UNIVERSITY OF SASKATCHWAN

Literature Review on Therapeutic Justice and Problem Solving Courts

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1 INTRODUCTION

Mental healthcare in Canada, as with many other western countries, began in the 'poor houses' in the 1800's. They evolved into mental hospitals over time and existed until the 20th century. As these facilities became overcrowded, the concept of deinstitutionalization emerged which shifted care into psychiatric units within in general hospitals and the community. This led to a considerable reduction in the bed capacity of Canadian mental hospitals between early 1960s and late 1970s matched only by a comparatively smaller increase in the number of beds in psychiatric units. Insufficient professional care, combined with the unprepared communities who failed to provide the necessary care originally envisioned by the decision makers of deinstitutionalization, rendered people with mental illness vulnerable to various societal problems, including homelessness and extreme poverty. Most notable of the negative outcomes of deinstitutionalization on the mentally ill persons was the sudden increase in their contact with the criminal justice. The frequent conflict of mentally ill offenders with the law brought about the revolving door patient syndrome and increasing amount of collaboration has been made between law and psychiatry. Therapeutic justice, which aims to address the root of the criminal offending in order to provide a more holistic and less punitive method for the troubled groups within the society, is the foundation of many such collaborative efforts. Problem solving courts are one of the many ways in which therapeutic justice has been employed to tackle complex social problems that underlie or accompany criminal behavior.

1.1 Rationale

Despite the paramount need, no concerted mental health strategy exists between the legal and medical sectors of Saskatoon. Empirical research on mentally ill offenders as a population has been scarce. A few studies provided basic description of regional review board populations.[1-6] Also, administrative reports are produced on a regular basis by most provincial governments, individual review boards and correctional services and more socio-demographic information is available through these channels.[7] Recently, a thorough needs assessment and an environmental scan of the Saskatchewan forensic mental health system has been conducted.[8]This project will provide information on the concept of therapeutic justice and forensic psychiatry. The aim is to build an academic bridge between the legal and medical system with regards to the care and management of mentally ill clients.

This will be followed by an exploration of tangible, practicable management options as seen in the currently operated Canadian problem solving courts. It is hoped that this information will lead to the establishment of a mental health court in the near future. In order to achieve this goal, various stakeholder groups including but not limited to the Department of Psychiatry, Crown Prosecutor's Offices and the police will be consulted.

Information from this study will provide a better understanding of the mentally ill population in the criminal justice system and of the field of forensic psychiatry. The role of the various professional groups and organizations, such as the provincial review board, will also be better illustrated. It is anticipated that the conclusions drawn from this project will largely complete the planning stage and facilitate the actual implementation of Mental Health Court Saskatoon. Finally, there are several similar research projects in Canada geared toward advancement in the knowledge and clinical management of forensic

populations. Together with the results of other regional efforts, outcomes of this study will provide a Canadian perspective, thereby contributing to the national knowledge on forensic populations as a whole while providing platforms on which relevant regional programs may be adjusted to best serve the respective communities.

2 PSYCHIATRY

Psychiatry is a medical specialty devoted to the study and treatment of mental disorders. It is often subspecialized according to various categorization methods including the client's age group (such as child and adolescent psychiatry), the types of disorders and disorder and the mode of treatment (such as pharmacopsychiatry). Forensic psychiatry, with its target population of mentally ill offenders, represents one of the most complex and challenging subspecialties of psychiatry.

2.1 Diagnostic and Statistical Manual of Mental Disorders

An accurate diagnosis of a medical disorder is the first step of psychiatry and requires a clear description of the disorder and determination of defining features.[9] Historically, the subjective nature of mental illness has made the fulfillment of this prerequisite difficult.[10] but description of mental illness by Diagnostic and Statistical Manual of Mental Disorders (DSM) provides an unambiguous and scientific characterization of psychiatric disorders. The issue of shared symptoms has been yet another hurdle in psychiatric diagnosis. There is a substantial overlap of symptoms among different disorders and characterization based on distinctive sets of symptoms is difficult. DSM circumvents this problem by using a categorical classification system, in which mental disorders that share a set of symptoms are grouped together into 16 categories of disorders and an additional list of conditions by a few distinguishing factors.[11,12] This classification, based on shared and distinguishing features, is a logical alternative of classification based on etiology because it is not possible to identify a single, principal cause of a mental disorder.[10,12]

DSM explores five axes, or dimensions, of the patient's life and allows the collection of additional information relevant for diagnosis and treatment. Axis I covers the majority of disorders, and particularly clinical disorders, such as autism spectrum disorder, bipolar disorder, and schizophrenia. Axis II encompasses personality disorders and intellectual disabilities, such as antisocial personality disorder, narcissistic personality disorder, and obsessive-compulsive personality disorder. The other three axes include medical and physical conditions, psychosocial and environmental factors, and assessments of functioning for children and youth.[11]

Finally, in many cases, symptoms are not externalized and therefore objective clinical manifestations are absent.[10,13] Psychiatric diagnosis must rely on subjective data such as self-reports and observations by relevant parties, which makes the diagnostic process more susceptible to confounding compared to diagnosis of other types of medical conditions that use objective data such as biological markers.[13] The patient may not accurately express their conditions to the attending professional either deliberately or because they lack the narrative power.[13] The diagnosis may also be affected by the professional's biases or by a selective rather than exhaustive use of available data.[13] DSM IV-TR emphasizes that its categories of mental disorder are not 'completely discrete entities with absolute boundaries.'[11] When multiple diagnoses have been made, the

condition that occasioned the admission is designated as the principal diagnosis. DSM IV-TR also recommends usage of severity and course specifiers as well as information on the recurrence of any previous psychiatric disorders. Global assessment of functioning (GAF) scores, which shows how the mental illness affects one's functionality in a scale of 1 to 100, are typically factored in when deciding which severity specifier to use. Most psychiatric conditions that affect the main clientele of problem solving courts are included in the DSM.

