An Evaluation of Fitness to Stand Trial Assessment Practices Across Canada

by

Brandon Burgess

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Abstract

Forensic assessments play a crucial role in the Canadian criminal legal system. One of the most common forensic assessments is fitness to stand trial evaluations, which determine whether an individual can competently engage with the legal system. While the United States is currently facing a "competency crisis" due to overwhelming demand for fitness assessments, the extent to which Canada is experiencing similar concerns is unknown. The present study used a mixed methods exploratory design to survey Canadian forensic mental health (FMH) service providers to a) capture a snapshot of the FMH services available in each province and b) determine and compare each province's current demand and capacity to meet demands for fitness evaluations. Forty FMH sites and 2031 designated inpatient forensic beds were identified across Canada, representing a 16% increase in sites and 31% increase beds since 2006. Thus far, data has been captured from 12 of these sites. The study also conducted semi-structured interviews of service providers involved in the operation of FMH sites across Canada to identify factors influencing our ability to meet fitness demands and highlight recommendations for policy and practice. Reflexive thematic analysis of study interviews (n = 11) identified four themes in participant responses including Challenges to Providing FMH Care, A Growing Burden on the FMH System, Stigma and Lack of Support, and Identified Needs and Attempts at Change. This study underscores the urgent need for enhanced communication, education, and standardized data collection across Canadian FMH services, alongside expanded forensic training and broadening the scope of practice for forensic psychologists. Addressing these issues is essential for averting further crisis in Canada and ensuring just and efficient FMH care.

Keywords: Forensic mental health services, Fitness to stand trial, National survey, Canada

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Contents

Glossary

Term	Definition
Forensic mental health system	Specialized mental health system focused on the treatment, assessment, and management of individuals involved with the legal system.
Fitness to stand trial evaluations	A court-ordered evaluation of an individual's mental state to determine their capacity to understand and participate in court proceedings. (Criminal Code of Canada, 1985, s. 672.11)
Mental illness/Mental disorder	Broadly construed under Canadian law as a "disease of the mind" (i.e., "any illness, disorder, or abnormal condition which impairs the human mind and its functioning, excluding…self-induced states caused by alcohol or drugs, as well as transitory mental states such as hysteria or concussion." (Government of Canada, 2017)
Serious mental illness	Inconsistently defined, depending on the source, however, typically refers to mental illnesses which are particularly severe in terms of the symptomology, chronicity, or the impact that it may have on an individual's life (Pedneault et al., 2023)
Mentally disordered accused	Individuals who have been accused of engaging in unlawful behaviour and have been determined to be either unfit to stand trial or not criminally responsible on account of a mental disorder (Criminal Code of Canada, s. 16)
Mentally disordered offender	Legal term referring to people who have been charged or convicted of crimes and are also suffering from a mental health disorder (Bonta et al., 2013)

Chapter I: Introduction

There is no national understanding of the scope or landscape of the Canadian forensic mental health (FMH) system. As a result, there may be previously unidentified gaps in Canada's provision of FMH care and unintended consequences for those in conflict with the system. It is important to understand gaps in FMH service provision because those who receive FMH services are among the most vulnerable and stigmatized populations who come into conflict with the legal system (i.e., severely mentally ill) and are often disproportionately members of cultural or ethnic minority groups (Chaimowitz et al., 2022). Unidentified gaps in knowledge can lead to substantial waste of both time and resources for the Canadian mental health and legal systems and lead to poorer outcomes for those in contact with the FMH system.

One such knowledge gap is an empirical understanding of Canada's current ability to meet the demand for fitness to stand trial (FST) evaluations. The United States is currently experiencing what some refer to as a "competency crisis" in which their FMH system can not keep up with the sheer demand for FST evaluations. Although research on FST evaluations in Canada is limited, increasing media attention has been directed to the impact of significant delays for FST assessments on the courts (e.g., Johnston, 2020; Lachaz & Anderson, 2023; Rutgers, 2021). The present study uses a mixed-method exploratory design to survey a sample of Canadian FMH clinics and providers. The first part of the study is to gain an understanding of the FMH care system in Canada on a national level by surveying representatives of all FMH clinics across Canada. Following this, the present study seeks to narrow in on FST assessments to understand Canada's current capacity to meet FST demands and compare service capacity across provinces. The goal of the second part of the study is to explore clinician-perceived

factors influencing their province's ability to meet demand for FST assessments and the impact that increasing forensic demand has on those ordered to undergo such evaluations.

The following chapter will describe the overall structure of the Canadian health system before reviewing the FMH system. The distinction of "mentally disordered" under Canadian law will be reviewed, highlighting the importance of FMH assessments in the criminal legal system. The chapter will then explore the role of FST evaluations in the legal system before touching on the impacts of the "competency crisis" and its potential implications for the Canadian context. Finally, the chapter will highlight the gap identified by the present study, and end with an in-depth review of study goals.

A Patchwork Mental Health System

The Canada Health Act (1985) is a federal legislation that establishes guidelines for the provision of physical and mental health care services in Canada. As per section 92 of the Constitution Act (1982), each Canadian province has the authority to dictate the implementation of its provincial health care system. The interaction between these two legislations is that provincial healthcare systems must adhere to the guidelines of the Health Act to receive funding from the federal government (Canada Health Act, 1985; The Constitution Acts, 1982). Due to provincial autonomy in health care delivery, the national physical and mental health care system in Canada has developed as a loosely connected patchwork quilt of policy, service provision, and service availability with little communication across provinces (Flood & Thomas, 2017; Marchildon, 2008).

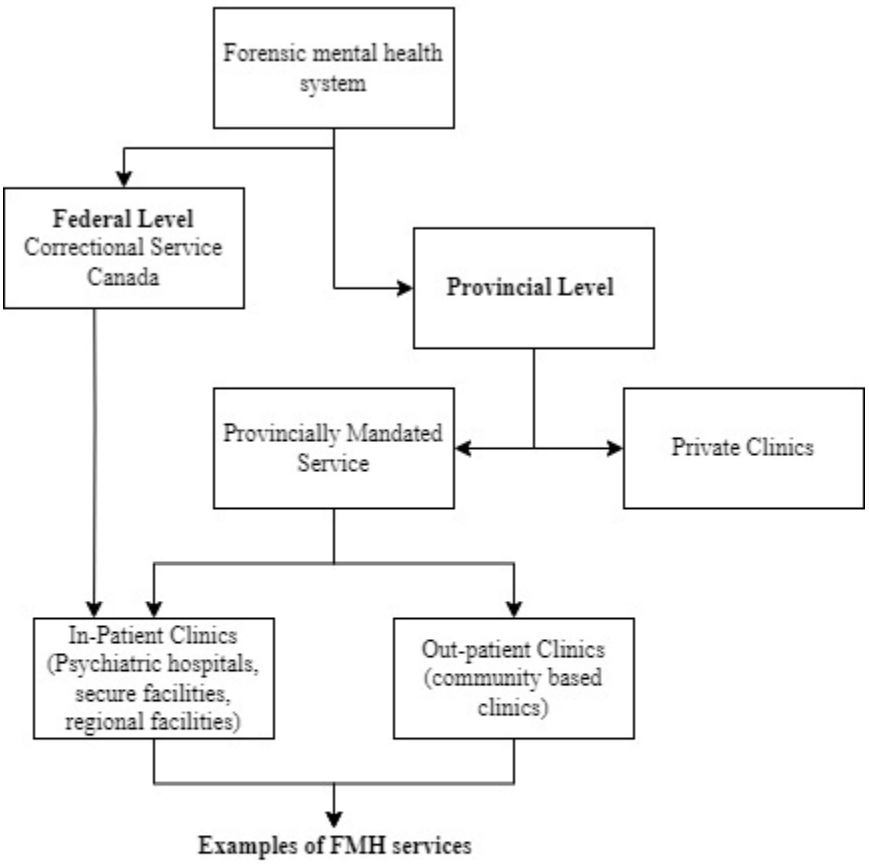
Noted consequences of this patchwork model of care are inequities and discontinuity in service delivery across provinces (The Conference Board of Canada, 2015), inefficiencies in healthcare spending (Sutherland & Hellsten, 2017), difficulties in sharing data and conducting

research on a national level (Expert Advisory Group, 2021; Plante et al., 2023), and a system which stalls potential innovation (Collier, 2018). Although there have been initiatives in the previous two decades to shift towards a national model of mental health care (Kates et al., 2011; Kirby, 2008), there remains a lack of communication *between* provinces, even while intra-provincial systems move towards a collaborative model of health care (Kates, 2017; Kates et al., 2023).

An essential subset of the Canadian mental health system is the FMH system or the intersecting services for individuals with mental health challenges involved in the criminal legal system. A brief overview of the FMH system can be found in Figure 1. It is important to note that this diagram has been streamlined for clarity. Broadly, the overarching structure consists of services mandated at both the federal and provincial level. Federally, the FMH system largely revolves around Correctional Service Canada's (CSC) obligation to address the mental health needs of incarcerated individuals while in custody (Correctional Service of Canada, 2019). Provincially, services are divided between government-mandated clinics, mental health hospitals, and private clinics that may contract their services to clinics or courts. The present study focuses primarily on provincially mandated clinics at the provincial level. However, there may be some overlap between these services and CSC. One example of potential overlap is the Regional Psychiatric Centre in Saskatchewan, a psychiatric hospital operated by CSC (Government of Canada, 2013). The exact structure and operationalization of the FMH system can vary significantly across provinces.

Figure 1.

Brief Overview of Canadian Forensic Mental Health System



Note. This diagram has been simplified for clarity.

The FMH system, like the broader mental health system, exists in a patchwork array of services with little communication between provincial bodies. The only national survey of the Canadian FMH system occurred nearly two decades ago and focused solely on in-patient programs (Livingston, 2006). The study identified 25 FMH programs across nine provinces.

Prince Edward Island and the three territories were not surveyed due to the absence of FMH clinics and their reliance on the systems of neighbouring provinces. The study identified 1523 designated forensic beds in Canada and found an average of 56 beds per 100 "mentally disordered accused" individuals nationwide. "Mentally disordered accused" is a term referring to individuals who have been accused of engaging in criminal behaviour and have been assessed and designated as being either unfit to stand trial or not criminally responsible due to mental illness (Criminal Code of Canada, s. 16). This ratio varied significantly across provinces with Quebec having 36 beds and Saskatchewan having 176 beds per 100 "mentally disordered accused."

The survey also found that provinces substantially differed in the number of available clinics, the centrality of services, and staff availability, which may have varying implications to the provision of mental health services in each context. For example, a higher centralization of FMH services could result in more strain on a single service to provide all types of forensic assessment and could present challenges for service delivery in geographically large provinces. On the other hand, reduced centralization of service delivery could allow for site specialization but could present issues for effective communication across sites. The lack of current understanding of the Canadian FMH system on a national level is important to address because it may lead to unrecognized inefficiencies, needs, or provincial inequities in service provision. More importantly, a system with inadequate bed availability could have substantial negative impacts on individuals who are required to access FMH services.

"Mentally Disordered" Accused

While the last captured estimates of individuals involved in the FMH system is severely outdated (Schneider et al., 2002), studies indicate a significantly higher prevalence of mental

illness in Canadian correctional populations than in the general population. The prevalence of mental illness as categorized by the DSM-IV, including substance use disorders, is estimated to be approximately three times higher than the general population (Brink et al., 2001; Office of the Correctional Investigator, 2015). Serious mental illness, such as psychosis, has been found to be two to four times higher in correctional populations than in the general population (Fazel & Danesh, 2002). A more recent review of men newly admitted to the Canadian correctional system in 2015 found that approximately 5% met criteria for psychotic disorders such as schizophrenia or delusional disorder (Beaudette & Stewart, 2016). Additionally, the overall rate of mental illness in the correctional system has increased by 61% from 1997 to 2010 (Sorenson, 2010), which may be reflective of an actual increase or could be the result of evolving policies regarding mental health assessment. The high and increasing prevalence of mental health needs in the correctional population highlights the importance of a well-functioning FMH system.

A robust and adequately supported FMH system is particularly crucial, considering the increased vulnerability of individuals in conflict with the legal system who also face mental health challenges. In the general population, those with mental health disabilities, defined as mental health disorders that limit daily activities, are four times as likely to be sexually or physically assaulted (Burczycka, 2014). A review of all residents in Manitoba aged 18 to 64 between 2007 and 2012 (n = 767,321) found that the prevalence of any mental health disorder, as assessed by the ICD-9 and 10, is higher in victims of crime (38.6%) than the general population (26.1%; Hensel et al., 2020) and as previously discussed, incarcerated individuals are significantly more likely than the general population to experience mental health challenges (Brink et al., 2001; Mental Health Commission of Canada, 2020; Office of the Correctional Investigator, 2015).

These issues appear particularly salient for correctional populations such as Indigenous Canadians, who, despite making up only 5% of the general Canadian population, make up approximately 27% of the correctional population and approximately 75% of the correctional population in provinces such as Saskatchewan (Public Safety Canada, 2023). Although the exact prevalence of mental disorders amongst incarcerated Indigenous peoples is not a publicly available figure, one report found that approximately 97% of incarcerated Indigenous women reported a history of trauma or the presence of a mental health disorder (Office of the Correctional Investigator, 2019). Indigenous Canadians are also 11 times as likely to experience suicidal ideations or suicide attempts (Mental Health Commission of Canada, 2020). A review of 1,240 individuals under the purview of the Ontario FMH system between 2014 and 2015 found that 23.5% of the sample identified as Black/African-Canadian, 16.1% identified as Asian, and 10.8% percent identified as Indigenous (Chaimowitz et al., 2022).

