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Trajectoires de soins de santé et de services sociaux avant un verdict de non-responsabilité criminelle: Quelles implications pour l'organisation des services?

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Résumé

Au Canada et ailleurs dans le monde, le système judiciaire occupe une place de plus en plus importante dans la prise en charge des personnes vivant avec un trouble mental grave. Le rôle du système judiciaire comme levier d'accès aux soins est particulièrement évident dans le cas des personnes déclarées non criminellement responsables pour cause de troubles mentaux (NCR). La vaste majorité des personnes déclarées non criminellement responsables pour cause de troubles mentaux (NCRTM), formant la clientèle principale des services psycho-légaux, était déjà connue des services de santé mentale. Cela questionne la présente capacité du réseau à répondre aux comportements perturbateurs et fait ressortir la possibilité de prévenir le potentiel passage à l'acte et la trajectoire judiciaire subséquence.

La présente thèse de doctorat utilise des données administratives provenant des secteurs de la santé, de la justice et de la sécurité publique pour plus de 1 000 personnes qui ont reçu un verdict de non-responsabilité criminelle au Québec. Ces données sont complétées par des entrevues qualitatives avec des parties prenantes. Ensemble, l'analyse de ce corpus de données permettent de mettre en lumière les barrières à l'accès aux soins et les interruptions de services que subissent, dans leur parcours de soins, les personnes atteintes de troubles mentaux sévères et ayant des comportements perçus comme perturbateurs ou dangereux qui les rendent susceptibles d'être judiciarisés.

Le premier article décrit les tendances d'utilisation de services de santé et des réclamations de médicaments sur ordonnances dans l'année précédant une infraction qui a entraîné un verdict de NRCTM. Les résultats indiquent que – bien que des résultats antérieurs montrent que plus de 70 % des personnes NCRTM avaient déjà été en contact avec des services pour des raisons de santé mentale – moins de la moitié des personnes déclarées NCRTM avaient bénéficié d'une réelle prise en charge médicale avant l'incident. Les résultats montrent également qu'une personne sur cinq avait commis l'infraction moins d'une semaine après le contact de santé mentale le plus récent. Parmi celles qui avaient au moins une prescription pour

un antipsychotique, près de la moitié ne prenaient pas d'antipsychotique au moment de l'infraction.

Le deuxième article identifie les facteurs individuels et contextuels facilitants et ceux faisant obstacles à l'accès aux services de santé mentale dans la période avant le délit. Les considérations géographiques jouent un grand rôle dans la possibilité d'accéder et de recevoir les services de santé mentale spécialisés – au-delà des facteurs individuels liés aux besoins. De plus, vivre avec des proches diminue de moitié la probabilité d'aller chercher des services de santé mentale et diminue l'intensité de l'utilisation de services de santé mentale spécialisés, même en tenant compte et ajustant les modèles pour les besoins.

Finalement, le troisième article repose sur l'analyse d'entretiens individuels et de groupes d'entretiens focalisés avec 16 personnes ayant de l'expérience vécue (pairs aidants, proches aidants), des praticiens et des administrateurs. Les résultats mettent en évidence comment les expériences passées de stigmatisation, de traumatisme, d'inefficacité et de discrimination au sein d'un système hospitalo-centrique influencent la capacité des utilisateurs de services et des proches aidants à chercher et à s'engager dans les soins. Les mécanismes d'accès existants en période crise, tels que l'intervention policière et les services d'urgence, sont des options inacceptables pour les utilisateurs de services et leurs aidants familiaux et sont donc souvent considérés comme des derniers recours. Par conséquent, les utilisateurs de services entrent dans le système de santé avec des besoins complexes qui sont difficiles à traiter avec les connaissances cliniques actuelles et qui résultent bien souvent en des mesures coercitives plutôt qu'axées sur le rétablissement.

Les résultats peuvent être interprétés à la lumière de la stigmatisation structurelle, qui fait référence aux politiques et pratiques institutionnelles qui ont un impact négatif sur les opportunités des personnes atteintes de maladies mentales. Dans le cas présent, la stigmatisation structurelle réduit l'accès aux soins en raison d'une allocation de ressources inadéquate, d'un manque de collaboration intersectorielle et d'intégration des soins, d'attitudes et de pratiques négatives des praticiens de la santé, et d'une surutilisation d'approches coercitives. Nous

proposons des stratégies pour réduire les barrières à l'accès liées au système et aux prestataires de soins.

Mots-clés : psychiatrie légale, accès aux services, prévention de la violence, santé mentale forensique.

Abstract

In Canada and elsewhere, the justice system is playing an increasingly important role in the care of individuals with severe mental illness. The role of the justice system as a lever for accessing care is particularly evident in the case of individuals found not criminally responsible on account of mental disorder (NCR). The vast majority of individuals found NCR, who make up the majority of forensic mental health service users, were already known to mental health services. This raises questions about the current capacity of the mental health system to respond to disruptive behaviors and highlights the potential for preventing future justice involvement.

This doctoral thesis uses administrative data from the health, justice, and public security sectors for over 1,000 individuals who received a verdict of NCR in Québec. These data are complemented by qualitative interviews with stakeholders. Together, the analysis of this data corpus highlights the barriers to accessing care and service interruptions that individuals with severe mental illness and behaviors perceived as disruptive or dangerous encounter in their care pathway, leading to the risk of judicial involvement.

The first article describes trajectories in health services use and prescription drug claims in the year preceding an offense that led to a NCR verdict. The results indicate that, although previous research has shown that over 70% of NCR individuals had already been in contact with mental health services, less than half of NCR individuals had received no consistent care prior to the offense. The results also show that one in five individuals committed the offense less than a week after their most recent mental health contact. Among those who had at least one prescription for an antipsychotic, nearly half were not taking an antipsychotic at the time of the offense.

The second article identifies individual and contextual factors that facilitate or hinder access to mental health services in the period prior to the offense. Geographic considerations play a major role in the possibility of accessing and receiving specialized mental health services, beyond individual factors related to needs. Additionally, living with family members decreases

the likelihood of seeking mental health services by half and decreases the intensity of specialized mental health service use, even after adjusting for models based on needs.

Finally, the third article is based on the analysis of individual interviews and focus groups with 16 individuals with lived experience (peer support workers, family caregivers), practitioners, and administrators. The results highlight how past experiences of stigma, trauma, inefficiency, and discrimination within a hospital-centric system influence the ability of service users and family caregivers to seek and engage with care. Existing access mechanisms during crisis periods, such as police intervention and emergency services, are unacceptable options for service users and their family caregivers and are often considered as a last resort. As a result, service users enter the healthcare system with complex needs that are difficult to address with current clinical knowledge and often result in coercive measures rather than recovery-oriented care.

The results can be interpreted in light of structural stigma, which refers to institutional policies and practices that negatively impact the opportunities of people with mental illness. In this case, structural stigma reduces access to care through inadequate allocation of resources, lack of intersectoral collaboration and care integration, negative attitudes and practices of healthcare practitioners, and overreliance on coercive approaches. We propose strategies to reduce system-level and provider-level barriers to access.

Keywords: forensic psychiatry, access to services, violence prevention, forensic mental health.

Table des matières

Liste des tableaux

Liste des figures

Liste des sigles et abréviations

BIC   Bayesian Information Criterion

BLRT   Bootstrap likelihood ratio test

ICD-9   International Classification of Diseases, Ninth Revision

MH   Mental health

NCRMD   Not criminally responsible on account of a mental disorder

NCRTM   Non criminellement responsable pour cause de troubles mentaux

SD   Standard deviation

Dédicace

À toutes les personnes affectées par un verdict de non-responsabilité criminelle.

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Chapitre 1 – Introduction et recension des écrits

Les services de psychiatrie légale : Un secteur en croissance exponentielle

On assiste au Québec, comme ailleurs au Canada et dans le monde, à une croissance de la place qu'occupe le système judiciaire dans la trajectoire de soins des personnes vivant avec des problèmes de santé mentale (Jansman-Hart et al., 2011; Keown et al., 2018; Lafore, 2010; Latimer & Lawrence, 2006; Priebe et al., 2008; Sheridan Rains et al., 2020). Le rôle du système judiciaire comme levier pour accéder à des soins de santé est particulièrement apparent dans le cas des personnes déclarées non criminellement responsables pour cause de troubles mentaux (NCRTM). Au Canada, selon l'article 16(1) du Code criminel, « la responsabilité criminelle d'une personne n'est pas engagée à l'égard d'un acte ou d'une omission de sa part survenu alors qu'elle était atteinte de troubles mentaux qui la rendaient incapable de juger de la nature ou de la qualité de l'acte ou de l'omission, ou de savoir que l'acte ou l'omission était mauvais » (Code criminel canadien, 1992). Bien que le critère légal soit transdiagnostic, la nature du critère fait que les personnes qui sont déclarées NCRTM ont généralement un trouble mental grave, soit un trouble psychotique ou un trouble bipolaire (Crocker, Nicholls, Seto, Charette, et al., 2015).

Au Québec, le nombre de personnes admises aux services de psychiatrie légale a presque triplé entre 1992 et 2004, passant de 173 à 486 (Latimer & Lawrence, 2006), et ce, malgré un déclin marqué de la criminalité pendant cette même période (Gannon, 2006). Plus récemment, pour la période de 2018 à 2021, le nombre annuel de verdicts NCRTM oscille entre 341 et 440 selon les données de la Commission d'examen des troubles mentaux du Tribunal Administratif du Québec. Cette croissance, combinée à une tendance à la baisse des libérations sous conditions ou absolues (Latimer & Lawrence, 2006), se traduit par une population croissante et une pression accrue sur les services de psychiatrie légale.

Les changements législatifs, structurels et sociosanitaires à l'origine de cette croissance

Les changements législatifs, structurels et sociosanitaires à l'origine de cette croissance sont nombreux et variés. Des modifications importantes ont été apportées au cours des années 1990 au Canada aux processus entourant la défense de la non-responsabilité criminelle. On souligne entre autres une plus grande protection des droits des personnes déclarées NCRTM, notamment à travers la mise en place de commissions d'examen[1], la valorisation du principe de la disposition la moins privative de liberté dans les décisions et la mise en place d'un processus de révision annuelle des décisions par les commissions d'examen. La détention n'étant plus la seule disposition possible suite à un verdict NCRTM, la défense NCRTM est ainsi devenue une option plus attrayante qu'auparavant pour les accusés, incluant pour des délits mineurs.

Simultanément, une restriction importante des critères pour les soins et hospitalisations sous contraintes a contribué à faire émerger des pratiques de justice thérapeutique (Ambrosini & Joncas, 2013), où la loi est appliquée de façon à répondre, entre autres choses, aux besoins thérapeutiques (santé mentale, toxicomanie, etc.) perçus des personnes qui ont des démêlés avec la justice civile ou criminelle (Winick, 1997). L'entrée en vigueur en 1998 de la Loi sur la protection des personnes dont l'état mental présente un danger pour elles-mêmes ou pour autrui (également connue sous le nom de loi P-38) vise à protéger les droits individuels en stipulant, notamment, qu'une personne dont l'état mental est perturbé ne peut être mise sous garde plus de 72 heures sans autorisation d'un tribunal. L'état mental doit également présenter un « danger grave et immédiat » (*L.R.Q., c. P-38.001*, 1997) pour que le tribunal ordonne une garde en établissement. Les soins sous contraintes doivent également être ordonnés par le tribunal (autorisations judiciaires de soins). Les proches des personnes qui ont un trouble mental grave et qui refusent les soins de santé mentale sont donc bien souvent contraints de passer par les tribunaux pour accéder aux soins. Cela a contribué, d'une part, à légitimer la juridicisation [2] des

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[1] Les Commissions d'examen pour troubles mentaux sont des tribunaux indépendants mandatés par le Code criminel du Canada pour prendre des décisions liées aux personnes déclarées NCRTM (Code criminel canadien, 1992).
[2] Nous distinguons ainsi « judiciarisation » et « juridicisation ». La judiciarisation fait référence dans ce texte à l'implication judiciaire de personnes, alors que la juridicisation fait plutôt référence à la place croissante dédiée aux mécanismes et procédures légaux dans la sphère de la santé et des services sociaux.

soins, entendue comme l'utilisation de leviers légaux pour l'accès aux traitements, et à contribuer à une culture où le recours au verdict de NCR pour accéder à des services spécialisés est souvent banalisé par les professionnels (Roy, Crocker, et al., 2020).

En effet, les transformations des modes d'intervention auprès de personnes ayant des troubles mentaux par un désinvestissement de la prise en charge hospitalière et de l'intervention sociale au profit d'une logique de soutien et d'accompagnement qui s'oriente autour de l'autodétermination et du citoyen à part entière se sont accompagnées depuis plusieurs années d'une prise en charge accrue par le biais de la justice et non de la santé, des services sociaux ou des communautés (Commaille & Dumoulin, 2009; Lafore, 2010; Ouellet, 2017; Schneider et al., 2016). Les programmes de « déjudiciarisation » mis de l'avant reposent sur un paradigme policier ou judiciaire, dont les unités policières d'intervention de crise en santé mentale – dont le modèle le plus célèbre est le Crisis Intervention Team : (Charette et al., 2014; Deveaux et al., 2018; Marcus & Stergiopoulos, 2022) – et les tribunaux en santé mentale (Hiday & Wales, 2011; Jaimes et al., 2020; Schneider et al., 2016). Le manque de services psychosociaux et médicaux adaptés aux personnes judiciarisées ou qui ont certains comportements dérangeants, perturbateurs et parfois violents entraîne une augmentation du recours aux services psycho-légaux pour répondre aux besoins en santé et comportementaux des utilisateurs de services (Crocker et al., 2017; Roy, Crocker, et al., 2020).

On ne peut passer non plus sous silence les impacts à long terme de la restructuration des services de santé mentale. Pendant les années 1960, au Québec comme ailleurs dans le monde, une grande entreprise de restructuration des services de santé mentale a été amorcée (Lesage et al., 2000). Cette restructuration visant à privilégier les soins offerts dans la communauté plutôt que ceux offerts dans un contexte d'hospitalisation a été motivée par différentes considérations, notamment humanitaires, financières et sociétales (Kim, 2016), et facilitée par l'accessibilité croissante de médicaments psychorégulateurs (Gronfein, 1985). Ce mouvement de désinstitutionnalisation comporte plusieurs phases dont la fermeture d'hôpitaux psychiatriques, l'augmentation du nombre de lits dédiés aux soins en santé mentale dans les hôpitaux généraux (la *trans*institutionnalisation) et l'augmentation des services offerts en ambulatoire (Fleury et al., 2012; Sealy & Whitehead, 2004).

Au Québec, entre 1970 et 1980, près de 17 000 lits en hôpitaux psychiatriques ont été fermés, passant de 20 000 à aussi peu que 3 000 (Lesage et al., 2000; Sealy & Whitehead, 2004). Le transfert vers les hôpitaux généraux n'a été que minimal, pour un total de moins de 5 000 lits en 1995 (Lesage et al., 2000). Cette réorganisation des services s'est traduite par une chute des jours de soins de santé mentale entre 1985 et 1999, à la fois dans les hôpitaux psychiatriques (- 49,6 %) et dans les hôpitaux généraux (- 47.8%) du Québec (Sealy & Whitehead, 2004). Bien que cette tendance se soit poursuivie dans le cas des hôpitaux psychiatriques, elle s'est renversée dans le cas des hôpitaux généraux (Sealy, 2012). Au Québec, ces phénomènes ont été accompagnés d'une sectorisation des services (Fleury et al., 2012), la responsabilité clinique d'une population d'une région géographique préétablie revenant donc à une équipe multidisciplinaire qui relève d'un établissement (Fleury & Grenier, 2004).

Le virage ambulatoire s'étant déroulé dans un contexte d'austérité visant à rétablir le déficit zéro (Hébert et al., 2017), les investissements prévus dans les services de santé mentale dans la communauté ont tardé à venir. En effet, la proportion des dépenses sociosanitaires dédiées à la santé mentale a diminué entre 1998 et 2002 (Ministère de la Santé et des Services sociaux, 2005). Dans le tout premier plan d'action en santé mentale, le Ministère de la Santé et des Services sociaux a dressé un constat d'échec : « la mise en place d'un système de services de santé mentale dans la communauté ne s'est pas encore véritablement concrétisée » (Ministère de la Santé et des Services sociaux, 1998, p. 11). En 1994-1995, aussi peu que 36 % du financement dédié à la santé mentale était dédié au financement des services dans la communauté (incluant les services externes offerts par les centres hospitaliers), alors que 64 % étaient dédiés aux services d'hospitalisations. En 1997-1998, cette tendance commençait à peine à être renversée avec seulement 41 % des dépenses publiques allouées à la santé mentale dédiées aux services offerts dans la communauté (Ministère de la Santé et des Services sociaux, 1998). En 2003, le vérificateur général du Québec produit un rapport grandement critique envers les avancées mineures accomplies (Vérificateur général du Québec, 2003). Le rapport souligne que les sommes nécessaires pour la restructuration complète des services de santé mentale, en particulier pour le développement et l'implantation de services offerts dans la communauté, n'ont pas été dégagées. Par exemple, le gouvernement a atteint à peine 20 % de sa cible d'offrir

le suivi intensif dans la communauté à au moins 100 personnes pour 100 000 habitants. Le financement disponible est aussi alloué de façon inéquitable entre les régions, provoquant des disparités d'accessibilité, de disponibilité et d'intensité des services. Par exemple, le délai moyen pour obtenir une consultation auprès d'un psychiatre varie entre 3,8 à 14 mois, alors que les dépenses moyennes par habitant varient entre 53,99 $ et 159,48 $, en pondérant pour tenir compte de certaines caractéristiques de la population et de sa mobilité interrégionale (Vérificateur général du Québec, 2003). Ce rapport a amené en 2004-2005 le Ministère de la Santé et des Services sociaux à modifier sa méthode de distribution des ressources pour réduire les iniquités entre les régions (Ministère de la Santé et des Services sociaux, 2005).