Table 1.1 Brief descriptions and an example of DSM IV-TR Diagnostic method.[11]

	Classification	Example	
Axis I	Clinical Disorders Other Conditions That May Be A Focus of Clinical Attention	292.23	Major Depressive Disorder, Single Episode, Severe Without Psychotic Features
		305.00	Alcohol Abuse
Axis II	Personality Disorders Mental Retardation	301.6	Dependent Personality Disorder, Moderate, In Partial Remission Frequent Use of Denial
Axis III	General Medical Conditions	None	
Axis IV	Psychosocial and Environmental Problems	Threat of Job Loss	
Axis V	Global Assessment of Functioning (on a scale of 1-100)	GAF = 35	

Table 1.2 An illustration of a personality disorder is diagnosed.[11]

General diagnostic criteria for personality disorder

A. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:
   (1) cognition (i.e., ways of perceiving and interpreting self, other people, and events)
   (2) affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response)
   (3) interpersonal functioning
   (4) impulse control
B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.
C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.
E. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.
F. The enduring pattern is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma).

Diagnostic criteria for 301.6 dependent personality disorder

1. has difficulty making everyday decisions without an excessive amount of advice and reassurance from others
2. needs others to assume responsibility for most major areas of his or her life
3. has difficulty expressing disagreement with others because of fear of loss of support or approval. Note: do not include realistic fears of retribution.
4. has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy)
5. goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant
6. feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself
7. urgently seeks another relationship as a source of care and support when a close relationship ends
8. is unrealistically preoccupied with fears of being left to take care of himself or herself

The patient here satisfied the general diagnostic criteria for personality disorder and was then subsequently interviewed for more specific personality traits. This person had met most of the 301.6 diagnostic criteria and was therefore given a final diagnosis of dependent personality disorder.

This system has now been widely replaced by the introduction of the fifth version of the DSM. In this, the multiaxial system has been removed, new conditions added and a few streamlined. There are still controversies with the categories but the DSM 5 has defined mental disorder as "a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation or behavior that reflects a dysfunction in the psychological, biological or developmental processes underlying mental functioning…". This definition stresses the importance of thresholds of significant distress and dysfunction in social, occupational and other important activities.

2.2 Schizophrenia

Schizophrenia increases the likelihood of commission of different types of crimes including violent crime. It is interesting to note that the first arrest frequently happens before the individual has had any involvement with mental health services. This has the effect of making the justice system the first institution to deal with their mental health problems.[14] A patient with schizophrenia is often at risk while in the custody of the justice system. While properly medicated mentally ill people commit fewer violent crimes than their peers without mental illness, co-occurrence of schizophrenia and substance abuse raises the chances of that person committing a violent crime.[15]

2.3 Substance Abuse (Addiction) – why they are a difficult population (b/c of the dual diagnosis nature; and its potential to exacerbate and be exacerbated by MI)

Substance dependence or abuse, often used interchangeably with the term addiction, is one of the most common mental illnesses.[16] The biggest problem with understanding and treating substance abuse is defining it.[17] Also, people with addictions vary greatly in personal attributes such as past trauma and losses and as such American drug courts often divide people into specialty groups based on a few key attributes such as childhood history.[18] On the other hand, some other variables in treatment have been shown to affect almost all substance abusers in the same way. One such variable is the duration of time elapsed between the search or plea for treatment and actual treatment. It has been repeatedly shown that a delay in this duration increases the likelihood of the treatment failure. Sometimes such a delay in treatment is caused by the patients themselves who do not realize or refuse to acknowledge the addiction. This phenomenon is known as "impaired insight".[19]

2.4 Personality Disorders

Two commonly found disorders in criminal offenders are antisocial personality disorder and narcissistic personality disorder.[16,20] Antisocial personality disorder is defined by traits such as failure to conform to social norms and lack of respect for lawful behaviors. It is indicated by repeatedly inciting arrests, reckless disregard for safety of self or others and lack of remorse. The lack of remorse is an important feature and includes indifference toward or rationalization of hurting or mistreating others. Narcissistic personality disorder

is defined by preoccupation with fantasies of unlimited success, power, brilliance, beauty, or ideal love. Those suffering from either of these two personality disorders are also interpersonally exploitative, in that they take advantage of others to achieve their own ends, and lack empathy, in that they are unwilling to recognize or identify with the feelings and needs of others.[11] Although not as common, borderline personality disorder by nature of its characteristic impulsivity, emotional dysregulation and aggressive outburst, occurs in sufficient numbers of offenders and is associated with elevated violent and general risks.

2.5 Fetal Alcohol Spectrum Disorders

Fetal Alcohol Spectrum Disorders (FASD) are fairly prevalent in the criminal justice system and in Saskatchewan in general.[21] Yet the disorder has only until recently become realized in the psychiatric system of nosology. Under the DSM 5, those affected by prenatal alcohol exposure (PAE) can be identified and likely diagnosed under Neurodevelopmental disorder – other specified, intellectual disability disorder and under conditions for future studies, neurobehavioural disorder due to PAE.[22] The neurological effects of fetal alcohol exposure often cause the sufferer to fail to conform to the social norms and render them susceptible to legal problems.[22] The biggest problem in the management of FASD patients is that the symptoms widely vary and it is difficult to identify the most common major issue to target.[22] Another problem in the management of FASD patients in the criminal justice system is that they often appear to be fit when they are in fact unfit.[21] For example, a FASD witness is capable of repeating the oath from the short term memory without understanding the contents of it. This predisposes them to inadvertently committing perjury, which effectively changes their status from a witness to an accused. An accused may be able to answer affirmatively when asked if he can understand what is happening around him in the courtroom, but he may be simply answering automatically without understanding the question or his own answer. The treatment of FASD is further compounded by the fact that the permanent brain damage renders the sufferer incapable of rehabilitation.[22] In the authors' view lawyers, including judges, often misunderstand the word "spectrum" in the condition's title. The spectrum relates to the brain domains affected in a given individual and not to the severity of the disorder. In each person with a diagnoses of FASD the diagnostician has determined that the individual has a significant impairment caused by maternal ingestion of alcohol.