Understanding the experiences of Indigenous, Black, and racialized individuals in conflict with the criminal legal system necessitates an understanding of intersectionality, or how overlapping social identities such as race, class, and gender may contribute to increased disadvantage or vulnerability (Balfour, 2013; Brav, 2021; Crenshaw, 1989). Racialized individuals with mental health challenges in conflict with the justice system face compounding challenges due to the effect of racial bias, mental health-related stigma, and systemic structures such as the “school-to-prison” pipeline (Najdowski & Stevenson, 2022; Wortley & Owusu-Bempah, 2011). The school-to-prison pipeline refers to how certain school policies can inadvertently funnel racialized students, particularly black and Indigenous students, from educational environments directly into the criminal legal system (Government of Canada, 2022).

It is also noteworthy that traditional Western assessment practices and therapeutic approaches might not align with Indigenous cultural perspectives (Day et al., 2022).

Individuals who experience mental health challenges have also been shown to experience additional challenges upon transitioning into the community, such as disruption or discontinuity of mental health services (Leclair et al., 2022), housing and employment stability, or access to primary care (Mental Health Commission of Canada, 2020). Understanding unrecognized failings in the policy and framework of our FMH system can lead to drastically different outcomes for a deeply vulnerable population of Canadians.

Individuals experiencing serious mental health challenges who are accused of a crime (defined under Canadian law as "mentally disordered offenders") are a particularly important subset within the Canadian legal system (Canadian Criminal Code, 1992). If there is reason to question the mental state of an accused individual, either at trial or at the time of the offence, the Court may order a mental health evaluation or assessment to occur (Canadian Criminal Code, 1992, s. 672). Under Canadian law, there are two important distinctions of "mentally disordered" accused. These distinctions are those who are found to be unfit to stand trial, and those found not criminally responsible due to mental disorder (NCRMD; Canadian Criminal Code, 1991, s. 16). As significant research has been devoted to those who have been questioned or found NCRMD, the present study chooses to focus on accused whose fitness to stand trial has been questioned (e.g., Chaimowitz et al., 2022).

Section 672.22 of the Canadian criminal code establishes that accused individuals are presumed fit for trial, placing the burden of proof on the accused or their representation to provide evidence to the contrary (Canadian Criminal Code, 1985). Common examples for being found to be unfit for trial or NCRMD include schizophrenia, acute psychosis, delusional

disorder, cognitive disorders, or intellectual disabilities (Chaimowitz et al., 2022; King et al., 2021). These conditions may prevent an individual from understanding their rights in the court process, the potential consequences of trial, or from effectively communicating with their lawyer or taking part in their defence (Criminal Code of Canada, 1985). When a question of fitness is raised, a judge may order an assessment of fitness to be conducted. Forensic assessments can also determine an individual's risk for violence or reoffending, highlight specific treatment needs, and inform sentencing or community supervision conditions. One of the most common types of forensic assessment completed in North America is the fitness to stand trial (FST) evaluation, in which an FMH professional completes a clinical assessment of an accused to assess whether the individual has the capacity to understand and meaningfully engage with the court process (Canadian Criminal Code, 1985; Melton et al., 2018). While the court has the authority to order an individual to undergo an FST assessment, the previously identified patchwork nature of the Canadian FMH system may interrupt an individual's ability to access the assessment in a timely manner (Kourgiantakis et al., 2023; Livingston, 2006) and may result in difficulties transitioning out of the FMH system. The current demand for FST assessments in Canada is unknown; however, a review of the FMH population of Ontario from 2014 to 2015 (n = 1240) found that 91% (n = 1128) were NCRMD. Of this number, 13.2% (n = 164) had been previously found unfit to stand trial. In addition, 8.4% (n = 104) of the sample had only been found unfit without any other designation, and 5.2% (n = 64) were found to be permanently unfit (Chaimowitz et al., 2022).

Fitness to Stand Trial Assessments

Fitness assessments are the most commonly ordered FMH service requested in North America (Pirelli et al., 2011). Although research on fitness evaluations in Canada is limited,

there is significantly more research devoted to the concept of "competency", an American term roughly equivalent to fitness,. At the time of writing, the United States is currently experiencing a "competency crisis", as its FMH system struggles to meet the demand for court ordered competency assessments, with an estimated 25-50,000 annual referrals on a national level (Callahan & Pinals, 2020; Gowensmith, 2019; Morris & McNiel, 2021). Despite the number of annual fitness referrals made in Canada is currently unknown, there has been growing attention on FST evaluations due to the impact of prolonged wait times for forensic psychology services on the Canadian legal system. This issue has been exacerbated by backlogs aggravated by the COVID-19 pandemic (Johnston, 2020; Lachaz & Anderson, 2023; Rutgers, 2021).

Although the concepts of competency and fitness originate from English common law, varying case law and legal statutes have led to discrepancies in the standards for determining unfitness between the United States and Canada. In the United States, competency is subject to the standards set forth by *Dusky v. United States* (1960), which requires that an accused have "a rational as well as factual understanding of the proceedings against him". Some states further specify that the accused must be able to appreciate the potential personal impact of the proceedings (Corrado et al., 2013). Conversely, in Canada, fitness is assessed by a more limited standard focusing on a "limited cognitive capacity" impacting the accused's ability to relay the factual information about the case and court process (*R. v. Taylor*, 1992). This more stringent standard has been criticized for neglecting the impacts that mental illness can have on an individuals behaviours and motivation (O'Shaughnessy, 2007).

The differing standards between the two countries could have significant impacts for the rates of fitness referrals being made in each jurisdiction. While no formal evaluation has yet to be conducted to examine this impact directly, it is plausible that the stringent criteria established

in *R. v. Taylor* (1992) might reduce the number of individuals found unfit to stand trial in Canada. In contrast, the more permissive definition set out by *Dusky* (1960) could result in higher rates of individuals being found unfit, potentially contributing to their overall volume of referrals.

Another major difference in the fitness evaluation process in Canada and the United States is that in Canada, only psychiatrists are permitted to complete FST assessments, and forensic psychologists are not. This distinction is due to section 672.1 of the Canadian Criminal Code (1985), which specifies that assessments should be conducted "by a medical practitioner or any other person who has been designated by the Attorney General." This provision has received significant criticism from Canadian mental health professionals, who argue that forensic psychologists are equally qualified to conduct FST assessments (Hill & Demetrioff, 2019; Kayfitz et al., 2017; Viljoen et al., 2003). As a result, Canada is severely limited in terms of mental health professionals permitted to conduct FST assessments, suggesting that Canada may be unnecessarily hobbling its ability to meet the demand for FST assessments even if the overall demand is not as high as in the United States.

Notably, it is unknown whether Canada is experiencing or moving toward a crisis like that in the United States. However, some potential peripheral indicators have been identified. Although there is a lack of empirical research on FST evaluations in Canada, research that has been conducted has identified a few troubling patterns. The first is that although federal legislation states that FST evaluations should be completed within seven days of referral (Criminal Code of Canada, 1985), research suggests that this time frame is often not met. Two studies have been conducted on this issue in Canada, which occurred over two decades ago. Both studies involved a file review of FST assessments completed in British Colombia (Zapf &

Roesch, 1998) and Quebec (Crocker et al., 2002) and found that average assessment time ranged from 19 to 23 days, respectively.

Although these two previously described studies were conducted upwards of twenty years ago, it is likely that completion times have not improved since then; in fact, they likely have worsened. Notably, there is evidence that the demand for FST has increased over time, yet it remains uncertain if our capacity to address this demand has kept pace (Hill & Demetrioff, 2022). One study conducted a retrospective file review of FMH records and referrals from 2003 to 2019 in Manitoba and found that referrals for FST evaluations increased by an alarming 80% from 2014 to 2019 (Hill et al., 2021). Furthermore, the study highlighted provincial FMH services' challenges in meeting this escalating demand. Specific statistics on referrals for FST evaluations are unavailable for other provinces, and there is no current understanding of whether the Canadian FMH system can meet the demand for FST evaluation on a national level.

An unmet demand for FST evaluations in Canada could have significant and sweeping consequences, such as stalling court processes, prolonging an individual's contact with the legal system, and increasingly mounting costs associated with the evaluation (Hill & Demetrioff, 2022). For example, costs associated with a seven-day stay in one Canadian forensic assessment clinic in 2013 were estimated to be approximately $3,000, with costs increasing as delays potentially extend the process (Hill & Demetrioff, 2022). Yearly cost savings of implementing a streamlined FST evaluation process at one location in 1997 were estimated to be upwards of $430,000 (Chaimowitz & Ferencz, 1999). When expanding the consideration of the cost of delays to the legal system, the impact quickly becomes incalculable.

Crucially, assessment delays can have profound negative impacts on individuals who are court-ordered to undergo FST assessments. Individuals referred for an FST evaluation are

inherently a vulnerable population and are often required to remain incarcerated or hospitalized while undergoing or awaiting assessment (Kayfitz et al., 2017). Those permitted to remain in the community while awaiting assessment may not have access to needed mental health resources that the evaluation could allow them to access, potentially increasing their risk of further legal conflict or their risk of harm to themselves or others. These challenges may be further magnified for individuals residing in a rural or remote communities, as forensic mental health services are often heavily centralized in major provincial population centers (Livingston, 2006). This could result in significant barriers such as long-distance and costly travel requirements for individuals without the economic means to do so (Friesen, 2019; Moroz et al., 2020; Upfold & Chaimowitz, 2021). Strengthening the accessibility and timelines of FST evaluations is thus of paramount importance for equitable justice and the well-being of those required to undergo FST assessments.

Present study

The present study aimed to establish a comprehensive understanding of the Canadian FMH system. By bridging this knowledge gap, this research has significant implications for provincial legal systems, forensic assessment practices, and individuals who are court-ordered to attend such assessments by highlighting recommendations for policy and practice. This exploratory and descriptive study adopted a mixed-methods design to address several interconnected goals.

The primary goal of this research was to update the findings of Livingston (2006) by providing an updated understanding of the scope of FMH services available in all provinces and territories in Canada. In relation to Figure 1, this primary goal was concerned with all provincially mandated FMH mental health services, including FST assessments, risk assessment,

and counselling services. The present study built on Livingston's (2006) findings by expanding the focus to include community-based programs in addition to inpatient services. This expansion of scope was important because of the ongoing transition of the Canadian mental health system towards a community-based model of care (Dyck, 2011). Exclusively focusing on inpatient services would have failed to accurately capture the scope of FMH care in Canada.

The remaining goals of the present study focused specifically on clinics involved in FST evaluations. The second goal, further building off findings from Livingston (2006), aimed to elucidate the demand for FST evaluations on a national level in terms of referral numbers, waitlist length, and current occupancy rates. The third goal of the study was to assess Canada's capacity to meet the existing demand for FST evaluations. This assessment involved examining factors such as caseload and bed count capacity, staffing numbers, average waitlist times, as well as assessment and report completion times at both the provincial and national levels. Once demand and capacity for FST evaluations was established on a national and provincial level, a comparison of service capacity across provinces was conducted with the purpose of highlighting strengths and challenges to service delivery.

The final goal of the present study was to gain insights through brief qualitative interviews with clinic directors and other service providers. The aim of these interviews was to identify factors that contribute to a province or clinic's ability to meet demands for FST evaluations, factors which may improve service capacity, and to identify the various impacts increased wait times on the lives of individuals required to undergo FST assessments.

In summary, the present study aimed to provide a current and national understanding of FMH services in Canada. It sought to assess the demand for FST evaluations and evaluate the capacity to meet this demand across provinces. Through qualitative interviews with service

providers, the study aimed to gain invaluable insights into the practical aspects of FMH care. While understanding the extent to which we are meeting the demand for FST evaluations is crucial, it was equally vital to explore the human impact of increased wait times on the lives of those required to undergo these assessments.

Chapter II: Method

Participants

Study participants were site managers, directors, and service providers for all provincially operated inpatient or community-based FMH clinics and hospitals across Canada. To be sampled in the present study, an in-patient or community FMH site had to meet the following inclusion criteria: the clinic must 1) be located in a Canadian province or territory, 2) have a primary purpose of providing specialized assessment or treatment/rehabilitative services to individuals in conflict with the Canadian legal system, 3) Be mandated by the provincial government (i.e., not a private practice or federal correction institution), and 4) primarily deliver services to individuals over the age of 18. These inclusion criteria ensured that the study maintained focus on provincially operated Canadian FMH clinics that specifically cater to adults in conflict with the legal system. Private practice clinics, individual mental health providers, and those primarily serving youth were excluded as they fall outside the scope of the present study. Only sites which were involved in FST assessments were asked to take part in the qualitative interview. In total 42 potential sites were identified. Of these 42 sites, two were excluded due to being operated by correctional services Canada and were therefore not provincial services.