Tous ses facteurs, pris ensemble, ont pu contribuer à la hausse fulgurante des verdicts NCR au Canada et, dans une moindre mesure, la hausse de la prévalence des besoins en santé mentale dans les populations carcérales (Butler et al., 2022; Fazel & Danesh, 2002). Finalement, il est essentiel de dire quelques mots sur le cas unique du Québec dans la fédération canadienne. L'utilisation de la section 16 du Code Criminel est plusieurs fois plus fréquente au Québec qu'ailleurs au pays.(Crocker, Nicholls, Seto, Côté, et al., 2015; Lukassen & Miladinovic, 2014; Tribunal administratif du Québec, 2012) En effet, le verdict de NCR est accordé pour des délits d'une moindre sévérité et pour une plus grande diversité de diagnostics, ce qui suggère que l'interprétation des critères du Code Criminel est opérationnalisée de façon plus libérale, que les évaluations sont menées différemment ou que cette alternative est préférée à d'autres mesures de déjudiciarisation qu'ailleurs au Canada.(Crocker, Nicholls, Seto, Charette, et al., 2015) Aucune étude ne permet de tirer de conclusions claires sur l'origine de ces disparités, mais chose certaine, la population NCR du Québec est plus semblable en termes de profils, de besoins et de trajectoires aux personnes ayant des troubles mentaux graves sans verdict NCR qu'aux personnes déclarées coupables (Crocker, Nicholls, Seto, & Côté, 2015; Dumais et al., 2014; Fleury et al., 2011; Kurdyak et al., 2021; Vanasse et al., 2022).

Hétérogénéité des profils et besoins en santé des personnes déclarées NCRTM

Ces changements législatifs et sociosanitaires ont entraîné une diversification de la clientèle psycho-légale (Latimer & Lawrence, 2006; Livingston et al., 2003; Penney et al., 2019). En Ontario, la proportion (et non le nombre absolu) de personnes déclarées NCRTM pour un délit violent sévère a chuté entre 1987 et 2012, alors que celles de personnes déclarées NCRTM pour un délit violent d'une sévérité moindre (p. ex., voies de fait simples) et un délit lié à l'administration de la justice (p. ex., non-respect des conditions) ont augmenté. La présence de troubles mentaux concomitants, tout particulièrement les troubles d'abus de substance, chez les personnes admises aux services psycho-légaux est également en croissance (Penney et al., 2019). Cette hétérogénéité a des implications importantes pour l'organisation des services de psychiatrie légale, des services de psychiatrie générale et des services médicaux de proximité. Étant donné les répercussions importantes que peut avoir l'entrée dans les services de psychiatrie légale dans la vie des utilisateurs de services (dont la stigmatisation structurelle et interpersonnelle (Livingston et al., 2011a; West et al., 2014) et une plus grande privation de liberté (Martin et al., 2022)), sans oublier la pression accrue sur les ressources et les coûts économiques considérables (Jacobs et al., 2016), il y a lieu de s'interroger sur la possibilité d'avoir plutôt recours à des alternatives à la judiciarisation et à la détention hospitalière pour certains sous-groupes de personnes.

En plus du trouble mental grave, les personnes déclarées NCRTM présentent des profils complexes et hétérogènes en termes de besoins psychosociaux et cliniques. Comme décrit plus haut, la proportion de personnes ayant des troubles concomitants d'usage de substance ont grandement cru dans les dernières décennies dans la clientèle psycho-légale (Penney et al., 2019). Au Canada et au Québec, la proportion de personnes déclarées NCRTM ayant un trouble d'abus de substance se situerait entre 30 % et 50 % (Crocker, Nicholls, Seto, Charette, et al., 2015; Latimer & Lawrence, 2006; Penney et al., 2019). À titre comparatif, une récente méta-analyse a trouvé que la proportion de personnes ayant un trouble d'usage de substances chez les personnes ayant une schizophrénie était de 42 % (Hunt et al., 2018).

Nous savons également que les troubles concomitants de santé physique sont fréquents chez les personnes ayant un trouble mental grave, et particulièrement chez celles vivant avec une schizophrénie (De Hert et al., 2011; Laursen et al., 2014; Moore et al., 2015). Ces dernières ont un risque deux à trois fois plus grand d'avoir des troubles de santé physique liés à l'obésité, au syndrome métabolique, au diabète et aux maladies cardiovasculaires, entre autres (De Hert et al., 2011; Mitchell et al., 2013). Les effets secondaires des traitements pharmacologiques sont souvent pointés du doigt, mais les difficultés à accéder à des soins appropriés et sécuritaires sont également à considérer, en plus des vulnérabilités socioéconomiques. Par exemple, les personnes ayant un trouble mental grave connaissent le plus haut taux de mortalité due aux maladies cardiovasculaires, mais sont les moins susceptibles de recevoir les interventions thérapeutiques appropriées (De Hert et al., 2011). Les personnes ayant un trouble mental grave sont également plus susceptibles de décéder des suites d'un cancer colorectal que la population générale, malgré une incidence similaire – association expliquée par un accès différencié aux traitements de pointe (Protani et al., 2022). Les patients ayant un trouble mental grave, et particulièrement les patients des services de psychiatrie légale, connaissent une surmortalité, à la fois due à des causes non naturelles (victimisation, accident, suicide, p. ex.) ainsi qu'à des causes naturelles. Les études spécifiquement auprès de la clientèle de psychiatrie légale s'étant intéressées à la question ont utilisés des échantillons trop petits pour obtenir un estimé précis (Tabita et al., 2012), mais une méta-analyse dans la population de personnes ayant des troubles mentaux graves générale est arrivée à la conclusion que le risque relatif de mortalité est 2.2 fois plus élevé chez les personnes ayant un trouble mental grave (95% CI : 2.12 – 2.33) et 2.5 fois plus élevé chez les personnes ayant une schizophrénie (95% CI : 2.35 – 2.75) (Walker et al., 2015).

La clientèle de psychiatrie légale présente donc des profils complexes de besoins cliniques et comportementaux (Rutherford & Duggan, 2009), amalgamant les besoins liés au trouble mental, aux troubles concomitants physiques, à l'usage de substances et aux comportements perturbateurs qui ont des conséquences importantes sur l'organisation des soins et services.

Épidémiologie de la judiciarisation et de la violence chez les personnes ayant un trouble mental grave

Le critère légal de NCRTM suppose implicitement un lien direct entre les symptômes du trouble mental et le délit. Avant d'examiner la littérature portant sur les trajectoires de soins des personnes déclarées non criminellement responsables (voir section suivante), il est donc nécessaire de s'attarder à l'épidémiologie de la judiciarisation et de la violence chez les personnes ayant un trouble mental grave. Nous avons récemment publié un chapitre de livre portant sur la violence chez les personnes ayant un trouble mental grave (Crocker et al., 2023) – nous en reprenons ici la section portant sur l'épidémiologie de la violence.

« Une première approche pour évaluer la relation entre troubles mentaux et violence vise à estimer la prévalence de comportements violents parmi les personnes ayant un trouble mental grave. Des études épidémiologiques américaines datant de plusieurs années suggèrent qu'en moyenne, environ 10 % des individus ayant un trouble mental grave manifestent une problématique de violence (Swanson et al., 1990). À titre comparatif, dans cette même étude, ce chiffre se situe à 24,7 % pour les personnes présentant un abus ou une dépendance à l'alcool et à 2,1 % pour les personnes n'ayant aucun diagnostic de trouble mental. Les comportements sévères de violence (p. ex., voies de fait armées ou causant des lésions corporelles, ou menaces avec arme létale) avaient quant à eux été manifestés chez moins de 4 % des personnes ayant un trouble de la schizophrénie (Swanson et al., 2006). Il est à noter qu'aucune étude de ce genre n'a été menée au Canada.

La deuxième approche vise à estimer le risque qu'un groupe, ici les personnes ayant un trouble mental grave, commette un acte de violence comparativement à la population générale. Les études prospectives longitudinales portant sur des cohortes de naissances échelonnées sur 30 à 40 ans, composées de 12 000 à 358 000 individus (Brennan et al., 2000; Hodgins et al., 1996; Tiihonen et al., 1997), montrent que les individus ayant un diagnostic de schizophrénie sont de quatre à sept fois plus susceptibles de commettre un délit avec violence que les individus n'ayant pas de trouble mental ni de trouble lié à l'utilisation de substances psychoactives (Arseneault et al., 2000). Toutefois, il demeure difficile de conclure à un lien de causalité. En effet, de nombreux

facteurs confondants sont impliqués dans la relation entre les troubles mentaux et la violence, ce qui force à nuancer les résultats de recherche présentés ci-dessus. On peut penser à l'iniquité socioéconomique vécue par les parents et à l'enfance, les traumatismes antérieurs, l'adversité sociale chronique, l'isolement et la consommation de drogues (Stilo & Murray, 2019). Dans bien des cas, ces facteurs précèdent le développement du trouble mental (et sont donc des facteurs confondants qui contribuent à une association au moins partiellement faussée entre trouble mental et violence), alors que dans d'autres cas ils sont un résultat direct des symptômes du trouble mental. En ce sens, une étude de Fazel et collègues (2009) a permis de montrer qu'une grande part du risque additionnel de violence chez les personnes ayant un trouble psychotique était expliquée par des facteurs confondants. Dans cette étude longitudinale reposant sur les données administratives suédoises de plus de 88 000 participants, les personnes vivant à la fois avec un trouble mental *et* un problème lié à la consommation d'alcool ou de drogues étaient plus susceptibles de commettre un délit violent comparé à la population générale (28 % vs 5 %), alors que les personnes vivant avec un trouble psychotique mais *sans* problème de consommation n'étaient pas plus susceptibles de commettre un délit violent que la population générale (8,5 % vs 5 %, différence non statistiquement significative) (Fazel et al., 2009). Chez les personnes ayant un double diagnostic, une grande partie de cette augmentation du risque était attribuable au milieu de vie dans lequel ils avaient grandi, puisque le risque diminue de plus de la moitié lorsque l'on compare ces personnes à leur frère ou sœur qui n'a pas de trouble mental.

Il est aussi possible d'adopter une approche de sécurité publique pour analyser la violence attribuable aux troubles mentaux graves. En s'intéressant aux différents facteurs qui augmentent le risque de violence, on constate que les troubles mentaux ne jouent tout au plus qu'un petit rôle – d'autres facteurs ont une incidence bien plus grande sur la violence présente dans notre société. Une revue internationale des méta-analyses portant sur les facteurs de risque de la violence interpersonnelle (Fazel et al., 2018) a estimé que seulement 2 % et 3 % de tous les actes de violence interpersonnelle étaient attribuables à la schizophrénie et aux troubles bipolaires, respectivement. Une méta-analyse met l'accent sur le fait que les crimes violents étant relativement rares même chez les personnes vivant avec un trouble de la schizophrénie, et qu'il faudrait restreindre inutilement la liberté de 26 personnes jugées à haut risque de violence pour

prévenir un seul crime violent ; 2 500 pour prévenir un homicide ; et 35 000 personnes pour prévenir un homicide contre un étranger (Large et al., 2011).

Toutefois, même lorsqu'on adopte des approches méthodologiques et statistiques qui permettent de prendre en compte les facteurs confondants, une certaine relation demeure bien réelle. Cela nous indique que, pour au moins certaines personnes, il y a un lien de cause à effet entre les troubles mentaux graves, comme la schizophrénie ou les troubles bipolaires, et la violence. Pour un petit sous-groupe de personnes, le lien de causalité semble être direct : on estime que moins d'un délit sur cinq parmi tous les crimes commis par des personnes vivant avec un trouble mental serait influencé principalement ou uniquement par les symptômes psychiatriques, comme les hallucinations ou les idées délirantes. En comparaison, 65 % des délits n'auraient aucun lien avec les symptômes (Peterson et al., 2014). Au Canada, ces personnes sont susceptibles d'être déclarées NCRTM.

On ne peut passer sous silence l'influence majeure des forces structurelles en violence et santé mentale (Hiday, 1995). Les personnes vivant avec un trouble mental sont plus susceptibles de se trouver dans des environnements hautement anxiogènes et hautement surveillés. Les hôpitaux psychiatriques, les logements supervisés, la rue, les refuges et les quartiers défavorisés ont tous en commun le fait de créer chez leurs usagers et habitants un manque d'intimité et une hyperproximité qui sont propices aux conflits (Cutcliffe & Riahi, 2013; Davison, 2005; Markowitz, 2011). En retour, ces conflits sont plus susceptibles d'être judiciarisés puisque les intervenants et les forces policières sont formés à s'attendre à des conflits et intervenir en tel cas (Markowitz, 2014). En l'absence de lieu intime où s'isoler quelques minutes, simplement s'impatienter contre un pair ou une personne en situation d'autorité peut rapidement escalader en agressivité ou en violence de part et d'autre (Davison, 2005). Les personnes vivant avec un trouble mental grave sont également plus susceptibles de vivre plus longtemps au domicile familial (Copeland & Heilemann, 2011; Saunders, 2003). Les études anthropologiques ont montré que ce contexte social est propice aux tensions en lien avec l'autodétermination, la gestion des finances et les mesures de contrôle informelles imposées, le plus souvent avec bienveillance, par leurs proches (Estroff, 1981). Ces situations sont également susceptibles de devenir des déclencheurs de

comportements dérangeants, voire agressifs, lorsque la frustration de ne pas contrôler son temps, sa liberté de mouvement et ses ressources s'installe (Estroff, 1981).

Prises dans leur ensemble, les études indiquent une association modérée, mais statistiquement significative, entre troubles mentaux graves et comportements violents. Ce lien est complexe et il doit être contextualisé, d'où l'importance de tenir compte d'un ensemble de facteurs, particulièrement l'organisation de ces facteurs dans l'évaluation et l'intervention, et ce, de manière personnalisée plutôt que sur la base d'une simple addition de variables. » (Crocker et al., 2023, pp. 649–655)

Contacts des personnes déclarées NCRTM avec les services psychiatriques

Des études récentes montrent que la majorité des personnes déclarées NCRTM avaient déjà obtenu, ou tenté d'obtenir, des soins de santé mentale. L'étude pancanadienne du projet national des trajectoires a montré que près du trois quarts des personnes déclarées NCRTM avaient été hospitalisées pour des raisons psychiatriques avant le délit NCRTM, avec une médiane de deux hospitalisations, et que le premier contact avec les services psychiatriques avait eu lieu plusieurs années avant le délit NCRTM (Crocker, Nicholls, Seto, Charette, et al., 2015). Ce résultat est cohérent avec ceux d'un rapport décrivant les caractéristiques des personnes déclarées non criminellement responsables pour cause de troubles mentaux en 1990 (Hodgins et al., 1990), ainsi que ceux d'une étude de 925 personnes admises aux services de psychiatrie légale néo-zélandais (Cavney et al., 2012). Il remet également en question la capacité du système de santé mentale à répondre aux besoins comportementaux de ses usagers, notamment en termes de prévention de la violence.

Sur le terrain, certains intervenants du système de la santé et des services sociaux, particulièrement ceux qui travaillent en première ligne avec les forces policières, rapportent que la judiciarisation devient un levier pour accéder à des services adaptés à leurs besoins (Roy, Crocker, et al., 2020). Dans la même étude, les intervenants de première ligne œuvrant auprès de personnes ayant un trouble mental et vivant de surcroit un épisode d'itinérance dépeignent

leur sentiment d'impuissance quant à la possibilité d'arrimer les utilisateurs de services à des soins intégrés adaptés à leurs besoins complexes (toxicomanie, troubles de la personnalité, troubles cognitifs et neurologiques, pauvreté). Les intervenants de première ligne se sentent souvent ainsi forcés d'avoir recours à des mécanismes d'accès par le biais de la justice criminelle qui augmentent la probabilité d'utilisation du verdict de NCRTM, pour que des soins adaptés et intégrés deviennent accessibles (Roy, Crocker, et al., 2020). Ces difficultés d'accès s'ajoutent aux perceptions parfois négatives des intervenants en santé mentale envers les personnes ayant des comportements perturbateurs ou un historique de démêlés avec la justice (Bandara et al., 2018).