Recently, with a growing attention on this special subpopulation of mentally ill offenders, many knowledgable people have suggested that an "external brain", in which other people, such as family, friends, or trained community members aid the individual with their decision-making process may help the sufferer make decisions which prevent a breach of the law It also appears that probation orders work best when they are easily understandable and include positive instructions rather than simple prohibitions.[21] With appropriate support delineated to match the neurocognitive dysfunction, those with FASD can be cared for, their suffering ameliorated and improvement sustained.

2.6 Intellectual Disabilities

Learning disabilities, formerly known as mental retardation, do not predispose the sufferer to a higher chance of offending.[22] However, once involved with the criminal justice system, the sufferer has very different needs for rehabilitation. An interesting example of such special needs is rehabilitation for sexual offenders with cognitive deficits. Understanding the sometimes complex concept of consent can be problematic for people

with learning disabilities and rehabilitation must be tailored to accommodate their diminished capacity.

2.7 Other Mental Illness

Other disorders such as intermittent explosive disorder could be prevalent in a domestic violence court, and several of the disorders could be prevalent in mental health courts. Psychopathy, a rare mental condition made popular by frequent portrayal in popular media, is usually classified as an extreme form of antisocial personality disorder comorbid with other types of personality disorders. Dissociative identity disorder, commonly known as multiple personality, is yet another rare mental illness frequently portrayed in popular media. This is almost never seen in forensic population as it is in the general population. To date, there is no official record of a crime committed by a DID patient.

2.8 Aboriginal Population/Ethnicity

The Government of Canada reports that 16% of the national population is born outside the country and 10% are refugees.[23] One of the biggest challenges faced by immigrants and refugees is integration into the Canadian culture. Mental health can be influenced in the process by identification with a specific race or ethnic group along with social issues such as racism, discrimination and poverty, which often feed on each other and generate a vicious cycle.[23]

2.8.1 Aboriginal People & Mental Health

Aboriginal peoples in Canada are not a homogeneous group. The umbrella term “Aboriginal people” include First Nations, Inuit and Métis peoples, all of which differ substantially in language, customs, living circumstances and areas of residence.[23] In 2001, approximately one million Canadians (about 3% of the population) reported that they belonged to one of these 3 groups.[23]

Aboriginal people tend toward a more holistic view of mental wellness. Health is a state of “balance” with family, community and larger environment. Many of the mental health problems afflicting Aboriginal communities today are believed to result from forced acculturation processes, both historical and ongoing.[23]

In addition to immigrants and refugees, Aboriginal peoples further diversify the Canadian population and represent another susceptible group for mental illness. While 8% of all Canadians had consulted a mental health professional between 2004 and 2005, the proportion of Aboriginal people seeking help was as high as 17% depending on the group.[23] It is thought that this figure would be even higher if mental health professionals and resources were available in northern and isolated areas. Aboriginal communities and communities with a high number of Aboriginal people exhibit a high substance abuse rate which leads to high prevalence of FASD. Frequently, this in turn leads to high crime rate.[23] Aboriginal people living on reserve are especially likely to need help for mental health problems.[23]

Factors affecting Aboriginal people are not unique to Canada. Aboriginal people in Australia have struggled for two centuries with similar losses of language, culture and lands. Other issues such as substance dependence, discrimination, homelessness, unemployment, poor health and lack of education have also been identified as contributors

of identity loss and reduced self-esteem.[24] There is "a continuing challenge raised by the complex relationship between Aboriginal people and the criminal justice system"[24] and Aboriginal people continue to be overrepresented in the Australian correctional systems. For example, the 2001 Australian census shows that 20% of the total prisoner population were Kooris people.[25]

2.8.2 Effect of Culture on Treatment

Culture plays an important role in how an offender responds to treatment. For example, treatment for substance abuse is only effective when counselors are culturally competent with regards to the background culture of the clientele.[26] Also, the Tupiq program, which is a sex offender treatment program tailored to accommodate the cultural characteristics of Inuit people, have shown effect after a long term failure of the undifferentiated general program.[27] The multi-faceted program operates bilingually in Inuktitut and English on the basis that violence against women and children is a learned behaviour that can be modified. The program adopts a holistic approach, uses motivational techniques, refers to the offender's Inuit community and engages specialized Inuit facilitators that model the desired behaviour to help offenders identify and supplant their abusive behaviours.[27] Sentencing circles are yet another example of the criminal justice system evolving to a higher cultural competence and employing therapeutic and restorative justice.[28,29]

Culture and loss of culture may also play a role in instigating the initial criminal behaviour. For example, an American study found that African American men suffer from "cultural identity diffusion" in which a sense of self deteriorates and the sufferer retreats from committing to values and goals.[30] Identity diffusion often leads to alienation of self from the society and increases the likelihood of criminal behaviour. Identity enhancement treatment is an effective way to curb identity diffusion and the subsequent criminal behaviour. The exact format of the treatment varies, but it generally involves increasing understanding and acceptance of one's self, environment, and culture. A similar attempt has been made in Canada to great success for young Aboriginal offenders. They were exposed to Aboriginal culture and activities in the wilderness and had greatly improved self-esteem and pro-social behaviour at the end of these programs.[31] Drug treatment programs that focused on the cultural elements of Aboriginal people have been similarly successful.[32]

3 FORENSIC PSYCHIATRY

Forensic psychiatry is a highly specialized field of medicine dedicated to helping the mentally ill with legal troubles in a continuum of social systems, namely mental health care, criminal justice and corrections.[33] Contributions of forensic psychiatry in the management of mentally ill offenders are multi-fold. Forensic psychiatrists perform three types of forensic assessment: fitness to stand trial, criminal responsibility, and dangerousness to community.[34] Results from these assessments are crucial in legal proceedings, as judges and counsel rely heavily on the expert reports in determining the sentences. As crucial as their duty as legal expert in determining the legal outcome for mentally ill offenders is a forensic psychiatrist's responsibility as a physician. Forensic psychiatrists are key members of the clinical teams tasked with the mental health care of thus sentenced mentally ill offenders.[33] Other ways through which the judicial system has endeavoured to meet the demands of mentally ill offenders include the introduction of various points of diversion in the forensic path of mentally ill accused and the

establishment of provincial review boards.[34]