Identified team leads were invited to respond to the study survey and complete a Zoom interview on behalf of the FMH site they represent. However, team leads could choose to delegate the survey or interview to another site employee, such as someone responsible for managing the clinic database or a clinician more directly involved in client care. To ensure that survey respondents had a comprehensive understanding of the site they represented and the clients serviced therein, participants were required to be fluent in English or French and had to be employed/contracted by the clinic (i.e., excluding practicum students or individuals in training

positions). In addition to the previous criteria, if an employee other than the identified team lead was delegated to complete the Zoom interview, the employee must have been employed with the clinic for at least 6 months and be directly involved in the provision of mental health services to clinic clients or the operation of the clinic in general. These eligibility criteria ensured that survey respondents possessed the knowledge and experience to provide valuable insights into the clinic's practices, strengths, benefits, and client-related matters.

Overall, 12 participants completed the study survey, and 11 took part in the optional qualitative interview. Participants represented a range of professional roles, including members of leadership such as site directors/leads, care managers, or zone chiefs (n = 6) who were actively involved in the provision of mental health service, staff psychiatrists or psychologists (n = 2), and nursing staff (n = 2). Participant experience with forensic populations was just over 16 years on average (M = 196.60 months, SD = 96.47 months), ranging from just over three years (44 months) to 26 years (196.60 months), and participants had been employed at the site for approximately 15 years (M = 187.20, SD = 117.89). The majority of our survey respondents were male (n = 7). No participants were excluded from the present study.

Measures

Clinic Survey. The Clinic Survey (Appendix A) was developed in line with previous research surveying national samples of forensic mental health services in Canada and the United Kingdom (Judge et al., 2004; Livingston, 2006). Data collected via the Clinic survey was primarily quantitative and descriptive in nature. The final version of the survey was translated into French by a bilingual research assistant

The survey was emailed as a fillable word document to identified FMH sites to gather information related to site demographics (e.g., catchment/service area, sources of referral, total

possible caseload or bed count, etc.), services offered (e.g., types of services available, assessment tools/treatment modalities used, etc.), staff information (# of staff, staff roles, employment status, etc.), and client information (e.g., acceptance criteria, legal status of clients, etc.). The structure of the survey was such that all general information questions (i.e., those which apply to all FMH clinics) were presented first, and then all questions relevant to sites involved in FST assessments occurred in a separate section.

Service Provider Interview Guide. Semi-structured interviews with representatives of each site involved in FST evaluations were conducted over Zoom. They lasted 30 to 60 minutes and were scheduled based on the site representative's availability. An interview guide (Appendix B) consisting of closed- and open-ended questions was developed for the present study and translated into French. A bilingual research assistant conducted all interviews (n = 1) with Francophone participants.

The goal of the interviews was to highlight participant-identified factors related to their site's ability to meet its current demands for FST evaluations, clinic practices, and client experiences of extended wait times. The interviews consisted of asking participants questions contained in the interview guide and following up with exploratory follow-up questions as relevant. Examples of questions contained in the interview guide include introductory questions (e.g., "What is your role with the clinic?"), questions related to FST service delivery (e.g., "How well do you believe that your clinic is currently meeting demand for FST assessments?"), questions related to specific strengths or challenges to meeting demand at their site (e.g., "What are some factors that limit your clinics ability to meet demand for FST evaluations?"), and questions related to client experiences and accommodations (e.g., "What accommodations, if

any, are in place for clients made for clients who face difficulties reaching the clinic for an FST assessment due to living remotely or very far away?").

Province Characteristics. To facilitate inter-provincial comparisons a range of general and derived provincial characteristics were examined. General provincial characteristics include factors such as the number of adults over the age of 18 in each province (Statistics Canada, 2024), number of individuals over the age of 18 who have been charged with a criminal code violation in each province in 2022 (Statistics Canada, 2023), and the number of individuals under the purview of the provincial Review Board (Alberta Ombudsman, 2023; Government of British Columbia, 2023; Shared Health, 2023). Derived provincial FMH characteristics were obtained through survey responses. These included the total number of beds and placements available, the overall length of the provincial waitlist, and the centrality of FMH services throughout the province.

Procedures

Ethics approval from the University of Manitoba Research Ethics Board was obtained prior to participant-related study activities. Throughout the study process additional ethics reviews were completed with British Columbia Mental Health and Substance Use Services Research Committee and the Vitalité Health Network Research Ethics Board. A pilot version of the Site Survey and Interview Guide was sent to clinical psychologists and psychiatrists involved in the delivery of FMH services in Manitoba, Quebec, and Nova Scotia to ensure relevancy and appropriateness for the intended audience. The resulting feedback was incorporated into the study materials to ensure that they would adequately capture the range of contexts and potential inter-provincial differences in FMH care delivery.

The screening process to identify all inpatient and community-based FMH clinics across Canada occurred in two phases, beginning in July 2023. The first phase used purposive

sampling, with a systematic province-by-province search strategy to identify potential FMH sites. These potential clinics were identified via exploratory internet searches and by reviewing existing provincial mental health directories, where applicable. This first phase produced a list of 42 potential sites in each province, rough notes on what services the site offered, and some form of contact information (e.g., phone numbers, email addresses, etc.). Additionally, existing contacts of members of the research team were leveraged to identify potential contacts in each province.

The principal researcher contacted potential sites via telephone or email where possible and attempted to connect with a team lead at each location. Once successfully identified and contacted, team leads were informed of the purpose of the present study and were invited to participate. The second phase of the clinic screening process occurred during the initial contact and involved asking participants to identify additional FMH programs within their province and to provide contact information if possible, resulting in one additional potential site. The purpose of the second phase was to identify any clinics missed during the initial screening, as well as collect contact information if not provided by other sources.

Following the initial email or telephone contact, team leads who agreed to participate in the present study were emailed an electronic package of study materials. This package included an informed consent form and the Clinic Survey. The survey was be provided as a fillable Word Document to allow participants to complete it in multiple sittings if needed. If the identified site was involved in FST evaluations, then the site representative was also invited to participate in the study interview. Although every site involved in FST assessments was invited to take part in the interview, a goal of interviewing a representative from at least 50% of sites in each province was set to ensure that interviews were reflective of the experiences in each province.

All interviews were audio recorded, and transcripts were automatically generated through Zoom. The audio recording and auto-transcription were saved to the University of Manitoba Zoom cloud servers. Obtained transcripts were reviewed by either the study author or a research assistant to ensure the accuracy of the automatically generated transcript. Changes to the automatic transcript were made where discrepancies between the video and transcript were found, and identifiable information was scrubbed from the files. A bilingual research team member translated transcripts of interviews conducted in French or survey responses recorded in French. Prior to data analysis, participants will be offered an opportunity to review the collected transcript and review or make changes as necessary. Names of individuals who participate in the study interview will be entered into a draw for one of the three $50 CAD prepaid credit cards. All participants will be offered the opportunity for the principal researcher to provide an in-clinic research presentation of study findings.

The entire recruitment process was repeated for any additional sites identified during phase two of recruitment until all inpatient and community-based sites in the province/territory were contacted. All sites that indicate that they provide FST evaluations were included in the present study analyses. When a site did not respond to attempts at contact or failed to complete the survey, survey information was retrieved from external sources such as clinic websites or other provincial resources.

Qualitative Analysis

Of the 40 identified Canadian FMH sites, 28 were directly involved in FST-related practices and were subsequently invited to participate in the study interview. These interviews were conducted over Zoom between January and July 2024, primarily facilitated by the principal

researcher of this study and a bilingual research assistant who conducted all French-language interviews (*n* = 1).

At the time of writing, eleven interviews have been completed. The majority of interviewees (*n* = 11) were the same individuals who completed the survey on behalf of their home site, including site leads (*n* = 4), staff psychiatrists and psychologists (*n* = 2), care coordinators (*n* = 2), and nursing staff (*n* = 3). On average, interviews lasted 45 minutes, ranging from 30 to 60 minutes.

Qualitative data analysis in the present study was conducted using a reflexive thematic approach outlined by Braun and Clarke (2020). The primary goal of these analyses was to highlight common attitudes among service providers and identify potential solutions or strategies to address existing concerns regarding FMH across Canada. Given the study's descriptive and exploratory nature, the analysis took a predominantly inductive approach to better allow participant responses to guide thematic development. However, some deductive influence is inevitable through researcher interpretation of participant responses. This research was inspired by literature and media highlighting the over-taxed nature of the Canadian FMH system and informal conversations with service providers reflecting similar concerns. At the outset of study planning, it was anticipated that participant interview responses would reflect these real-world issues. As such, it cannot be said that the researchers entered this analysis blind to possible response patterns. Participant’s responses were primarily analyzed semantically and experientially, taking their meanings at face value, though some interpretation and latent analysis were employed to uncover underlying assumptions of their responses.

Braun and Clarke (2020) highlight six intertwined stages of reflexive thematic analysis, which guided the following analyses. The first stage, familiarization with the data, began early in

the analysis process. The principal researcher and research assistant reviewed the automatically generated interview transcripts while listening to recordings of the interview. Corrections were made to these automatically generated transcripts as discrepancies were found, and potentially identifying snippets of information such as specific names or location were anonymized. During this initial process, researchers took note of interesting quotes or data points throughout the interviews. Finalized transcripts were then sent back to interviewees to allow them to review the transcript and either remove, amend, or clarify statements made during the interview. After approval of the final transcript, the primary researcher began repeatedly reading the finalized transcripts, continuing to take notes as new thoughts or questions arose, placing them in a separate Word document.

The second phase, generating initial codes, began after these initial viewings of the data. This process involved analyzing previously taken notes and identifying patterns and connections to begin formalizing potential codes to represent ideas captured through participant responses. The principal researcher began sorting these codes to create initial themes to explain the underlying relationships or meaning between the initial identified codes. As the coding process continued to unfold, these initial codes and themes were revised, adapted, and removed as the researcher continued to become more familiar with the captured data. Any changes to these initial codes or themes were recorded, thereby maintaining a record of evolution across codes (Byrne, 2021; Saldana, 2013). The fifth analysis stage involved carefully defining each finalized theme and pulling carefully chosen excerpts from the data to reflect each identified theme. These themes will be sent participants prior to publication to allow them to reflect on whether the conclusions align with their knowledge and experience, an exercise known as member checking (Birt et al., 2016; Carlson, 2010).

Chapter III: Results

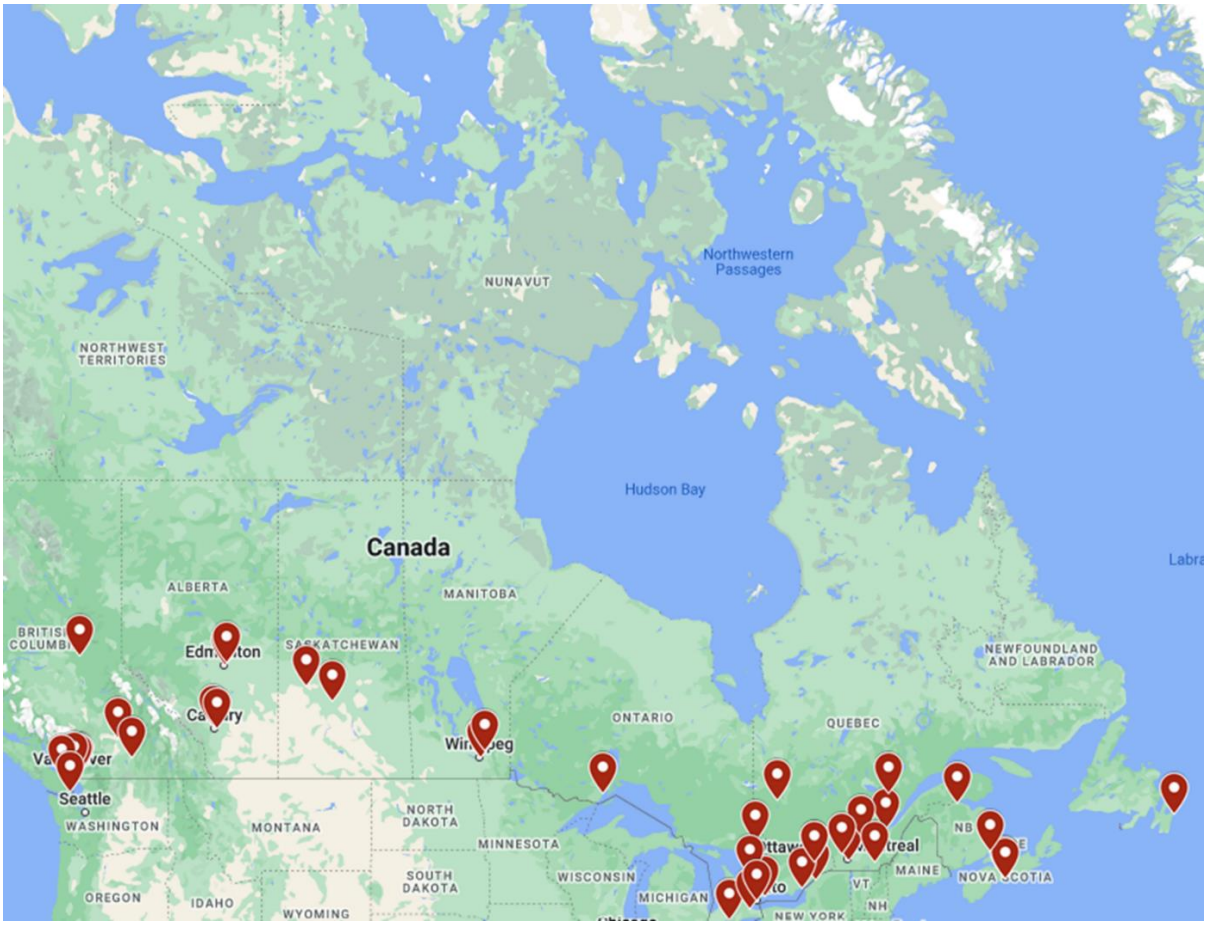
Quantitative Results

Canadian Forensic Mental Health Services

Data collection for the present study began in January 2024 and is currently ongoing. Overall, 40 provincially mandated FMH sites were identified across Canada, representing an 88% increase over the number of FMH sites identified by Livingston in 2006. Refer to Figure 2. for map of services across Canada and accompanying link.