Les personnes ayant eu des démêlés avec la justice ou ayant des comportements perturbateurs rapportent également avoir des difficultés à accéder à des services pertinents et de qualité. Une étude qualitative auprès d'utilisateurs de services à l'interface justice et santé mentale, connaissant de surcroit des périodes d'itinérance, a souligné le sentiment d'injustice et de discrimination vécu par les participants au sein des services de santé (Roy, Leclair, et al., 2020). Les participants ont soulevé leur manque de crédibilité et de légitimité auprès des acteurs du personnel des urgences hospitalières et des médecins, souvent en lien avec des étiquettes de personnes ayant des troubles mentaux, d'utilisateurs de drogues, de personnes ayant des troubles de la personnalité et de personnes ayant des comportements perturbateurs de façon plus globale (Roy, Leclair, et al., 2020). Ces expériences sont cohérentes avec les données quantitatives qui suggèrent que les traits de personnalité impulsifs compliquent l'accès aux services de santé, notamment en raison des longs temps d'attente et des difficultés d'être écoutés et crus par les acteurs des services de santé, et ainsi nuit au rétablissement clinique et à la capacité des personnes d'avoir espoir en le futur et définir des objectifs de vie (Leclair et al., 2020a, 2020b).

À notre connaissance, très peu d'études se sont intéressées à la nature, à la fréquence et à la pertinence des soins et services médicaux reçus dans la communauté par des personnes ayant un trouble mental grave et qui commettront éventuellement un délit, qu'ils soient déclarés criminellement responsables ou NCRTM. Une étude de Hodgins et collègues (2009) a abordé l'association entre la présence et la fréquence de comportements perturbateurs et l'intensité et la nature des services offerts dans la communauté dans un échantillon de personnes ayant un

trouble mental grave. Après avoir ajusté pour le genre et l'âge, les antécédents de comportements agressifs n'avaient aucune incidence sur le type de services reçus par l'équipe traitante ou la fréquence des rencontres, alors que la présence active de comportements agressifs était associée à une fréquence plus grande des rencontres entre le client et l'équipe traitante. Dans les deux cas, aucun service ou intervention n'était offert afin de répondre spécifiquement à la problématique des comportements perturbateurs ou agressifs. Quelques modèles visant à réduire les comportements perturbateurs des utilisateurs de services de santé mentale ont pourtant été éprouvés. Bien que d'en faire l'inventaire sort de l'objectif du présent contexte théorique, nous attirons tout de même l'attention sur les équipes de suivi intensif dans la communauté qui intègrent les connaissances forensiques (*Forensic Assertive Community Treatment*). Bien que davantage de recherches rigoureuses soient nécessaires (Jennings, 2009; Marquant et al., 2016), les récents essais randomisés suggèrent une efficacité à limiter les comportements perturbateurs susceptibles d'être judiciarisés et les risques de passage à l'acte (Cusack et al., 2010; Goulet et al., 2021; Lamberti et al., 2017).

L'accès aux services de santé

La notion d'accès aux services et aux soins de santé est le sujet de multiples modèles conceptuels (Lévesque et al., 2013; Ricketts & Goldsmith, 2005). Différentes difficultés sont soulevées dans la littérature, dont le débat quant à savoir si l'accès est une caractéristique des systèmes ou encore une caractéristique des utilisateurs (Frenk, 1992; Lévesque et al., 2013). Par exemple, selon Donabedian, l'accessibilité est une caractéristique des ressources qui facilite ou limite son utilisation, médiant la capacité de produire des services et leur utilisation réelle (Donabedian, 1973). D'autres auteurs, dont Penchansky et Thomas (1981), conceptualisent plutôt l'accès comme étant à l'interface de l'utilisateur et du système – ici, l'accès est une fonction de l'arrimage (*fit*) entre les caractéristiques du système de soins et des prestataires de soins, d'une part, et les besoins, les caractéristiques et les attentes des utilisateurs de services, d'autre part (Penchansky & Thomas, 1981). Cette conceptualisation permet de définir l'accès comme la capacité d'une population de chercher et d'obtenir des soins, en fonction du degré d'ajustement entre les caractéristiques du système et celles de la population (Frenk, 1992).

Deux modèles conceptuels de l'accès retiennent ici particulièrement notre attention.

Le modèle d'accès centré sur le patient

Le modèle de Lévesque et al. (2013) s'appuie sur une recension des définitions et des conceptualisations de l'accès dans la littérature pour définir l'accès aux services comme n'étant pas un simple contact initial ou l'utilisation de services, mais plutôt comme la possibilité de recevoir une réponse adéquate à ses besoins en matière de soins de santé. En cohérence avec le modèle de *fit* de Penchansky & Thomas (1981), Lévesque et collègues proposent que l'accès aux soins de santé soit une fonction de l'arrimage entre les caractéristiques du système et les caractéristiques des utilisateurs de services sur cinq dimensions des systèmes de soins et cinq capacités des utilisateurs potentiels de services: l'accessibilité/capacité à percevoir, l'acceptabilité/capacité à chercher, la disponibilité/la capacité à atteindre, le coût abordable/la capacité à payer et la pertinence/la capacité à s'engager. Le modèle conceptuel de Levesque et al. (2013) nous permet donc de prendre en compte l'entièreté de l'expérience des utilisateurs de services avec le système de santé, incluant les enjeux liés au premier contact, à la prise en charge soutenue par les services ainsi qu'à la qualité et pertinence des services et soins reçus (voir Figure 1).

Premièrement, l'accessibilité (*approachability*), entendue comme la possibilité pour les futurs utilisateurs de services qui ont besoin de services de savoir qu'ils existent et peuvent être utilisés, est influencée à la fois par la transparence de l'offre de services et les interventions de proximité. L'accessibilité requiert également la capacité de la part des futurs utilisateurs de services de reconnaître leurs besoins de services et de désirer ces services – capacité qui peut varier en fonction de la littéracie en santé, des croyances et des connaissances. L'accessibilité des systèmes et la capacité des utilisateurs à percevoir les besoins en santé interagissent pour mener à la perception des besoins et au désir de soins.

Deuxièmement, l'acceptabilité (*acceptability*) réfère aux normes culturelles, professionnelles et institutionnelles qui rendent acceptables et appropriés les services pour les utilisateurs. Les mêmes services peuvent être acceptables pour certains groupes et non pour d'autres, comme ceux qui font l'objet de discriminations ou de stigmatisation. La capacité des

utilisateurs à chercher est influencée par les valeurs personnelles, la culture et l'autonomie. L'acceptabilité des services interagit avec la capacité des utilisateurs à chercher pour mener à la recherche de services.

Troisièmement, la disponibilité et l'accueil (*availability*) réfèrent à la possibilité pour les populations de rejoindre physiquement et en temps opportun les services, ce qui peut être influencé par la localisation géographique des services, les heures d'ouverture, le processus de prise de rendez-vous. La capacité des utilisateurs à atteindre les services est influencée par l'accès au transport, la mobilité, la proximité aux services et le soutien social. La disponibilité et l'accueil interagissent avec la capacité des utilisateurs à atteindre les services pour mener à l'atteinte des services.

Quatrièmement, le coût abordable (*affordability*) réfère aux coûts directs et indirects ainsi qu'aux coûts d'opportunité liés à l'utilisation des services. Elle interagit avec la capacité des utilisateurs de services de payer, soit de débourser temps et ressources financières pour accéder aux soins, en tenant compte de l'accès aux congés de maladie payés et du temps requis pour accéder aux services.

Finalement, la pertinence (*appropriateness*) fait référence à la capacité des services de répondre adéquatement et en temps opportun aux besoins des utilisateurs. La pertinence est une fonction des qualités techniques et relationnelles, de l'adéquation entre les services et les besoins, ainsi que de la coordination et de la continuité des soins. La pertinence interagit avec la capacité des utilisateurs de s'engager dans leurs soins, qui est une fonction de l'information disponible, du soutien aux proches et de l'autonomie de l'utilisateur.

Figure 1. – Modèle d'accès centré sur le patient de Lévesque et collègues

Transparence
Sensibilisation
Information
Accessibilité

Valeurs
professionnelles
Normes
Culture
Acceptabilité

Localisation
Accueil
Heures d'ouverture
Prise de rendez-vous
Disponibilité et accueil

Coûts directs/indirects
Coûts d'opportunité
Abordabilité

Qualités techniques
Qualités relationnelles
Adéquation
Coordination/continuité
Pertinence

Besoins — Perception des besoins et désir de services — Recherche de services — Atteinte des services — Utilisation des services — Conséquences des services

Capacité à percevoir
Littératie en santé
Connaissances
Croyances

Capacité à chercher
Valeurs personnelles
Culture
Autonomie

Capacité à atteindre
Espace de vie
Transport
Mobilité
Soutien social

Capacité à payer
Revenu
Assurances
Actifs
Capital social

Capacité à s'engager
Autonomisation
Information
Adhérence
Soutien aux proches

Caractéristiques de l'utilisateur

Note. Figure adaptée et traduite de (Lévesque et al., 2013)

Le modèle comportemental d'utilisation de services de soins de santé

Quant à lui, le modèle comportemental d'utilisation de services de soins de santé d'Andersen (Andersen, 1995, 2008) conceptualise l'utilisation comme l'accès réalisé. La version la plus récente du modèle (Andersen, 2008; Andersen & Davidson, 2007) souligne l'importance des facteurs contextuels et des facteurs individuels, qui sont tous deux de nouveau divisés en trois catégories : les facteurs prédisposants, les facteurs facilitateurs (et les obstacles) et les facteurs liés aux besoins (voir Figure 2).

Les facteurs prédiposants contextuels constituent les caractéristiques sociodémographiques d'une communauté, dont la structure d'âge, la composition en genre, la diversité culturelle, le niveau d'éducation global, la proportion d'immigrants récents, le taux de criminalité et le taux de chômage (Andersen & Davidson, 2007). Ils peuvent aussi référer aux valeurs et aux croyances, religieuses ou politiques, d'une communauté, qui influencent la propension de ses membres à avoir recours ou non à des services de santé. Ces facteurs prédisposants influencent, toujours au niveau contextuel, les politiques publiques, le financement des services et la distribution des ressources (facilitateurs et obstacles). Par

exemple, le nombre de lits par 100 000 habitants ou encore la dépense per capita dans une région administrative sont des facilitateurs ou des obstacles. Finalement, les facteurs liés aux besoins au niveau contextuel réfèrent à la présence de conditions pour lesquelles la communauté médicale reconnaît un besoin de traitement. Ils sont influencés à la fois par les facteurs prédisposants et les facilitateurs et obstacles, possiblement dans un effet de boucle (Andersen & Davidson, 2007). Il faut souligner que ces facteurs contextuels sont mesurés au niveau agrégé, et non au niveau individuel.

D'un point de vue individuel, les facteurs prédisposants font référence aux facteurs individuels qui peuvent influer sur la propension d'un individu à recourir à des services de santé, dont les facteurs sociodémographiques habituels (âge, genre, état civil), ainsi que ses croyances et valeurs et la force de son réseau social. Ces facteurs influencent les facilitateurs et les obstacles individuels, dont l'accès à un médecin de famille, le revenu personnel et la couverture d'assurance, ainsi que la disponibilité d'un moyen de transport et le temps requis pour se rendre sur les lieux où les services sont offerts. Finalement, parmi les facteurs liés aux besoins (perçus par l'individu ou évalués par le corps médical), on trouve la symptomatologie, la nature du diagnostic et les troubles concomitants (Andersen & Davidson, 2007).

Ensemble, selon le modèle comportemental d'Andersen, ces facteurs contextuels et individuels influencent les comportements des patients vis-à-vis leur santé, mais également les comportements des cliniciens et de leur capacité à répondre aux besoins des patients (Andersen, 2008). Ce modèle est donc particulièrement pertinent pour comprendre l'utilisation de services de santé chez une population vulnérable (Gelberg et al., 2000; Stein et al., 2007) qui peut présenter des comportements perturbateurs. La pertinence de ce modèle en contexte psychiatrique a d'ailleurs été soulignée (Carr et al., 2003; Fleury et al., 2014; Lemming & Calsyn, 2004; Simo et al., 2018), bien qu'il n'ait jamais été validé, à notre connaissance, auprès d'une clientèle de psychiatrie légale ou autrement judiciarisée.

Figure 2. –   Le modèle comportemental d'utilisation de soins de santé d'Andersen

Déterminants contextuels.

Facteurs prédisposants
- Caractéristiques sociodémographiques d'une communauté
- Croyances, opinions politiques et valeurs d'une communauté

Facilitateurs/Obstacles
- Politiques publiques
- Financement des services
- Organisation des services

Facteurs liés aux besoins
- Taux de morbidité et mortalité

Déterminants individuels.

Facteurs prédisposants
- Caractéristiques sociodémographiques d'un individu
- Croyances, opinions politiques et valeurs d'un individu
- Réseau et soutien social

Facilitateurs/Obstacles
- Accès à un médecin de famille
- Moyen et temps de transport aux services
- Revenu personnel, couverture d'assurance

Facteurs liés aux besoins
- Symptômes
- Troubles concommitants

Comportements liés à la santé et variables de résultat.
- Accès aux services
- Utilisation des services
- Adhérence au traitement
- Communication patient-prestataire de services
- Soins offerts par le personnel
- Satisfaction du patient
- Rétablissement

Note. Figure adaptée et traduite de Andersen & Davidson (2007).

Accès aux services de santé mentale

Une récente recension sur l'accès aux services de santé mentale au Canada (Moroz et al., 2020) fait ressortir les barrières existantes particulières au système de santé mentale. En termes d'accessibilité (Lévesque et al., 2013), la principale barrière consiste à ne pas savoir où aller chercher les services (Statistics Canada, 2019). Cela est cohérent avec le fait qu'avoir un médecin de famille ou avoir déjà interagi avec les services de santé mentale soit parmi les prédicteurs les plus importants de l'accès aux services de santé mentale (Simo et al., 2018). Les services de thérapie sont également difficilement accessibles, requérant soit de longs temps d'attente au public ou encore d'avoir recours à des services de psychothérapie au privé, avec une couverture au privé (lorsque disponible) seulement partielle (Canadian Mental Health Association, 2018).

La stigmatisation pose également une barrière à l'accès aux services tout au long du continuum (Knaak et al., 2017), particulièrement lorsque les expériences précédentes dans le système de soins ont été négatives (Henderson et al., 2014; Thornicroft, 2008). Cette stigmatisation peut se vivre à travers des attitudes négatives de la part des intervenants, un pessimisme thérapeutique, un manque de connaissances ou de compétences, ou encore une culture institutionnelle où les personnes qui ont un trouble mental sont perçues comme « dangereuses » ou « difficiles » (Hamilton et al., 2014; Henderson et al., 2014). Sur le plan du souhait de soins (capacité à percevoir), l'autostigmatisation (ou la stigmatisation internalisée)

peut entraîner de la honte qui contribue au déni du problème ou la croyance que les soins n'auront pas d'effets positifs sur la santé mentale (Corrigan et al., 2014). La volonté d'éviter l'étiquette « maladie mentale » (Pedersen & Paves, 2014) peut également influencer le désir de soins (Corrigan et al., 2014; Livingston, 2020). La stigmatisation vécue précédemment par les utilisateurs de services les amène à anticiper de la discrimination ou des attitudes négatives et déshumanisantes de la part des prestataires de soins (Üçok et al., 2012), ce qui limite ou retarde la recherche de services (Henderson et al., 2014). Une fois dans les services, la stigmatisation vécue influence la capacité des patients à s'engager dans leurs soins, notamment à travers un sentiment d'autoefficacité réduit (Corrigan et al., 2014) et une relation thérapeutique moins positive (Kvrgic et al., 2013; Nakash et al., 2015).

Les personnes qui ont des troubles mentaux graves et des comportements perçus comme dérangeants ou dangereux par les intervenants ou leurs proches sont encore plus susceptibles de vivre ces barrières (Leclair et al., 2020b; Roy, Leclair, et al., 2020). En effet, ces utilisateurs de services ont parfois vécu des démêlés avec le système de justice, ce qui leur impose une étiquette « délinquance » ou « criminalité » additionnelle à celle de « maladie mentale » (Livingston et al., 2011b; West et al., 2014; Williams et al., 2011), et les amène à être perçus comme dangereux ou trop difficiles par les prestataires (Schanda et al., 2009). Leur implication judiciaire et les diagnostics concomitants (usage de substances, troubles de personnalité) rendent les services fragmentés et les trajectoires de soins (MacDonald et al., 2021) encore plus difficiles à naviguer.

Chapitre 2 – Objectifs et questions de recherche

L'objectif général de ce projet doctoral est d'analyser les trajectoires d'utilisation de services de santé par des personnes ayant un trouble mental grave dans la période précédant l'incident menant à l'entrée dans les services psycho-légaux suite à un verdict NCRTM (l'incident). Ce but global se décline en trois objectifs spécifiques.

Le premier objectif spécifique est de décrire la nature, l'étendue et la diversité des profils d'utilisation des services de santé et de traitement de pharmacothérapie dans l'année précédant l'incident.