3.1 Deinstitutionalization

Deinstitutionalization refers to the large scaled bed cuts in mental health care that started in the 1960's and continued well into the 1990's.[35] In Canada, this reduction was done mainly through closing long stay psychiatric hospitals and discharging patients into alternative care homes and communities.[36] Humanitarian and financial challenges of institutionalized care for psychiatric patients, such as the public outrage against conditions of asylums and budget cuts, brought in this model with an aim to involve the broader community in a holistic treatment of mental illness.[37] However, due to financial constraints and the lack of preparedness on the part of the receiving communities, the model has been generally perceived as having produced negative outcomes. Deinstitutionalization in Canada has not been followed by re-creation of matching available specialized psychiatric care. Psychiatric departments were created in general hospitals as an alternative, but this did not increase in the overall number of beds available for mental health care. Many researchers believe that deinstitutionalization merely unloaded the burden of care onto various parties such as the families of patients, other community services like nursing homes and community housing, and the criminal justice system.[38]

Deinstitutionalization appears to have had a particular impact on the criminal justice system. A rising crime rate immediately followed deinstitutionalization in most countries and a steep increase in psychiatric behaviours such as suicide and self-harming rates in prisons was observed in the United States.[39,40] In 1939, Penrose proposed the idea of an inverse relationship between mental health care and the criminal justice system, in which a decrease in supply for one increased the use of another.[41] Penrose's Law accurately predicted the outcome of deinstitutionalization in Canada when the increased crime rate of those with mental illnesses directly followed. Furthermore, prevalence of mental illness in federal inmates has increased following deinstitutionalization. While numbers in Canada have not been clearly reported, by 2004 in the United States, where crime rate trends have been observed, mentally ill offenders incarcerated in federal prisons grew as a population by 60%, or 84% including substance abuse as a mental illness, since 1967.[42] Some authors have gone so far as to assert that the treatment has been substituted by punishment (Liska, Markowitz et al. 1999).

3.2 Criminality

In 1972, Abramson coined the term criminalization of the mentally ill to describe the increase in the number of mentally ill persons reaching the judicial system (14). As the link between mental illness and crime became more pronounced, several mechanisms by which the two spheres might influence each other were proposed. Some scholars assert that psychiatric conditions diminish the capacity for one to understand their own actions and this increases one's chance of inadvertent violation of the law.[43,44] These researchers rely on the tendency of severely ill individuals to commit disorganized rather than premeditated offences for evidence.[43-45] Highly reported cases of deliberate and scheming psychiatric offenders comprise only a small fraction of crimes committed by mentally ill offenders and mentally ill offenders have been repeatedly shown to mainly commit opportunistic, minor crimes.[5]

Lange (2011) stated that "the criminal justice system has become responsible for

controlling the occasional deviant behaviour of persons with MI".[46] In addition, the general mental health system is more inclined to take the less aggressive and malodorous of the incoming patients. This is because the general mental health system has been originally developed to care for the general public with mental illness and not to house criminal offenders. As such, those that are most likely to run into trouble are back on the streets first[47] and persons with major psychiatric disorders have a considerably higher risk of multiple incarcerations, especially in rural areas and northern communities.[46,48]

It has also been proposed that mental illness and crime often concur because they share many of the same predispositions. Developmental history, such as child abuse, and sociological factors, such as having criminal associates and coming from a low socioeconomic background, contribute to both psychiatric development and criminal offending.[49-51] Differing combinations of similar genetic and developmental factors drive which of the two outcomes will be generated. It is not surprising that often it results in both of these outcomes simultaneously occurring; experience in one sphere increases the likelihood to enter the other.

Psychiatrization of criminal behaviour is an intriguing approach to explain the criminalization of the mentally ill. According to this theory, criminalization of the mentally ill is a combined result of mentally ill persons entering the judicial system as well as criminal offenders being sent to psychiatric inspection.[43] Proponents of the thesis argue that a psychiatric label is affixed to individuals who commit illegal and violent behaviours, and mental illness is viewed as a result of crime in the same way criminal offending is viewed as a result of mental illness.

There are more sociological factors that collectively point to the lack of adequate accommodation for psychiatrically affected persons as a reason for the criminalization of the mentally ill. In addition to the reduction in availability of institutionalized psychiatric care, resulting from deinstitutionalization, there is also a severe lack of integrative community care programs through which the general psychiatric patients and mentally ill offenders are re-introduced and re-integrated into the community.[52] Studies have shown that mentally ill persons sometimes commit crime intentionally, in order to be brought back to incarceration settings to which they are accustomed and where they can continue to receive systematic care, or unintentionally, as a result of failure to adapt to society.[52] It has also been found that personnel in the crime-fighting sector often assume hostile attitudes when working with mentally ill offenders. Their general belief that deviant behaviours are best dealt with by taking a firm stance, rather than treating them with an accommodating mindset, is detrimental to the prognosis of mental illness in these people.[52] Stigmatization on mentally ill offenders also appears to be a crucial factor in criminalizing the mentally ill. Studies have shown that persons with mental illness or suspected to have mental illness are more likely to be reported and arrested rather than diverted.[53]

Studies that investigated the causal role of mental illness on violence have mostly produced negative results. These studies have shown associations of moderate strength at best and the direction of causality is yet to be clearly established.[54-56]

In summary, contrary to the popular belief that mental illness is conducive to violence, scientific evidence is absent.

