “moral contract” between the person and the court. It consists in an ongoing process over a given period of time, during which the person must comply with a number of conditions that vary in scope, depending on the person's condition. The accused is given the opportunity to receive services in the community, in order to improve or stabilize his or her psychic and psychosocial health. Participation is voluntary. However, if a person refuses to participate, either at the beginning or during the process, he or she must revert back to the regular municipal court path⁶⁴. The program is intended for adults in Montreal who are accused of “minor” offences. UPS-Justice liaises with the court for the program's psychosocial element.

Cases managed by psychosocial teams in the community are more likely to be successful.

The scientific data are more eloquent on the need for the courts to be able to refer people to effective non-judicial programs that involve treatment in the community. Scientific data and expert comments are in agreement here: cases managed by psychosocial teams in the community are more likely to be successful^{23, 27, 41-48, 53, 55, 58, 59, 66-71}.

An evaluation report on the Montreal pilot project is currently under preparation^{XIX}. We have monitored the experience closely, and are aware of the implementation problems encountered^{30,63-66}. Although the preliminary data suggest that the program has been successful to some extent in reducing repeat offences, the model's effectiveness has not yet

^{XIX} In the first year, 566 people were referred to the project, 43% of whom had serious and persistent mental disorders and 60% of whom had no prior criminal record. The Québec Ombudsman has critically analyzed the scientific papers published on the project. However, none of the findings address the model's effectiveness⁶⁵.

been proved and further attention will be needed before it can be extended into general use⁶⁵. This view is supported by comments made by some of the people who experienced the program in the field.

According to the Ministère de Justice, Québec's other first-instance penal jurisdictions could develop similar initiatives, but in doing so they should consider local volume, needs and resources, to ensure that every assistance service and adjustment to the justice system is geometrically variable and has the region's support. The Québec Ombudsman feels that if non-judicial initiatives are to be offered, alternatives to detention should be available to all Québec's citizens, even though specialized teams and organizations such as PECH and UPS-Justice do not exist everywhere.

The Mental Health Action Plan⁷⁶ provides for a community-based treatment service derived from an intervention model that meets proven success criteria⁷²⁻⁷⁴. The health and social service network does in fact offer assertive or variable treatment programs for people with mental health disorders^{xx}. These programs are similar in many respects to the treatment programs used in initiatives offering alternatives to judicial intervention. In areas outside the major cities, which do not have specialist organizations such as PECH or UPS-Justice, it may therefore be interesting to consider the possibility of liaising with these programs.

However, nothing has been done to ensure that this type of treatment is consistent with the chosen model, or that it will systematically produce positive results. Moreover, the Ministère de la Santé et des Services sociaux points out that the number of treatment programs implemented so far has been insufficient to meet the targets set in some regions. It is therefore vital that access to these programs be improved, for the general public as well as for people facing legal action.

Clearly, the success of initiatives with court involvement offering alternatives to judicial intervention depends to a significant extent on the availability of rigorous, effective and safe community treatment programs.

The success of initiatives with court involvement offering alternatives to judicial intervention depends to a significant extent on the availability of rigorous, effective and safe community treatment programs.

^{xx} Assertive community treatment is intended for people with serious mental disorders whose condition is both instable and fragile. A sustained intervention by a multi-disciplinary team is required to treat disorders such as these, and must include treatment by a physician. Case management-type variable intensity support is intended for people whose functional problems are less severe. The goal in their case is to develop individual aptitudes and provide support. The primary case worker (the case manager) is the person with whom the closest relationship is developed during treatment. Given the large number of people involved in treatment, the case manager must use an inter-disciplinary approach, and must personally perform some of the support activities chosen in collaboration with the person treated, and coordinate the others^{76, 92}. In 1997, the Ministère de la Santé et des Services sociaux reviewed the literature on community treatment initiatives that had been shown to help reduce the number of cases brought before the courts⁶⁸. Before the decision was made to adopt these models, the health technology and intervention method assessment board carried out an evaluation, and other researchers examined issues relating to implementation⁷²⁻⁷⁴.

RECOMMENDATIONS CONCERNING INITIATIVES OFFERING ALTERNATIVES TO JUDICIAL INTERVENTION

Given that there is very little evidence on which to base a definition of the ideal mental health court;

Given the evidence concerning the effectiveness of programs involving treatment in the community;

Given that the Mental Health Action Plan provides for a supply of treatment in the community that satisfies the criteria for success;

The Québec Ombudsman recommends:

8. That the Ministère de la Justice should work with the Ministère de la Santé et des Services sociaux to prepare an inventory of the best community treatment programs and draw up a plan to implement such programs in regions that are less well-served;

9. That the Ministère de la Justice should submit a list of the programs available in each region to the courts, and should define the access conditions and target client groups for whom the programs would provide a valuable alternative to legal action, in compliance with the provisions to this effect in the Criminal Code;

That the Ministère de la Justice should provide the Québec Ombudsman, first, with a review of existing initiatives offering alternatives to judicial intervention and their availability to people with mental health disorders alone, or mental health disorders in conjunction with other problems, and second, with a list of treatment programs that satisfy the criteria for success.

That the Ministère de la Justice should report annually to the Québec Ombudsman, on March 31 for the next three years, on the use of such programs and on plans to develop them in regions where the service does not yet exist.

Needs expressed by legal stakeholders for the implementation of programs offering alternatives to judicial intervention

The development of programs offering alternatives to judicial intervention should also include the provision of information on the resources available in the community, and training and awareness activities for people involved in the legal process. Lawyers and

judges need support with cases involving people with mental health disorders^{XXI}. In short, lawyers need to develop the reflex of proposing alternatives to judicial intervention wherever appropriate, and judges need sufficient information to assess the validity of these requests on a case-by-case basis^{2,65-66}.

Lawyers and judges need support with cases involving people with mental health disorders.

RECOMMENDATIONS CONCERNING THE AWARENESS OF PEOPLE INVOLVED IN THE LEGAL PROCESS

Given that the development of effective programs offering alternatives to judicial intervention must also include the provision of information on the resources available in the community, training and awareness for legal system stakeholders on the best way to intervene with people who have mental health disorders, including the relevant legal aspects;

The Québec Ombudsman recommends:

10. That the Conseil de la magistrature should provide its members with proper training on initiatives offering alternatives to judicial intervention and the conditions for success of such initiatives;

11. That the Ministère de la Justice should provide the courts with a list of the programs available in each region, and identify both the target client groups for whom recourse to the programs would be a valid alternative to judicial intervention, and the conditions for access to such programs;

12. That the Ministère de la Justice should join forces with the authorities that prepare training for the various legal system stakeholders, in order to circulate information on initiatives offering alternatives to judicial intervention and promote contacts with organizations able to give training and raise awareness on the subject;

That the Ministère de la Justice should provide the Québec Ombudsman with a progress report on its work, including the steps proposed and taken, by March 31, 2012.

^{XXI} A critical review of the scientific literature on the Montreal pilot project also supports this observation; in the implementation study, judges and lawyers all expressed a need for support, especially in the form of training⁶⁵.

4.3 During detention: access to the necessary socio-sanitary services

In this section, we will look at what happens to people with mental health disorders in detention facilities, from admission to release. Our goal is to answer the following question: **Do the current conditions in detention facilities allow people with mental health disorders to obtain the health services and social services they need?**

The data collected during the study, in focus groups, during visits to detention facilities and from examinations of complaints, revealed a number of deficiencies in service delivery^{xxii}:

4.3.1 Non-systematic screening procedures

The scope and type of screening for mental health disorders other than suicide vary from one facility to the next. Systematic screening for potential suicide victims is performed throughout Québec^{96,97} and the results of suicide screening are the only mental health findings that are systematically entered into the DACOR system. Entries of findings relating to other mental health disorders, obtained using in-house screening methods, are variable. Given that information from DACOR is used to draw up service plans, it is clear that not all the detention facilities will have access to accurate profiles of their detainees. People with mental health disorders who are not identified by screening receive less attention from medical care personnel^{xxiii}.

Not all the detention facilities will have access to accurate profiles of their detainees.

4.3.2 Overly frequent transfers^{xxiv}

In 2009-2010, detention facilities under Québec jurisdiction admitted 40,827 people and transferred 24,400. The problem of screening effectively in such a context is therefore obvious. In addition, treatment, once begun, is often interrupted by a transfer^{xxv}.

^{xxii} In a recent report on the mental health strategy, the Office of the Correctional Investigator of Canada identified problems with screening, community mental health initiatives, isolation, continuity of care personnel, and personnel training and selection⁹³. The impacts of these problems are also described in the Office's investigation of deaths in custody⁹⁴. A House of Commons committee has just produced a report containing a series of recommendations to address these problems⁹⁵. Similar problems also exist in detention facilities under Québec jurisdiction.

^{xxiii} This general observation reported by the focus groups can be explained in part by the fact that a person who has not been screened has little chance of obtaining a classification at the health care unit where medical and nursing staff are available.

^{xxiv} In the last three years, 27.5% of the complaints made to the Québec Ombudsman by people with mental health disorders were related to transfers and their consequences. The Québec Ombudsman, in its 2006-2007 Annual Report, noted that transfers often cause interruptions in medication.

^{xxv} An analysis of focus group findings revealed that clinical personnel, in conjunction with correctional services managers at some facilities, are currently attempting to enter into an agreement concerning people receiving psychiatric treatment, to reduce the number of transfers.

Transfer-related issues are especially likely to affect people with mental health disorders. Sudden and recurrent interruptions of medication due to transfers can compromise a person's mental stability^{xxvi}.

Transfer-related issues are especially likely to affect people with mental health disorders.