Le deuxième objectif spécifique est de cerner les facteurs psychosociaux, contextuels et systémiques associés à l'accès à différents services de santé mentale chez les personnes qui commettront éventuellement un délit NCRTM. Pour ce faire, nous empruntons la définition et conceptualisation d'accès de Lévesque et collègues (Lévesque et al., 2013).

Le troisième objectif spécifique se décline lui-même en sous-objectifs. Il s'agit d'abord d'explorer les expériences des services de santé en communauté par les utilisateurs de ces services au cours de la période précédant un délit menant à un verdict NCRTM et décrire leurs perceptions quant aux obstacles et aux facilitateurs pouvant influencer la capacité du système de santé à répondre à leurs besoins. Dans un deuxième temps, nous voulons décrire la façon dont les acteurs du système de santé et de services sociaux, les acteurs d'organismes communautaires et les proches perçoivent les enjeux liés à l'accès et à l'utilisation de services de santé pertinents par les personnes ayant un trouble mental grave et des comportements perturbateurs susceptibles d'être judiciarisés.

Chapitre 3 – Présentation des données

Ce chapitre vise à décrire la provenance et la structure des données utilisées pour les chapitres 4 et 5, soit les deux premiers articles. Les stratégies analytiques adoptées ne sont pas décrites ici, mais plutôt dans les chapitres pertinents.

Le projet national des trajectoires

Les données utilisées dans le cadre des deux premiers objectifs de ce projet doctoral ont été extraites du projet national des trajectoires/*National Trajectory Project* (Crocker, Nicholls, Seto, Côté, et al., 2015; https://ntp-ptn.org/), une étude longitudinale sur dossiers de personnes déclarées NCRTM au Canada entre 2000 et 2005. Pour des raisons liées à la disponibilité des données de santé, seules les données du Québec ont été utilisées dans le cadre de cette thèse.

Les données utilisées dans le cadre de cette thèse datent donc d'environ 20 ans. Bien qu'il s'agit d'une des limites de l'étude, l'utilisation de ces données issues du projet national des trajectoires offrait une occasion inégalée d'examiner les trajectoires de soins dans une cohorte de plus de 1000 participants. Bien qu'il aurait été possible de mener une étude similaire avec des données plus récentes, les coût importants liés à l'accès aux données administratives en santé au Québec auraient fortement limité la taille de l'échantillon. Nous n'aurions non plus pas pu obtenir des données aussi riches en tant que facteurs individuels et contextuels, limitant ainsi la possibilité d'identifier les barrières et facilitateurs à l'accès. L'utilisation des présentes données a donc été privilégié, en ajoutant un volet qualitatif en tant que troisième article afin de valider la pertinence contemporaine des résultats quantitatifs des deux premiers articles.

Échantillonnage

La période d'échantillonnage au Québec a été établie entre le 1er mai 2000 et le 30 avril 2005. Un total de 2 389 verdicts NCRTM concernant 1 964 individus différents a été identifié pour cette période (le premier verdict NCRTM compris dans la période d'échantillonnage a été retenu comme le verdict désigné). Un échantillonnage aléatoire avec facteur de correction de population

finie a été appliqué dans chaque région administrative afin d'obtenir un portrait représentatif de l'ensemble du Québec, pour un total de 1 094 sujets. Toutes les analyses ont donc été pondérées.

Données tirées des dossiers des Commission d'examen des troubles mentaux

Pour chaque cas échantillonné, les dossiers des Commissions d'examen des troubles mentaux du Québec ont été obtenus et codés pour une période couvrant les 5 années précédant le verdict NCRTM désigné et jusqu'au 31 décembre 2008. Comme seulement 9,9 % de l'échantillon avait déjà reçu un verdict NCRTM avant la période d'échantillonnage, les dossiers des commissions d'examen débutent dans la majorité des cas au moment du verdict NCRTM désigné. Cinq catégories de données ont été codées à partir des dossiers de la commission d'examen : (1) les données sociodémographiques (p. ex., âge au moment du verdict, genre, statut civil au moment du délit, niveau d'éducation, statut autochtone, adresse de résidence au moment du délit); (2) les données cliniques (p. ex., diagnostic au moment du verdict NCRTM, âge au moment de la première hospitalisation psychiatrique, présence d'historique psychiatrique); (3) les antécédents judiciaires (p. ex., la nature des infractions résultant en un verdict NCRTM, la date de ces infractions, la présence de verdicts NCRTM dans le passé); (4) le détail des évaluations du risque de violence; et (5) les détails des procédures de la commission d'examen (p. ex., décisions et conditions). À noter que la qualité de ces données est limitée à ce qui était mentionné dans les dossiers de la Commission d'examen des troubles mentaux.

Données criminelles provenant de la Gendarmerie Royale du Canada

Les dossiers criminels ont aussi été obtenus auprès de la Gendarmerie Royale du Canada par les dossiers du système d'empreintes digitales et codés pour toute la durée de la vie, mais seulement les délits ayant eu lieu avant le verdict de NCR menant à l'entrée dans cette étude ont été identifiés pour la présente étude.

Données administratives en santé

Nous avons obtenu les données liées à l'utilisation de soins et services de santé à travers la Régie d'assurance maladie du Québec (RAMQ) et le Ministère de la Santé et des Services sociaux (MED-ECHO) pour la période couvrant les 5 années précédant le verdict NCRTM désigné

et jusqu'au 31 décembre 2008 (pour les présentes analyses, seules les données précédant la date du délit NCRTM sont utilisées). Des 1 094 sujets québécois, la concordance nom complet et date de naissance a permis de lier les données de 1 020 d'entre eux (93.2%). Parmi les participants dont les données administratives de santé n'ont pu être obtenues, les femmes, les personnes issues des communautés autochtones, ainsi que les personnes ayant un pays de naissance autre que le Canada étaient surreprésentées.

Les données liées à l'accès et à l'utilisation des services de santé mentale, de santé physique et de dépendance ont été obtenues auprès de la RAMQ. La nature des services ainsi que le lieu et la date de dispensation sont disponibles pour les 5 années précédant le verdict NCRTM. Dans le cadre des présentes analyses, nous nous concentrons sur les services obtenus précédant le *délit* NCRTM. La durée de suivi sera donc variable pour un individu à l'autre, en fonction du temps requis pour les procédures judiciaires (c'est-à-dire la période entre le délit et le verdict). Ces données sont disponibles pour la vaste majorité des services médicaux tant que les personnes ont demeuré au Québec.

Les données de la RAMQ comprennent aussi les détails liés à la pharmacothérapie (nature du médicament prescrit, dose, date du renouvellement de l'ordonnance), à l'exception de ceux qui auraient été couverts par une assurance privée. Étant donné que seulement 15.7% de notre échantillon a comme principale source de revenu un emploi rémunéré, nous estimons que le pourcentage de personnes couvertes par une assurance privée est minime. Ces données sont disponibles pour les 5 années précédant le verdict NCRTM, à l'exception des périodes d'hospitalisation. Les médicaments prodigués pendant des hospitalisations ne sont donc pas disponibles dans nos données.

Chapitre 4 (Article 1) – Care Pathways, Health Service Use Patterns and Opportunities for Justice Involvement Prevention Among Forensic Mental Health Clients

Leclair, M. C., Charette, Y., Caulet, M., & Crocker, A. G. (2022). Care Pathways, Health Service Use Patterns and Opportunities for Justice Involvement Prevention Among Forensic Mental Health Clients. *Canadian Journal of Psychiatry*, *67*(12), p. 907-917. https://doi.org/10.1177/07067437221076723

Note. Le format des références suit celui exigé par *Canadian Journal of Psychiatry*.

Objectives: The objective of the present study is to describe the patterns of health service use and of prescription claims in the year preceding an offense leading to a verdict of non-criminal responsibility on account of a mental disorder (NCRMD). **Methods:** Provincial health administrative databases were used to identify medical services, hospitalisations, and ambulatory prescription claims among 1,014 individuals found NCRMD in Québec. Contacts in the year preceding the offense were analyzed using descriptive analyses and latent class analysis. **Results:** Overall, 71.4% of sub-jects were in contact with services for mental health reasons within a year of their NCRMD offense. Among those that received services and who were not hospitalised for psychiatric reasons at the time of the offense, 20.7% committed the NCRMD offense within a week of the most recent mental health contact. Among those that had at least one prescription claim for an antipsychotic, 45.8% were not taking any antipsychotic at the time of the offense. Latent class analysis provided a multidimensional representation of mental health service use and showed that 58.4% of subjects had had no or very rare contact with services. **Conclusions:** Many forensic patients are likely to have experienced service disruption or discontinuity while in the community, for reasons that may relate to perceived need for care, to service organization, or to the acceptability, availability, and accessibility of services. Given the serious impact of the "forensic" label on the lives of service users, not to mention the increased pressure on resources, the considerable economic costs, and the im-pact on victims, there is reason to advocate for a greater involvement of mental and physical health service providers in early prevention of violence, which requires reorganizing resources to share the forensic knowledge upstream, before an offense is committed.

The remarkable growth in the number of admissions to forensic mental health (MH) services over the past decades, particularly in Québec,[1,2] suggests that the justice system has become a gateway to specialized MH care for many individuals with severe mental illness with disruptive behaviours.[3–7] In Canada, the majority of individuals who are admitted to forensic MH services have been found Not Criminally Responsible on account of a Mental Disorder (NCRMD)1 for an offense committed "while suffering from a mental disorder that rendered [them] incapable of appreciating the nature and quality of the [offense] or of knowing that it was wrong".[8]

The use of section 16 of the Criminal Code is several folds more frequent[9–11] from what is observed in the rest of the country: indeed, the NCRMD defense is used in Québec for offenses of lesser severity and for a greater diversity of diagnoses, suggesting that the NCRMD defense crite-ria of the Criminal Code may be operationalized more liberally or that there are less diversionary interventions used than elsewhere in Canada.[12] Using the NCRMD verdict as a de facto diversion scheme is not without consequences. Admission to forensic MH services increases stigma,[13–15] in turn creating structural barriers to accessing and maintaining employment[16] and housing,[17,18] and reducing the capacity of health and social services to appropriately meet their needs.[15] In addition, treating a patient in forensic MH services incurs costs almost five times greater compared to general MH services.[19] Some observers have also argued that this leads to a loop effect, with more re-sources allocated to forensic rather than general MH services, making access to care in the community increasingly difficult.[2,20]

Canadian studies have highlighted that nearly three quarters of people found NCRMD had been hospitalised for psychiatric reasons before the offense,[12,21] which is similar to what was found in New Zealand.[22] This highlights the importance of examining which services are accessed by individuals before they are charged with an NCRMD offense to better meet their needs in the community. However, to our knowledge, the nature and frequency of MH services received before entry to forensic services remain undocumented.

Objectives

The objective of the present study is to describe the nature and extent of mental and physical healthcare use in the 12 months prior to an offense leading to a NCRMD verdict.

Methods

Sample and Procedures

Data were extracted from the National Trajectory Project,[9] a longitudinal file-based study of people declared NCRMD in Canada between 2000 and 2005. Due to the availability of administrative health services data, the present analyses are based on the Québec subsample only. There were a total population of 1,964 individuals with at least one NCRMD verdict in Québec during the sampling period. Random sampling with a finite population correction was applied in all administrative regions to obtain a representative sample of 1,094 subjects. Matching based on full name and date of birth with administrative health services data was successful for 1,020 subjects. The exact date of the offense was unknown for an additional 6 subjects, who were excluded. The pre-sent analyses therefore involve 1,014 subjects, for a total of 92.1% of the original sample. Women and people born outside of Canada were less likely to be included in the analyses due to unsuccessful matching with health data (see Table S1 of the online supplement for a detailed comparison).

The research protocol was approved by appropriate institutional ethics review committees (Douglas Mental Health Research Institute and Institut national de psychiatrie légale). Governmental health records were obtained through authorization from the Québec *Commission d'accès à l'information*.

Measures

Health services data were obtained from the Ministry of Health and Social Services' MED-ECHO and the *Régie de l'assurance maladie du Québec* (RAMQ), a physician fee-for-service database on all medical interventions and prescription claims completed under the public insurance system. Given that provinces in Canada rely on universal, public, single-payer systems, these data are available for most services if people have remained in Québec.

A first dataset described all hospitalisations. We selected all hospitalisations with an admission date within a year of the offense and up to the day before the offense. Hospitalisations for a primary diagnosis of mental disorder (ICD-9 codes 290-319) were classified as psychiatric.

A second dataset described all medical services. We selected all services within a year of the offense, outside of psychiatric hospitalisation periods, up to the day before the offense. Consistent with the literature,[23] we assumed that various medical acts provided for the same diagnosis, on the same day and at the same institution represented a single visit. We classified services in the following mutually exclusive categories: (1) emergency room visits for MH reasons with no resulting hospitalisation; (2) ambulatory psychiatric consultations outside of the emergency room; (3) primary care consultations for MH reasons; (4) primary care consultations for physical health reasons; and (5) specialist consultations for physical health reasons.

Finally, a third dataset described all ambulatory prescription claims. All public assistance or disability benefit recipients, and all individuals not eligible for coverage by a private plan, have pre-scription coverage through the RAMQ. We identified psychotherapeutic agents based on the American Hospital Formulary Service classification, including antidepressants (281604), antipsychotics (281608), anxiolytics (282400), and antimanic agents (282800). To address the fact that the dataset does not include medications given during hospitalisation, we assumed that people hospitalised for MH reasons had most likely received some form of psychotherapeutic agent. However, because of the diversity in prescription practices for severe mental illnesses and increased off-label use[24–26], we did not attempt to guess what family of medication (antidepressant, antipsychotics, etc.) had been administrated based on the primary diagnosis for the hospitalisation.

Review Board files were used to extract sociodemographic variables, clinical variables, and justice-related variables. The severity of the NCRMD offense was evaluated using the Crime Severity Index.[27] Criminal justice involvement history was identified using files from the Royal Canadian Mounted Police.

Analytic Approach

As a first step, we used descriptive analyses to outline the nature and extent of service use and pharmaceutical claims in the 12 months preceding the date of the NCRMD offense. As a second step, we used latent class analyses[28–30] to identify patterns of MH services use, using the sum of four types of MH services contacts within a year of the offense as observed indicators and

random starts. We elected to conduct latent class analyses based on the hypothesis that a significant proportion of participants had had very few MH services contacts. Using latent class analyses allowed a more multidimensional and nuanced perspective compared to simply describing the proportion of participants with zero MH services contacts. Under the latent class framework, we would be able to identify a group of participants who had one or two contacts with the healthcare system but no consistent follow-up. Participants with different service use pattern were compared on several sociodemographic, clinical, and offense-related characteristics using adjusted F-statistics for survey design from regressions followed by Sidak-adjusted pairwise comparisons. All analyses were weighted to account for the sampling strategy. We conducted the latent class analysis using Mplus 8 and all other analyses using Stata 15.

Results

The analysed sample was composed of 86.2% men who were, on average, 36.6 years old (*SD*=12.7). The majority were single (85.3%), born in Canada (66.0%) and had pensions, welfare or disability benefits as main income (74.6%). Psychotic disorder was the most common diagnosis at the time of the verdict (66.0%), along with mood disorder (28.4%). Almost a third (29.7%) had concomitant substance use disorder and 9.7% had a concomitant personality disorder.

Overall, 71.4% of subjects (n = 727) were in contact with MH services within a year of their NCRMD offense, a proportion that decreased to 59.0% in the 6 months prior (n = 602; see Table 1). Among those that received services and who were not hospitalised for psychiatric reasons at the time of the offense, one in five (20.7%, n = 148) committed the NCRMD offense within a week of the most recent contact (see Figure 1).

Nature and extent of service use

Medical services. A total of 11,156 medical services were provided to 866 participants (85.4%), of which 54.2% were MH services. In terms of physical health services, the most common categories of diagnoses associated were injury or poisoning (35.5%). Among services provided for MH reasons, 3.0% were for drug or alcohol misuse, whereas schizophrenia spectrum psychoses (34.7%) and affective psychoses (12.7%) were the reason for most services. As many as 32.5% of

MH services were provided by general practitioners, with the rest almost exclusively provided by psychiatrists.

A total of 44.2% (n = 452) consulted a psychiatrist on an ambulatory basis and 32.1% (n = 340) consulted a general practitioner for MH reasons. Almost half of subjects (43.9%, n = 151) that consulted a general practitioner regarding their MH received no services from a psychiatrist for the same period. A substantial proportion of subjects visited the emergency room for MH reasons without subsequent hospitalisation: 42.9% (n = 429) in the previous 12 months, and 32.5% (n = 322) in the previous 6 months. Among those that visited the emergency room within 12 months of their offense, 21.8% (n = 96) were not in contact with any other non-emergency ambulatory MH services for the same period.

Hospitalisations. Overall, there were 746 hospitalisations among 410 participants (40.4%). Of all psychiatric hospitalisations, 43.7% were for schizophrenia spectrum psychoses and 20.4% for affective psychoses. Less than 5% were for drug or alcohol misuse. MH concerns were noted in 55.7% of physical health hospitalisations. A third (33.0%, n = 346) of subjects were hospitalised for psychiatric reasons within a year of their offense.