3.3 The 1992 Reform of the Criminal Code

Fueled by the landmark case of *R v Swain*, a major reform of the Criminal Code was introduced and passed by 1992. The amendments included both conceptual ones, such as replacing the stigmatizing "insanity defence" term with a newer and more current "defence of mental disorder" term as well as procedural ones. The new label "not criminally responsible" was apparently intended to lessen the stigma of the NCR verdict but it is apparent that it is still widely misunderstood. The process through which an accused is psychiatrically evaluated and arrives at sentencing has become more humane, systemic and decentralized.[57]

A definition of "unfit to stand trial" was codified, which stated the accused is unable on the account of mental disorder to understand the legal proceedings, and procedures for determining fitness were implemented.[57]

A new requirement of assessment orders was added, replacing the warrants of remand. In the past, an accused suspected of being mentally unstable could be detained indefinitely on the warrant of remand whereas the assessment orders are now to be made with specified purposes and a strict cap is placed on the duration of remand. Another crucial change concerned treatment orders, which in the past dictated how the accused should be treated. Mandatory treatment orders without the accused's consent are now only given to those found unfit.[57] The only jurisdiction for mandatory treatment of NCR offenders or even those of convicted of crimes in Canadian jurisdictions is through Provincial law which normally is entitled the Mental Health Act or, in some Provinces, through a Consent specific statute.

Quasi-judicial bodies called review boards were established to manage mentally ill offenders at a provincial-level, replacing the former Lieutenant Governor advisory board system that existed in some, but not all, provinces. Review boards were also empowered to make disposition orders, which determine whether and how the mentally ill accused should be located. They may be discharged absolutely, discharged with some requirements or detained in forensic psychiatric hospitals.[34]

Finally, the concept of criminal responsibility replaced the system of deciding between the guilty and the innocent. For instance, an accused may be found to have diminished responsibility or not be responsible for the crime they committed on the account of mental disorder as opposed to being found not guilty, which implies that the person is not the one who committed the said offence,[57] assuming a crime is found to have occurred.

3.4 Alternative Sentencing

Many offenders now serve their sentences in the community. There are many terms that can be attached to probation orders under a suspended sentence or discharge or conditional sentence orders. The simplest of these orders take the form of a ban, in which an abuser is separated from a victim or from an area. Such sentences are often paired with therapeutic goals as a condition of remaining in society.[58] The Supreme Court of Canada upheld the use of hospitalization as a condition of a conditional sentence order in *R. v, Knoblauch*, 2000 SCC 58.

The most complex of deinstitutionalizing orders is a community treatment order

under a Provincial statute. A mentally ill patient and sometimes offender is ordered to receive treatment as a condition of remaining in the community.[34,57] Despite insufficient research on the effectiveness to date, community treatment orders are gaining popularity and becoming available in increasingly more jurisdictions. Provincial legislation govern the use of community treatment orders and sometimes also govern how frequently they can be used. The subsection 24.3(1) of the *Saskatchewan Mental Health Services Act* sets forth the criteria that must be satisfied before a psychiatrist can issue a community treatment order in Saskatchewan.[59] There are six criteria in total. First, the person must suffer from a 'mental disorder' that require treatment or care and supervision in the community setting. Second, during the past two years, the person must have been detained in an in-patient facility for a total of sixty days or longer, detained on three or more separate occasions or have been the subject of a community treatment orders on a previous occasion. The responsible psychiatrist must also have probable cause to believe that the lack of treatment and supervision may lead to harm to self or others or substantial mental or physical deterioration. The requisite services must also exist in the community and be accessible to the patient. Also, the person must be incapable of consenting but capable of complying with the treatment plan set out in the order.[59] Given these onerous and cumbersome conditions, community treatment orders are rarely used in Saskatchewan and physicians more commonly certify the patients. It has also been frequently opined by doctors working in the field that the *Mental Health Services Act* does not adequately protect them from lawsuits.[8]

4 Therapeutic Justice

4.1 Definition

Therapeutic jurisprudence is defined as "the use of social science to study the extent to which a legal rule or practice promotes the psychological or physical well-being of the people it affects".[60] Therapeutic jurisprudence sustains that the law should be administered and applied in a way that incorporates therapeutic goals and that the principle of punishment is not the main concern of the court. It advocates that the law should address the main factors – the roots – of what may lead the individual to come into contact with the law. Therapeutic jurisprudence acts as a vehicle to provide a more holistic and less punitive approach, resulting in an overall more complete sense of justice.[47,61] It is interesting to note that some therapeutic courts actually employ quite aggressive measures that appear almost retributive along with therapeutic ones. For example, drug courts often require a guilty plea for participation and mental health courts issue community treatment orders that force mentally ill people to take medication.[62,47]

4.2 Restorative Jurisprudence and Other Related Concepts

Restorative justice is a concept that has been incorporated into sentencing in the Canadian justice system for many years. Restorative justice is often confused with, and used interchangeably with, the term therapeutic jurisprudence. While restorative justice can indeed achieve therapeutic outcomes, therapeutic jurisprudence is a separate concept from restorative justice.[63] For example, restorative justice exclusively focuses on the rehabilitation of the offender while therapeutic jurisprudence usually involves mediation between victim and offender in order to assist in the victim's recovery from the trauma.[63]

A closely related concept to restorative justice is community justice, which is

distinguishable based on its goal of fixing some of the underlying social problems that cause crime, a similar goal to that of therapeutic jurisprudence.[63] Community justice is closely related to restorative justice and the terms are used interchangeably in literature.

Finally, it must be understood that all three of the above concepts are very different from retributive justice. This is the very traditional theory which asserts that punishment, when appropriate, is the best response to crime.[63]

4.3 Problem Solving Courts

Problem solving courts, also known as specialized courts and therapeutic courts, are one of many methods in which the principles of therapeutic jurisprudence are upheld.

4.3.1 Drug Treatment Courts

A significant amount of the literature available on therapeutic jurisprudence is about drug treatments courts since these were the forerunners of therapeutic courts. In fact, many of the earlier articles on therapeutic jurisprudence apply only to drug courts.