4.3.3 A recurrent problem of access to medication, medication management and compliance with pharmaceutical treatment^{xxvii}

It is crucial that people with mental health disorders should take their medication as prescribed, so that their condition does not deteriorate. However, the Québec Ombudsman noted that the continuity of a new detainee's medication may be compromised in the 48 hours following admission to a detention facility. In some cases the interruption, although brief, may, when combined with the radical change of living environment, be sufficient to destabilize the person's mental state and can have significant consequences⁹⁸ including **withdrawal symptoms^{xxviii}** and their **associated undesirable effects on stability**.

The continuity of a new detainee's medication may be compromised in the 48 hours following admission to a detention facility.

One of the problems with access to medication is the fact that many of the drugs used to treat mental health disorders are sought-after by detainees for trafficking purposes. Some detention facility physicians therefore reduce the doses prescribed by their counterparts outside the prison system as soon as the detainee is admitted, to avoid the possibility that he or she will use the drugs for illicit purposes. Similarly, some detainees may not be permitted to take their medication when they are admitted to a detention facility, regardless of whether or not they have valid prescriptions. Generally speaking, they must wait until the facility's own physician writes a new prescription, and this can take several days.

^{xxvi} Without addressing the complex legal framework governing prescription renewals, in the case of some of the medications needed to treat mental health disorders (e.g. the benzodiazepines), the ability to transfer prescriptions from one facility to another is limited. In cases such as these, a physician must examine the person and write a new prescription, meaning that there will be a delay before a further supply of the medication can be obtained.

^{xxvii} Compliance is a correspondence between a person's behaviour and a professional's recommendations concerning preventive or curative treatment. Complaints regarding access to medication account for 70.5% of all grounds for complaints from people with mental health disorders, making it the most frequent ground for complaint in each of the last three years. In 35.5% of cases, the problem was due to a transfer.

^{xxviii} Withdrawal is the term used to refer to a situation in which consumption of a substance (alcohol, amphetamines, cocaine, nicotine, opiates, sedatives, hypnotic drugs or tranquilizers) is either stopped or reduced, causing a negative change in behaviour with physiological (e.g. high blood pressure, respiratory rate or pulse, and high body temperature) and cognitive repercussions. A withdrawal syndrome is a set of symptoms triggered by suddenly ceasing to consume a psychotropic substance. The syndrome can vary in form and intensity, depending not only on the substances and doses in question, but also on the person and the social and cultural situation in which he or she lives (detention facility, hospital, home). It goes without saying that withdrawal is more complicated where the person was consuming several interacting substances. It can be dangerous, if not life-threatening, to suddenly stop consuming certain psychotropic substances that have been used on a regular or sustained basis. For example, use of tranquilizers or sleeping pills should only be cased with approval from and under the supervision of a qualified person. (Source: www.etape.qc.ca)

4.3.4 Problems concerning confidentiality and sharing of information^{xxix}

It can often be difficult, in a detention facility, to maintain the confidentiality of medical information.

It can often be difficult, in a detention facility, to maintain the confidentiality of medical information. Information exchanges are one of the cornerstones of safety, and confidentiality of discussions between a patient and his or her carer is one of the foundations of the therapeutic relationship. Detention facility personnel and care personnel are no less respectful of the right to confidentiality than anyone else; however, the custodial context sometimes makes it more difficult to uphold that right, and introduces a number of pitfalls into the process⁹⁹.

The first pitfall lies in the fact that an information exchange can trigger conflicts in which a detainee may feel the other people concerned are working against him or her. This would be the case, for example, where a detainee is reported for saving up medication, causing the physician to stop prescribing it.

The second pitfall lies in the fact that there are very few specific guidelines concerning the information that can legitimately be exchanged between correctional personnel and medical care personnel. Despite the goodwill of the people concerned, the rules are still not clear and the Québec Ombudsman regularly observes considerable inter-facility differences in the information that is or is not disclosed to other staff members.

The problem is even worse in the case of people under protective supervision – for example, those with mental health disorders who are unable to look after themselves, exercise their civil rights or administer their own property. These people are extremely vulnerable and often socially isolated^{xxx}. Their tutors or curators are not always informed immediately if their wards are taken into custody, and cannot therefore ensure they are adequately represented at disciplinary hearings or intervene in the care plan or release plan^{xxx1}.

^{xxix} In its 2008-2009 Annual Report, the Québec Ombudsman criticized the lack of confidentiality of discussions between care personnel and detainees due to the presence of correctional officers during the consultation.

^{xxx} The person appointed by the court as a tutor or curator is responsible for overseeing the ward's civil rights, defending the ward's interests and administering his or her property, in the ward's best interests and with due respect for his or her independence.

^{xxx1} In July 2009, following up on a recommendation made by the Québec Ombudsman, the Public Curator entered into an information exchange protocol with the Ministère de la Sécurité publique and the detention facilities. Correctional Services appointed resource people in each facility. These people were trained, and alliances were set up to facilitate information sharing. In the first year, a number of problems arose, especially with the computer system. Improvements have recently been made, but it is still too soon to say whether the problem of information sharing has been solved.

4.3.5 Crisis management limited to the application of physical measures administered by personnel members without support^{xxxii}

Crisis situations often have to be managed within the detention facility itself^{xxxiii}. Chemical restraint, if used, requires a medical prescription, and the rules applicable in hospitals and correctional facilities (e.g. regarding consent to care) are similar. Lack of availability or recourse to medical expertise limits access to emergency medication to solve crisis situations in detention facilities.

The most severe measures involve the use of physical restraints or containment^{xxxiv}. Detention facilities may have special cells for physical restraint – in other words, cells with no furniture other than a bed that is attached to the floor, to which a person in crisis may be tied using specially-designed straps.

The rules governing the use and duration of isolation in health and social service institutions do not apply to detention facilities. Restraint is governed by administrative procedure 3N1, which entrusts responsibility for the measure to the correctional service officers. When physical restraint is required, the procedure states that the officers must call in members of the health care personnel for assistance and advice. Clearly, there is the question of whether or not these people will be available when the crisis occurs. The CICC study found that only 25% of the detention facilities that took part in the research had health care personnel (usually nurses) on duty 24 hours per day.

Only 25% of the detention facilities that took part in the research had health care personnel (usually nurses) on duty 24 hours per day.

In its 2007-2008 Annual Report, the Québec Ombudsman noted the need for training in physical intervention methods. In 2008-2009, it recommended the introduction of a register of isolation and segregation use, so that practices could be monitored and assessed. The recommendation was accepted and implemented. In 2009-2010, the Québec Ombudsman noted numerous cases of non-compliance with the provincial instruction providing for segregated detainees to be visited on a daily basis by health care personnel.

^{xxxii} Complaints regarding isolation accounted for 2.5% of all grounds for complaint by people with mental health disorders, making this the fourth most common ground for complaint for each of the last three years. The complaints concerned the use or duration of isolation measures, and in a handful of cases, the requirement for the detainee to wear an anti-suicide smock during isolation. There were no complaints relating specifically to the use of restraints or containment.

^{xxxiii} Problems relating to crisis management, isolation and restraining are not specific to detention facilities under Québec's jurisdiction. Similar problems have also been reported in Canadian federal prisons and in American prisons^{93-95, 100}.

^{xxxiv} In detention facilities, "containments" are instruments used to limit freedom, such as handcuffs, leg or waist chains, whereas "restraints" are used to immobilize a person, such as leather wrist or ankle straps and vest restraints.

4.3.6 *Fragmented services^{xxxv} that do not reflect the general needs of detainees*

It is difficult to organize longer-term services such as these in detention facilities because of the short average duration of the detention period.

Detainees can usually obtain medical services, some basic nursing care, and medication therapy. However, it is rare for them to have access to rehabilitation and psychosocial monitoring. It is difficult to organize longer-term services such as these in detention facilities because of the short average duration of the detention period.

In addition, in facilities where psychiatrists are called upon to give expert testimony to the courts, pre-court assessments for accused detainees tend to take priority. In reality, convicted inmates almost never have access to psychiatric consultation services. The possibilities for transfers to hospital on medical grounds are limited to cases considered urgent by the medical personnel.

The supply of services for detainees is focused around a number of plans (rehabilitation plan for accused detainees, correctional intervention plan for detainees incarcerated for more than six months or exhibiting a documented risk, draft plans for other people, based on a summary assessment). A more extensive risk assessment is carried out, usually by a probation officer, before preparing a correctional intervention plan. The assessment covers elements such as addiction, antisocial attitudes and antisocial personality traits. Aspects relating to mental health disorders are not included in the assessment, but appear to be considered nevertheless. However, the health-related goals of all these plans are secondary to their primary purpose.

Some group therapy activities may, however, be organized in detention centres, usually as a result of initiatives by facility management, the community or the health and social services centre. Such activities, if they exist, are never included in the individualized service plan^{xxxvi}.

Despite the problem of obtaining access to medical care personnel in detention facilities, the Ministère de la Sécurité publique has, as yet, made no attempt to introduce initiatives aimed at improving the use of these resources, either by addressing the organization of work or by entering into partnerships^{xxxvii}.

^{xxxv} Complaints concerning access to care (medical personnel or hospitalization) account for 6% of the total number of complaints made by people with mental health disorders.

^{xxxvi} These plans, described in the Act respecting health services and social services¹⁰¹, are prepared when a person must receive services delivered by more than one service provider working in more than one institution as in a detention facility. The plans fall under the responsibility of a coordinator, who is responsible for implementing them. Their content generally includes a review of the person's needs, the goals of the plan, the likely duration of the services and a note concerning periodic reviews. This is similar to the content of the intervention plans described in the Act. One problem with these plans lies in the fact that the nursing staff in correctional facilities is usually composed of nurses or auxiliary nurses who, as the law currently stands, are not qualified to draw up individualized service plans.