Figure 2

Map of all Forensic Mental Health Services Across Canada



Note. See https://www.google.com/maps/d/u/0/edit?mid=1VpTjor4fd_azsOBM1T1j7tt-e6m6Gr4&usp=sharing for interactive map and further information.

Of the 40 identified FMH sites, ten (25%) were fully sampled for this study (i.e., the site completed both the study survey and interview, if applicable), 22 (55.0%) are currently in-progress (i.e., have been successfully contacted and have agreed to participate – we are either waiting on consent, the survey, or the interview), three (7.5%) declined to participate, and five (12.5%) have not yet been successfully contacted at the time of writing. As previously mentioned, partial information for forensic sites that have either declined or have not yet participated in the present study have been collected from publicly available sources such as hospital websites or other provincial resources.

Of the identified sites, 10 (25.0%) were located in Quebec, 10 (25.0%) in Ontario, eight (20.0%) in British Columbia, four (10.0%) in Alberta, three (7.5%) in Manitoba, two (5%) in Nova Scotia, and one (2.5%) located in each of Saskatchewan, New Brunswick, and Newfoundland. As highlighted by Livingston (2006) Prince Edward Island, Yukon, Northwest Territories, and Nunavut continue to not maintain their own dedicated FMH services and instead rely on the services of neighbouring provinces. For a summary of forensic sites and bed availability by province, see Table 1.

Table 1.

Bed count and site distribution of forensic mental health programs in Canada, ranked

Province	Total sites in 2024	Inpatient sites in 2006[a]	Inpatient sites in 2024	Total inpatient beds	Beds per 10,000 adult population[b] (ranked)	Beds per 10,000 charged adult population[c] (ranked)	Beds per 100 mentally disordered accused[d] (ranked)
BC	8	1	1	190	0.43(8)	40.19(4)	74.22(3)
AB	4	2	2	132	0.36(9)	14.28(9)	82.50(1)
SK	1	2	1	96	1.06(1)	22.68(8)	-
MB	3	2	2	64	0.58(5)	23.68(7)	52.03(5)
ON	10	10	10	979	0.79(4)	56.40(2)	59.48(4)
QC	10	5	10	398	0.57(6)	36.23(5)	19.88(6)
NB	1	1	1	60	0.89(3)	53.50(3)	-
NS	2	1	1	90	1.05(2)	71.54(1)	81.81(2)
NFLD	1	1	1	22	0.49 (7)	31.51(6)	-
Canada	40	25	29	2031	0.59	35.23	47.27

Note. Prince Edward Island, Nunavut, Northwest Territories and Yukon excluded for lack of dedicated forensic mental health programs. The Regional Treatment Centre in Saskatchewan and the Shepody Healing Centre in New Brunswick have been excluded from the present analyses due to being federally mandated by Correctional Service Canada

[a] Livingston (2006) solely identified inpatient programs.

[b] Provincial population over the age of 18 (Statistics Canada, 2024b)

[c] Total adults (18+) charged with Criminal Code violation in 2023 (Statistics Canada, 2023).

[d] Figures for individuals under the review board retrieved from following sources: British Columbia (*n* = 256; Government of British Columbia, 2023), Alberta (*n* = 160 [estimated]; Alberta Ombudsman, 2023), Ontario (*n* = 1646; Ontario Review Board, 2023), Quebec (*n* = 2002;) Manitoba (*n* = 123 [estimated]; Shared Health, 2023), Nova Scotia (*n* = 110; estimation provided during study interview). Review board numbers are currently unavailable for Saskatchewan, New Brunswick, Newfoundland.

Geographically, sites were primarily either located in the capital cities of their given province (*n* = 13, 32.5%) or in an additional large (population greater than 100,000; *n* = 14, 35.0%) to medium-sized (population 30,000 to 99,999; *n* = 7, 17.5%) city. On average, the largest distance a client might be required to travel to access FMH services was over 700km (*M* = 706.82, *SD* = 334.59), ranging from 250km in Ontario and 1169 km in Newfoundland and Labrador. Most sites offered a mix of both inpatient and outpatient services (*n* = 19, 47.5%), with smaller numbers offering solely outpatient (*n* = 11, 27.5%) or inpatient services (*n* = 9, 22.5%). Of the locations offering inpatient services, sites were most frequently specialized clinics within a larger mental health hospital (*n* = 16, 40.0%), general hospital (*n* = 4, 10.0%), or freestanding forensic mental health facility (*n* = 5, 12.5%).

Note that all remaining data is based on *n* = 12 unless stated otherwise. Sites tended to provide services to clients with a range of security designations, with the largest percentage of clients falling under either a medium security classification (*M* = 40.42%, *SD* = 41.47%), unclassified security designation (*M* = 27.89%, *SD* = 41.44%), or an open facility (*M* = 9.55%, *SD* = 30.04%), with fewer clients falling under either low (*M* = 9.55%, *SD* = 30.04%) or high (*M* = 4.73%, *SD* = 10.29%) security designations. The most frequently reported referral sources for forensic assessments were judges (*n* = 13, 92.9%), review boards (*n* = 8, 57.1%), federal or provincial correctional facilities (*n* = 5, 35.7%), or community mental health facilities (*n* = 4, 30.8%). Of clients accessing services at identified sites, the largest percentage on average were previously designated to be NCRMD (*M* = 42.33%, *SD* = 39.53%), were post-sentencing (i.e., had been convicted and sentenced for an offence; *M* = 17.17%, *SD* = 36.69%), were accused of a crime and pre-trial (*M* = 12.50%, *SD* = 24.13%), or were previously found unfit (*M* = 11.50%, *SD* = 12.77%).

Services Offered

The majority of identified FMH sites offered both in-person individual (*n* = 11, 100.0%) and group-based therapy (*n* = 10, 90.9%) and assessment services (*n* = 11, 100.0%), however substantially fewer sites offered remote or telehealth versions of the same services (individual therapy: *n* = 5, 45.5%; group therapy: *n* = 1, 9.1%; assessment: *n* = 6, 54.5%). The most common assessment services offered were FST assessments (*n* = 22, 95.7%), NCRMD assessments (*n* = 21, 91.3%), violence risk assessments (*n* = 11, 64.7%), and sexual violence risk assessments (*n* = 11, 64.7%). Of the sites that offered assessment services, the most commonly reported measures used were the Psychopathy Checklist-Revised (PCL-R; *n* = 10, 90.9%), the History Clinical, and Risk – 20 – Version 3 (HCR-20^{V3}; *n* = 10, 90.9%), the Wechsler Adult Intelligence Scale IV (WAIS-IV; *n* = 9, 81.8%), Personality Assessment Inventory (PAI; *n* = 9, 91.8%), and Violence Risk Appraisal Guide – Revised (VRAG-R; *n* = 7, 63.6%).

Inpatient Services and Fitness to Stand Trial

Of the 40 identified FMH sites, only 29 provided inpatient services representing a 16.0% increase over the 25 sites identified by Livingston (2006). These inpatient services represented a combined 2031 designated forensic beds, a 33.4% increase over the 1523 beds identified in 2006. Ontario (*n* = 979, 48.2%), Quebec (*n* = 389, 19.2%), and British Colombia (*n* = 190, 9.4%) accounted for over three quarters (76.8%) of forensic beds in the entire country, with the least beds situated in New Brunswick (*n* = 60, 2.6%) and Newfoundland and Labrador (*n* = 22, 1.1%). Sites had a total average bed count of 62 (*M* = 62.40, *SD* = 73.82) which ranged from 8 to 295. At the time of sampling all participants indicated that their site was currently working at capacity (i.e., all available beds filled). On a national level, Canada was found to have 47.27 forensic beds per 100 mentally disordered accused, decreasing from 56.14 in 2006. Provincially, this ratio

ranged from 19.88 beds in Quebec to 82.50 in Alberta. At the same time, Alberta, Ontario, Quebec, and Nova Scotia all experienced a decrease in beds per 100 mentally disordered accused while British Columbia and Manitoba experienced improvements in this domain. Although Alberta and Nova Scotia experienced relative declines in their bed ratios, they both remained within the top three rankings. It's important to note that not all provinces in Canada report review board statistics, and so estimations were made for Alberta (Alberta Ombudsman, 2023) and Manitoba (based on number of reports to review board and new admissions; Shared Health, 2023), and estimated figures for Nova Scotia were provided during the study interview. It is likely that these estimations under report the actual number of patients under provincial review boards. Data was unavailable for Saskatchewan, New Brunswick, and Newfoundland.

In terms of staffing capacity, clinics employed, on average, one full-time psychologist (*M* = 1.22, *SD* = 0.87, Max = 3), one part-time psychologist (*M* = 0.67, *SD* = 1.41, Max = 4), two full-time psychiatrists (*M* = 2.44, *SD* = 2.74, Max = 8), one part-time psychiatrist (*M* = 0.89, *SD* = 1.17, Max = 3), or contract psychiatrist (*M* = 1.67, *SD* = 3.94, Max = 12), 37 nursing staff (*M* = 37.67, *SD* = 42.72, Max = 170), and four social workers (*M* = 4.11, *SD* = 4.72, Max =15; See Table 2 for staffing ratios to beds and referrals for fitness assessments). On a national scale, this represents up to 19 psychologists, 43 psychiatrists, 41 social workers, and 358 nursing staff employed at FMH sites sampled across Canada; however, some individuals likely fill part-time positions at multiple clinics within larger provinces.

On a national level, Canada has a total of 12.39 direct client care staff per 10 designated forensic beds. Across professions this represents 0.22 psychologists, 0.92 psychiatrists, 0.90 social workers, 9.74 nurses, 0.62 program therapists. Ontario had the highest ratio for all staff types but psychologists and program therapists, and Saskatchewan ranked near or at the bottom

for all staff types. Overall Manitoba had the lowest ratio of total staff to designated forensic beds but had the highest ratio of psychologists to beds in the country, which may be reflective of the overall lower level of beds. Staffing data was unavailable for British Columbia, Quebec and New Brunswick.

Table 2.

Staff per ten beds ratio at Canadian inpatient forensic mental health sites, ranked

Province	Psychologists	Psychiatrists	Social work	Nursing staff	Program Therapists	Total Staff
BC	-	-	-	-	-	-
AB[a]	-	0.81(2)	-	-	-	-
SK	0.21(3)	0.42(6)	0.21(5)	5.52(4)	0.00(4/5)	6.35 (4)
MB	0.47(1)	0.78(3)	0.63(3)	3.13(5)	0.47(3)	5.49 (5)
ON[b]	0.20(4)	1.27(1)	1.63 (1)	15.99 (1)	1.14(2)	20.23(1)
QC	-	-	-	-	-	-
NB	-	-	-	-	-	-
NS	0.44(2)	0.56(4)	0.33(4)	8.89(2)	0.00(4/5)	10.22 (3)
NF	0.00(5)	0.46(5)	0.91(2)	7.27(3)	1.82 (2)	10.46(2)
Canada	0.22	0.92	0.90	9.74	0.62	12.39

Note. Staffing data currently unavailable for British Columbia, Quebec, and New Brunswick.