Drug treatment courts oversee cases involving drug abusing offenders who have agreed to accept treatment for their addictions. Drug treatment courts require offenders to acknowledge their addictions and accept responsibility for them. They implement a unique combination of traditional criminal justice system processes and drug treatment. They are also praised as a cost-efficient and effective way to reduce crime and improve the lives of marginalized citizens.[64] Drug treatment courts commonly use “smart punishment” which employs only the minimum amount of punishment required to reduce criminality and drug use when the offender has a relapse or breaches the order. This is in sharp contrast with probation orders which send the offender back to the court or even imprison them in the same contingency. The emphasis is not on punishment but on altering behaviour to prevent drug use.[64]

The first drug treatment court in Canada was established in December 1998 in Toronto. All offenders with drug related charges are eligible, but the court has a particular focus on prostitutes, youth, and visible minority groups. The court has two “tracks” or streams through which the offender goes. Track One allows non-violent offenders with minor charges to enter the drug treatment court prior to a plea and results in charges being withdrawn upon completion. Track Two is for offenders with more serious charges and requires a guilty plea. In addition, a “consent to dispense with Crown disclosure must be signed, and an agreement that the imposition of the sentence will be delayed is made.” The prosecutor of the drug treatment court reviews every drug charge in Toronto, and informs the accused or their counsel if the accused is eligible.[65]

Another major drug treatment court in Canada is located in Vancouver, British Columbia and was implemented over a four-year period between 2001 and 2005. All offenders charged under the *Controlled Drugs and Substances Act* are eligible. This court requires a guilty plea in exchange for lighter sentences. Participants are enrolled in a supervised drug treatment program that includes individual and group counseling and social activities.[66]

4.3.2 Mental Health Courts

Mental health courts are criminal courts specifically designed to serve persons

with a mental illness who have come in contact with the criminal justice system. The first mental health court in the world was established in Broward County, Florida in the mid-1990s and offered treatment instead of punishment to accused with mental illness. While this mental health court was the first of its kind, mental health courts are often derived from the drug court model. Given the frequent co-occurrence of drug addiction and mental illness, some mental health courts actually replace the pre-existing drug courts. In 2010, there were more than 250 mental health courts in the United States alone.[67]

The first court in Canada that addressed the issue of mentally disordered accused in the criminal justice system opened in Toronto, Ontario in May 1998. The "diversion of mentally disordered accused" officially became part of the Crown Policy Manual in 1994. This program closely resembled those referred to as mental health courts in the US.[68] Mental health courts now exist in Nova Scotia, New Brunswick, Newfoundland, other cities in Ontario, and Manitoba, which just recently opened their mental health court in May of 2012. British Columbia, Nunavut, and Yukon, are among other Canadian jurisdictions in the process of developing mental health courts. As with other types of problem solving courts, mental health courts respond to the unique needs of the population being served.[69] For example, in discussions with the Judge in charge of the Boward County mental health court the authors' were surprised to hear the suggestion that FASD is not recognized in that court. It is obvious to us, that in Saskatchewan, FASD must become part of any mental health strategy that is implemented.

4.3.3 Domestic Violence Courts

Domestic violence courts are another common type of problem solving courts in Canada. Currently, 54 domestic violence programs are in operation in Ontario alone and Manitoba, Alberta, Saskatchewan, New Brunswick, Newfoundland and Labrador and Yukon all have domestic violence courts now. One strong, positive aspect of these courts is that their existence is reassuring to victims and victims become more willing to report these crimes.[70] Interestingly, domestic violence courts were first established when there were no known effective treatments for partner abuse.[70] Also, correlation between domestic violence and substance abuse has been often reported in literature. For instance, roughly half of the men enrolled in batterer's treatment programs had substance abuse problems and roughly half of the men in substance abuse treatment self-reported domestic violence.[71]

4.3.4 Community Courts

Community courts are different from other problem solving courts because they focus on the community in which they are located, rather than the specific problem that caused the offender's behaviour. Unlike other problem solving courts which focus on a particular type of offence or offender, community courts will accept offences of almost any kind that occur within a certain geographical area including offences falling under the *Controlled Drugs and Substances Act.*[72] Community courts tend to focus on a geographical area and function in inner city areas in large metropolitan centres, but the term, like many others, is fairly ambiguous, and could also refer to those set up in rural settings like the Cree community court. While community courts are not as well equipped to deal with general ongoing problems such as drug addiction or mental illness, they are better able to address the specific problems of a particular area. For example, while drug courts can only impose therapeutic sanctions, community courts frequently impose therapeutic sanctions, community service sanctions, or job training for offenders with help from partnering community organizations.[72]

Most of the American literature that discusses community courts focuses on the Red Hook Community Justice Center in Brooklyn, New York. This centre is located in a low-income community in which 70% of the residents live in a large housing development. The area is suffering the effects of government cuts and economic disinvestments. The centre features a court that provides a variety of sanctions, several different programs available to the community and a "problem-solving team" of court personnel.[73]

Most of the Canadian literature that discusses community courts focuses on the Downtown Community Court in Vancouver. This court mostly deals with most offences committed in the downtown eastside area, particularly summary offenses and drug possession charges, and employs a team-based approach to strive to "improve outcomes for offenders; implement innovative criminal case management to improve justice efficiencies; and provide new opportunities for community participation in the justice system".[72]

4.3.5 Indigenous or Aboriginal Courts

There are Aboriginal or indigenous courts operating in various parts of the world, but most of the available literature comes from Australia and Canada. Many of these courts have been functioning for several years and tend to rise out of both the restorative and therapeutic justice principles. Concepts employed in these courts are also increasingly being used in traditional courts. As of 2008, Indigenous Sentencing Courts operate in all jurisdictions of Australia except for Tasmania. The Gladue Court in Toronto, the Cree Courts in Saskatchewan, the Tsuu T'ina Peacemakers Court in Alberta and the Hollow Waters Healing Circles in Manitoba are in operation in Canada.[74]

Canadian Aboriginal courts have broader diversion programs than seen in other problem solving courts. Only minor offenses are diverted in a typical problem solving court, but in the Tsuu T'ina Peacemakers Court, every offense except for homicide and sexual assault are eligible. The Tsuu T'ina Peacemakers Court judge may also override a prosecutor's non-consent to diversion.[75] It is unclear how the *Criminal Code* structure is overcome, but one of the possible ways in which the court was authorized to do so would be at the permission of the Attorney General or the Lieutenant Governor of Alberta.