^{xxxvii} This situation is not new. The Corbo Report proposed the following solutions: a protocol to facilitate access to health and social service network resources; an approach to other government departments, asking

4.4 Towards services that are better adjusted to the situation of detainees with mental health disorders

The Québec Ombudsman, after noting certain deficiencies in the service supply, believes sustainable improvements should focus on four main goals:

- Clarifying the respective responsibilities of the people involved in providing socio-sanitary services in detention facilities;
- Obtaining effective collaboration;
- Considering the specific needs of the prison population;
- Developing a coherent clinical vision of service provision in detention facilities.

4.4.1 Clarifying the responsibilities of the various parties

In the present context, it is up to the detention facilities themselves to deliver health services, including mental health services, to detainees. They must also respond appropriately to crisis situations^{xxxviii}.

In the present context, it is up to the detention facilities themselves to deliver health services, including mental health services, to detainees.

In 1989, to help the facilities with these responsibilities, the Ministère de la Sécurité publique entered into a memorandum of understanding¹⁰⁷ with the Ministère de la Santé et des Services sociaux in accordance with the provisions of the Act respecting correctional services, which was in force at the time. The memorandum sets out the division of responsibilities between the two departments, and structures access to services so as to ensure continuity.

The purpose of this is to ensure that detainees are able to obtain the socio-sanitary services they need. The Act respecting the Québec correctional system¹⁰⁸ and its application regulation¹⁰⁹ provide among other things for a “temporary absence for medical purposes”, which may be authorized by the facility’s director^{xxxix}.

them to support less well-off regions attempting to develop their community resources; and consideration for the possibility of specialized detention facilities¹⁰².

^{xxxviii} In the detention facilities, the condition of people with mental health disorders can deteriorate during their detention^{93-95,103-106}. In some cases it is sufficient simply to adjust their treatment, but in others, deterioration is a sign of disorganization leading up to crisis. In a few cases, crises may occur spontaneously.

^{xxxix} The Québec Ombudsman’s experience shows that where the medical care personnel feel that an examination or treatment is required due to the person’s state of health, correctional network managers usually give permission. It sometimes happens that authorized examinations or treatments cannot be carried out because officers are not available to escort the person to the appointment, causing it to be cancelled. Such situations are particularly harmful to detainees who are being treated in outpatient clinics for physical health problems; outpatient treatment is usually not an option for mental health disorders.

In Québec, coordination of the various partners involved in providing mental health services is far from complete. However, inter-sector collaborative initiatives can result in a more complete supply of services. The networks should be informed of successful initiatives such as those in the Québec City and Laurentides regions, and they should be able to obtain help in adapting and implementing more satisfactory service structures. Although discussion tables are useful, they are not sufficient, alone, to ensure full collaboration.

Although the Ministère de la Sécurité publique is mainly responsible for implementing and coordinating the government social reintegration plan¹¹⁰, the plan's success depends to a large extent on effective partnerships with the Ministère de la Santé et des Services sociaux among others.

The need to develop collaborative initiatives was underscored recently by the publication of a number of government and inter-sector action plans containing measures for the entire prison population, for detainees with mental health disorders or people with concurrent disorders. The boundary between the responsibilities of the Ministère de la Sécurité publique and the Ministère de la Santé et des Services sociaux appears to be somewhat fluid. For example, although the Ministère de la Sécurité publique is mainly responsible for implementing and coordinating the government social reintegration plan¹¹⁰, the plan's success depends to a large extent on effective partnerships with the Ministère de la Santé et des Services sociaux among others.

In the interministerial plan for addiction³⁶, the interministerial plan for homelessness³⁷ and the government social reintegration plan¹⁰⁹, we have identified 88 measures that may be applied during the trajectory of people with mental health disorders as they face legal proceedings or imprisonment. These measures pertain to prevention, screening, early intervention, awareness and training, and are designed to improve individual case management, among other things by providing easier access to resources with the necessary level of expertise. In addition, they are designed to foster reintegration through access to community treatment, housing, education and employment measures. The interministerial working committee on forensic psychiatric services, created pursuant to the Criminal Code, has also made 12 recommendations. **The existence of all these measures highlights the need to clarify the respective responsibilities of everyone concerned, and to ensure proper coordination.**

Recently, the Ministère de la Sécurité publique confirmed its interest in transferring responsibility to the Ministère de la Santé et des Services sociaux.

In recent years, the Ministère de la Santé et des Services sociaux and the Ministère de la Sécurité publique have attempted to transfer responsibility for the provision of health services and social services in detention facilities to the health and social service network. However, despite the signature of service agreements, and although the Ministère de la Santé et des Services sociaux has been identified as a collaborator in some of the action plans, access has not, as yet, been improved⁶⁰. Recently, the Ministère de la

Sécurité publique confirmed its interest in transferring responsibility to the Ministère de la Santé et des Services sociaux. This is one of the formal recommendations of the interministerial working committee on forensic psychiatric services.

In the Québec Ombudsman’s opinion, responsibility for all health services and social services should be transferred. Regardless of the implementation issues, transfer of responsibility is a necessary condition to ensure that the recommendations contained in the forthcoming sections of this report, on clinical needs and social reintegration, are implemented in the most effective and efficient way possible.

The potential for reducing repeat offender rates through proper management of people with mental health disorders is clear^{27,41-43,48,53,55-59,70,86,111-123}. Proper case management is an investment in public safety. However, if it is to be effective, clear responsibilities must be assigned from the outset to actors who have the means to take action. At the present time, the Ministère de la Santé et des Services sociaux and its networks have all the levers required to provide preventive, curative and social integration services following release from a detention facility.

The potential for reducing repeat offender rates through proper management of people with mental health disorders is clear.

At the same time, the Ministère de la Sécurité publique’s responsibility for custodial aspects should also be confirmed, not only in terms of physical custodial premises, but also by ensuring effective collaboration between its personnel and the health and social service teams. This could be done, for example, through a multidisciplinary team structure that would be responsible for drawing up and implementing integrative correctional intervention plans and individualized service plans.

4.4.2 The need for effective collaboration

If responsibility is eventually transferred, experience in other countries has shown that the task of coordinating the health and correctional communities demands time and some considerable adjustments^{103,111,124-133}. Effective joint action will therefore be even more important than before. Our analysis has identified the following conditions for success:

- Clear leadership by the health and social services agency.
- A good knowledge of the partner networks’ strengths, constraints and limitations.
- A stable team to be responsible for coordination.
- A decision-making structure that includes decision-makers who have the power to allocate resources.
- A willingness on the part of managers to support initiatives emerging from the joint efforts of field workers in the various networks.
- Decision-makers who are able to identify the benefits obtained from the investments made.
- A gradual approach that involves improving services through greater involvement by the partner networks as the benefits of the approach become visible.

- Use of the reintegration support fund^{XL}, in particular for the development of services by community resources with which contacts have already been established.

4.4.3 Consideration of the prison population's needs by the health and social services network

The health and social services network has taken a population-based approach, meaning that the service structure must reflect the needs of everyone who lives in the territory served by the authority in question¹⁰¹. The approach also covers institutional and community pharmaceutical services. Regional pharmaceutical service committees have been set up, among other things to make recommendations concerning service organization and to give its opinion on service access and innovative approaches^{XLI}.

However, the socio-sanitary services available in detention facilities are funded to a large extent by the Ministère de la Sécurité publique (MSP), and it is the MSP, not the Health and Social Services Agency in the region in which the detention centre is located,^{XLII} that is responsible for deciding on service levels, even though the agency does this for the rest of the population.

The clinical organization of mental health services in Québec was structured without really considering the specific features of the prison network.

Clearly, then, the clinical organization of mental health services in Québec was structured without really considering the specific features of the prison network. Interestingly, the 2005-2010 Mental Health Action Plan⁷⁶ of the Ministère de la Santé et des Services sociaux barely touches on the services to be offered in detention centres.

Only two sections of the Plan address the list of institutions with forensic psychiatry missions and the need for collaboration with the judicial system, in particular for social integration services. As far as forensic psychiatry is concerned, the Action Plan simply notes that the Ministère de la Santé et des Services sociaux *has taken steps to guide the hierarchization of forensic psychiatry services and will submit a proposal for a provincial structure at a later date*. This was in 2005. The Plan terminated in 2010, and the proposal still had not been made. As far as inter-sector collaboration is concerned, the Plan simply noted that it was necessary. Recently, however, the interministerial committee on forensic

^{XL} The Act respecting the Québec correctional system¹⁰⁸ stipulates that the function of the Fund is to establish, each year, a program of activities for offenders (work, training, leisure), and to see to its implementation. The money comes from detainees who work in exchange for a salary that is adjusted to reflect their contribution to the fund. The fund is therefore able to finance other social reintegration activities thanks to the paid work done by detainees.

^{XLI} Another goal is to foster continuity of care and the implementation of new provisions of the Pharmacy Act¹³⁴ aimed at ensuring better use of the professional skills of pharmacists.

^{XLII} As early as 1989, the memorandum recognized the role of regional authorities in organizing services and controlling service quality, especially in the mental health field. However, the agencies' leadership varies from one region to another. Some have developed joint action and collaborative mechanisms with Correctional Services, including formal agreements for service provision in some cases¹⁰⁷.

psychiatric services produced a report containing recommendations on service hierarchies, although it did not consider the issue of providing adequate and sufficient mental health services in detention facilities or upon release⁹¹. Nevertheless, the report does define the role that should be played by the hospitals, including the Institut Philippe-Pinel^{XLIII}.