TABLE 1 – FIGURE 1

Prescription claims. Half of participants (50.8%, n = 512) filled at least one prescription for a psychotherapeutic agent within a year of their offense. When assuming that people who had been hospitalised for MH reasons had most likely received a psychotherapeutic agent during their hospitalisation, the proportion increased to 59.8% (n = 602). Outside of a hospitalisation, 40.1% (n = 404) filled at least one prescription for an antipsychotic drug – and 45.8% of those were not on any antipsychotic at the offense – and 16.6% (n = 167) for an antidepressant. Only 3.4% of all antipsychotic prescriptions were long-acting injectables, prescribed to a total of 66 subjects.

Patterns of MH service use

Based on best fit indices and parsimony, we selected the 4-class model (BIC = 21,833.152, entropy = 0.935, BLRT p < .001). While the 5-class model also presented good fit indices, it resulted

in minimal improvement of indices (BIC = 21,340.255) and included classes of fewer than 1% of the sample, indicating overfitting (see Table S2 in the online supplement).

The largest class (58.4%) represented a pattern of no or rare contact with MH services (see Figure 2 and Table 2). One in five participants (18.9%) had been hospitalised for psychiatric reasons but 71.4% of those did not consult a psychiatrist outside of the period of hospitalisation. A third (34.2%) had filled a prescription claim in the community for a psychotherapeutic agent, and 22.9% for an antipsychotic agent specifically.

The three other classes presented qualitatively different service use patterns but were similar in terms of other characteristics (see Table 3). Class 2 (21.9%) comprised participants with a pat-tern consistent with specialized care, with relatively frequent psychiatrist consultations, but few visits to primary care or emergency room for MH reasons. Class 3 (16.6%) comprised participants with a pattern of primarily non-specialized care, with the greatest mean of visits to general practitioners and the emergency room. Finally, class 4 (3.1%) included individuals with a pattern of highly intensive service use, with highly frequent psychiatrist consultations, but also emergency room visits and primary care visits.

FIGURE 1 – TABLES 2-3

Discussion

The present paper is the first study to provide a clear picture of the frequency, nature, and pattern of health services use, including prescription claims, of a large group of people found NCRMD prior to their offense. It highlights that around half of future forensic patients receive no consistent care within the MH system in the year prior to their offense despite being known by MH services for a severe mental illness. While it is possible that some participants received MH services that were not available through our dataset, for example from a salaried physician or another professional , this finding may also suggest that many forensic patients are likely to have, voluntarily or involuntarily, experienced service disruption while in the community, for reasons that may relate to perceived need for care or to the acceptability, availability and accessibility of services.[31] For example, data indicates that patients are often discharged from a psychiatric hospitalisation with no follow-up appointments, either scheduled or attended. Research has

shown that about one third of patients with severe mental illness disengage from MH services,[32] and that a forensic history is a predictor of disengagement, as service users report not being listened to by providers,[33] perceiving the providers' attitude as negative or discriminating, and experiencing service discontinuity.[34]

On the other hand, our findings show that a large proportion of individuals accesses care, often with monthly psychiatrist consultations. Notably, reasons for MH service use before an offense are different from those from a cohort of people incarcerated in provincial jails.[36] Less than 5% of all psychiatric hospitalizations were for substance-related disorders in the NCRMD sample, compared to a third among people found criminally responsible.[36] We did not find any differences between patterns of MH service use in terms of other characteristics, which suggests that systemic factors may play a more important role than individual factors.

Together with the finding that many committed the NCRMD offense within a short period after a MH services contact, this turns the attention towards potential for early intervention in terms of violence and justice involvement prevention within the health care system (potential intervention strategies are detailed below, in the implications). While it is not possible to know with certainty who will be admitted to forensic MH services in the near future, early intervention can target service users that have a severe mental illness and are at risk of criminal justice involvement, based on risk assessments.

Analysis of the pharmaceutical data suggests that half of those who had a prescription claim for an antipsychotic were no longer on any antipsychotic at the time of the offense. This result is consistent with those of a study of antipsychotic discontinuation in Québec, which found that continuation of antipsychotic therapy was very low, both among new users (around 5.5% at 1-year) and among past users beginning a new course of treatment (less than 5% at 1-year).[44] Unfortunately, given the administrative nature of the present dataset, it is unclear what proportion of treatment discontinuations is the result of a decision made by the patient, the physician, or both. A recent review of MH service users' experiences highlight that the decision to discontinue medication may be motivated by the desire to regain a certain sense of control and autonomy,[45] highlighting the importance that providers work with the patients when it comes

to the subject of medication and discuss acceptability and potential side effects so that they can make an informed decision that respects their right to self-determination. In fact, a systematic review found that therapeutic alliance and illness literacy were among the most important dynamic predictors of treatment adherence in patients with schizophrenia or bipolar disorder.[46] It should also be highlighted that, for some service users, compliance may be improved using long-acting injectable antipsychotics. An ethnographic examination of barriers to using long-acting injectable antipsychotics suggested that psychiatrists unnecessarily restrict the prescription of long-acting injectable antipsychotics to service users with demonstrated non adherence to oral medication,[47] whereas algorithms suggest considering and discussing this option with most patients.[48]

Implications

Our findings highlight the opportunity for greater involvement from primary care clinicians and general psychiatry clinicians in the early prevention of entry to forensic services through a NCRMD offense. There is a need for an in-depth investigation of strategies for engaging and supporting them in playing this pivotal role.

For the past decades, services have been highly fragmented, and the role of coordinating care has been relegated to the service user and their loved ones. A qualitative meta-synthesis of the experience of pathways to MH services highlight that patients and their caregivers often do not know what resources exist, experience difficulties with narrow eligibility criteria, and report lack of discharge planning after hospitalisation and multiple unwanted service interruptions.[49] Navigating the system after the initial contact may prove to be a challenge for several patients, especially for those who have behaviours that can be perceived as disturbing or aggressive and be rejected by services. The present findings show that, while some receive sustained MH care, improving the integration of services to reduce fragmentation and service discontinuity may improve the quality of services received for many, and possibly reduce the need for forensic MH services. Several strategies to improve continuity of care among people with severe mental illness has been put forth, including community MH teams and assertive community treatment.[50] For

those with past justice involvement, forensic assertive community treatment[51] could be used to address the psychiatric symptoms and the risk of additional offenses.

In addition to service fragmentation, the organization of clinical and financial resources in a reactive rather than preventative manner limits the possibility of the healthcare system to respond appropriately to the needs of patients with severe mental illness and disturbing or aggressive behaviours in a timely manner. Currently, the expertise and investments in violence and crime prevention are concentrated in highly specialized forensic MH services, which are accessible to patients only after an offense. Forensic MH services have traditionally been conceived as a tertiary care system, but there is an argument to be made for a balanced care continuum, with forensic-informed low-intensity community services as the lower tier and high-security custodial services as the upper tier.[6] This would require sharing the knowledge upstream and offer additional training to general practitioners, nurses, and psychiatrists. The scientific literature has discussed the potential of approaches based on the assessment of risk of violence in MH services, often using structural professional judgment tools that are increasingly implemented internationally[52] as they show promises assisting multidisciplinary and intersectoral teams in formulating and communicating a structured judgment regarding risk to prevent entry to forensic MH services or the criminal justice system more generally.[53]

Limits and future studies

The present paper has some limitations. First, the data dates to 2000-2005 – however, very little changes have been made to the organization of MH services in the past years, except for psychotherapy coverage by public insurance, to which access remains very difficult. Nevertheless, we would suggest that a replication study be done with a more recent sample, in Québec and other Canadian provinces. Such a study could also shed light on the prescribing practices and patterns of pharmacotherapy in this population, and compare with a matched sample of service users who were not admitted to forensic services to highlight the specific barriers and challenges experienced by people who are susceptible to justice involvement. Furthermore, exploring the pathway that leads to several NCRMD finding could be worth exploring in this context.[37] Second, while the RAMQ dataset provide a complete portrait of

physician-provided services and prescription claims, it remains medically oriented and does not provide details regarding contacts with community organizations and other psycho-social services that can play a key role in risk assessment and management. Third, as discussed in the introduction, Québec is a unique jurisdiction in Canada when it comes to the application of the NCRMD verdict, but also in terms of the duration and criteria for community treatment order and involuntary hospitalization.[54] While this may limit the generalizability of the findings, it should be highlighted that the vast majority of people found NCRMD annually are in Québec, which suggests that our findings remain highly relevant. Finally, administrative health data provide very little explanations regarding the reasons behind lack of access, treatment interruptions, and discontinuity of care. A qualitative study to understand the experiences of services in the community by patients found NCRMD could shed light on barriers to accessing ap-propriate healthcare.

Conclusion

Given the serious impact of the "forensic" label on the lives of service users, not to mention the increased pressure on resources, the considerable economic costs, and the impact on victims, there is reason to advocate for a greater involvement of mental and physical health service providers in early prevention of violence, which requires reorganizing resources to share the forensic knowledge upstream, before an offense is committed. Equitable access to health services should also be further examined among people with severe mental illness and behaviours perceived as disturbing or aggressive, so that the care of this underserved population is better coordinated after an initial contact with services so that their needs are fully met, without having to use the justice system to access specialized, appropriate care.

References

1.   Latimer J, Lawrence A. The review board systems in Canada: Overview of results from the Mentally Disordered Accused Data Collection Study. Ottawa: Department of Justice Canada; 2006. 52 p.

2.   Jansman-Hart EM, Seto MC, Crocker AG, et al. International trends in demand for forensic mental health services. International Journal of Forensic Mental Health 2011;10(4):326–336.

3.   Rice M, Harris G, Cormier C, et al. An evidence-based approach to planning services for forensic psychiatric patients. Issues in Forensic Psychology 2004;513–49.

4.   Kirby M, Keon WJ. Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada. Ottawa: The Standing Senate Committee Ontario Social Affairs, Science and Technology; 2006. 282 p.

5.   Bernheim E. Le refus de soins psychiatriques est-il possible au Québec? Instrumentalisation du droit et mission thérapeutique de la justice. Aporia 2019;11(1):28–40.

6.   Crocker AG, Livingston JD, Leclair MC. Forensic mental health systems internationally. In: Roesch R, Cook AN, editors. Handbook of Forensic Mental Health Services. New York: Routledge; 2017. p3–76.

7.   Luther G. Mental health, treatment and the criminal justice process. In: Chandler JA, Flood CM, editors. Law and Mind: Mental Health Law and Policy in Canada. Toronto, Canada: LexisNexis; 2016. p283–301.

8.   Canadian Criminal Code. L.R.C. C-46. 1992.

9.   Crocker AG, Nicholls TL, Seto MC, et al. The National Trajectory Project of individuals found Not Criminally Responsible on Account of Mental Disorder in Canada. Part 1 - Context and methods. Canadian Journal of Psychiatry 2015;60(3):95–105.

10.   Lukassen J, Miladinovic Z. Verdicts of not criminally responsible on account of mental disorder in adult criminal courts, 2005/2006-2011/2012. Statistics

Canadahttps://www150.statcan.gc.ca/n1/pub/85-002-x/2014001/article/14085-eng.htm (2014).

11.   Tribunal administratif du Québec. Rapport annuel de gestion 2011-2012. Québec 2012.

12.   Crocker AG, Nicholls TL, Seto MC, et al. The National Trajectory Project of individuals found Not Criminally Responsible on Account of Mental Disorder in Canada. Part 2 - The people behind the label. Canadian Journal of Psychiatry 2015;60(3):106–16.

13.   Livingston JD, Rossiter KR, Verdun-Jones SN. "Forensic" labelling: An empirical assessment of its effects on self-stigma for people with severe mental illness. Psychiatry Research 2011;188(1):115–122.

14.   Whitley R, Wang J, Carmichael V, et al. Newspaper articles related to the Not Criminally Responsible on Account of Mental Disorder (NCRMD) designation: A comparative analysis. Canadian Journal of Psychiatry 2017;62(10):697–701.

15.   West ML, Yanos PT, Mulay AL. Triple stigma of forensic psychiatric patients: Mental illness, race, and criminal history. International Journal of Forensic Mental Health 2014;13(1):75–90.

16.   Talbot EC, Völlm B, Khalifa N. Effectiveness of work skills programmes for offenders with mental disorders: A systematic review. Criminal Behaviour and Mental Health 2017;27(1):40–58.

17.   Salem L, Crocker AG, Charette Y, et al. Housing trajectories of forensic psychiatric patients. Behavioral Sciences and the Law 2016;34(2–3):352–365.

18.   Nijdam-Jones A, Nicholls TL, Crocker AG, et al. History of forensic mental health service use among homeless adults with mental illness. International Journal of Forensic Mental Health 2017;16(1):69–82.

19.   Jacobs P, Moffatt J, Dewa CS, et al. Mental health services costs within the Alberta criminal justice system. International Journal of Law and Psychiatry 2016;47102–108.

20.   Seto MC, Lalumière ML, Harris GT, et al. Demands For Forensic Services In The Province Of Ontario. 2001. 84 p.

21.   Hodgins S, Webster CD, Paquet J, et al. Canadian Database: Patients Held on Lieutenant Governor Warrants. Ottawa 1990.

22.   Cavney J, Skipworth J, Madell D, et al. Patterns of mental health service contact before and after forensic mental health contact in New Zealand. Australasian Psychiatry 2012;20(3):225–227.

23.   Anderson KK, Fuhrer R, Wynant W, et al. Patterns of health services use prior to a first diagnosis of psychosis: The importance of primary care. Social Psychiatry and Psychiatric Epidemiology 2013;48(9):1389–1398.

24.   Robinson DG, Schooler NR, John M, et al. Prescription practices in the treatment of first-episode schizophrenia spectrum disorders: Data from the National RAISE-ETP study. American Journal of Psychiatry 2015;172(3):237–248.

25.   O'Brien PL, Cummings N, Mark TL. Off-label prescribing of psychotropic medication, 2005-2013: An examination of potential influences. Psychiatric Services 2017;68(6):549–558.

26.   Alexander GC, Gallagher SA, Mascola A, et al. Increasing off-label use of antipsychotic medications in the United States, 1995-2008. Pharmacoepidemiology and Drug Safety 2011;20(2):177–184.

27.   Wallace M, Turner J, Matarazzo A, et al. Measuring Crime in Canada: Introducing the Crime Severity Index and Improvements to the Uniform Crime Reporting Survey. Ottawa, Canada: Canadian Centre for Justice Statistics; 2009. 45 p.

28.   Tu YK, Greenwood DC. Modern methods for epidemiology. New York: Springer; 2012. 314 p. Epub ahead of print 2012. DOI: 10.1007/978-94-007-3024-3.

29.   Nylund K, Asparouhov T, Muthén BO. Deciding on the number of classes in latent class analysis and growth mixture modeling: A Monte Carlo simulation study. Structural Equation Modeling: A Multidisciplinary Journal 2007;14(4):535–569.

30.   Geiser C. Data analysis with Mplus. New York: Guilford Press; 2013. 305 p.

31.   Levesque J-F, Harris MF, Russell G. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. International Journal for Equity in Health;12(18):. Epub ahead of print October 2013. DOI: 10.1002/cber.189502803178.

32.   Kreyenbuhl J, Nossel IR, Dixon LB. Disengagement from mental health treatment among individuals with schizophrenia and strategies for facilitating connections to care: A review of the literature. Schizophrenia Bulletin 2009;35(4):696–703.

33.   Roy L, Leclair MC, Côté M, et al. Itinérance, santé mentale, justice: Expérience et perceptions des utilisateurs de services à Montréal. Criminologie 2020;53(2):359–383.

34.   O'Brien A, Fahmy R, Singh SP. Disengagement from mental health services: A literature review. Social Psychiatry and Psychiatric Epidemiology 2009;44(7):558–568.

35.   Contandriopoulos D, Brousselle A, Breton M, et al. Analyse des impacts de la rémunération des médecins sur leur pratique et la performance du système de sant é au Québec. Québec. 41 phttp://www.frqsc.gouv.qc.ca/documents/11326/448958/2015_D.Contandriopoulos_remun-med_rapport-annexes.pdf/ff739688-c91e-488e-b556-fb0dda7c1efb (2018).

36.   Kurdyak P, Friesen EL, Young JT, et al. Prevalence of Mental Health and Addiction Service use Prior to and During Incarceration in Provincial Jails in Ontario , Canada : A Retrospective Cohort Study. 2021;1–11.

37.   Remington G, Addington D, Honer W, et al. Guidelines for the Pharmacotherapy of Schizophrenia in Adults. Canadian Journal of Psychiatry 2017;62(9):604–616.

38.   Frogley C, Taylor D, Dickens G, et al. A systematic review of the evidence of clozapine's anti-aggressive effects. International Journal of Neuropsychopharmacology 2012;15(9):1351–1371.

39.   Victoroff J, Coburn K, Reeve A, et al. Pharmacological management of persistent hostility and aggression in persons with schizophrenia spectrum disorders: A systematic review. Journal of Neuropsychiatry and Clinical Neurosciences 2014;26(4):283–312.