In Canada, these courts primarily exist to sentence Aboriginal offenders with some expertise about the cultural background of those offenders.[76] Such cultural considerations have been required by new amendments to the *Criminal Code* such as the section 718.2(e), and interpretations of these amendments by the Supreme Court of Canada.[77,78] In Saskatchewan, there has been much debate about whether or not to expand the Cree Court's substantive jurisdiction so that it can address the civil and family issues in Aboriginal people's lives that may be influencing their criminal behavior.[79]

The Koori Court in Victoria, Australia started as a pilot project in 2002. There are currently four Koori Courts and one Children's court pilot program. These courts address many of the needs specific to Aboriginal people, leading to a reduction in recidivism and better participation of local Aboriginal communities in the legal process. Although less formal, the Koori Courts are respectful, are culturally sensitive and follow all legal procedures of the traditional court. The courts showcase Aboriginal art and share an oval shaped table in the centre. Three flags are at the front of the court, representing Australia, Aboriginal and Torres Strait Islander flag, respectively. The magistrate sits at the oval table

together with all other participants including the family of the defendant. The elder and respected person sits on either side of the magistrate and provides the court with advice relating to cultural matters. People do not stand for the magistrate entrance. Markers of prestige in the courtroom are dispensed with and the language is plain English.[25]

One of the aims of the Koori Court is to have participation by the Koori community in the court process and to create sentencing orders more appropriate to Aboriginal offenders. Aboriginal elders and other respected persons of the community are invited to participate. The Courts require that an adult Koori defendant must be Aboriginal or Torres Strait Islanders and live locally. The accused must plead guilty to an offence and show intention to take responsibility for their actions. As is done in Canada, the adult Koori Court hears all cases that can be heard in the Magistrates' courts except for family violence and sexual offences.[25] The types of charges vary from drug problems, theft, breaking and entering, possessing weapons and aggressive behaviours.

Other courts in Australia that target Aboriginal people are the Circle Sentencing Court of New South Wales and Nunga Court of South Australia. Circle sentencing was modeled after a Canadian program of the 1990s.[28] Circle Sentencing in Australia most often involves an offence of common assault; the next most prevalent offences are unlicensed driving and breaching an apprehended violence order.[28] Australian Indigenous Sentencing Courts are similar to community courts. The goal of these courts is to build a connection between "white justice" and Indigenous people. This is accomplished through procedures that follow the tenets of restorative justice, such as improving communication between parties, applying procedural justice, using persuasion and support to encourage offenders to be law-abiding and to avoid incarceration.[28] One of the most prominent and effective methods used is to draw on the knowledge of elders or other respected individuals from the Indigenous community in which the offender is a member. The presence of these elders also aids in overcoming language barriers. Hearings also take place in a courtroom where the judge is sitting eye-level with the offender, not on an elevated bench. Courtrooms are decorated with culturally appropriate symbols of authority.[80]

4.3.6 Youth Court & Sentencing Circles

Youth courts are not problem solving courts in the traditional sense. Instead, they are a mandatory, basic branch of the traditional court system. Youth courts use the same principles of criminal justice as traditional courts except that they sentence offenders aged between 12 and 17and that they oversee all *Criminal Code* offences under the *Youth Criminal Justice Act*. More serious offences such as murder that are committed by older youth offenders may be transferred to adult court. Nevertheless, youth courts still function in a largely therapeutic, problem-solving manner by focusing more on helping than punishing. They focus more on rehabilitation of the specific individual offender rather than deterrence and retribution. They also tend toward keeping juvenile offenders within the community instead of incarceration.[24]

There is one specialized youth problem solving court in Canada. The Youth Mental Health Court Ottawa opened in 2008 and has a particular focus on rehabilitating the offender. It appears to be similar to basic youth courts except that it only accepts youths with mental illness. It also appears to consider drug addiction as a mental illness and places a heavy focus on charges under the *Controlled Drugs and Substances Act*. The court requires a guilty plea in which the accused must accept responsibility for their offense to the Crown's satisfaction. In addition, youth are sometimes subject to diversions or

extrajudicial sanctions such as section 810 orders.[81]

One of the main purposes for repealing the *Young Offenders Act* and enacting the *Youth Criminal Justice Act* was to reduce the number of incarcerated youth. While restorative justice practices under the *Youth Criminal Justice Act* have reduced the number of youth reaching courtrooms, there is disagreement on whether the number of youth in custody has changed.[81]

Literature shows that a young offender's chances of successfully readjusting to society upon release depend on with how well they adjusted to incarceration. Pre-existing vulnerabilities and fear of victimization may indicate whether a youth will well-adjust to custody. Despite the importance, it is unclear what and how factors affect a youth's adjustment to custody and to society upon release.[82]

Aboriginal people have generally supported community-designed and community-based responses to offending especially where offending involves youth and have resisted incarceration.[24] In British Columbia, youth aged between 12 and 17 are 9 to10 times more likely to be in prison if they are Aboriginal. Indigenous youths in Australia are also overrepresented in the criminal justice system at a rate 23 times higher than their non-Indigenous counterparts. The police who apprehended the accused make the decision on whether to divert the youth following the criteria and procedures set out in the *Youth Justice Act*[83]. Difficulties in mobilizing the Indigenous communities in planning and implementing the diversion system, present a challenge in Indigenous youth diversion.[83]