The fact remains that there is still no complete hierarchy for forensic psychiatric services, unlike other components of the Mental Health Plan, where specific objectives have been established for front-line services (private physicians' or psychologists' clinics, community organizations and health and social services centres or CSSS), second-line services (CSSS psychiatric hospital departments) and third-line or ultra-specialized services (university hospitals or psychiatric institutions^{XLIV} and the Institut Philippe-Pinel) and the division of roles. As a result, tensions exist that may prevent some people from obtaining the level of expertise required to address their condition.

There is still no complete hierarchy for forensic psychiatric services.

The health and social services network is present to some extent in Québec's detention facilities. For example, 75% of the facilities use the network's personnel to fulfill their obligations. Several facilities have set up informal collaborative networks with health and social service network authorities or other regional partners, in order to publicize and meet the specific needs of their inmates.

The Québec Ombudsman's feels that the Ministère de la Santé et des Services sociaux should include the needs of detainees in its supply of services, in accordance with the population-based approach currently in force.

RECOMMENDATIONS CONCERNING THE ORGANIZATION OF SERVICES AND RESPONSIBILITY FOR SERVICE DELIVERY

Given the various deficiencies currently observed in the delivery of health services and social services in detention facilities;

Given the need to clarify the responsibilities of the various parties concerned, and to ensure more effective collaboration between the health and social services network and the public security network;

^{XLIII} Montreal's Institut Philippe-Pinel has a special status in the organization of mental health services in Québec, and plays a supraregional role. It addresses specific needs, such as: determining fitness to appear in court; criminal responsibility and other issues considered appropriate by the court; assessments of danger and short-term treatment for people with acute mental disorders and concurrent disorders who need to be hospitalized in secure units; treatment and social reintegration plans for people who are a danger to others due to certain psychiatric pathologies; and special programs for men who have murdered or attempted to murder family members.

^{XLIV} Hospitals: Robert Giffard, Douglas, Louis H. Lafontaine, Rivière-des-Prairies and Pierre Janet.

Given that the health and social services network has the principal resources and means required to deliver preventive, curative and social reintegration services in detention facilities;

The Québec Ombudsman recommends:

13. That, as of April 1, 2012, the Ministère de la Santé et des Services sociaux should take responsibility for delivering socio-sanitary services to people in detention facilities, in collaboration with the Ministère de la Sécurité publique;

14. That the transfer of responsibility should be accompanied by an implementation plan that clearly sets out the roles, responsibilities and resource levels that must be provided respectively by the health and social service network and the correctional service network;

15. That the Ministère de la Santé et des Services sociaux should clarify its supply of socio-sanitary services for detainees and include it in its orientations and action plans, along with its reporting mechanisms.

That the Ministère de la Santé et des Services sociaux and the Ministère de la Sécurité publique should inform the Québec Ombudsman of the follow-up action taken in respect of these recommendations, by March 31, 2012.

4.4.4 A coherent clinical vision

People with mental health disorders need medical, nursing, pharmaceutical, social, rehabilitation and social reintegration services that are dispensed by a host of different service providers, raising issues relating to access, continuity and quality.

The health and social services needs of people with mental health disorders are complex. For example, service duration and intensity requirements will differ from one individual to the next. These people need medical, nursing, pharmaceutical, social, rehabilitation and social reintegration services that are dispensed by a host of different service providers, raising issues relating to access, continuity and quality.

To ensure that the clinical and organizational aspects are fully integrated, the health and social service network has developed a number of tools that are used by the health and social services centres (CSSS) to prepare clinical projects¹³⁵. The purpose of a clinical project is to improve access, among other things by providing a balanced supply of general and specialist services adjusted to the needs of different client groups. Such projects help ensure continuity, among other things by providing uninterrupted services when a person moves from one organization to another. A

further purpose is to improve quality in a number of areas, including case worker expertise, intervention relevance, compliance with professional standards, and knowledge.

Clinical projects are implemented through six proven clinical models, each of which is relevant to the needs of a given population segment^{XLV}. In the case of the prison population, some detainees have occasional needs, while others have chronic conditions that must be stabilized (e.g. serious and persistent problems^{XLVI}). Among other things, the clinical models provide:

- an individualized response;
- better access, along with individual accountability with regard to their health;
- a service hierarchy based on the need for general and specialized services;
- integration of preventive clinical practices and biopsychosocial approaches;
- continuity and standardization, based on the best practices for chronic conditions;
- cooperation with various partner organizations in complex cases.

Implementation of these clinical models involves^{XLVII}:

- standardization of care and service trajectories;
- coordination, through the creation of referral mechanisms between different service levels, as well as communication mechanisms and mechanisms to share clinical information;
- case management (liaison officer or case manager) to coordinate the various plans (intervention plan, individualized service plan).

The Québec Ombudsman notes that there is no clinical vision to support adequate, efficient service delivery throughout the detention period. And yet, the following aspects are common to both clinical and correction goals:

The Québec Ombudsman notes that there is no clinical vision to support adequate, efficient service delivery throughout the detention period.

^{XLV} These models are: (1) focused on the person, with an individualized response to his or her need for occasional general or specialized services; (2) coordinated care and services, based on a team structure, to meet the need for occasional specialized services and general services involving more systematic monitoring of vulnerable clients; (3) community-based, establishing close ties with inter-sector partners and public health authorities to meet the need for occasional services under different programs; (4) disease-management, standardized on a continuum to meet the needs of clients with chronic unstable pathologies; (5) integrated care and services which, along with case management, cover the need for occasional specific and specialized services for clients with complex problems; and (6) collaborative, based on partnerships to meet needs relating to the management of multiple problems.

^{XLVI} For example, people with personality disorders need extensive rehabilitation and social integration services. In the CICC study, personality disorders were fairly common: 18% of all detainees had been diagnosed with them¹³⁶⁻¹³⁷.

^{XLVII} These requirements are consistent with the implementation guidelines for local integrated mental health service networks, issued in 2002^{73,138}.

- the need to stabilize or avoid deterioration of the person’s clinical condition in order to reduce the number of hospital transfers and incidents within detention facilities;
- the need to implement effective interventions to foster social integration and discourage repeat offences.

A clinical vision appropriate to the context of the detention facilities should therefore focus on the following eight goals^{2,4,18,62,84,93-95,98,103-104,106,118,122,130-131,133,135,137-144}:

- introduce systematic screening for mental health disorders;
- allow for effective sharing of relevant information, in compliance with the rules of confidentiality;
- ensure adequate and ongoing case management during detention;
- provide immediate access to appropriate medication and encourage compliance with pharmacological treatment;
- manage transfers more effectively;
- provide better support for personnel dealing with crisis situations;
- provide adapted training for correctional services officers;
- develop innovative methods to foster service access.

4.4.5 *Systematic screening for mental health disorders*

Proper screening requires an awareness of needs, which should be assessed as soon as a detainee arrives at the detention facility¹⁴⁴. Although the need to be aware of suicide risks is self-evident, the same cannot be said of other mental health disorders, which are often not identified. While the number of admissions, transfers and court appearances can clearly cause some significant practical difficulties, many detention facilities in Québec, Canada and abroad^{104,130,141,144} nevertheless manage to implement systematic screening^{XLVIII}.

What we are talking about here is screening, not diagnosis, and screening does not necessarily require input from health professionals.

What we are talking about here is screening, not diagnosis, and screening does not necessarily require input from health professionals (at the present time, correctional services officers often screen new detainees for suicide risks), does not contravene the rules regarding confidentiality of

^{XLVIII} For example, one facility wrote a short document entitled *Repérage de la clientèle psychiatisée en détention*, which is a simple self-assessment test. Subjects are asked to say if they have received psychiatric treatment in the past, who was their last psychiatrist, the last time they were admitted to a psychiatric hospital, and the location of their drugstore. They are also asked if they would like a mental health residential resource, and where they were living when they entered the facility. All this information becomes extremely important when it is time for them to be released back into society. For example, it is important to know if they were living in a different city, if they are no longer being treated by their psychiatrist, or if they are homeless, so that outside resources can be identified for their release.

medical information, and does not require extensive resources. Moreover, addiction screening – currently under consideration by the detention facilities^{XLIX}— could also be incorporated into a systematic screening strategy.

Some people may not want to be identified as having a mental health disorder, and this raises questions concerning the reliability of information they provide during the screening process. This problem can be addressed in part in two ways. First, systematic screening of medication would ensure that people who do not wish to reveal their problem still have an opportunity to obtain the medication they need. Second, awareness of the need to screen continuously for abnormal behaviour (e.g. withdrawal) would make it easier to provide help where necessary, and prevent crises from occurring. In addition, screening would show whether the person would benefit from treatment in the community, and whether he or she is willing to be put into contact with a community case worker. In the case of people who do not receive treatment, it would show whether or not there is a need to ensure proper treatment after release.

Could correctional services officers play a role in systematic screening for mental health disorders? Must screening always be done by medical care personnel? This question raises a number of issues relating to admission volumes, personnel availability and client profiles. Either way, it is important for systematic screening to be introduced and appropriate training (including awareness training on stigmatization issues) to be given to the people who will be responsible for administering it, regardless of whether they are health professionals or correctional services officers. When a case is identified, an interview with the medical care personnel should take place within 24 hours, to identify the person's needs, classify the problem and refer the person to the most appropriate resources for his or her needs^L.