40. Kane JM, Leucht S, Carpenter D, et al. Expert consensus guideline series. Optimizing pharmacologic treatment of psychotic disorders. The Journal of clinical psychiatry 2003;64 Suppl 1(suppl 12):2–97, quiz 98.

41. Citrome L, Volavka J, Czobor P, et al. Effects of Clozapine, Olanzapine, Risperidone, and Haloperidol on Hostility Among Patients With Schizophrenia. Psychiatric Services 2001;52(11):1510–1514.

42. Buchanan RW. Clozapine: Efficacy and safety. Schizophrenia Bulletin 1995;21(4):579–591.

43. Volavka J. The effects of clozapine on aggression and substance abuse in schizophrenic patients. Journal of Clinical Psychiatry 1999;60(SUPPL. 12):43–46.

44. Moisan J, Grégoire JP. Patterns of discontinuation of atypical antipsychotics in the province of Québec: A retrospective prescription claims database analysis. Clinical Therapeutics 2010;32(Supplement A):S21–S31.

45. Keogh B, Murphy E, Doyle L, et al. Mental health service users experiences of medication discontinuation: a systematic review of qualitative studies. Journal of Mental Health 2021;0(0):1–12.

46. García S, Martínez-Cengotitabengoa M, López-Zurbano S, et al. Adherence to antipsychotic medication in bipolar disorder and schizophrenic patients. Journal of Clinical Psychopharmacology 2016;36(4):355–371.

47. Robinson DG, Subramaniam A, Fearis PJ, et al. Focused ethnographic examination of barriers to use of long-acting injectable antipsychotics. Psychiatric Services 2020;71(4):337–342.

48. Stip E, Abdel-Baki A, Roy MA, et al. Antipsychotiques à Action Prolongée: Révision de l'algorithme QAAPAPLE. Canadian Journal of Psychiatry 2019;64(10):697–707.

49. MacDonald K, Ferrari M, Fainman-Adelman N, et al. Experiences of pathways to mental health services for young people and their carers: a qualitative meta-synthesis review. Social Psychiatry and Psychiatric Epidemiology 2021;56(3):339–361.

50.	Crawford MJ, de Jonge E, Freeman GK, et al. Providing continuity of care for people with severe mental illness - A narrative review. Social Psychiatry and Psychiatric Epidemiology 2004;39(4):265–272.

51.	Goulet MH, Dellazizzo L, Lessard-Deschênes C, et al. Effectiveness of Forensic Assertive Community Treatment on Forensic and Health Outcomes: A Systematic Review and Meta-Analysis. Criminal Justice and Behavior 2021;1–15.

52.	Challinor A, Ogundalu A, McIntyre JC, et al. The empirical evidence base for the use of the HCR-20: A narrative review of study designs and transferability of results to clinical practice. International Journal of Law and Psychiatry 2021;78(July):101729.

53.	Viljoen JL, Cochrane DM, Jonnson MR. Do risk assessment tools help manage and reduce risk of violence and reoffending? A systematic review. Law and Human Behavior 2018;42(3):181–214.

54.	Frank D, Fan E, Georghiou A, et al. Community Treatment Order Outcomes in Quebec: A Unique Jurisdiction. Canadian Journal of Psychiatry 2020;65(7):484–491.

55.	Crocker AG, Martin MS, Leclair MC, et al. Expanding the early and late starter model of criminal justice involvement for forensic mental health clients. Law and Human Behavior 2018;42(1):83–93.

Table 1 – *Nature and extent of individual mental health service use*

	12 months prior to the NCRMD offense	6 months prior to the NCRMD offense
Contacts with services for mental health reasons		
At least one contact	71.4% (*n=727*)	59.0% (*n=602*)
Consultations with general practitioner for mental health reasons		
At least one contact	32.1% (*n=340*)	21.6% (*n=231*)
Number of contacts for those with at least one contact	*M* = 3.01 (*SD* = 3.30)	*M* = 2.22 (*SD* = 1.93)
Emergency room visits for mental health reasons, with no resulting hospitalisations		
At least one contact	42.9% (*n=429*)	32.5% (*n=322*)
Number of contacts for those with at least one contact	*M* = 3.8 (*SD* = 4.6)	*M* = 3.3 (SD = 3.9)
Consultations with psychiatrist (outside of the emergency room or psychiatric hospitalisation)		
At least one contact	44.2% (*n=452*)	34.4% (*n=345*)
Number of contacts for those with at least one contact	*M* = 7.9 (*SD* = 13.2)	*M* = 4.7 (*SD* = 8.2)
Hospitalisations for mental health reasons		
At least one hospitalisation	33.0% (*n=346*)	22.0% (*n=229*)
Number of hospitalisations for those with at least one hospitalisation	*M* = 1.7 (*SD* = 1.0)	*M* = 1.4 (*SD* = 0.7)

Note. Weighted statistics.

Table 2 – *Detailed service use in the 12 months prior, by mental health use pattern*

	Class 1 (58.4%)	Class 2 (21.9%)	Class 3 (16.6%)	Class 4 (3.1%)	Test statistic
Mental health service use					
Emergency room visits for mental health reasons, with no resulting hospitalisations					
Sum over 12 months (*M*, SD)	0.5 (0.9)	1.2 (1.7)	5.6 (5.8)	4.8 (8.4)	$p < .001$ (1 vs. all, 2 vs. all)
Any over 12 months (%)	27.1%	48.8%	85.3%	70.6%	$p < .001$ (1 vs. all, 2 vs. 3)
Consultations with psychiatrist (outside of the emergency room or psychiatric hospitalisation)					
Sum over 12 months (*M*, SD)	0.2 (0.5)	8.0 (5.0)	2.3 (2.6)	41.7 (30.7)	$p < .001$ (all different)
Any over 12 months (%)	12.4%	100%	72.3%	100%	$p < .001$ (1 vs. all)
Consultations with general practitioner for mental health reasons					
Sum over 12 months (*M*, SD)	0.4 (0.8)	0.3 (0.6)	3.8 (4.4)	2.4 (3.0)	$p < .001$ (1-2 vs. 3-4)
Any over 12 months (%)	22.7%	17.9%	78.3%	61.7%	$p < .001$ (1-2 vs. 3-4)
Hospitalisations for mental health reasons					

Days over 12 months (*M,* SD)	5.8 (23.5)	19.7 (43.2)	18.5 (36.4)	34.8 (50.3)	*p* < .001 (1 vs. all)
Sum over 12 months (*M,* SD)	0.3 (0.6)	0.8 (1.1)	1.1 (1.3)	1.2 (1.4)	*p* < .001 (1 vs. all)
Any over 12 months (%)	18.3%	49.4%	59.6%	54.2%	*p* < .001 (1 vs. all)
Physical health service use					
Visits to general practitioner for physical health reasons					
Sum over 12 months (*M,* SD)	2.0 (3.3)	2.9 (5.7)	5.5 (8.2)	6.4 (12.5)	*p* < .001 (1-2 vs. 3)
Any over 12 months (%)	56.9%	69.9%	84.5%	64.8%	*p* < .001 (1 vs. 2-3, 2 vs. 3)
Visits to specialist for physical health reasons					
Sum over 12 months (*M,* SD)	1.3 (3.5)	4.0 (10.3)	2.5 (5.4)	4.8 (6.3)	*p* < .001 (1 vs. all)
Any over 12 months (%)	33.6%	48.0%	58.8%	70.5%	*p* < .001 (1 vs. all)
Prescription claims					
1+ prescription claim for psychotherapeutic agents	34.2%	73.8%	74.1%	76.7%	*p < .001* (1 vs. all)
1+ prescription claim for antipsychotic agents	22.9%	67.5%	58.4%	74.5%	*p* < .001 (1 vs. all)

Note. Weighted statistics. The test statistics report *p*-values from adjusted F-statistics for survey design from regressions. A significant *p*-value indicates that at least one group mean or proportion is different from the others. In parenthesis, we report which group mean or proportion is significantly different based on Sidak-adjusted pairwise comparisons.

Table 3 – *Sociodemographic, clinical and offense- or justice-related characteristics, by mental health use pattern*

	Class 1 (58.4%)	Class 2 (21.9%)	Class 3 (16.6%)	Class 4 (3.1%)	Test statistic
Sociodemographic					
Women (%)	14.4%	10.2%	17.0%	10.8%	*p* = .256
Age (*M*, SD)	37.6 (13.1)	34.8 (11.6)	36.1 (11.9)	32.5 (12.0)	*p* = .016
					(no pairwise sig. differences)
Indigenous (%)	.9%	.9%	1.7%	0	*p* = .644
High school diploma (%)	46.5%	60.7%	42.4%	46.8%	*p* = .063
In a relationship (%)	82.5%	90.5%	87.0%	92.5%	*p* = .036
					(no pairwise sig. differences)
Earning income (%)	18.8%	9.5%	13.6%	10.1%	*p* = .059
Homeless (%)	9.1%	8.1%	17.2%	11.3%	*p* = .111
Clinical					
At least one lifetime contact with mental health services (%)	57.1%	87.8%	74.8%	92.8%	*p* < .001 (1 vs. all, 2 vs. 3)
Primary diagnosis at verdict (%)					
Psychotic spectrum disorder	65.5%	69.3%	60.2%	83.3%	*p* = .108
Mood spectrum disorder	28.1%	27.6%	34.0%	10.5%	

Others	6.4%	3.2%	5.9%	6.3%	
Concomitant diagnoses at verdict (%)					
Substance use disorder	9.5%	7.9%	13.4%	6.2%	*p* = .274
Personality disorder	29.6%	26.1%	35.7%	25.6%	*p* = .288
Offense- or justice-related					
Number of prior charges (*M*, SD)	2.5 (4.4)	1.8 (3.8)	2.3 (4.2)	2.5 (4.9)	*p* = .445
NCR history (%)	8.4%	15.4%	8.7%	19.8%	*p* = .031
					(no pairwise sig. differences)
Sequence of crime onset in relation to illness onset (Early/Late starter(Crocker et al., 2018))					*p* < .001 (Preillness, after 18: 1 vs. 2-4; First presenters: 1 vs. all)
Preillness, before 18	8.1%	6.0%	7.2%	12.9%	
Preillness, after 18	27.9%	18.3%	26.6%	11.1%	
Postillness, before 35	25.8%	46.3%	37.3%	56.5%	
Postillness, after 35	17.0%	23.3%	19.2%	12.3%	
First presenters[a]	21.1%	6.1%	9.6%	7.2%	
Most serious index offense					*p* = .215
Homicide	5.1%	5.4%	1.6%	7.1%	
Assaults and sexual assaults	24.2%	33.5%	26.1%	33.3%	
Other against the person	32.2%	26.0%	33.3%	27.3%	

Property	21.6%	15.5%	21.6%	13.7%	
Other	17.0%	19.6%	18.5%	17.7%	
Crime severity index	287.0	285.4	130.7	425.8	*p* < 0.001
	(953.8)	(956.7)	(207.7)	(1381.8)	(1 vs. 3)
Victim of the index offense					*p* = .024
Family member	39.4%	22.9%	36.6%	8.5%	(professional: 1 vs. 2)
Stranger	17.9%	22.2%	21.1%	24.1%	
Professional	21.5%	33.3%	28.3%	42.6%	
Other known	21.2%	21.6%	13.9%	24.8%	

Note. Weighted statistics. The test statistics report *p*-values from adjusted F-statistics for survey design from regressions. A significant *p*-value indicates that at least one group mean or proportion is different from the others. In parenthesis, we report which group mean or proportion is significantly different based on Sidak-adjusted pairwise comparisons.

[a] First presenters consist of participants for whom the NCR offense was both the first evidence of criminal behavior and the first evidence of mental illness.

Figure 1 – Failure function showing the cumulative proportion of subjects who committed the NCRMD offense at different time points after their last mental health contact
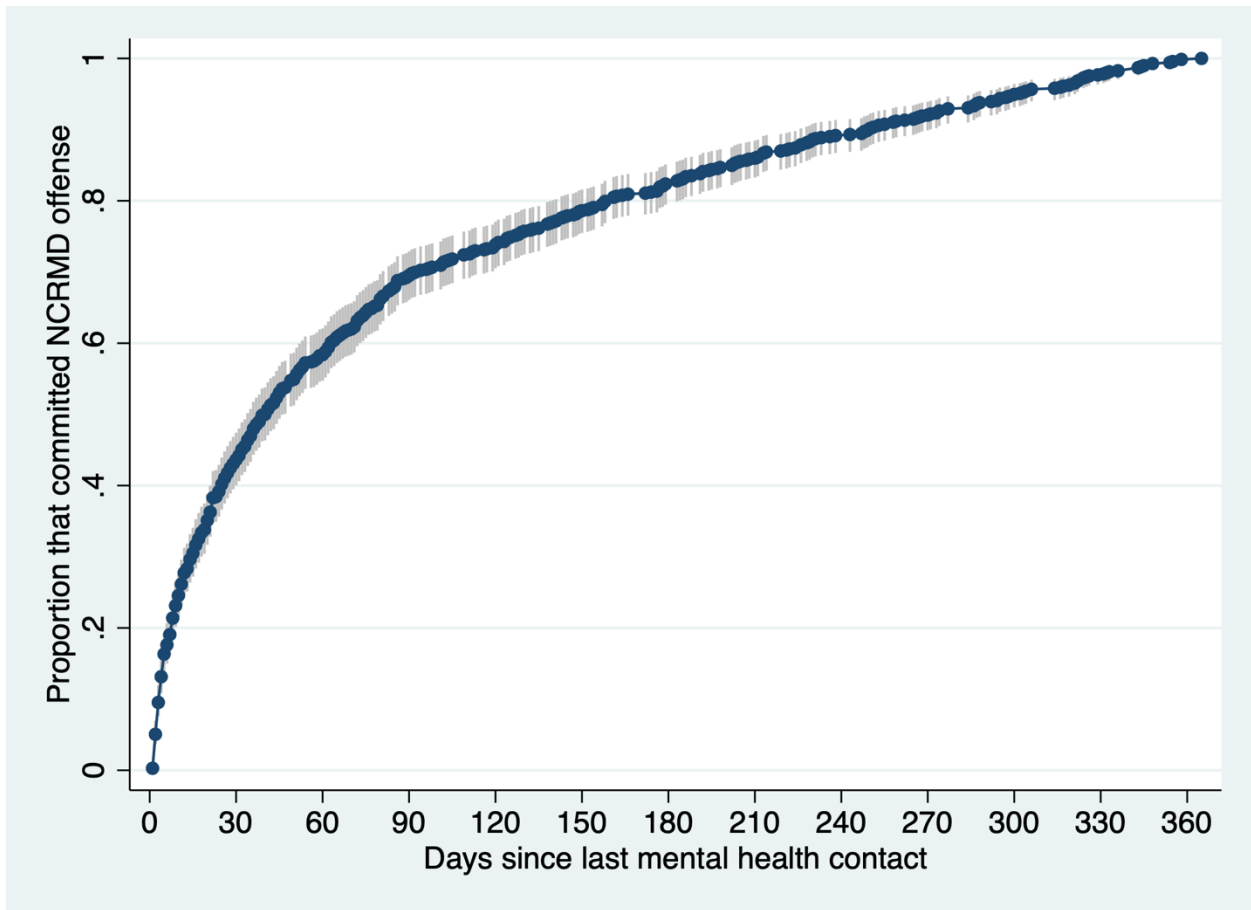
Note. This failure function graph includes only subjects (*n*=692) who had a least one contact with mental health services in the 12 months within their offense and who were not hospitalised at the time of the offense.