[a] Staffing data was obtained from one of two inpatient forensic mental health programs in Alberta representing 99 of 132 (75%) of beds in the province. The site declined to provide staffing information for any other position but psychiatrists

[b] Staffing data was obtained from three of ten inpatient forensic mental health programs in Ontario, representing 307 of 979 (31.34%) beds in the province

Highlighting the demand for fitness evaluations, participants reported receiving 123 (M = 123.88, SD = 116.37) referrals on average in 2023, ranging from 30 to 398. This represented approximately 983 referrals for fitness assessments being made to the 12 sampled Canadian forensic mental health sites in 2023, however this number is continually being updated. At the same time, only 97 clients (M = 97.75, SD = 125.69) on average were seen at these clinics in the

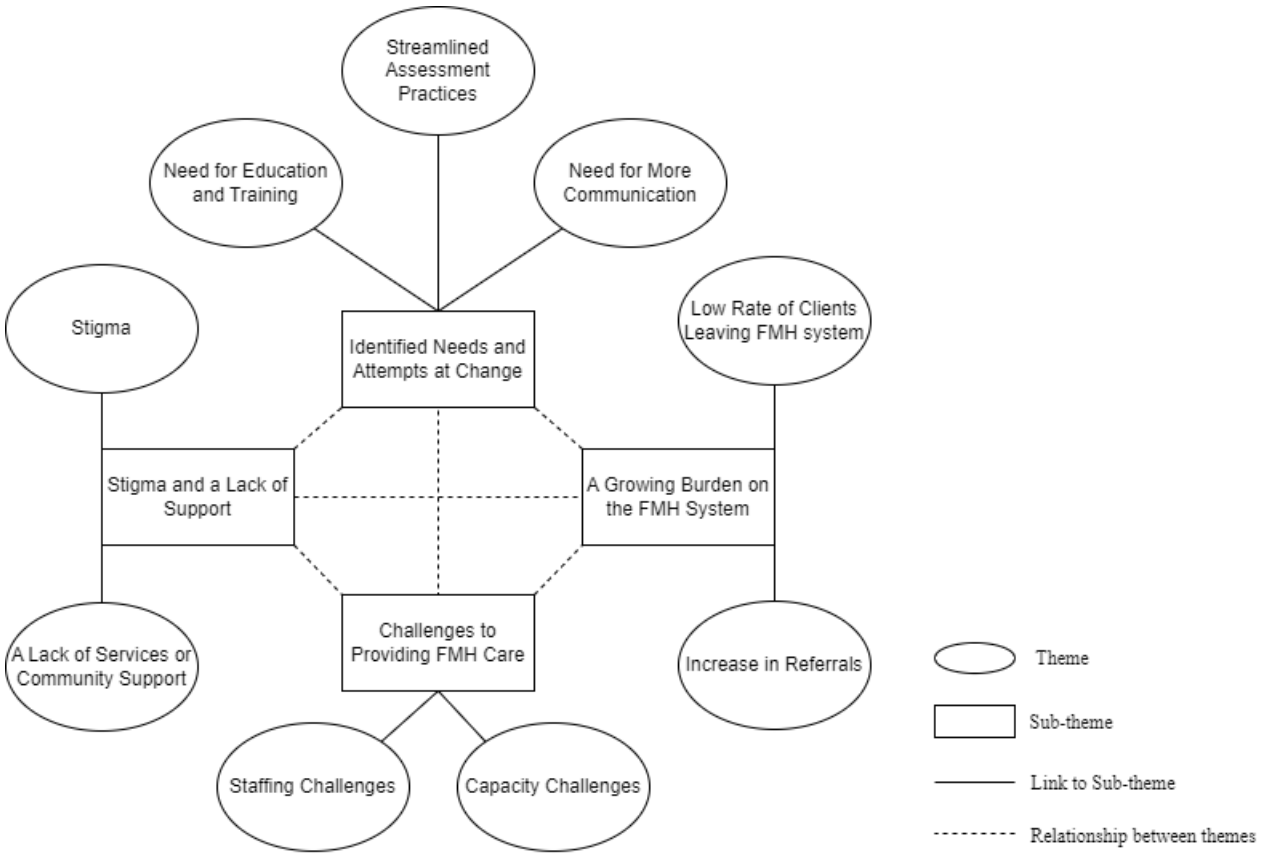
same year, with the most clients seen in Alberta (*n* = 392, 50.13%), Manitoba (*n* = 141, 18.03%), and Ontario (*n* = 84, 10.74%). Clients spent an average of 18 days (*M* = 18.00, *SD* = 9.89) on the waitlist before being seen at a clinic for FST assessment, highlighting the need for improved efficiency in the system; however, two sites indicated that they legally could not have a waitlist, citing that courts expected "immediate" fitness assessment and that clients would be seen regardless of current capacity. After being seen, clients spent an average of nine (*M* = 9.56, *SD* = 12.53, Range = 0-33 days) days in the clinic while waiting for assessment, and the average completion time for FST reports was 14 days (*M* = 14.25, *SD* = 9.60, Range = 0-30 days). Survey respondents in most provinces indicated that they felt the number of referrals for fitness assessment was average (*n* = 6, 66.7%) or above average (*n* = 2, 22.2%) compared to the rates of the past five years.

Qualitative Results

Eleven interviews were completed with representatives of Canadian FMH sites. Transcripts collected from these interviews were analyzed via reflexive thematic analysis (Braun & Clarke, 2020), resulting in the development of four central themes: Challenges to Providing FMH Care, A Growing Burden on the FMH System, Stigma and Lack of Support, and Identified Needs and Attempts at Change (see Figure 3). The finalized themes elucidate the systemic issues many provinces face in keeping up with the demand for forensic assessments while maintaining legislated timelines. As one participant succinctly stated, "It depends on what you look at, but we are constantly late at providing assessments. We always take longer than the legislative timeframe. They're getting done, but on the whole, they take a long time" (Participant 1).

Figure 3.

Thematic Map of Canadian Forensic Mental Health Service Provider Interview Responses



Challenges to FMH Care

Challenges to FMH Care is defined as any within-site factors that interviewees identified as limiting their ability to meet the demand for forensic evaluations. This theme captured two underlying subthemes: *Staffing Challenges* and *Capacity Challenges*. *Staffing Challenges* encompass several interrelated issues concerning the recruitment and retention of FMH staff. These challenges are particularly acute among psychiatrists, psychologists, and nursing staff, with one participant noting, “It's a human resource issue is what it comes down to. You need a psychiatrist who's able to do [assessments] every week, and we have been chronically under resourced for, psychiatry, psychology, and other disciplines” (Participant 1). The recent increase

in staff turnover further exacerbated these challenges. For example, another participant explained, “I can't blame everything on COVID, but certainly it's been worse since COVID. We've had a tremendous turnover in nursing staff in particular…although we've also gone through other professional staff like OTs and psychology positions” (Participant 4). This turnover has resulted in longstanding vacancies, with significant delays in filling critical positions. For example, one participant highlighted that they had been recruiting for 1.5 positions for psychiatry and a full-time psychologist position for “a year and a half, two years” (Participant 2) without success, and another described their situation as, “We are a facility that typically would have six psychiatrists. [Right now] we have two for the whole facility. We also have four psychologists plus a director of forensic services, all of which are vacant right now” (Participant 5). This pervasive staffing crisis not only undermines the efficacy of FMH services but also exposes a critical vulnerability in the system’s capacity to provide timely and effective care.

FMH is recognized as a challenging field, a sentiment echoed by participants who noted the dual pressure of its demanding client population, and the increasing demand for forensic evaluations. One participant elaborated on these inherent challenges stating, “It's a population where you know there is always the inherent risk that there can be violence on the unit…It's an environment some people are suited for and can acclimatize to and some can't” (Participant 4). This environment contributes to high attrition rates, as prospective hires may be deterred by the field’s reputation, and the intense demands of its related roles. Retaining existing staff poses its own challenges as the strain increases with limited staffing. As demands escalate, those remaining may consider departing for more appealing opportunities in private practice or in other practice areas, where the conditions and compensation may be more favourable.

Capacity Challenges encompass structural limitations within FMH care, particularly concerning the access to and competition for forensic beds. Participants vividly described bed shortages, with one noting, “If we were a 300 bed facility, we would have 300 people…wherever there's a mental health bed there's a mental health consumer that's going to be in need of it” (Participant 3). Another participant shared their personal distress over this issue, stating “Really, [bed] availability is such a huge issue…That's what keeps me up at night, honestly, it’s the bed pressures” (Participant 7). The competition for these limited resources is exacerbated as different client groups vie for the same beds as many facilities are unable to allocate beds for specific needs. This dilemma was succinctly captured by another participant, “So you do need more beds. But you need more beds for the right people in the right spot. For example, we need more medium-term beds for review board cases because they often take up all the acute short-term beds and block these other admissions when they need a bed” (Participant 1). Such competition not only strains the system but also complicates the management of both acute and long-term cases within the same facilities.

Capacity Challenges are further complicated by geographical factors, particularly in large, sprawling provinces such as Ontario, Quebec, or British Columbia. Across all provinces 67.5% (n = 28) of all FMH sites were located in either the capital city or an additional large population centre (+100,000 population). The centralization of services poses significant logistical hurdles, impacting client transportation and the continuity of care when they return to their home communities. One participant detailed these logistical challenges, explaining, “[Our province is] quite spread out…there's challenges in getting people down from the more remote regions. It takes up to sometimes one to two weeks to even get them…and then you gotta account for that time to get them back to their region. So you have a 30 day assessment - you

almost burn half of it just in transportation" (Participant 3). These issues are especially pronounced in highly rural provinces such as Manitoba, where 28% of Manitobans reside outside metropolitan or agglomeration areas, nearly doubling the national average (Statistics Canada, 2022). The isolation of a client's home community can severely restrict access to necessary care and monitoring, further exacerbating difficulties in providing effective FMH services.

While many provinces face escalating challenges in managing their capacity to meet current demand for FMH care, Alberta and Nova Scotia reported fewer concerns, albeit for slightly different reasons. A notable commonality is their higher ratio of beds to the FMH population, which significantly eases capacity strains (see Table 1). In Alberta, this advantage is compounded by a robust staffing model; one patient elaborated on their strategic resource allocation, "Some of our psychiatrists, a large portion of their role is dedicated to strictly doing just fitness. So I would say, allocation of resources. Yeah, most of our psychiatrists are part time, but we're able to meet the demands" (Participant 8). This participant also discussed the benefits of having available FMH services spread around the province (e.g., having a clinician physically located in a larger northern city), and the availability of telehealth options for more northern communities. Conversely, Nova Scotia benefits from its smaller population and limited geographical area which naturally mitigates pressures on the system. As a local service provider noted, "I mean, we're a relatively small province. So population wise the volume is, I suspect, consistent with sort of what you would see with a smaller province of just over a million people now" (*Participant number intentionally redacted*).

Growing Burden on the FMH System

The theme, *Growing Burden on the FMH System,* captures the external factors which worsen the overall demand on the Canadian FMH system. This theme consists of two primary

subthemes: *Increasing Referrals* and a *Low Rate of Clients Leaving the FMH System*. Reflecting the burgeoning demand, one participant noted an increase in the demand for forensic evaluations in recent years, particularly for fitness assessments which increased by "about 300% over the past five years" (Participant 6). This increase was attributed to a few factors but most prominently related to an increase in substance-induced referrals. Another participant elaborated on the complexities this brings to the judicial and health systems, stating:

> I think one of the biggest challenges for us over the last number of years is the increase in individuals with substance use disorders that come before the court. That creates a significant potential source of referrals, of course, but it also presents a number of potential problems…depending on what the substances that the person might have issues with…they may go to court, and…either as a result of being still under the influence of the substance, or withdrawing from the substance, they may present as quite mentally unwell to the court, and that that can generate a referral to us. (Participant 4)

Furthermore, when clients with concurrent substance use disorders are found unfit or not criminally responsible, they often pose additional challenges in terms of treatment and community reintegration, complicating their "long-term care and rehabilitation efforts" significantly as "substance use consumes a fair amount of time and energy required to manage that person" (Participant 4). Notably, this increase in referrals can be the result of both genuine increases in demand, and an increase in potentially inappropriate referrals.

The FMH system is structured to ensure that clients are not discharged without considerable thought, care, and planning designed to minimize risk to both the patient and their community. This prudence, however, intersects with the increased demand for forensic services, resulting in a scenario where the influx of clients surpasses those exiting the system. One

participant illustrated this challenge by stating, “it seems to be pretty hard to place folks who have an NCR designation - or our long term unfits - that you might transition to the community. They stick with us for quite some time and end up blocking beds” (Participant 5). FMH clients may remain under the purview of the review board for a number of years, and some will never be able to live independently in the community. A report from the Ontario Review Board demonstrated this dynamic, reporting 212 newly admitted clients while only 115 were granted an absolute discharge in the 2022/2023 fiscal year, a trend consistent over the past four decades (Ontario Review Board, 2023). This enduring backlog of clients, combined with the previously discussed staffing challenges, results in an increasingly “stretched thin” (Participant 7) workforce tasked with managing an ever-growing and complex client population. Furthermore, the difficulties in discharging clients are not solely due to an inability to be managed in the community, but often due to a stark lack of community services or adequate housing options available to them (Participant 5).

Stigma and a Lack of Support

The theme *Stigma and a Lack of Support* captures key barriers to community reintegration for FMH clients. This theme encompasses several critical issues, such as a *Lack of Services in the Community*, and the pervasive impacts of *Forensic and Mental Health Related Stigma* from the community and various stakeholders. A *Lack of Services in the Community* was highlighted as one of the primary barriers for successfully transitioning clients into the community. Research has shown that outpatient psychiatric follow up is associated with effective reduction of criminal recidivism (Krammer et al., 2020), while unstable access community based services and housing was associated with the opposite (Probst et al., 2020). In the current study,

this gap was noted not only in the complete absence of community services, but also in their limited capacity when they do exist. As one participant described:

> Community supports for people who come through the criminal justice system and through forensic services need to be bolstered. We have lots of repeat people coming through for assessment, and…the reality is there's nowhere for them to go that would meet their mental health needs…within a year, within two years you're going to see that person back in the service, and that's unfortunate. But if the support and the community aren't there to help them, what else can you do? (Participant 5).