When a case is identified, an interview with the medical care personnel should take place within 24 hours,

The benefits of screening immediately upon admission to a detention facility appear to have been underestimated. Proper screening allows for cases to be classified appropriately, the detainee's needs to be assessed more quickly and more accurately, and the relevant health services to be provided. As a result, the correctional services become more effective, in the best interests of the detainees. For example, in one facility, the introduction of an integrated model involving ongoing identification of cases, with referrals to a psychiatrist for medical follow-up if stabilization is required, has completely eliminated the need for hospitalization to deal with mental health disorders. Before the model was introduced, the facility spent a

^{XLIX} This type of screening is proposed in the inter-sector plan on substance abuse³⁶ and in the government social reintegration plan¹¹⁰. At the present time, case workers from the Centre de détention de Québec and at the Montreal Law Courts have received training on early detection and treatment, under the substance abuse plan.

^L Training should be provided by the government department whose personnel are responsible for performing the screening. It is also vital for post-screening services to be available when required, otherwise the process will be of no use.

lot of money on hospitalizing detainees in crisis, and had two officers posted 24 hours per day in the hospital.

4.4.6 More effective sharing of relevant information, in compliance with the rules of confidentiality

If mechanisms to foster continuity, such as access to appropriate expertise, are to be introduced, the question of sharing information effectively between the people concerned, without breaching the rules of confidentiality, must first be addressed. If cases are to be managed properly, the detention facility must have access (with the detainee's consent) to relevant information collected prior to admission, and it must also be able to forward this information to the case workers who will take over after release (e.g. adjustments to medication and nursing care plans).

Part of the solution may lie with the intervention plans and individualized service plans already in use in the health and social service network.

Deficiencies in this respect have been observed, despite the existence of well-known coordinated intervention mechanisms that respect confidentiality^{99,145} and are available to different client groups requiring multidisciplinary, inter-sector interventions. Part of the solution may lie with the intervention plans and individualized service plans already in use in the health and social service network¹⁰¹.

The goals of these two plans are strictly clinical, and if they are to be implemented in the context of a detention facility, they will need to be coordinated with the correctional plans. Specific guidelines are therefore needed to help case workers identify the aspects for which information may be exchanged, with due regard for medical confidentiality and the relationship of trust that must exist between the medical care personnel and the detainee in question.

It is therefore important for the Ministère de la Sécurité publique, with the cooperation of the Ministère de la Santé et des Services sociaux, to prepare a policy for all detention facilities on the subject of medical record access and confidentiality, which is consistent with the professional codes of ethics.

4.4.7 Proper, ongoing management of clinical conditions during incarceration

The Québec Ombudsman notes the difficulty, in detention facilities, of providing the basic services normally available to people with mental health disorders. However, this is a challenge the facilities must meet. The same applies to other basic front-line services, including nursing and pharmaceutical care, and rehabilitation and social services. Detainees with mental health disorders may need services such as these, for varying periods and at different levels of intensity.

There is no pre-established model to suggest that these services must be provided by detention facility personnel, or personnel from the health and social service centres, the community network or partners in other sectors (e.g. education). The specific features of each detention facility, including any collaborative initiatives already underway, must be taken into account.

The detention facility's detainee profile and any resources available in the region must also be considered when establishing the conditions for service access, continuity and quality assessment. In addition, clear goals must be set to prevent service interruptions or breakdowns in continuity.

It is extremely important that integrated correctional intervention plans and individualized service plans should be prepared and implemented for every case, to establish the level of service required during detention and after release.

For example, if a detainee was monitored by a case worker before being detained, it is not only appropriate, but also essential for service continuity and quality, that he or she should continue to be monitored by the same person during the detention period.

If the person was not treated in the community, a mechanism providing access^{LI} to case management services during the detention period and upon release should be introduced quickly, since waiting lists may be long. The impact of lack of clinical follow-up at release on repeat offender rates is well-known^{4,70,97,123,146-148}.

If a detainee was monitored by a case worker before being detained, it is not only appropriate, but also essential for service continuity and quality, that he or she should continue to be monitored by the same person during the detention period.

4.4.8 Immediate access to and compliance with appropriate medication

An effective screening process will identify the people who take medication, and they can then be asked to consent to the renewal of their prescriptions with the pharmacists they used prior to their imprisonment. Detainees should be able to provide this information when they are admitted to the detention facility. Our experience in dealing with complaints suggests that this information is in fact often available, because when complainants were approached by the Québec Ombudsman for details of their case, they were able to give clear indications regarding the medications they needed.

It is important to understand the central role played by medication during short detention periods^{120,147}. However, the problem of non-compliance or refusal to take prescribed

^{LI} Most of the regions already have mechanisms to facilitate access to mental health services for citizens who are not in prison, for example via a single CSSS wicket. The mechanism most useful to the region in question should be identified at regional level, based on region-specific mental health service access criteria. However, the MSSS should provide clear guidelines to the effect that detainees have the same right to service and the same priority level as the rest of the population, both during the detention period and after their release.

medication in a facility where drug trafficking is a concern can be extremely complex. The detention facilities do not necessarily have access to pharmaceutical care^{LII} from pharmacists working in health and social service network institutions or in the community, but the expertise of these pharmacists would be useful, not only in improving compliance rates by intervening as needed with individual detainees, but also in providing more general advice on issues relating to drug management in institutions or the application of withdrawal protocols. If services such as these are to be made available, regional pharmaceutical committees will be required to establish a supply of services adjusted to the detention facility's detainee profile.

4.4.9 More effective management of transfers

The Ministère de la Sécurité publique must do everything it can to reduce the negative impacts of transfers^{LIII}. Better planning is needed, and priority levels must be established. Some of the criteria to be considered when deciding whether or not to transfer a detainee include not only correctional aspects, but also the detainee's state of health, whether or not he or she takes chronic medication, and the need for an intervention plan or an individualized service plan. In addition, if the transfer is inevitable, the MSP must ensure that data forwarding mechanisms are available to share the information in the service plans. This aspect is extremely important; it is unacceptable that so many interruptions of medication should result from deficient transfer procedures^{LIV}. The goal is to ensure continuity of service in cases where transfers are inevitable.

It is unacceptable that so many interruptions of medication should result from deficient transfer procedures

4.4.10 More support for personnel in crisis situations

The methods used to admit and manage detainees have a real impact on the number of crisis situations. In some cases, however, crises simply cannot be avoided¹⁰⁴⁻¹⁰⁶. The Mental Health Action Plan⁷⁶ provides for access to a crisis centre that is open 24 hours a day, seven days a week, for the entire population served by the health and social services network.

^{LII} The definition of pharmaceutical care used by the Ordre des pharmaciens du Québec is: "(...) the set of acts and services that a pharmacist **must** provide to a patient, in order to improve his or her quality of life by achieving preventive, curative or palliative medication therapy goals (Source: <http://guide.opq.org>, free translation from the French). The pharmacist's role is therefore not simply to prepare and deliver medication. A general approach in respect of all the medications required by detainees is essential to ensure that access depends on health reasons, and not on the type of pathology or medication concerned. For example, feasibility studies are underway for methadone substitution pilot projects, to ensure that treatment continues uninterrupted in detention facilities. It is laudable that such efforts are being made for drug-dependent clients, but a sustainable solution is also required for all drug-related problems.

^{LIII} The detention facilities each have their own methods of managing detainees with mental health disorders, and transfers are sometimes inevitable. Transfers may also be necessary if medical services are not available in a given facility, or because of overcrowding.

^{LIV} This situation is documented in 25% of the grounds for complaint from detainees with mental health disorders.

Unfortunately, case workers in prisons do not have access to the services they need to manage crises effectively, because as mentioned earlier, the Plan does not cover the services that must be provided in detention facilities. Current liaison mechanisms between detention facilities and hospitals do not allow cases to be managed adequately. More formal agreements^{LV} are therefore required.

Case workers in prisons do not have access to the services they need to manage crises effectively.

In addition, given the shortage of medical care personnel able to provide 24-hour coverage, correctional services officers often do not have clinical support from crisis workers. Innovative forms of support therefore need to be considered to help overcome these problems. Officers need access to the expertise available in crisis centres, to help guide their actions and decisions^{LVI}.

4.4.11 Adapted training for correctional services officers

A number of training needs have been identified for correctional services officers^{2,84,93-95,144-145}. Although they have the expertise to assess correctional-related risks and impose disciplinary measures (e.g. segregation), they readily admit that they are less skilled at detecting and interpreting behaviours that need to be reported to the medical authorities. In detention facilities, the terms “confinement”, “preventive isolation”, “segregation” and “administrative measure” have specific meanings in the context of isolation. Beyond these terms, however, the procedural aspects are not always recognized and differentiated by officers. In other words, the same behaviour may be treated differently by different officers; it could, for example, give rise to a disciplinary penalty in the form of confinement, or administrative isolation to ensure the safety of the detainee and/or a third party.

4.4.12 Innovative ways of providing access to services

Some potential ways of solving the problem of access to medical care personnel have not been explored. For example, telepsychiatry has been shown to be effective, and patient satisfaction levels are high¹⁴⁸⁻¹⁵⁴. This is an avenue that should be explored in more detail, especially as many detention facilities already have video equipment.

^{LV} In the health and social services network, there is talk of setting up service corridors for agreements to facilitate transfers between institutions. By including in-facility services in the clinical project, it would be possible to access the mechanisms required to establish effective corridors that would solve problems arising from the lack of a hierarchy of forensic psychiatric services for detainees. This same mechanism was recommended by the interministerial committee on forensic psychiatric services for all aspects relating to the location of detainees held under orders of assessment⁹¹.