Figure 2 – Patterns of mental health service use
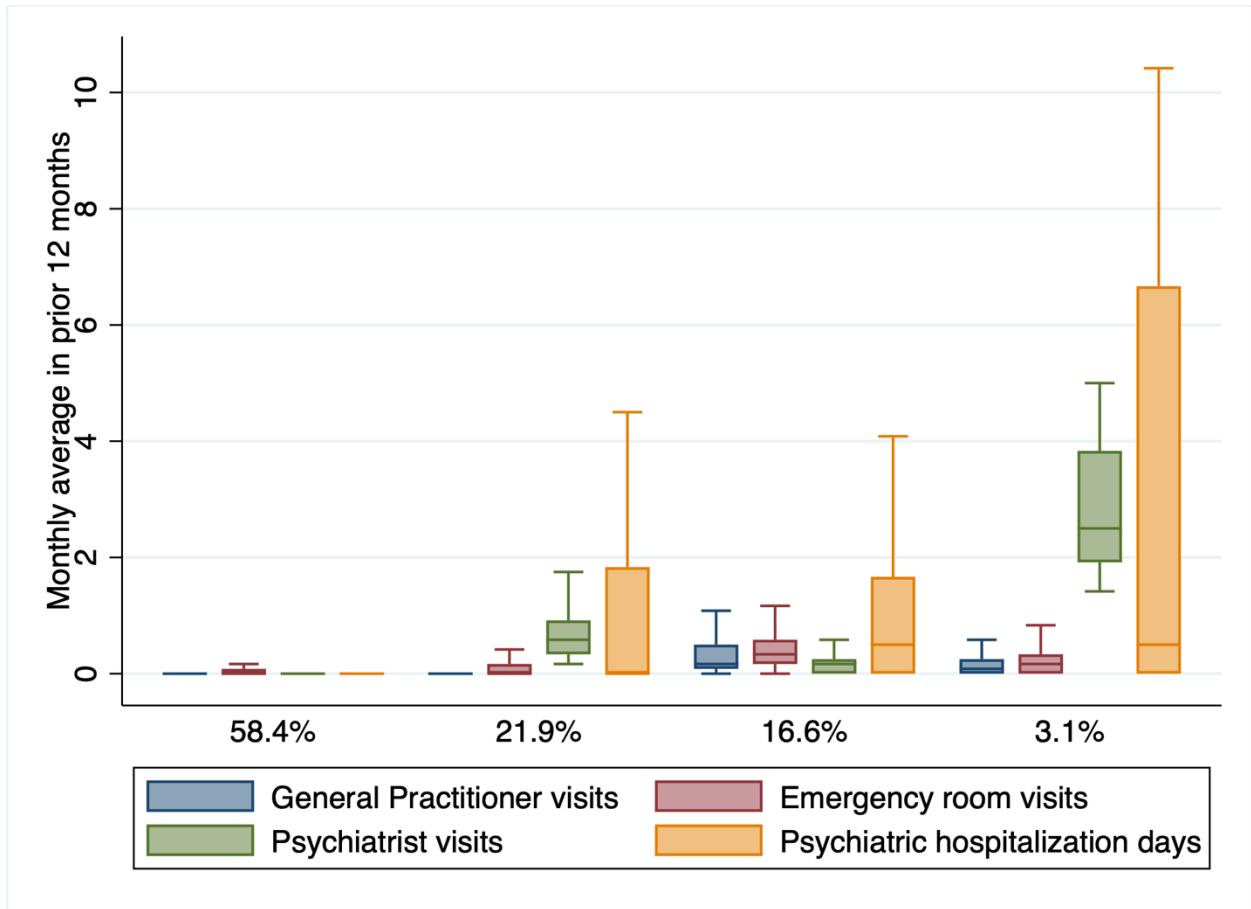
Note. The box plots represent the distribution of monthly average service use in the 12 months prior to the NCRMD offense. The boxes represent the interquartile range and are divided by a line that represent the median.

Online supplement

eTable 1 – *Characteristics and index offenses of participants included and excluded from the present analyses*

Sociodemographic and clinical characteristics			Offense characteristics and criminal justice history		
	Included	**Excluded**		**Included**	**Excluded**
Variables	**(n=1014)**	**(n=80)**		**(n=1014)**	**(n=80)**
Gender, %			Most severe index offense, %		
Women	13.8	31.9	Causing death or attempting to cause death	4.6	3.5
Men	86.2	68.1	Sexual offense	1.3	6.7
Age, *M* (*SD*)	36.6 (12.7)	34.2 (11.6)	1st degree assault	5.6	7.3
Completed high school, %	48.8	43.2	Other assault	20.0	17.0
Civil status, %			Threats	21.7	9.9
In a relationship	14.7	16.1	Other against the person	9.1	16.8
Single	85.3	83.9	Property offenses	20.0	23.2
Born in Canada, %	66.0	40.7	Administration of justice	4.7	2.3
Indigenous, %	1.0	4.4	Other	12.9	13.3
Revenue, %			Criminal history, %	46.8	39.3
Own paid work (or partner's)	15.6	16.7	NCRMD history, %	10.3	4.5
Pensions, welfare, disability	74.6	68.0			
Other	9.8	15.3			

71

Primary diagnosis, %		
Psychotic disorder	66.0	65.4
Mood disorder	28.4	24.8
Other	5.6	9.8
Concomitant personality disorder, %	9.7	15.8
Concomitant substance use disorder, %	29.7	16.6

Note. Weighted statistics.

eTable 2 – *Fit indices for 2- to 6-class models*

	2-class	3-class	4-class	5-class	6-class
BIC	--	23113.034	21833.152	21340.255	20793.861
Entropy	--	0.922	0.935	0.935	0.929
Smallest class size	--	61	30	11	8
Model convergence	No	Yes	Yes	Yes	Yes

Note. BIC: Bayesian Information Criterion. Bootstrapped Likelihood Ratio Tests significant at *p* <.001 for 4-6 classes.

Chapitre 5 (Article 2) – Barriers and facilitators of access and utilization of mental health services among forensic service users along the care pathway

Leclair, M. C., Charette, Y., Seto, M. C., Nicholls, T. L., Roy, L., Dufour, M., & Crocker, A. G. (2022). Barriers and facilitators of access and utilization of mental health services among forensic service users along the care pathway. BMC Health Services Research, 22, p. 1-12. doi: 10.1186/s12913-022-08848-9

Note. Le format des références suit celui exigé par *BMC Health Services Research*.

Background. The verdict of Not Criminally Responsible on account of a Mental Disorder (NCRMD) is increasingly used to access specialized mental health services in Canada and elsewhere. This situation highlights the importance of ensuring timely access to services in the community to prevent violence and justice involvement. The objective of the present study is to identify individual and contextual barriers and facilitators of access to mental health services during the period preceding an offense leading to a verdict of NCRMD.

Methods. The sample includes 753 people found NCRMD in Québec, Canada. All episodes of mental health hospitalizations and service use before the index offense were identified using provincial administrative health data, for an average period of 4.5 years. Access was conceptualized as a function of the possibility of seeking, reaching and receiving appropriate health care services, based on Lévesque and colleagues patient-centred model of access to care.

Generalized linear models were computed to identify the individual and contextual predictors of: (1) seeking mental healthcare (at least one contact with any type of services for mental health reasons); (2) reaching psychiatric care (at least one contact with a psychiatrist); (3) receiving psychiatric care, operationalized as (3a) continuity and (3b) intensity. Factors associated with volume of emergency mental health services were examined as exploratory analysis.

Results. Geographical considerations were highly important in determining who reached, and who received specialized mental health care – above and beyond individual factors related to need. Those who lived outside of major urban centres were 2.6 times as likely to reach psychiatric services as those who lived in major urban centres, and made greater use of emergency mental health services by 2.1 times. Living with family decreased the odds of seeking mental healthcare by half and the intensity of psychiatric care received, even when adjusting for level of need.

Conclusions. Findings support efforts to engage with the family of service users and highlights the importance of providing resources to make family-centred services sustainable for health practitioners. Health policies should also focus on the implementation of outreach programs, such as Forensic Assertive Community Treatment teams as part of prevention initiatives.

Barriers and facilitators of access and utilization of mental health services among forensic service users along the care pathway

The criminal justice system has been increasingly used to access mental health services in a timely manner in Canada and elsewhere (1–3), as illustrated by the remarkable growth in the number of verdicts of non criminal responsibility on account of a mental disorder (NCRMD) and associated admissions to forensic mental health services (4,5). In Canada, a person is found NCRMD when their psychiatric symptoms made it so that they were "incapable of appreciating the nature and quality of the act [...] or of knowing that it was wrong" (6). In the province of Québec, the verdict has been used more extensively than in other provinces as a lever to access specialized mental healthcare. Indeed, the NCRMD defense is used in Québec for offenses of lesser severity and with persons with a greater diversity of diagnoses (7). This forensication of mental health services (8) results in important implications for the persons and their loved ones, including additional stigma (9) and greater privation of liberty (10). In addition, treating a patient in forensic mental health services incurs costs five times greater compared to general mental health services (11).

Better access to responsive, integrated and equitable mental health services has been highlighted time and time again as a priority for provincial Canadian healthcare systems (12–14), especially for people who are considered at high risk of committing an offense due to their mental illness symptoms (15). The situation related to the COVID-19 pandemic has exacerbated these issues, accelerating the fragilization of certain groups and of health systems, resulting in a deterioration in accessibility of mental health services (16,17). People who have a severe mental illness and who are at risk of committing an offense are likely to experience several of the barriers to mental health services identified in the literature (18) in ways that pose unique challenges (19). For example, those service users may have concerns about stigma or experience discrimination within services (20–23) as they are labeled as "dangerous" or "too difficult" by providers (24). They often have a history of criminal justice involvement (7) and several concurrent diagnoses (25) which, in addition to lack knowledge of available resources (26), may make fragmented services and complex care pathways (27) even more difficult to navigate.

This situation highlights the importance of ensuring access to mental health services in the community and of understanding the barriers and facilitators along pathways to care for these high-need service users. Lévesque et al.'s patient-centered model of access to health care (28), and the older Goldberg and Huxley model (29), have emphasized the importance of operationalizing access to care in multilevel ways that encompass the possibility of recognizing healthcare needs, seeking services, reaching healthcare resources, and receiving services that are relevant and appropriate to the individual's healthcare needs, where relevance and appropriateness can be understood through the lense of quality (e.g., continuity) or adequate intensity (28). This allows an account of the entire experience of service users across the healthcare system. Different models of access to care (28,30), including Andersen's behavioral model of health services use (31–33), have emphasized that both service-level (e.g., geographic location of services, availability of services, referral mechanisms, coordination of care) and individual-level (e.g., social support, criminal history, housing) variables are relevant to informing our understanding of how and by whom health care services are accessed and used, above and beyond health needs.

The objective of the present study is to identify individual and contextual barriers and facilitators of access to mental health services specifically during the period preceding an offense leading to an NCRMD verdict (index offense). For the purpose of the present investigation, we borrow from Lévesque and colleagues' definition and conceptualisation of access. We define access as the "opportunity to have healthcare needs fulfilled" (28) as a function of the possibility of seeking, reaching and receiving appropriate healthcare services.

Methods

Sample and Procedures

Data were extracted from the Québec sample of the National Trajectory Project (34), a longitudinal file-based study of 1,094 people declared NCRMD between 2000 and 2005. Given our focus on the period prior to the index offense and on community healthcare service use, we excluded service users for whom matching with administrative health services data was unsuccessful (n = 74), for whom the exact date of the index offense was unknown (n = 6), who

79

were in an institution at the time of the index offense (n = 53) or homeless (n = 86), or who lived outside of the province of Québec (n = 5), or for whom the address at the time of the offense was missing (n = 106). Address matching with data from Institut national de santé publique du Québec (Québec Public Health Institute, INSPQ) (35) (which provided data regarding proximity to services, for example – see Measures below) was successful for 753 of the eligible participants. The present analyses therefore involve 753 service users who were housed in the community at the time of their index offense. The majority of participants were men (85%), 84% were single, only 17% had employment or a partner's employment as main source of revenue, and 45% had prior criminal history (see Table 1). In terms of clinical characteristics, at the verdict, 64% had a primary diagnosis of psychotic disorder, 30% of mood disorder (most frequently bipolar disorder), and 6% had another primary diagnosis. Concurrent personality disorder was found in 9.7% of service users, and concurrent substance use disorder in 30.0%. There were no notable differences between included and excluded participants (see Table S1 of the online supplement for a detailed comparison).

The research protocol was approved by appropriate institutional ethics review committees. Governmental health records were received through the Québec Access to Information Commission (Commission d'accès à l'information).

Measures

Administrative health services data for the five years prior to the NCRMD verdict were received from the Ministry of Health and Social Services' MED-ECHO and the provincial medical insurance plan (Régie de l'assurance maladie du Québec; RAMQ), a physician fee-for-service database on all medical interventions completed under the public insurance system. We selected all hospitalizations and services before the index offense, up to the day before, for an average observation period of 4.53 years (SD = 0.55, minimum = 0.77 years, maximum = 5.0 years – less than 1% of the sample had a follow-up time shorter than 2 years and 84.8% had a follow-up time longer than 4 years). Given that provinces in Canada rely on universal, public, single-payer systems, these data are available for medical services received in Québec in the public system. Given that only 15.7% of our sample had paid employment and that there are very few

psychiatrists whose services are not covered by the RAMQ (36), we estimate that the proportion of participants who may have used private healthcare – which is not covered by private or public insurance – to meet their health needs is minimal. Hospitalisation associated with a primary or secondary diagnosis of mental disorder (ICD-9 codes 290-319, which includes substance use disorders) and services associated with a primary diagnosis of mental disorder were classified as "mental health related". Consistent with the literature (37), multiple medical services provided for the same diagnosis, on the same day and at the same institution or by the same provider were coded as a single visit.

Three categories of data were coded from the Review Board files: (1) sociodemographic data (e.g., age, gender, marital status at time of index offense, address of residence at the time of the index offense); (2) clinical data (e.g., diagnoses at the NCRMD verdict); and (3) judicial history (e.g., nature and date of index offenses, presence of past NCRMD offenses). Criminal history was identified from the files of the Royal Canadian Mounted Police criminal records (for a full explanation, see Crocker et al., 2015 (34)).

Dependent variables. Outcome variables represent different levels of access to care. First, the concept of "seeking mental healthcare" was operationalized as a dichotomous variable where those who had at least one contact with any type of services for mental health reasons prior to their index offense were considered to have "successfully" sought care. This operationalization relies on the assumption that all people in our sample had a need for mental healthcare, which is a reasonable assumption given that all people found NCRMD must have had a mental disorder that rendered them unable to appreciate the nature and quality of the act or of knowing that it was wrong, and that 72.5% of people found NCRMD in Québec had been hospitalized for a mental health problem in their lifetime (7). However, there may be a small proportion of people for whom the index offense was the first manifestation of their mental illness (38).

Second, we operationalized "reaching psychiatric care" as having had at least one contact with a psychiatrist, on an outpatient or inpatient basis, prior to the index offense. Given the vast majority of people with a NCRMD verdict had a severe mental illness (i.e., psychotic spectrum

disorder or bipolar disorder; see Table 1), this operationalization assumes that all those who sought contact with the healthcare system for a mental health reason should have been referred to a psychiatrist. As in most provinces, psychiatric care in Québec is accessible almost solely through referral from a primary care physician or through psychiatric emergency services.

Third, we operationalized "receiving psychiatric care" as two distinct outcomes used as proxy for intensity and quality of services: volume of psychiatric care (sum of psychiatric visits [consultations and follow-up], as an inpatient or outpatient) and continuity of psychiatric care. We calculated the Bice-Boxerman continuity of care index (39), which reflects the extent to which regular psychiatric care is provided by a single psychiatrist, outside of hospitalization periods and emergency room visits. This index takes continuous values from 0 to 1; if all psychiatric visits were exclusively with the same provider, the index would be 1, whereas all visits to different providers would result in an index of 0. To calculate continuity, we used only evaluation and management visits, as suggested in the literature (39).

As an exploratory analysis, we sought to identify contextual and individual factors related to volume of emergency mental health services among those who had had at least one contact with services for mental health reasons (sum of emergency room visits where a service was provided for mental health reasons). The reason we decided to frame it as an exploratory analysis rather than an indicator of receiving psychiatric care, is that emergency room visits can both be interpreted an indicator of access in times of distress and crisis or as an indicator of lack of access (for example, if a person is unable to access services in a timely manner until the situation requires emergency care, or if a person seeks routine mental healthcare through the emergency room).

Independent variables. Contextual and individual independent variables were selected based on the factors put forward by the behavioral model of health services use (32).

For contextual factors, based on the address of the participant at the time of the verdict, we considered the annual expenditure in health and social services per capita, the number of physicians per 1,000 population in every regional health district (40), whether the area of residence was considered as part of a major urban centre or not, as per the INSPQ, and proximity

to services (measured using the number of physician offices and local community service center within a 15 minute drive radius, the number of hospital centers providing outreach services within a 30 minute drive radius, or the number of hospital centers providing services for complex conditions upon referral within a 60 minute radius, as calculated by the INSPQ (35)). Outreach services aim to improve the availability of services and the coordination of care through initiatives such as community health workers or mobile clinics (41). We also considered the index of social and material deprivation of the area of residency, which are represented using quintiles of deprivation (42).

For individual factors, we considered the following predisposing and enabling factors: age at the start of the observation period, gender, if the person lived with relatives at the time of the index offense (i.e., a partner, a family members or friends, as proxy for social support), having a criminal record, having a significant connection to a primary care physician (understood as a Usual Provider Care index (43) greater than 75% or a complete medical examination by the same provider at least once every two years, consistent with proposed algorithms (44)). Factors related to mental health need included the presence of a history of a prior NCRMD verdict, and the diagnoses by the psychiatrist at verdict.

Analytical plan

We conducted different multivariate generalized linear models for each outcome, adjusting for the length of the observation period as exposure variable. To limit the bias in the association of distal correlates due to the inclusion of intermediates in a single model (45), we opted for a series of regressions entering blocks of variables one at a time, progressing from the most distal covariates to the most proximal covariates (block 1: contextual factors; block 2: individual predisposing and enabling factors; block 3: individual need-related factors). A similar strategy has been used in other studies examining predictors of access to mental health services (46,47). We used the binomial function for seeking and reaching, the gamma function for continuity of care and the negative binomial function for volume of psychiatric care and volume of emergency mental health services. All analyses used sample weights.