This quote underscores the cyclical nature of the challenge – without adequate community support, FMH patients are likely to re-enter the system, emphasizing the importance for a sustainable support structure that extends beyond institutional care.

The *Lack of Services in the Community* is particularly acute for clients from remote areas where services are not simply insufficient, but virtually non-existent. For example, the same participant noted:

> We can't just fly somebody up north to do a site visit on a potential home…It's often you're sending them hundreds of kilometers away. [In] some of the communities there aren't mental health approved homes and group homes…Is that in the patient's best interest? And what supports will be there for them?...Especially for our Northern folks, our Indigenous folks who want to stay connected to their culture and community…*Maybe* there's a healthcare clinic there and somebody that could give them a med injection. (Participant 5)

This reflection not only highlights the geographical disparities in service provision but also points to the cultural and social isolation experienced by Indigenous patients who are often

forced to choose between adequate mental health support and remaining connected to their community and culture.

Another critical aspect of the *Stigma and Lack of Support* theme is the community *Stigma* that impacts FMH patients. Even when patients are ready and willing to engage in employment or independent living they often encounter significant barriers due to societal prejudices. As one participant described, “I think the forensic population gets stigmatized twice because they're dealing with mental illness *and* they have involvement with the criminal justice system, and sometimes they're difficult to place because of that…many [mental health group homes] just won't take somebody who’s been through the forensic service” (Participant 5). This double stigma greatly impacts forensic patients’ ability to find housing, leaving many to remain in inpatient settings longer than necessary. Another participant explains the implications of this stigma “preventing movement” (Participant 6) of forensic clients once they have been designated as such. This participant went on to provide a specific example of a client who could have been discharged in 2015, but voluntarily remains in-patient due to lack of housing. This testimony highlights how stigma can trap patients in the system indefinitely, undermining their progress towards recovery and reintegration.

Furthermore, the precariousness of community resources exacerbates these challenges. Funding cuts and threats to “cut some of the community resources that patients have access to” (Participant 1) undermine critical supports that assist in managing risk associated with reintroduction to the community. One participant warned:

> That's not going to help the bed situation. Because if you cut supports and stuff that can help manage risk, then you increase risk of rehospitalization…if you don't have access to those anymore, and there's no group homes that will have spots for forensic patients -

> then it's like, where do you go? We can't discharge somebody from hospital without the right supports to manage risk. (Participant 1)

This underscores the dire consequences of diminishing community supports which not only hinders the discharge process but also increases the likelihood of rehospitalization, thereby straining the already overburdened FMH system further.

Identified Need for Change/Attempts at Change

The theme of *Identified Need for Change/Attempts at Change* outlines crucial areas where participants highlighted the necessity for improvements, along with measures some sites have taken to address these make these issues. Subthemes captured under this include a *Need for More Communication* across relevant parties, a *Need for Education and Training* regarding forensic services, and the need for *Streamlined Assessment Practices*.

Communication between the various stakeholders involved in the FMH system, including clinicians, members of the courts, corrections, law enforcement, and community partners, is often insufficient, despite their close working relationships. This lack of communication can severely impact client outcomes, as exemplified by one participant who recounted a critical incident:

> We had an inquiry a number of years ago about a case that was seen in hospital and was recommended to go to the forensic service but the communication didn't pass from the clinical side to the criminal justice side and the client ended up dying in corrections because of that. (Participant 4)

This event highlights the potentially life-threatening consequences of communication failures, underscoring the need for robust mechanisms to ensure information flow across all sectors.

Furthermore, misunderstandings about the roles and purposes of forensic services frequently occur, complicating the effectiveness of service provision. Clarifying these roles through targeted education and training could mitigate inappropriate referrals, as one service provider described, “They used to order fitness and NCR together, on one order…It's kind of legally inappropriate to order both at the same time, which I won't get into. But we had a push to encourage the courts to do one thing at a time.” (Participant 1). This reflects the broader need for ongoing communication and education among stakeholders to manage the volume of referrals being made to the FMH system.

Efforts to improve communication between relevant stakeholders in the FMH system have led to the establishment of practices such as forensic working groups and specialized liaison roles. These initiatives are crucial in bridging gaps between different sectors involved in FMH care. For example, one participant detailed the benefits of regular interdisciplinary meetings, “We do have regular team meetings between [forensic services]…it's really important that we value that relationship and make sure that we do have those regular touch points with them to avoid those silos, even within our own program, let alone some outside agencies.” (Participant 2). Such meetings ensure that all parties are aligned and informed, thereby reducing the risk of operational silos that can adversely affect client care.

Moreover, the role of individuals in specialized court/corrections liaison positions is pivotal, not only in facilitating communication but also in serving an educational purpose within the judicial system. A participant illustrates the impact of having an experienced court worker:

> Another key factor in how well we're doing, I think is the court support worker that we have in place... She's a registered nurse with a lot of experience. She's been in that role for I'm going to say 20 years, probably longer. She's very familiar with the Criminal Code

> and what the requirements are for forensic assessments. If somebody in the courthouse thinks that somebody's got a mental health issue, she can go and talk to them and then recommend if she thinks an assessment might be beneficial or appropriate. She does a lot of education with everyone in the courts. I think she's diverted a lot of unnecessary movement into the Review Board honestly and also diverted admissions from our unit as well. (Participant 7)

This role not only prevents unnecessary referrals and inpatient admissions, but also educates court personnel about the nuances of FMH care, streamlining the process and preventing clients from falling through the cracks. Increased communication and education are therefore critical in preventing clients from falling through the cracks and improving the flow and management of clients through the FMH system.

Education serves multiple vital roles within in the FMH system, particularly in instructing judges and lawyers about the responsibilities of forensic clinicians and the appropriate circumstances forensic evaluations. This targeted education aims to minimize the frequency of inappropriate or unwarranted referrals, thereby reducing system strain. As one participant from Alberta noted, “We work really diligently with our stakeholders, and they're very aware of what are appropriate clients to be referring to us and what aren't, and that really helps. Because then we're not being bogged down by inappropriate referrals” (Participant 8). Such educational efforts ensure that referrals are judicious and warranted, optimizing the use of forensic services.

Efficient assessment practices such as outpatient or courthouse fitness assessments, also play a crucial role in alleviating demand on inpatient resources. One participant emphasized the positive impacts brought on by these methods, “We're probably better than we used to be, and

the data would back that up because we have this rapid fitness clinic, and we have a mental health court docket that helps process these cases" (Participant 1). Allowing patients to be assessed in the community or existing custody arrangements can alleviate bed pressures by diverting unnecessary inpatient admissions. Additionally, one participant mentioned the importance of conducting ongoing program evaluation and "quality improvement initiatives" to ensure that services or programs are operating on an optimal level (Participant 8).

The widespread adoption of remote assessment and telehealth practices following the COVID-19 pandemic has also significantly impacted the FMH system by mitigating geographical barriers to access. A clinician shared, "Years ago, if I was going to do an outpatient assessment, that patient would have to come all the way here…Now, I can connect with them by Zoom wherever they happen to be" (Participant 4). This technology allows service providers to reach across vast distances, enhancing accessibility and efficiency in initial assessments, thereby improving the overall functionality of the FMH system.

Chapter IV: Discussion

The FMH system is an integral component of the Canadian legal system, designed to protect an inherently vulnerable subset of the population. Recent increased media scrutiny has highlighted the adverse consequences of delays within the FMH system, including escalating court backlogs and dire outcomes for clients (Hainsworth, 2023; Lachaz & Anderson, 2023; Rutgers, 2021; Shreve, 2024; Tutton, 2018). These concerns arise against the backdrop of the "competency crisis" in the United States, where many states struggle to keep up with the growing demand for fitness assessments (Gowensmith, 2019). While researchers hesitate to declare that Canada is facing a similar crisis, it appears that we have been quietly in a state of crisis for the past two decades. The present study is the first national review of the Canadian FMH system since Livingston's (2006) review of forensic inpatients services and sought to develop a snapshot of forensic services across the country and to quantify both the demand, and our capacity to meet the demand for fitness evaluations.

Addressing the first goal of this study, we revealed that there has been only a modest increase in both inpatient FMH sites (16.0%) and designated forensic beds (33.4%) across Canada since 2006. Of the 508 added beds, 76.2% of them are situated in Ontario and Quebec, with the remaining provinces realizing only minor additions, or not changing at all in the case of British Columbia and Nova Scotia. Despite increases to bed capacity, the ratio of designated forensic beds to forensic clients worsened in Alberta, Ontario, Quebec, Nova Scotia, and Canada as a whole. Over this same period, many participants reported a precipitous increase in the number of fitness referrals they receive on a yearly basis. A previous review identified an 80% increase in referrals for forensic assessment from 2015 to 2019 (roughly 56 assessments to 105; Hill et al., 2021) and at least one participant in Ontario reported an increase of 300% over the

previous five years. Notably, this pattern is comparable to increases seen in both Colorado (~275% from 2009 to 2021) and Virginia (218% from 2007 to 2018); states which have been highlighted as particularly egregious examples of the competency crisis (Murrie et al., 2023).

Service providers interviewed for this study noted that the rise in referrals is partly attributed to an increase in substance-induced conditions. Patterns of substance use, polysubstance use, and the comorbidity of other mental health disorders have been increasing over time (Khan, 2017; Zuckermann et al., 2019), particularly among males and members of Indigenous groups (Firestone et al., 2015; Zuckermann et al., 2019). While broader statistics for rates of substance-induced psychosis in Canada are not available, two studies analyzing emergency department presentations across the country reported that the incidence rate for cannabis-induced psychosis doubled from 2006 to 2015, and then again from 2015 to 2019 (Callaghan et al., 2022; Maloney-Hall et al., 2020). Furthermore, an analysis of unhoused men (*n* = 437) in Vancouver revealed high rates of psychotic disorder history (60.9%), cannabis use (72.8%), and methamphetamine use (46.5%; Jones et al., 2020). Both cannabis and methamphetamine use are linked to increased risk for developing of psychotic symptoms, and the prevalence of these substances in Canada is on the rise (Government of Canada, 2023; Moore et al., 2007; Semple et al., 2005). Given the clear connection between substance use and the exacerbation of mental health challenges, it is important to bolster the availability of access to substance abuse programming in the community for FMH patients. Such resources can provide essential support and resources to manage substance use, thereby beginning to mitigate the cycle of substance induced conditions and FMH involvement.

Alongside the increase in fitness referrals, participants also reported extensive concerns around the recruitment and retention of crucial FMH staff such as psychologists, psychiatrists,

and nursing staff, resulting in burnout and longstanding vacancies threatening service delivery. Even while FMH sites report struggling to keep with the demand for services, they also experiencing challenges related to funding and access to vital community resources which facilitate the transfer of clients out of the forensic system. One site representative provided an example of a client who despite receiving an absolute discharge in 2015 remains on the unit due to community housing waitlists. Using a previous estimate of costs for one day of care on a forensic assessment unit ($422.25; Hill & Demetrioff, 2022), this patient has incurred approximately $1,374,423.75 worth of care to date, highlighting the potential costs of delayed movement through the system.

Although most provinces reported challenges to FMH service delivery, not all provinces voiced concerns to the same extent. Both Alberta and Nova Scotia indicated that although they were experiencing similar increases in fitness referrals, they were still managing to adequately meet the demand and highlighted similar factors contributing to that relative success. Of note, Alberta and Nova Scotia were found to have the first and second highest ratios of designated beds to forensic clients in the country, likely reducing the overall competition for beds in these jurisdictions. Both provinces also reported that diligent engagement with members of the courts, corrections, and law enforcement both reduced the number of inappropriate referrals and improved client flow through the system. Increased collaboration with members of the court has been cited as a recommendation for states being impacted by the competency crisis (Gowensmith, 2019).

While policy and practice matter greatly, contextual factors can also influence the provision of care in a province. With a population of just over one million, Nova Scotia is the smallest province that maintains its own FMH system (Statistics Canada, 2024b). Although they

reported similar challenges related to staffing and access to community resources, one participant noted that the smaller population and geographical size helps facilitate communication and collaboration between relevant stakeholders and mitigates potential practical challenges regarding transportation or physical access to service that more expansive provinces might face. For example, the population of Ontario is over 14 times larger and covers 19 times the geographical area of Nova Scotia (Statistics Canada, 2024b). As a FMH system becomes larger, challenges around transportation and communication grow as more distal stakeholders (i.e., larger pool of courts, more clients, community partners, etc.) become involved.

Strengths and Limitations

The Canadian FMH system is quite fragmented and varies significantly across provinces. This variability extends to features as basic as the availability of up-to-date contact information at each site. Even when appropriate contact information was identified we experienced difficulties establishing contact with certain locations, despite repeated attempts to do so. Similar to Livingston (2006), these data collection challenges were particularly true for locations in Ontario and Quebec. It is a theorized that some of these challenges may be representative of the concerns highlighted elsewhere in this paper, as service providers do not have the time or resources to take part in external research activities. Some information about uncontacted clinics has been retrieved from external sources to mitigate the impact of missing data, however data for more specific questions related to FST practices (i.e., referral numbers, report times, etc.) remains unavailable. With these considerations in mind, at the time of writing, data collection for 29 (72.5%) of the 40 identified FMH sites is currently in progress and key players in Ontario and Quebec have been contacted and are expected to facilitate contact with the remaining sites in

those two provinces. Notably, once data collection is complete, a 72.5% response rate represents an improvement over that captured by Livingston in 2006 (68%).