^{LVI} For example, a telephone help line would be better than allowing correctional services officers to decide whether or not to use physical control measures without any input from a crisis worker or health professional.

RECOMMENDATIONS TO ENSURE PROPER MANAGEMENT OF MENTAL HEALTH DISORDERS DURING DETENTION

Given that the health and social service needs of people with mental health disorders are complex and variable, especially in terms of intensity and duration;

Given the need for a coherent clinical vision to support a sufficient and effective supply of medical and social services during the detention period;

Given that tried-and-tested clinical models can be used to identify goals for the development of a clinical vision;

The Québec Ombudsman recommends:

16. That the Ministère de la Santé et des Services sociaux and its network, in collaboration with the Ministère de la Sécurité publique, should prepare and implement a clinical structure to provide an adequate supply of services to detainees with mental health disorders, including:

- a systematic procedure to screen for mental health disorders upon admission, along with training for the officers responsible for administering the procedure, in order to ensure its reliability and avoid stigmatization;
- a systematic procedure to screen for people requiring medication, along with rapid contact with a pharmacist to renew valid prescriptions;
- a systematic procedure to contact the case manager responsible for the service plan of a detainee who was previously treated in the community, with the detainee's consent;
- a systematic procedure to contact the Public Curator or legal representative in the case of a person under protective supervision, in compliance with the agreement between the Public Curator and the Ministère de la Sécurité publique;
- registration in a regional mechanism providing access to a case worker able to work with members of the multidisciplinary team to draw up an integrated correctional intervention plan and individualized service plan that will establish the level of service required during the detention period and upon release, in the case of detainees who consent thereto and are not already being

treated;

- **an introductory and continuous training program for correctional services staff, including the acquisition of multidisciplinary teamwork skills and the implementation of integrated plans.**

That the Ministère de la Santé et des Services sociaux, in collaboration with the Ministère de la Sécurité publique, should provide the Québec Ombudsman with a progress report, by March 31, 2012, on the implementation of mechanisms in each region to introduce an adapted clinical structure.

That the Ministère de la Sécurité publique, in collaboration with the Public Curator, should submit a progress report to the Québec Ombudsman on compliance with the signed agreement, by March 31, 2012.

4.5 Reintegration and re-entry into society

The benefits of effective social reintegration are well-known, both for the person and for society as a whole^{23,27,41-48,53-59,62,67-72,74,80,86,98,111-123,137,143,156-161}. The Québec Ombudsman has questioned the way in which detainees with mental health disorders are prepared for their release and what awaits them in the community.

In the following sections, the observed problems are described, and some potential solutions are presented with a view to reconciling individual interests (the person's well-being) with the collective interest (public safety).

The benefits of effective social reintegration are well-known, both for the person and for society as a whole.

4.5.1 The problems observed

Inadequate preparation at the end of the detention period

It is important to remember that the short average duration of detention, combined with the shortage of human resources to prepare detainees for release, makes any kind of individual approach extremely difficult. This is particularly true for accused detainees, due to the very short detention period. It is vital that the right information be made available to help them return to the community. Unfortunately, the computerized correctional service records of many accused detainees are incomplete, and in addition, this category of detainee has limited access to the activities available to other detainees^{LVII}.

The Ministère de la Sécurité publique must ensure that information relating to accused detainees is collected as rigorously as that relating to other detainees, and that it is used to facilitate access to appropriate social reintegration activities. Without this information, it is difficult to establish any kind of continuity with community-based resources.

4.5.2 People who are left to their own devices upon being released from a detention facility

There is no point in providing more specialist resources for detention facilities or improving case management and release preparation if detainees are left to their own devices when released back into the community^{18,20,22,26-27,61,70,86,113,117,119,146-148,162-163}.

The gains made, especially in terms of stabilizing the person's mental state, will evaporate quickly if the person is forced to start over upon being released and find a new source of treatment in the community.

During the detention period, health and social services case workers often close the files of people who were treated in the community prior to being taken into custody. Similarly, very few of the clinical personnel who provide socio-sanitary services in correctional facilities offer follow-up after the person is released. Obviously, the gains made, especially in terms of stabilizing the person's mental state, will evaporate quickly if the person is forced to start over upon being released and find a new source of treatment in the community. The stigmatization of having been in prison, in addition to the person's initial reluctance to ask for help, may make the task even more difficult.

^{LVII} According to the CICC study, data were missing from 32.2% of records (1.6% for convicted detainees and 30.6% for accused detainees).

4.6 Towards an integrated vision of social reintegration

Preventing initial and repeat offences is a vital element in public safety, and a public health priority for vulnerable people. Plans have been made, scientific data is available to help identify intervention methods, innovative initiatives have been introduced in Québec, and the success factors for inter-sector cooperation are known. However, there is still a need for an overall plan and an integrated supply of social reintegration services throughout Québec.

While the measures recommended in the various government plans are beneficial in and of themselves, little has been done to incorporate them into the everyday practice of case workers.

As for clinical management during detention, the main observation concerns the lack of an integrated vision of social reintegration. While the measures recommended in the various government plans are beneficial in and of themselves, little has been done to incorporate them into the everyday practice of case workers, with due respect for the individual characteristics of each client.

4.6.1 Better inter-ministerial coordination and monitoring measures

In the last five years, a number of government initiatives have been announced, including the Mental Health Action Plan⁷⁶, the interministerial action plan for homelessness³⁷, the interministerial action plan for addiction³⁶ and more recently, the government social reintegration action plan¹¹⁰. It was the Québec Ombudsman that recommended the preparation of the social reintegration action plan, and it has carefully examined the new plan's content. It is pleased to note that its recommendations were in fact taken into consideration. The next step is to ensure that sufficient resources are made available to support the proposed measures.

A variety of measures in the plans address different issues relating to the social reintegration of detainees with mental health disorders. In the Québec Ombudsman's view, five actions should be given priority to ensure that the proposed measures produce satisfactory results:

1. The government departments concerned by the measures set out in the various plans should complete the planning exercise by clearly establishing a basket of services.
2. The government departments concerned should establish targets that can be used to measure the impact of the results on repeat offender rates and health.
3. The government departments concerned should prepare guidelines identifying the best practices for implementation of the proposed measures.
4. The government departments concerned should introduce a requirement for monitoring during transitions between the sectors, until another case worker is available to take over the reins.
5. The government departments concerned should introduce incentives for the development of best practices and adjustment of those practices to the situation in

each individual region, among other things by implementing effective mechanisms to share information on successful initiatives.

4.6.2 Assertive treatment programs in the community

The best results in terms of social reintegration and lower repeat offender rates for former detainees with chronic mental health disorders appear to be obtained by ensuring continuity of medical, social and control services^{71,86,117-121,123}. Continuity must be associated with individualized service plans (including treatment) in a relatively stable environment, and in a context where the person's vital needs are met. Access to last-resort assistance for the underprivileged is vital in this respect.

The goal is for every person with a mental health disorder to have an integrated, coherent plan coordinated by a case worker familiar with the person's needs.

The goal is for every person with a mental health disorder to have an integrated, coherent plan coordinated by a case worker familiar with the person's needs, providing services that are sufficiently assertive, along with the resources required to achieve the plan's objectives.

In Québec, there are a number of assertive community treatment programs providing access to post-release treatment specialists for people with mental health disorders. A number of teams have been created in recent years. However, at the present time these programs are available only to detainees in federally-administered detention facilities.

The teams in question work with the Program of Assertive Community Treatment, also known by its acronym PACT. PACT offers an integrated supply of medical, social and rehabilitation services designed to overcome the problem of clinical isolation. It is intended for clients who are released from detention facilities, and is able, among other things, to detect danger signs, prepare plans that reflect the potential for violence or aggression, manage crises, and deal with exclusion and stigmatization. Where necessary, it allows for police involvement, and also provides a safety net for families dealing with severe emotional baggage⁴. These days, PACT programs are increasingly being replaced by other programs such as Forensic Assertive Community Treatment (FACT). FACT programs focus more on the detention facilities themselves, and FACT teams include at least one probation officer^{86,117,157}.

The basic elements that are required if these models are to succeed include an individualized plan and the presence of a case manager or liaison officer who is responsible for implementing the plan. The case manager must be able **to work with accommodation resources, welfare authorities and probation officers to ensure that services are integrated, coordinated and delivered in accordance with the intervention plan.**

For both the correctional portion of the plan and the health and social services follow-up, service intensity will vary from one case to the next. The elements that affect this aspect

include the person’s social skills, medication compliance, and alcohol or drug addiction. The ratios suggested in the literature^{72,73,157} are as follows:^{LVIII}

Intensity Level	Ratio of one case worker per	Mandatory for
Intensive follow-up	8 to 15 people	1 to 2 people per 1,000 inhabitants
Variable intensity follow-up	12 to 25 people	2.5 à 3 people per 1,000 inhabitants
Basic follow-up	25 to 45 people	5 to 6 people per 1,000 inhabitants

The benefits of an approach such as this are real. When people with mental health disorders are treated, there is a significant reduction in the relapse rate, both legally and in terms of hospitalization^{70,86,117}. Treatment also results in personal well-being for the people concerned.

Other models developed for detainees in detention facilities under provincial jurisdiction also deserve attention, since they, too, are based on the concept of service continuity^{86,116,121,164}. The model used in the Québec City region and the model recently introduced in the Laurentides region are both effective at meeting the priority needs of their users.

4.6.3 Helping the most vulnerable people to make sure their basic needs are met

Individual accountability is an excellent goal for service management in general. However, some people with mental health disorders will never be fit for work and may well find it hard, without help, to complete application forms for last-resort assistance or support from community organizations¹⁶⁵⁻¹⁶⁶. These people need help from correctional services officers or personnel from the Ministère de l’Emploi et de la Solidarité sociale to obtain last-resort benefits when they are released from the detention facility^{LIX}.