One alternative measure encouraged by the Canadian *Youth Criminal Justice Act* is a conference between offenders, victims, and members of the community at various stages in the criminal justice process according to a restorative justice concept. Conferencing can be in various forms, including Aboriginal sentencing circles, although sentencing circles are onerous and therefore are not used frequently for youths. More frequently used types of conferences are family group restorative conferences for serious or chronic offenders and youth justice committees for minor or first-time offenders. A study on victims of young offenders found that victim-offender mediation was a good experience for most victims even if the victims' initial feelings were negative.[84]

4.3.7 Gambling Treatment Courts

Although it has been almost 30 years since the medical community recognized compulsive and pathological gambling as a mental illness, the legal community has been hesitant in viewing gambling as a psychiatric condition which requires special accommodation. At first, gambling was used in the United States as a reason for a "downward departure" from typical sanctions because the society encourages gambling and it would be unfair to hold gamblers independently accountable for the crimes committed in relation to gambling.[85]

In 2003, the first gambling treatment court was opened in Amherst, New York. It is currently the only one of its kind and was modeled after drug treatment and domestic violence courts. The court incorporates several therapeutic justice concepts including the involvement of gambling experts and health care professionals. The Amherst court requires the defendant to plead guilty and forfeit rights to a plea bargain. All charges are dropped when the offender successfully completes the program. Upon failing to do so, the offender is returned to criminal court and charged with a felony offence. Exclusion programs have

been suggested as a possible alternative intervention for problem gamblers, but effectiveness of such programs in North America has been doubted.[86]

4.3.8 Homeless Courts

Starting at San Diego, California in 1989, homeless courts are available in some jurisdictions. These court sessions are held in homeless shelters for easy access by the main clientele. These courts impose restorative or therapeutic sentences and incarceration used very rarely as an alternative sanction. This is primarily seen in the United States.[87]

4.3.9 John School Diversion Programs

Therapeutic justice programs are increasingly used in prostitution-related criminal charges. Usually, this takes the form of "John school" which teaches the male clients of female prostitutes about the harms and risks of prostitution. It is argued that curbing the demand for prostitution through John schools is the most effective way to reduce prostitution altogether. Providing treatment for the female prostitutes is argued to be less effective because women involved in the sex trade are usually coerced into it.[88-90]

4.4 Therapeutic Measures in Traditional Judicial System and Courts

Given various reasons such as insufficient resources and distrust in a new inititiatives, some jurisdictions choose not to establish a specialized court. Instead, they employ therapeutic measures as a part of their usual practice. In criminal justice system, some of such measures include diversion, therapeutic sentencing delays, differentiated sentencing method and alternative sentences.

4.4.1 Criminal Code Sections on Diversion & Therapeutic Sentencing Delays

As a general rule, delay of a criminal proceeding, particularly sentencing, is prohibited by common law sentencing practice. The *Criminal Code* was recently amended to allow sentencing delays in therapeutic courts. (s. 720(2).[77]

All diversion programs, regardless of their format, have in their core the goal of redirecting the mentally ill from the criminal justice system to appropriate mental health care services while protecting the respective person and the public. As such, diversion can and often does result in avoiding a conviction and is actively used by the problem solving courts that do not seek a guilty plea.[47]

Conditional discharges are available for offenses with minor consequences. These include offences that do not have minimum sentences or a potential sentence of over fourteen years imprisonment. These conditional discharges are often paired with a probation order with therapeutic conditions. The *Criminal Code* does not specify that such orders and sentences are to be made exclusively in therapeutic courts. Therefore, these orders can be and commonly are made in any provincial court.[77]

4.4.2 Curative Discharges for Impaired Drivers

The *Criminal Code* allows for a sentencing court to enter a conditional discharge for an alcoholic who is convicted of impaired driving (S. 255(5)). However, provinces may choose not to proclaim this section and thereby voiding this option. Ontario has chosen not to proclaim this section and it is argued that proclamation of the section, along with an increased use of the ignition interlock program, could save up to 72 lives each year in Ontario.[91] Saskatchewan has proclaimed this section of the Code.[77]

Earlier writings on diversion programs for impaired driving charges in the US show resistance at various levels of the society to the idea of rehabilitating these people. For example, Oregon established strict limits on the circumstances under which diversion could be used for impaired drivers in 1980s and commentators have welcomed similarly tough measures in various jurisdictions.[92]

4.4.3 Aboriginal Sentencing – Gladue Factors

All Canadian courts must give special cultural considerations when assessing Aboriginal people charged with a crime. This is a particularly pressing need in traditional courts. Section 718.2(e) of the Criminal Code mandates that judges apply the principles of sentencing through an alternative method of analysis.[77] This is especially strictly required for all Aboriginal offenders regardless of their declaration status, specific Aboriginal ancestry, and places of residence.[78] Section 718.2(e) also requires courts to order sentences that align more closely with the Aboriginal views of justice and are more likely to rehabilitate the offenders.[77] Usually this presumably requires the implementation of some therapeutic measures without incarceration. Through the milestone case of *R v Gladue* at the Supreme Court, an analysis has been developed and termed Glaude analysis in order to assist judges in the process.

The Gladue analysis aims at focusing on the underlying factors that may have caused the crime rather than the committed crime itself. Factors to be considered include:[78]

- substance abuse by the offender;
- substance abuse in the offender's family;
- poverty;
- unemployment;
- witnessing or experiencing abuse and violence;
- separation from Aboriginal culture or community; and
- whether the offender or a family member attended residential school.

Gladue analysis acknowledges a sentence for an Aboriginal offender should attempt to address these issues and mend ties between the offender, victim, and community according to the principles of restorative justice.[78]

It must be noted that these sections while not guaranteeing lighter sentences for Aboriginal offenders will often have that result. All other principles of sentencing apply equally to all offenders. Also, despite the addition of s.718.2(e) and *Gladue*, many cases involving Aboriginals do not reference either. Partially in response to this problem, the Supreme Court reiterated its stance established in *Gladue* by stating that the court must consider the "gravity of the offense and the degree of responsibility" in *R v Ipeelee*[93] in 2012.

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