Another significant challenge identified in this study is the lack of formal data keeping practices in some jurisdictions, leading to reliance on estimates or potentially imperfect information. Notably in one province, conflicting reports about provincial referral numbers were provided by two participants and only one of these reports could be corroborated by external documentation. Moreover, in some provinces, the responses of participants did not align with media portrayals of the systems functionality. This discrepancy could stem from participants presenting an overly positive view of their circumstances or the media presenting an overly negative interpretation. Additionally, some participants chose not to provide key information requested in the survey, such as referral numbers and staffing details. Thus, although the present study is the only source of similar information on a national level since 2006, results should be interpreted with some caution as they may over or underestimate the current challenges FMH services face in Canada.

Despite these limitations, this study provides an important contribution to the field of FMH in Canada. This study stands not only as the first national review of the Canadian FMH system in nearly two decades but it significantly broadens the scope of analysis by including outpatient services, a previously underexplored area. Another notable strength is it's mixed-methods approach, which leveraged both quantitative and qualitative methodologies to provide a more nuanced understanding of the system. While the quantitative data offers a robust framework for analyzing trends and patterns, the qualitative interviews have been instrumental in uncovering insights into the operational realities and challenges faced by the FMH system. These interviews have revealed the complexities of service delivery and highlighted varying regional

practices, which are crucial to for developing targeted improvements and policy recommendations.

Implications and Recommendations

Prior to this study, our most recent data on timelines to complete fitness assessments occurred over two decades ago. At the time of the studies, researchers identified that report timelines ranged from 19-23 days in British Columbia and Quebec, significantly exceeding the (at the time) federally mandated timeline of five days (Crocker et al., 2002; Zapf & Roesch, 1998). Despite the passage of time, the results of the current study indicate that there has been little improvement in report timelines across the country, extending beyond 30 days in some provinces while improving in others. This deterioration in timelines can be attributed to a proportional decrease in the system's functional capacity as the ratio of available forensic beds and staffing has not kept pace with demands in the intervening years. As previously discussed, unmet demand and delays for FMH evaluations can have a myriad of consequences for the criminal legal system including stalling court processes, prolonging legal involvement, and escalating costs to provincial courts and health care (Chaimowitz & Ferencz, 1999; Hill & Demetrioff, 2022). These delays can also negatively impact vulnerable individuals awaiting assessment and trial who may be required to remain incarcerated or institutionalized in the interim (Kayfitz et al., 2017).

Beyond the individual and financial consequences, delays in the legal process significantly undermines the integrity and ethical application of the legal system. The right to "trial within a reasonable time" is enshrined in section 11(b) of the Canadian Charter of Rights and Freedoms (1982). More recently, "within a reasonable time" has been interpreted in the Canadian Supreme Court as cases in provincial courts being completed within 18 months, and

those in superior courts within 30 months (*R. v. Jordan,* 2016). Exceeding these limits may render a case eligible for dismissal.

Despite the absence of precise data on trial completion times for FMH patients, approximately 28% (*n* = 55,610) of criminal court cases took over one year from charge to final hearing in 2021/2022, with completion times increasing alongside added case complexity (Statistics Canada, 2024c). In 2015/2016 approximately 6% (*n* = 66,453) of criminal charges in provincial or superior courts exceeded the limits set by *R. v. Jordan* (2016), with 2% (*n* = 1,329) involving questions of criminal responsibility, fitness, or other special decisions (Maxwell, 2018). While court backlog metrics largely improved from 2016 to 2019 (Karam et al., 2020), the number of cases exceeding *Jordon* limits surged immediately following the COVID-19 pandemic. In 2021/2022, 10.5% (*n* = ~17,446) of criminal court cases (*n* = 165,960) exceeded these limits, resulting in 39.1% (*n* = ~6,820) of those cases being stayed or withdrawn due to *Jordan* considerations, including 2,988 cases involving offences against the person (Statistics Canada, 2024a). Although the identified delays do not solely involve FMH patients, they not only contravene the charter rights of Canadians but risk eroding public confidence in the judicial system. Ensuring timely access to FMH evaluations is essential to not only uphold legal and ethical standards but also to maintain the credibility and effectiveness of our legal system.

The findings of this study prompt a critical question: What actions can Canadian FMH services take in response to this knowledge? While service providers cannot alter the geographical realities of their provinces, they can certainly implement and advocate for policy and practice changes enhance the efficiency of service delivery. This study has pinpointed specific areas in need of improvement and offers targeted recommendations for initiating these changes on a site, provincial, and federal level (See Table 3). Notably, many of these

recommendations coincide with those proposed by American researchers addressing the US competency crisis (Callahan & Pinals, 2020; Gowensmith, 2019). This alignment suggests that the challenges faced in Canada are not isolated but part of broader systemic issues in Western FMH systems.

Site-Level Recommendations

A primary recommendation at the site level includes the collection and reporting of critical statistics related to FMH care. Although at its core, this is a site-level recommendation, data collection could be standardized on both a provincial and federal level. Some sites reported either not collecting site level data, or only recently beginning the practice in a formalized way. Notably one service provider expressed an interest in beginning to collect site data after participation in this study. Current inconsistencies in data collection practices not only hinder the assessment of system-wide performance, but also impedes the identification of clinic-level needs for improvement. One strength identified in the province of Alberta is a robust model of continual program evaluation and quality improvement, thereby promoting the optimal use of existing resources. Therefore, it is recommended that all FMH sites in Canada begin systematically tracking a core set of statistics to enhance transparency and facilitate ongoing evaluation of service efficacy. Key metrics to track could include referral numbers per year, number of new patients entering under the Review Board, number of assessments completed per year, assessment completion times, report completion times, recidivism statistics for patients, the number of absolute discharges per year, and the total time spent in inpatient care.

Implementing a unified system for collecting these metrics will require communication and cooperation across various levels of the FMH service network. This initiative would not only

support better resource planning and management but foster improvements in policy making, and patient care strategies based on empirical evidence.

Province-Level Recommendations

The clearest recommendation taken from this study is the imperative to increase both communication and education across all parties involved in the FMH system. Educating judges, lawyers, probation officers, corrections, and law enforcement about the roles and objectives of the FMH care can significantly reduce the number of inappropriate referrals by diverting clients towards more suitable services like mental health or drug treatment courts (Gowensmith, 2019; Murrie et al., 2023). Further, effective communication and ongoing education with community partners are essential to mitigate the impact of stigma on forensic patient's transition back into the community and to prevent these clients from "falling through the cracks" (Vorstenbosch et al., 2022).

One noted challenge to providing FMH care is that larger systems create more complex networks of courts and stakeholders. Some provinces such as Alberta appear to have alleviated this issue by creating designated "zones" of FMH care, creating smaller pockets of service provision that can effectively communicate between each other if needed. Several sites have also attempted to meet this goal through establishing multidisciplinary "forensic working groups" that ensure frequent and consistent touchpoints among stakeholders, while others have created liaison roles to streamline communication across disciplinary boundaries.

Another key recommendation taken from the present study is the establishment of venting points to reduce reliance on inpatient care and alleviate bed competition. These venting points can be effectively implemented both before and after a judge issues an assessment order. Prior to the assessment order, it is advised that service providers institute formal screening

processes to determine the appropriateness of a referral before an assessment order has been made (Gowensmith, 2019). While some Canadian sites have adopted informal screening processes, these are often based on unstructured clinical judgment and are constrained by clinician time and resources. To enhance the effectiveness and consistency of these screenings, it is recommended that sites either adopt an existing screening tool such as the Competency Screening Test (Lipsitt et al., 1971), or develop and validate a new tool for the contemporary Canadian context. Notably, the previously described court liaison role, which falls well within the scope of practice for a registered nurse (College of Registered Nurses of Manitoba, 2023), could incorporate the use of such a formal screening tool.

Post-assessment order, these venting points could include outpatient assessment, which are already practiced in various forms across Canada, including rapid assessments in court or custody (Government of British Columbia, 2023; Hill & Demetrioff, 2022). Additionally, clients whose index offences are not severe and who do not pose risk for violence could be diverted to general psychiatric units, further reducing demand on forensic beds or (Callahan & Pinals, 2020).

Federal-Level Recommendations

In terms of broader federal-level recommendations, two key pieces must be addressed to enhance the FMH system. First, many participants reported challenges filling current or upcoming vacancies at their sites, a problem that may stem from the limited forensic training opportunities available in Canada. Although a study found that 24 of 36 (67%) surveyed universities offered at least one forensic-related course or training opportunity, only four locations provided extensive structured forensic training (Helmus et al., 2011). Furthermore, researchers have identified an ongoing need for expanded forensic training opportunities (Goldenson et al., 2023). Although similar research on psychiatry and nursing training is

unavailable, it is likely that similar deficiencies are present, underscoring an urgent need to bolster forensic training opportunities across the country.

A final recommendation includes expanding the scope of practice for forensic psychologists in Canada. Currently, Section 672.1 of the Canadian Criminal Code restricts the ability of forensic psychologists to conduct fitness assessments, specifying that the evaluations should be completed "by a medical practitioner or any other person who has been designated by the Attorney General as being qualified to conduct an assessment of the mental condition of the accused under an assessment order" (CCC, 1992). This limitation persists despite the qualifications of forensic psychologists who routinely conduct such assessments in other countries like the United States, the Netherlands, Australia, and the United Kingdom, and have occasionally been permitted to do so in Canada (Goldenson et al., 2023; Hill & Demetrioff, 2019; Roesch et al., 2019). Moreover, Canadian forensic psychologists are qualified to conduct other complex psycholegal assessments, such as dangerous offender assessments (Hill & Demetrioff, 2019; Kayfitz et al., 2017). Despite decades of advocacy to amend this restriction, change has yet to be realized (Roesch et al., 1997, 2019; Viljoen et al., 2003). This recommendation could help alleviate staffing challenges by reducing the reliance and burden on forensic psychiatrists and better utilizing psychologists already embedded in these roles. The above recommendations aim to address significant barriers and improve the efficiency and effectiveness of the FMH system at a national level.

Table 3.

Specific recommendations to improve Canadian FMH system based on level of operation

	Site level	Provincial level	Federal level
Recommendations	Standardized data collection and reporting practices	Standardized data collection and reporting practices Increase in communication and education for parties involved in FMH practices through liaison roles or working groups Adopting formal screening practices for potential referrals Adopting alternatives to inpatient assessment	Standardized data collection and reporting practices Bolstering forensic training opportunities Expanding scope of practice for forensic psychologists by amending Section 672.1 of Canadian Criminal Code

Note. FMH = Forensic Mental Health

Future Research

Although this study marks a significant step towards understanding FMH care in Canada, the area remains substantially understudied, highlighting the need for more research. Notably, this study revealed that the territories (Northwest Territories, Yukon, and Nunavut) continue to not maintain their own FMH systems, and instead rely on the services of neighboring provinces. Given the recognized challenges of mental health care in these regions, including both increased need for mental health and limited access to care (Upfold & Chaimowitz, 2021), it is critical to explore the policies and practices within these unique contexts and assess the experiences and outcomes of FMH clients from these communities.

Additionally, the study identified significant barriers related to access to services and housing as FMH clients transition out of inpatient care. While outpatient services were included

in the first goal of this study, a more concerted effort is required to understand the pressures these essential services face. Moreover, fitness restoration practices deserve closer examination to determine how they intersect with the identified challenges and to explore outcomes post-restoration (Martin et al., 2023).

In conclusion, the findings of the present study suggest that a fitness crisis similar to that experienced in the United States may be unfolding in Canada. Although Canada receives an overall lower volume of referrals than the United States, our capacity to meet this demand has remained largely stagnant for two decades. Due to the ever-growing burden on the FMH system, this crisis is likely to worsen if changes are not made. This underscores an urgent need for policymakers and provincial health services to confront and address the myriad of challenges within the FMH system. The highly vulnerable patient population of the FMH system necessitates just and efficient care, and only through comprehensive policy reform and dedicated resource allocation can we hope to resolve these pressing issues and safeguard the civil rights and wellbeing of FMH patients across the country.

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Appendix A: Clinic Survey

1. **Please enter the date you begin this form (e.g., mm/dd/yy):**

   Click or tap here to enter text.

2. **Please indicate your role at the clinic:** Click or tap here to enter text.
3. **How long have you been employed at this location (e.g., 2 years, 3 months)?** Click or tap here to enter text.
4. **How long have you worked with forensic populations (e.g., 2 years, 3 months)?** Click or tap here to enter text.
5. **Please indicate the name of the clinic which you are representing:**

   Click or tap here to enter text.

6. **Please indicate the postal code of the clinic which you are representing:**

   Click or tap here to enter text.

Clinic Information

Please select only one option unless otherwise specified.

1. **What province or territory is your clinic located in?**

   ☐ = Ontario
   ☐ = Québec
   ☐ = Nova Scotia
   ☐ = New Brunswick
   ☐ = Manitoba
   ☐ = British Columbia
   ☐ = PEI
   ☐ = Saskatchewan
   ☐ = Alberta
   ☐ = Newfoundland and Labrador
   ☐ = Yukon
   ☐ = Nunavut
   ☐ = Northwest Territories

2. **What health administrative region of the province is the clinic located in (if applicable)?** Click or tap here to enter text.