^{LVIII} If we apply these standards to the data presented in the CICC profile, for a prison population of 4,000 people where severe disorders are 10 times as common and other disorders are three times as common, a maximum of 16 case workers would be required to coordinate treatment. Similar ratios are also proposed in the Mental Health Action Plan⁷⁶: one case worker for 8 to 12 people — 70 places per 100,000 inhabitants — for assertive treatment; and one case worker for 12 to 25 people — 250 places per 100,000 inhabitants — for moderately assertive treatment.

^{LIX} When it visited the detention facilities, the Québec Ombudsman observed that some had entered into contact with respondents from the local employment centre network who came to the facility to help detainees with applications for last-resort benefits. In some cases the help did not come from the local

The Ministère de la Sécurité publique, in conjunction with the Ministère de l'Emploi et de la Solidarité sociale, should incorporate this practice into the basket of basic social reintegration services required by the Social Reintegration Action Plan^{110LX}. Some care is needed here, to avoid compartmentalized approaches with disparate measures that would prevent the development of a true individualized intervention plan or individualized service plan that is consistent with the detention facility's own intervention plan^{73,147,162,167-168}.

4.6.4 Assessing the costs and benefits of this approach

In the current difficult context for public finances, interventions must be shown to be effective.

In the current difficult context for public finances, interventions must be shown to be effective, since this makes it easier to obtain transitional resources to cover any desired changes. The pitfalls encountered during the deinstitutionalization of mental health patients are a good example of this. And yet, economic assessments of an intervention's costs and benefits are less common in the mental health sector than in other sectors, including physical health.

To identify the benefits obtained from the resources invested, reliable data is needed on client profiles and effective follow-up resources for each profile. Scientific information is also needed on repeat offences, hospitalization numbers and quality-of-life improvements from social reintegration.

To determine economic impacts, direct costs must also be assessed – in other words, the per-diem cost of incarceration for repeat offenders needs to be compared with the cost of community treatment programs.

In addition, there are a number of benefits that cannot be quantified, such as the well-being experienced by detainees who are able to take back control over their lives and their disease, and the fact that their families, who may worry about and be the primary targets of crisis-related aggression, are able to feel safe. These benefits also need to be discussed. Reporting should not be based on numbers alone; many qualitative methods have been shown to be effective in reporting on the impacts of programs and interventions.

employment centre located closest to the detention facility, and sometimes no such service was available, except for telephone interviews upon request.

^{LX} Some of the measures described in the government plan for social reintegration¹¹⁰ follow on from those in the Mental Health Action Plan⁷⁶ and the interministerial plans on substance abuse³⁶ and homelessness³⁷. Obviously, it is too soon to estimate the impacts of these plans, but attention is nevertheless needed to ensure that the various goals and measures in all the plans are not only coordinated, but are also extended to offenders.

RECOMMENDATIONS CONCERNING SOCIAL REINTEGRATION

Given the deficiencies observed in current social reintegration interventions;

Given the need to develop and implement an integrated vision of social reintegration interventions;

Given the Social Reintegration Action Plan, published recently;

The Québec Ombudsman recommends:

17. That the Ministère de la Santé et des Services sociaux, in cooperation with the Ministère de la Sécurité publique, should determine the resources required to provide every person likely to benefit from it with access to an appropriate level of treatment in the community;

18. That the Ministère de la Santé et des Services sociaux, in its supply of detention facility services, should ensure that a clinical case worker who works mainly in a detention facility cannot terminate the treatment of a person until another case worker working in the health and social services network has taken over responsibility for meeting the person's socio-sanitary needs, with the person's consent;

19. That the Ministère de la Sécurité publique, as the department responsible for establishing the basic level of support services, should include services designed to help detainees to apply for last-resort benefits in order to meet their needs upon being released, and should also introduce an effective procedure to liaise with community resources and the Ministère de l'Emploi et de la Solidarité sociale, in order to extend these services to the entire correctional network as part of an integrated social reintegration plan;

That the Ministère de la Sécurité publique and the Ministère de la Santé et des Services sociaux should provide the Québec Ombudsman with a progress report on the follow-up to these recommendations, by March 31, 2012.

RECOMMENDATIONS CONCERNING COSTS AND BENEFITS

Given the necessity in showing the efficiency of interventions financed through public funds;

Given the absence of an economic evaluation of costs and consequences of interventions conducted in Quebec in the field of mental health for people subject to judicial control;

Given that the implementation of recommendations from this report will modify the allocation of budgets in detention centres, hospitals and the community;

The Québec Ombudsman recommends:

20. That the Ministère de la Santé et des Services sociaux should instruct the Institut national d'excellence en santé et services sociaux to conduct an economic evaluation to estimate the impacts of the recommendations in the present report in collaboration with the Ministère de la Sécurité publique;

That the Ministère de la Santé et des Services sociaux should present the results of the economic evaluation to the Québec Ombudsman by January 31, 2012.

RECOMMENDATIONS TARGETING THE IMPLEMENTATION OF THE QUÉBEC OMBUDSMAN'S RECOMMENDATIONS

21. That the Ministère de la Sécurité publique, the Ministère de la Santé et des Services sociaux and the Ministère de la Justice should appoint a person responsible for the follow-up of recommendations to the Québec Ombudsman by June 30, 2011.

5 Conclusion

In the introduction to this report, we expressed an opinion to the effect that incarceration and the need for care should not be in opposition, so as to ensure that the person concerned is sustainably rehabilitated and is able to return successfully to society whenever possible. We do not consider this view to be far-fetched; on the contrary, we feel it is absolutely essential to simultaneously pursue socio-sanitary and social reintegration goals not only in the interests of the detainee, who will serve his or her sentence, but also in the interests of the detainee's family and society in general. To achieve this, the condition of detainees with mental health disorders must first be stabilized, to reduce the need for hospital transfers and ensure that fewer incidents occur in detention facilities. Effective interventions, designed to foster social reintegration, are also required, since they have been shown to have a positive impact by reducing repeat offences.

If these goals are to be achieved, a coherent clinical vision will be needed to support effective delivery of services during the detention period. Current service organization structures in the detention facilities are not conducive to this. On the contrary, mental health services in Québec have been structured with virtually no regard for the specific features of the prison network. If we truly want to improve the condition of detainees and reduce repeat offender rates, we need to consider all their socio-sanitary needs (medical, nursing, pharmaceutical, psycho-social, rehabilitation and social reintegration).

The health and social services network has all the levers it needs to deliver preventive, curative and social integration services to detainees when they are released from detention facilities. This same network should also be responsible for providing socio-sanitary services to detainees with mental health disorders. Responsibility therefore needs to be transferred from the Ministère de la Sécurité publique to the Ministère de la Santé et des Services sociaux, along with consequent action methods.

Responsibility therefore needs to be transferred from the Ministère de la Sécurité publique to the Ministère de la Santé et des Services sociaux, along with consequent action methods.

The Québec Ombudsman is aware of the difficult budgetary context. However, it would be wrong not to consider the highly positive impact of successful social reintegration in reducing repeat offences and their considerable financial, human and social costs, not to mention the risk they pose to public safety. Providing appropriate services for detainees with mental health disorders is one way of improving their well-being and helping to build a sustainable sense of safety for their families and for society as a whole.

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APPENDIX

LIST OF RECOMMENDATIONS

RECOMMENDATIONS AIMED AT SUPPORTING POLICE INTERVENTIONS INVOLVING PEOPLE WITH MENTAL HEALTH DISORDERS

Given that police officers must intervene regularly as front-line resources in situations involving people with mental health disorders;

Given the considerable contribution that can be made by various specialist organizations and crisis centres in the health and social service network to support the work done by police officers in situations involving psychosocial or psychiatric emergencies;

Given that the availability and use of these resources by police officers varies significantly from one region to the next;

The Québec Ombudsman recommends:

- 1. That the Ministère de la Sécurité publique should work with the Ministère de la Santé et Services sociaux to determine the need, in each region, to support police officers in the management of psychosocial or psychiatric emergencies;**
- 2. That the Ministère de la Santé et des Services sociaux should enter into management agreements with the health and social service agencies to set targets stipulating that the agencies must make available, in a given priority order, the services required to help police officers manage psychosocial and psychiatric emergencies.**

That the Ministère de la Sécurité publique and the Ministère de la Santé et des Services sociaux should present the Québec Ombudsman with an action plan and implementation schedule for the measures retained, by March 31, 2012.

RECOMMENDATIONS AIMED AT ENRICHING POLICE TRAINING

Given that needs have been identified at the level of initial training and continuous training for police officers, so that they are better able to deal with people who have mental health disorders;

Given that there is also a need for training in connection with other types of problems, clearly showing the benefits of an integrated training plan;

Given that the Ministère de la Santé et des Services sociaux and its network have the expertise required to help prepare appropriate content for training given by public safety sector partners in order to meet the need for training on various problems

relating to mental health, substance abuse and homelessness;

The Québec Ombudsman recommends:

3. That the Ministère de la Sécurité publique should agree with the École nationale de police and the Ministère de l'Éducation, du Loisir et du Sport on a minimum number of college-level training hours for all aspiring police officers on the subject of interventions involving people with mental health disorders, including the related legal aspects, such as the application of P-38.001, and that it should establish a memorandum of understanding to this effect with the colleges;

4. That the Ministère de la Sécurité publique, in conjunction with the École nationale de police and Québec's police forces, should identify the need for continuous training on the subject of interventions involving people with mental health disorders, including the related legal aspects, and that it should make this training available to working police officers;

5. That the Ministère de la Sécurité publique should work with the École nationale de police and the Ministère de la Santé et des Services sociaux to prepare a coherent, integrated training plan for police officers, covering their basic training and ongoing professional development, and aimed at enriching their expertise so that they are able to work effectively with people suffering from a variety of problems, such as substance abuse and homelessness.

That the Ministère de la Sécurité publique should provide the Québec Ombudsman with a progress report on this issue, along with a schedule for implementation of the chosen measures, by March 31, 2012.

RECOMMENDATIONS AIMED AT IMPROVING ACCESS TO APPROPRIATE SOCIAL SERVICES RESOURCES

Given that a social services referral is the most appropriate solution for many people in psychosocial emergencies;

Given that the current resources, including emergency shelters and adapted dwellings for people in crisis or suffering from concurrent disorders, are not sufficient;

The Québec Ombudsman recommends:

6. That the Ministère de la Sécurité publique and the Ministère de la Santé et des Services sociaux, in collaboration with the other government partners in the

homelessness plan, should ensure that target groups have fair and sufficient access to places in shelters or, where necessary, in drug addiction resources, so that police officers are able to direct people to the places best suited to their needs;

7. That the Ministère de la Santé et des Services sociaux should assess the number of places required in each region for these types of resources, in order to establish a realistic timeframe for their development.

That the Ministère de la Sécurité publique and the Ministère de la Santé et des Services sociaux should submit an action plan and an implementation schedule for the chosen measures to the Québec Ombudsman by March 31, 2012.

RECOMMENDATIONS CONCERNING INITIATIVES OFFERING ALTERNATIVES TO JUDICIAL INTERVENTION

Given that there is very little evidence on which to base a definition of the ideal mental health court;

Given the evidence concerning the effectiveness of programs involving treatment in the community;

Given that the Mental Health Action Plan provides for a supply of treatment in the community that satisfies the criteria for success;

The Québec Ombudsman recommends:

8. That the Ministère de la Justice should work with the Ministère de la Santé et des Services sociaux to prepare an inventory of the best community treatment programs and draw up a plan to implement such programs in regions that are less well-served;

9. That the Ministère de la Justice should submit a list of the programs available in each region to the courts, and should define the access conditions and target client groups for whom the programs would provide a valuable alternative to legal action, in compliance with the provisions to this effect in the Criminal Code;

That the Ministère de la Justice should provide the Québec Ombudsman, first, with a review of existing initiatives offering alternatives to judicial intervention and their availability to people with mental health disorders alone, or mental health disorders in conjunction with other problems, and second, with a list of treatment programs that satisfy the criteria for success.

That the Ministère de la Justice should report annually to the Québec Ombudsman, on March 31 for the next three years, on the use of such programs and on plans to develop them in regions where the service does not yet exist.

RECOMMENDATIONS CONCERNING THE AWARENESS OF PEOPLE INVOLVED IN THE LEGAL PROCESS

Given that the development of effective programs offering alternatives to judicial intervention must also include the provision of information on the resources available in the community, and training and awareness for legal system stakeholders on the best way to intervene with people who have mental health disorders, including the relevant legal aspects;

The Québec Ombudsman recommends:

10. That the Conseil de la magistrature should provide its members with proper training on initiatives offering alternatives to judicial intervention and the conditions for success of such initiatives;

11. That the Ministère de la Justice should provide the courts with a list of the programs available in each region, and identify both the target client groups for whom recourse to the programs would be a valid alternative to judicial intervention, and the conditions for access to such programs;

12. That the Ministère de la Justice should join forces with the authorities that prepare training for the various legal system stakeholders, in order to circulate information on initiatives offering alternatives to judicial intervention and promote contacts with organizations able to give training and raise awareness on the subject;

That the Ministère de la Justice should provide the Québec Ombudsman with a progress report on its work, including the steps proposed and taken, by March 31, 2012.

RECOMMENDATIONS CONCERNING THE ORGANIZATION OF SERVICES AND RESPONSIBILITY FOR SERVICE DELIVERY

Given the various deficiencies currently observed in the delivery of health services and social services in detention facilities;

Given the need to clarify the responsibilities of the various parties concerned, and to ensure more effective collaboration between the health and social services network and the public security network;

Given that the health and social services network has the principal resources and means required to deliver preventive, curative and social reintegration health services and social services in detention facilities;

The Québec Ombudsman recommends:

13. That, as of April 1, 2012, the Ministère de la Santé et des Services sociaux should take responsibility for delivering socio-sanitary services to people in detention facilities, in collaboration with the Ministère de la Sécurité publique;

14. That the transfer of responsibility should be accompanied by an implementation plan that clearly sets out the roles, responsibilities and resource levels that must be provided respectively by the health and social service network and the correctional service network;

15. That the Ministère de la Santé et des Services sociaux should clarify its supply of socio-sanitary services for detainees and include it in its orientations and action plans, along with its reporting mechanisms.

That the Ministère de la Santé et des Services sociaux and the Ministère de la Sécurité publique should inform the Québec Ombudsman of the follow-up action taken in respect of these recommendations, by March 31, 2012.

RECOMMENDATIONS TO ENSURE PROPER MANAGEMENT OF MENTAL HEALTH DISORDERS DURING DETENTION

Given that the health and social service needs of people with mental health disorders are complex and variable, especially in terms of intensity and duration;

Given the need for a coherent clinical vision to support a sufficient and effective supply of medical and social services during the detention period;

Given that tried-and-tested clinical models can be used to identify goals for the development of a clinical vision;

The Québec Ombudsman recommends:

16. That the Ministère de la Santé et des Services sociaux and its network, in collaboration with the Ministère de la Sécurité publique, should prepare and implement a clinical structure to provide an adequate supply of services to detainees with mental health disorders, including:

- a systematic procedure to screen for mental health disorders upon admission, along with training for the officers responsible for administering the procedure, in order to ensure its reliability and avoid stigmatization;
- a systematic procedure to screen for people requiring medication, along with rapid contact with a pharmacist to renew valid prescriptions;
- a systematic procedure to contact the case manager responsible for the service plan of a detainee who was previously treated in the community, with the detainee's consent;
- a systematic procedure to contact the Public Curator or legal representative in the case of a person under protective supervision, in compliance with the agreement between the Public Curator and the Ministère de la Sécurité publique;
- registration in a regional mechanism providing access to a case worker able to work with members of the multidisciplinary team to draw up an integrated correctional intervention plan and individualized service plan that will establish the level of service required during the detention period and upon release, in the case of detainees who consent there to and are not already being treated;
- an introductory and continuous training program for correctional services staff, including the acquisition of multidisciplinary teamwork skills and the implementation of integrated plans.

That the Ministère de la Santé et des Services sociaux, in collaboration with the Ministère de la Sécurité publique, should provide the Québec Ombudsman with a progress report, by March 31, 2012, on the implementation of mechanisms in each region to introduce an adapted clinical structure.

That the Ministère de la Sécurité publique, in collaboration with the Public Curator, should submit a progress report to the Québec Ombudsman on compliance with the signed agreement, by March 31, 2012.

RECOMMENDATIONS CONCERNING SOCIAL REINTEGRATION

Given the deficiencies observed in current social reintegration interventions;

Given the need to develop and implement an integrated vision of social reintegration interventions;

Given the Social Reintegration Plan, published recently;

The Québec Ombudsman recommends:

17. That the Ministère de la Santé et des Services sociaux, in cooperation with the Ministère de la Sécurité publique, should determine the resources required to provide every person likely to benefit from it with access to an appropriate level of treatment in the community;

18. That the Ministère de la Santé et des Services sociaux, in its supply of detention facility services, should ensure that a clinical case worker who works mainly in a detention facility cannot terminate the treatment of a person until another case worker working in the health and social services network has taken over responsibility for meeting the person's socio-sanitary needs, with the person's consent;

19. That the Ministère de la Sécurité publique, as the department responsible for establishing the basic level of support services, should include services designed to help detainees to apply for last-resort benefits in order to meet their needs upon being released, and should also introduce an effective procedure to liaise with community resources and the Ministère de l'Emploi et de la Solidarité sociale, in order to extend these services to the entire correctional network as part of an integrated social reintegration plan;

That the Ministère de la Sécurité publique and the Ministère de la Santé et des Services sociaux should provide the Québec Ombudsman with a progress report on the follow-up to these recommendations, by March 31, 2012.

RECOMMENDATIONS CONCERNING COSTS AND BENEFITS

Given the necessity in showing the efficiency of interventions financed through public funds;

Given the absence of an economic evaluation of costs and consequences of interventions conducted in Quebec in the field of mental health for people subject to judicial control;

Given that the implementation of recommendations from this report will modify the allocation of budgets in detention centres, hospitals and the community;

The Québec Ombudsman recommends:

20. That the Ministère de la Santé et des Services sociaux should instruct the Institut national d'excellence en santé et services sociaux to conduct an economic evaluation to estimate the impacts of the recommendations in the present report in collaboration with the Ministère de la Sécurité publique;

That the Ministère de la Santé et des Services sociaux should present the results of the economic evaluation to the Québec Ombudsman by January 31, 2012.

RECOMMENDATIONS TARGETING THE IMPLEMENTATION OF THE QUÉBEC OMBUDSMAN'S RECOMMENDATIONS

21. That the Ministère de la Sécurité publique, the Ministère de la Santé et des Services sociaux and the Ministère de la Justice should appoint a person responsible for the follow-up of recommendations to the Québec Ombudsman by June 30, 2011.