3. **Where in the province or territory is the clinic located?**

   ☐ = Province capital
   ☐ = Large city other than capital (population of 100,000 or more)
   ☐ = Medium city other than capital (population between 99,999 and 30,000)
   ☐ = Small city other than capital (population between 29,000 and 1,000)
   ☐ = Rural community (population < 1,000)
   ☐ = Other: Click or tap here to enter text.

4. **What is the name of the community the facility is located in?**

   Click or tap here to enter text.

5. **What is the geographical catchment area served by the facility? (i.e., indicate the geographical area from which the facility typically draws its clients from).**

   Click or tap here to enter text.

6. **What is the approximate distance in kilometres from the clinic to the farthest community or area which a client may reside? (i.e., what is the farthest distance a client might travel to receive services at the facility?).**

   Click or tap here to enter text.

7. **Is the facility inpatient or outpatient?**

   ☐ = Inpatient facility
   ☐ = Outpatient/Community based
   ☐ = Both
   ☐ = Other: Click or tap here to enter text.

8. **Please select the most appropriate descriptor of the facility.**

   ☐ = Federal corrections psychiatric centre/unit
   ☐ = Provincial corrections psychiatric centre/unit
   ☐ = Freestanding forensic hospital
   ☐ = Clinic within larger psychiatric hospital
   ☐ = Clinic within larger general hospital
   ☐ = Community/outpatient mental health clinic
   ☐ = Other: Click or tap here to enter text.

9. **What percentage of clinic clients fall under the following security levels? (Summed total should equal 100%)**

   Open facility: Click or tap here to enter text.
   Low: Click or tap here to enter text.
   Medium: Click or tap here to enter text.
   High: Click or tap here to enter text.
   Other: Click or tap here to enter text.

10. **If "Other" please explain:** Click or tap here to enter text.

11. **What are the primary sources of *treatment* referrals for the facility? (Select all that apply).**

☐ = Federal/provincial or territorial correctional facilities
☐ = Review board
☐ = Judge
☐ = Lawyers
☐ = Probation services
☐ = Other inpatient psych units
☐ = Community mental health teams
☐ = Private referrals
☐ = Other: Click or tap here to enter text.

12. **What are the primary sources of *assessment* referrals for the facility? (Select all that apply).**

☐ = Federal/provincial or territorial correctional facilities
☐ = Review board
☐ = Judge
☐ = Lawyers
☐ = Probation services
☐ = Other inpatient psych units
☐ = Community mental health teams
☐ = Private referrals
☐ = Other: Click or tap here to enter text.

13. **What percentage of clients are referred from the sources selected above? (Summed total should equal 100%).**

Federal/provincial or territorial correctional facilities: Click or tap here to enter text.
Review board: Click or tap here to enter text.
Judge: Click or tap here to enter text.
Lawyers: Click or tap here to enter text.
Probation services: Click or tap here to enter text.
Other inpatient psych units: Click or tap here to enter text.
Community mental health teams: Click or tap here to enter text.
Private referrals: Click or tap here to enter text.
Other: Click or tap here to enter text.

14. **What percentage of clients fall under the following legal statuses? (Summed total should equal 100%).**

Accused: Click or tap here to enter text.
Convicted, awaiting sentencing: Click or tap here to enter text.
Convicted, post-sentencing: Click or tap here to enter text.
Incarcerated in provincial jail: Click or tap here to enter text.

Incarcerated in federal prison: Click or tap here to enter text.
Held in forensic mental health unit: Click or tap here to enter text.
Not criminally responsible due to mental disorder:
Click or tap here to enter text.
Unfit to stand trial: Click or tap here to enter text.
Other: Click or tap here to enter text.

Care Information

15. **Which of the following therapy modalities are used at the clinic? Select all that apply.**

☐ **In-person individual therapy**
☐ **Remote/telehealth individual therapy**
☐ **In-person group therapy**
☐ **Telehealth group therapy**
☐ **Other (please specify):** Click or tap here to enter text.

16. **What percentage of each of the following therapy modalities are used at the clinic? (Summed total should equal 100%).**

In-person individual therapy: Click or tap here to enter text.
Remote/telehealth individual therapy: Click or tap here to enter text.
In-person group therapy: Click or tap here to enter text.
Telehealth group therapy: Click or tap here to enter text.
Other: Click or tap here to enter text.

17. **Which of the following assessment modalities are used at the clinic? Select all that Apply.**

☐ **In-person**
☐ **Remote/telehealth**
☐ **Other (please specify):** Click or tap here to enter text.

18. **What percentage of each of the following assessment modalities are used at the clinic? (Summed total should equal 100%).**

In-person: Click or tap here to enter text.
Remote/telehealth: Click or tap here to enter text.
Other: Click or tap here to enter text.

19. **What assessment services are offered at your clinic? Select all that apply**.

☐ = NCRMD evaluations
☐ = Fitness to stand trial assessment
☐ = Violence risk assessment
☐ = Sexual violence risk assessment

☐ = Other specified risk assessment
☐ = Neuropsychological assessment
☐ = Pre-sentence report
☐ = Dangerous offender assessment
☐ = Other assessment (Please specify): Click or tap here to enter text.

20. **Approximately what percentage of cases fall into the options that you have chosen above? (Summed total should equal 100%)**

NCRMD evaluations: **Click or tap here to enter text.**
Fitness to stand trial assessment: **Click or tap here to enter text.**
Violence risk assessment: **Click or tap here to enter text.**
Sexual violence risk assessment: **Click or tap here to enter text.**
Other specified risk assessment: **Click or tap here to enter text.**
Neuropsychological assessment: **Click or tap here to enter text.**
Other: **Click or tap here to enter text.**

21. **What assessment tools are used at your clinic? Select all that apply.**

☐ = Psychopathy Checklist - Revised
☐ = Violence Risk Appraisal Guide
☐ = Violence Risk Appraisal Guide – Revised
☐ = Static-99R
☐ = Static-2002
☐ = Sex Offender Risk Appraisal Guide
☐ = Violence Risk Scale
☐ = Level of Service – Case Management Inventory
☐ = Level of Service Inventory – Revised
☐ = STABLE-2007
☐ = Historical Clinical and Risk Management - 20
☐ = Sexual Violence Risk - 20
☐ = Spousal Assault Risk Assessment
☐ = Risk for Sexual Violence Protocol
☐ = Short-Term Assessment of Risk and Treatability
☐ = Dangerousness, Understanding, Recovery, and Urgency Manual
☐ = Dynamic Appraisal of Situational Aggression
☐ = Minnesota Multiphasic Personality Inventory - 2
☐ = Minnesota Multiphasic Personality Inventory - 3
☐ = Millon Clinical Multiaxial Inventory - IV
☐ = Personality Assessment Inventory

☐ = Wechsler Adult Intelligence Scale - IV
☐ = Wechsler Abbreviated Scale Intelligence - II
☐ = MacArthur Competence Assessment Tool – Criminal Adjudication
☐ = Evaluation of Competence to Stand Trial – Revised
☐ = Other (please specify): Click or tap here to enter text.

Staff Information

In the following table, indicate the number and type of staff employed by the clinic you are representing. Fill in blanks in the "Staff type" column as needed. For part-time and contract workers specify whether they occupy < .5 of a full position, or > 0.5 of a full-time position (e.g., Part-time: 1 <.5, 2 >.5; Contract: 3 < .5).

Staff Type	Full-time	Part-time	Contract
Psychologist	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Psychiatrist	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Criminologist	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Psychological Associates	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Psychometrists	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Nursing Staff	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Psychoeducators	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Social Workers	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Security	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Administrative staff	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
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Survey Continues below

Fitness to Stand Trial

If the clinic you are representing conducts fitness to stand trial assessments or is involved in the fitness restoration process, complete the following section. If your clinic is not involved in either fitness to stand trial assessments or fitness restoration, please do not fill out the following section.

In answering this section, answer as pertaining to clients referred specifically for fitness assessment or restoration.

1. **What are the acceptance criteria for clients to be admitted to the waitlist for FST assessments?**

   Click or tap here to enter text.

2. **What are the acceptance criteria for clients to be admitted to the waitlist for fitness restoration?**

   Click or tap here to enter text.

3. **Approximately how many FST *assessment* referrals were made to the clinic in 2023?**

   Click or tap here to enter text.

4. **Approximately how many clients were referred to the clinic for *fitness restoration* following an unfit finding in 2023?**

   Click or tap here to enter text.

5. **Approximately how many clients were seen at the clinic for a *FST assessment* in 2023?**

   Click or tap here to enter text.

6. **Approximately how many clients were seen at the clinic for *fitness restoration* following an unfit finding in 2023?**

   Click or tap here to enter text.

7. **Approximately how many individuals are currently on the clinic waitlist to undergo a *FST assessment*?**

   Click or tap here to enter text.

8. **Approximately how many individuals are currently on the clinic waitlist to undergo *fitness restoration*?**

   Click or tap here to enter text.

9. **What is the average amount of time in days that individuals are on the waitlist prior to being seen for a *FST assessment*?**

   Click or tap here to enter text.

10. **What is the average amount of time in days that individuals are on the waitlist prior to being seen for *fitness restoration*?**

    Click or tap here to enter text.

11. **What is the average amount of time in days spent in clinic for a *FST assessment*?**

    Click or tap here to enter text.

12. **What is the average amount of time in days spent in clinic for *fitness restoration*?**

    Click or tap here to enter text.

13. **If applicable, what is the average time in days for report completion following a *FST assessment*?**

    Click or tap here to enter text.

14. **What is the maximum capacity of your clinic (specifically regarding FST assessments)? If inpatient, report posted bed count. If outpatient report maximum caseload at any given time.**

    Bed count: Click or tap here to enter text.

    Maximum Caseload: Click or tap here to enter text.

15. **What is your current occupancy rate? (I.e., How many clients are currently being housed/seen by your clinic for an FST assessment)?**

    Inpatient: Click or tap here to enter text.

    Outpatient: Click or tap here to enter text.

16. **Where are your clients primarily located prior to accessing a fitness related service at your clinic? (Select all that apply).**

☐ = Federal correctional institution
☐ = Provincial jail
☐ = Secure forensic mental health unit (e.g., forensic hospital).
☐ = Community hospital
☐ = Residential treatment facility
☐ = Community based
☐ = Other: Click or tap here to enter text.

17. **What procedures are in place for those on the waitlist when current occupancy is full? (Select all that apply)**

☐ = They remain incarcerated if already in custody
☐ = There are overflow units in which a client can be temporarily accommodated
☐ = They remain in the community while awaiting service
☐ = They are prioritized based on urgency or severity of the case
☐ = Alternative service options or referrals are provided
☐ = Other: Click or tap here to enter text.

18. **How does the current occupancy rate for fitness assessment compare to the average fitness assessment occupancy rate over the last five years?**

☐ = Average for past 5 years
☐ = Below average for past 5 years
☐ = Above average for past 5 years

Thank you for your participation!

Appendix B: Interview Guide

For all of the following questions prompt, "Could you elaborate on that?" or ask relevant follow up questions if it seems like more information could be gained.

1. **Could you please share your role and position within the clinic?**

Click or tap here to enter text.

2. **How long have you worked at this clinic? (If not answered, how long have you been in your current position?)**

Click or tap here to enter text.

3. **How long have you worked in the field of forensic mental health?**

Click or tap here to enter text.

4. **What is the mandate for your clinic?**

Click or tap here to enter text.

5. **How well do you believe your clinic is currently meeting its demand for FST evaluations?**

Click or tap here to enter text.

6. **What factors do you believe contribute to your clinic's ability to effectively meet the current demands for FST evaluations?**

Click or tap here to enter text.

7. **What factors do you believe contribute to your clinic's challenges in meeting the current demand for FST evaluations?**

Click or tap here to enter text.

8. **What specific factors, if changed, do you believe would improve your clinic's ability to meet the demand for FST evaluations? (i.e., if they specifically identify challenges, what do they think would alleviate those challenges).**

Click or tap here to enter text.

9. **If resources weren't a barrier, what would be an ideal service delivery approach for FST assessment be for you?**

Click or tap here to enter text.

10. **How do increased wait times effect the lives of your clients undergoing FST assessments?**

Click or tap here to enter text.

11. **What accommodations, if any, are in place for clients made for clients who face difficulties reaching the clinic for an FST assessment due to living remotely or very far away? (If examples needed: lodgings, meal vouchers, transportation, etc.) These accommodations could be made directly through the clinic, through the courts, or through a correctional facility?**

Click or tap here to enter text.

12. **What accommodations, if any, are in place for clients who may face financial burden associated with travel to the clinic or missed work? These accommodations could be made directly through the clinic, through the courts, or through a correctional facility (e.g., lodgings, meal vouchers, transportation, etc.)**

Click or tap here to enter text.

13. **What accommodations, if any, are in place for clients from diverse cultural or language backgrounds who are required to participate in the assessment? (e.g., modified assessment procedures, translation services, etc.)**

Click or tap here to enter text.

14. **Is there anything that I have not asked that you would like the opportunity to discuss?**

Click or tap here to enter text.