Sensitivity analysis. To account for the fact that the intensity of psychiatric care received (i.e., volume of psychiatric care) may be both indicative of greater access and of greater mental health need, we adjusted for the annual number of days in psychiatric hospitalization as a proxy for mental health needs. The results of this sensitivity analysis are reported in text.

Results

Half of participants lived in a major urban centre (50.5%) at the time of the index offense, and a disproportionate proportion lived in neighborhoods of the most materially deprived (34.5%) or socially deprived (34.2%) quintile. On average, they were hospitalized for psychiatric reason 8.2 days every year (SD = 18.2), and only 18.0% were considered as having a significant connection to a family physician based on the algorithm.

Seeking Mental Healthcare

Of the full sample (n = 753), as many as 87.0% of participants sought mental healthcare in the average 4.5 year observation period prior to their index offense. No contextual characteristics increased the odds of seeking care, but individual factors did (see Table 2). Among predisposing factors, presence of a criminal history (OR = 2.20, p = .004) and having an connection to a general practitioner (OR = 3.58, p = .001) increased the odds of seeking care for mental health reasons, whereas living with family or a partner was associated with a reduction in healthcare seeking (OR = 0.53, p = .012). No factors associated to need predicted seeking care.

Reaching Psychiatric Care

Among the participants who sought services for mental health reasons (n = 661), 85.9% reached psychiatric care (i.e., at least one contact with a psychiatrist). Several contextual factors increased the odds of reaching psychiatric care: the number of physicians per 1,000 residents of the area of residence (OR = 1.84, p = .010), living outside of a major urban centre (OR = 2.61, p = .016), and proximity to hospitals providing outreach (OR = 1.31, p = .055) or referral services (OR = 1.11, p = .003). Living with family or a partner marginally reduced the odds of reaching psychiatric care (OR = 0.64, p = .081). Finally, several factors related to mental health needs were predictive of reaching psychiatric care: having a history of forensic involvement (OR = 16.3,

p = .007), a diagnosis of psychotic spectrum disorder (OR = 2.29, p = .024) or of concurrent substance use disorder at verdict (OR = 2.53, p = .002). Of note, availability of physicians, living outside of a major urban centre, and proximity to services continued to have an effect above and beyond those need-related factors, with very stable size effects.

Receiving Psychiatric Care

Participants who had reached psychiatric services (n = 555) consulted on average annually a psychiatrist 9.1 times (SD = 11.6) in any context. Among contextual factors, living in an area with a greater number of physicians was associated with more visits to a psychiatrist (RR = 1.31, p = .033), whereas greater proximity to hospitals providing outreach services was associated with fewer visits (RR = 0.86, p = .026). In terms of individual factors, living with family or friends reduced the volume of psychiatric consults (RR = 0.73, p = .006) whereas a NCRMD history (RR = 1.86, p < .001) and a diagnosis of psychotic disorder at verdict (RR = 1.71, p = .026) increased it. Effect sizes related to proximity to services remained stable when inserting variables related to predisposition or need. As sensitivity analysis, we adjusted for days in psychiatric hospitalization as a proxy for need, to ensure that the factors aforementioned were related to access rather than than need. Adding this variable to the model resulted in two changes: material disadvantage was associated with fewer psychiatric visits (OR = 0.92, p = .042) and psychotic disorder was no longer a significant variable.

Of the 437 participants who had at least two contacts with a psychiatrist, the Bice-Boxerman index indicating continuity of psychiatric care (outside of hospitalization periods and emergency room visits) was 0.62 (SD = 0.37) for an average of 2.0 different psychiatrists (SD = 1.44). Three factors were associated with continuity of psychiatric care. Proximity to outreach services (β = 0.18, p = .046) and concurrent substance use disorder (β = 0.26, p = .047) increased continuity of care, whereas age decreased it (β= -0.01, p = .011). The effect of proximity to outreach services remained significant with a stable effect size when adding individual factors.

Exploratory Analysis: Volume of Emergency Mental Health Services

The model for volume of emergency mental healthcare used as a target sample all those who had sought mental health services (n = 661). Annually, on average, participants visited an

emergency room 1.3 times (SD = 2.15) for mental health reasons. Living outside of major urban centres was a predictor of greater use of emergency mental health services (RR = 2.05, p < .001), whereas greater social deprivation of the area of residency marginally decreased the use (RR = 0.91, p = .052). Age (RR = 0.98, p = .002), female gender (RR = 1.67, p = .011), a criminal history (RR = 1.29, p = .043), a prior NCRMD finding (RR = 1.77, p = .022) and concurrent substance use disorder (RR = 1.31, p = .024) were also associated with volume of emergency mental health services in the observation period.

When adding greater continuity of psychiatric care (outside of periods of hospitalization or emergency room visits) in the predisposing factors block, thus limiting the model to the 436 service users with at least two visits to a psychiatrist, it was found that greater continuity of care was associated with reduced use of emergency mental health services (RR = 0.64, p = .020).

Discussion

This paper provides an overview of who accesses and receives various types of mental health medical services, in a sample of participants who were selected as a result of being found NCRMD. Traditional models of access to care highlight that needs are the main predictors of service utilization (48); however, that was not the case here. While facilitators and barriers may differ for every level of care, general trends emerged: the person's living situation, both in terms of geography and in terms of people with whom the person lived, had major influences on what services were accessed and used or not, even when adjusting for need-related variables such as primary and concurrent diagnoses. There was one major exception in terms of need-related variable: a history of NCRMD was by far the largest size effect in determining who reached psychiatric services, and was a significant predictor of volume of psychiatric care and of emergency mental healthcare. These findings show that a NCRMD verdict changes how service users interact with the mental health system.

Geographical considerations were highly important in determining who reached, and who received, psychiatric care – even when including individual factors related to need in the models. All else – including proximity to services – being equal, those who lived outside of major urban centres were 3 times as likely to reach psychiatric services as those who lived in major urban

centres. They were also 2 times more likely to frequently visit the emergency room for mental health reasons. This may reflect the lack of access to primary care physicians in rural regions, with ratios of physicians per capita being between 30% to 50% greater in major urban centres compared to other regions (40), a situation that has barely evolved over the past 20 years (49). General practitioners in rural areas may be especially overwhelmed and not able/willing to treat severe mental illnesses (50), preferring to refer to psychiatric care (51,52). Community psychosocial services are also lacking outside urban areas (53), which may result in a greater involvement of medical professionnals. For example, a study of Québec general practitioners' practices in mental healthcare found that general practitioners of rural areas were 1.5 times more likely to refer to outpatient psychiatric clinics than general practitioners in urban or semi-urban areas, while they were less susceptible to refer to psychosocial services, psychologists offices, community organisms or crisis centres (53). Another study in the United States supports the hypothesis that rural populations are less likely to rely on psychosocial services, with data suggesting that they are half as likely to initiate psychotherapy when needed as urban populations – but that they engaged in similar intensity and for similar lengths once initiated (54). It is also possible that lack of access to first line mental health services outside of major urban centres, including primary care and non-medical resources (54), result in increased use of the emergency departments (55), thus increasing the odds of being evaluated by a psychiatrist. This would explain the findings that living in a rural zone influence the odds of reaching specialist care, but not the volume of specialist care used. Finally, it is also possible that existing resources are better known in smaller communities, and that fewer service points results in a more patient-centred, better coordinated care.

When adjusting for urbanization of the area of residence, closer proximity to hospital centres offering services upon referral also increased the odds of reaching specialized mental health care, but proximity to outreach services decreased the volume of psychiatric visits and improved continuity of psychiatric care. This may reflect a greater connection with community-based organisations that offer non-medical mental health services, or interaction with multidisciplinary teams such as Assertive Community Treatment where service users may see non-medical team members more often than the physician associated with the team. Given that

nearly half of people with a NCRMD verdict had a history of criminal justice involvement, there is an opportunity to implement Forensic Assertive Community Treatment teams for people with a severe mental illness and who are believed to be at risk of committing an offense to address both their mental health needs and their criminogenic needs (56,57). These Forensic Assertive Community Treatment teams may also be offered to people with severe mental illness who are not justice-involved but who are considered at risk of violence or criminal justice involvement.

Another important trend that emerged from the findings was that living with a partner or family decreased the odds of accessing and receiving mental healthcare. While Andersen's model of behavioral access to care purports that social support is a facilitator for health services use (48), it was not the case here. Instead, living with relatives decreased the odds of seeking mental healthcare, of reaching psychiatric care, and the volume of psychiatric visits. The empirical literature on social networks and mental health service use among people with severe mental illness tends to show that smaller social networks or lower social/family support are associated with greater inpatient service use (47,58). Epidemiological catchment area studies (in Montréal, Québec (59) and Baltimore, USA (60) respectively) have also shown that greater social support reduced the likelihood of reaching psychiatric care (59,60). It is possible that living with loved ones increases the self-perceived stigma both from the service user perspective and from the relatives, as the "marked difference that [is] negatively appraised" may become more apparent when cohabiting (61). This may increase the preference for self-reliance, as stigma related to severe mental illness, especially when combined with that of a history of criminal justice involvement (62–64), may interfere with the ability and willingness of service users and their loved ones to fully participate in care (65). Living with relatives may also increase the perceived ability to self-manage (66), as some may take the role of caregiver and provide some aspects of care, thus reducing the reliance on psychiatric visits or or delaying the referral to a psychiatrist by a family physician. This may be especially true in health systems that rely heavily on families and loved ones for daily care and help seeking. Another possible explanation is that families may protect their loved ones with mental illness from services that they do not find acceptable or that are accessed through judicial levers that families are not willing to use (e.g., involuntary treatment orders, involuntary admission) (67,68). Issues related to the acceptability of mental

health services are important barriers to access and use of healthcare in Québec (69) and elsewhere (27), especially in a context where living with a severe mental illness is still heavily stigmatized. A narrative synthesis of access to services for another highly stigmatized group (people who inject drugs) has highlighted the strong role of non-judgmental health workers, high confidentiality, and flexibility of services made services more acceptable to service users and increased access (70). In the context of mental health services, families may be unwilling to use levers to access care that may jeopardize their relationship with their loved one (67), that may subject them to discrimination or judgement from health workers, or that they may perceive themselves as unsafe or ineffective (27). A fragmented system of care (71) may have also left many families and service users – especially those with concurrent substance use disorders – frustrated, having experienced considerable discrimination and disregard from some practitioners (72), and having received very little support in return. For some service users, the association may be reverse: people who are unable to access appropriate mental healthcare in a timely manner may be more susceptible to moving in with relatives and loved ones, such as parents, siblings or adult children. Regardless of the direction of the association, this finding is important as people who are found NCRMD are especially likely to victimize family members (73). Resources should be invested to provide psycho-education and support to relatives (74), who are primary sources of financial, psychological and social support. This requires sufficient resources so that healthcare providers have the time to listen to families and engage with them, and that they are well-trained in the ethical and legal considerations that such a close collaboration with the family entails (75). Relatives are too often in untenable positions, having to juggle seeking care, understanding the administrative maze and civil court provisions, and their own health and safety.

Finally, findings suggest that general practitioners, to the extent that they have a sustained relationship with their patient, may play an important role in the first line of identification of mental health problems. Nearly all participants who had a significant connection to a general practitioner were identified as having mental health needs and received primary mental health care in response to those needs. Yet, less than one in five participants were considered as significantly attached to a general practitioner, which is slightly lower than what is

observed in the general population of the province of Québec during the same period (44), despite considerably higher needs. The decision to seek help for a health problem has been found to be associated to the sense of affinity to a primary care practice and the sense of trust in a primary care provider, especially for those who are socioeconomically disadvantaged (30). Health policies should continue focusing on providing access to family physicians, supporting greater involvement from primary care clinicians, and access as appropriate to specialists in mental health, substance use and the plight of socially marginalized persons in prevention of criminal justice involvement. Those changes may require more structural transformations, such as to the mode of remuneration of physicians. The traditional fee-for-service adopted throughout Canada has shown to have deleterious effects on access to services by service users who are perceived as difficult or vulnerable, and thus less "cost-effective" (76). Other models may be more appropriate for this population, especially as mental health care should be interprofessional (76). For example, a study in Ontario robustly showed that a blended capitation model for primary care physicians was associated with better outcomes in terms of psychiatric health than a blended fee-for-service, as it may promote continuity of care and accessibility to services as well as promote interdisciplinary work (77).

Limitations and Future Research

The present paper has some limitations. First, the use of governmental administrative health data limits us to linked medical services data, and does not provide insight into the use of other psycho-social services that can play a key role in risk assessment and management (e.g., psychological, counselling services, or spiritual counsellors for some). The analyses may also be conservative as some contacts with health services may not have been recognized as related to mental health reasons. We were also unable to adjust for the level of need associated to the mental illness, as any proxy we could have identified based on the governemental administrative database would have simultaneously been an indicator of access. Second, contextual factors are static and retrospective rather than dynamic and prospective, which limits the ability to draw causal inferences. The only address available to identify contextual factors were those at the time of the index offense (i.e., at the end of the observation period), which is true also for other variables such as living with relatives. It is thus possible that needs for mental health services

influenced where the subject chose to reside and with whom. Finally, the data dates back to 2000–2005—however, relatively few changes have been made to the organization of MH services since that time, except for psychotherapy coverage by public insurance, to which access remains very difficult to access.

We would suggest that a replication study be done with a more recent sample. This study could take the form of a case-control study with a matched sample of service users who have not committed an NCRMD offense to identify difference in access and service use. While the present study relies entirely on administrative data, preventing the examination of psychological factors, such as beliefs and attitudes, that may underlay decisions to seek and receive different types of services (30), this case-control study could adopt a mixed design to shed light on "why" and "how" services are accessed and received. This could allow us to understand whether geographic inequity in access to care is similar among forensic and nonforensic samples, and identify practices and service trajectories that may play a role in violence prevention, all else being equal.

Conclusion

The findings reveal inequities in opportunities to access mental health services in the trajectories of forensic service users. Geographic factors and the presence of relatives in the lives of service users have a greater influence on the odds of seeking, reaching and receiving mental healthcare than factors related to the intensity of needs. Engagement with family members – both in the clinical setting with family-centred services and in the research setting with participatory action research – is an area that is vastly underprioritized, especially as close relatives are the most likely victims of NCRMD offenses. Family-centred services are potentially an important lever to improve engagement with mental healthcare among people who have a severe mental illness and who have behaviors that make them at risk of criminal justice involvement. Access to mental health services may prevent violence and criminal justice involvement for a subset of mental health service users, as long as services are appropriate in nature and intensity.

Table 1 – *Characteristics and index offenses of participants*

Variables	Participants (n=753)
Gender, %	
Women	14.5
Men	85.5
Age, *M* (*SD*)	36.7 (12.4)
Civil status, %	
In a relationship	15.7
Single	84.3
Born in Canada, %	62.7
Indigenous, %	1.0
Revenue, %	
Own paid work (or partner's)	16.7
Pensions, welfare, disability	74.8
Other	8.5
Primary diagnosis, %	
Psychotic disorder	64.2
Mood disorder	29.6
Other	6.2
Concurrent personality disorder, %	9.7
Concurrent substance use disorder, %	30.0
Most severe index offense, %	
Causing death or attempting to cause death	4.9
Sexual offense	1.5
1st degree assault	5.2
Other assault	19.8
Threats	22.0
Other against the person	8.2
Property offenses	19.9
Administration of justice	4.9

Other	13.7
Criminal history, %	45.0
NCRMD history, %	8.5

Note. Weighted statistics.

Table 2 – *Barriers and facilitators to mental healthcare access in the 4.5 years before a NCRMD offense*

Variables	*Seeking* mental health care (N = 753) OR	95% CI	*Reaching* psychiatric care (N = 661) OR	95% CI	*Receiving*: Volume of psychiatric care (N = 555) RR	95% CI	*Receiving*: Continuity of psychiatric care (N = 437) β	95% CI	Volume of emergency mental healthcare (N = 661) RR	95% CI
Block 1: Contextual										
Physicians per 1,000 pop.	1.16	0.64, 2.09	**1.84**	**1.15, 2.85**	**1.31**	**1.02, 1.67**	0.07	-0.14, 0.27	1.20	0.91, 1.59
Residency outside of major urban centres	1.36	0.55, 3.35	**2.61**	**1.20, 5.66**	0.78	0.52, 1.19	0.13	-0.25, 0.52	**2.06**	**1.40, 3.02**
Material disadvantage of residency area	0.84	0.70, 1.00	0.93	0.78, 1.10	0.95	0.87, 1.04	-0.00	-0.08, 0.07	0.91	0.83, 1.00
Social disadvantage of residency area	1.12	0.95, 1.34	0.92	0.78, 1.08	1.03	0.95, 1.12	0.07	-0.01, 0.13	0.98	0.87, 1.11
Community ressources within 15 min.	1.00	1.00, 1.00	1.00	1.00, 1.00	1.00	1.00, 1.00	-0.00	-0.00, 0.00	1.00	1.00, 1.00
Hospital centres offering outreach services within 30 min.	1.00	0.74, 1.35	1.31	0.99, 1.71	**0.86**	**0.75, 0.98**	**0.18**	**0.01, 0.36**	1.01	0.87, 1.17
Hospital centres offering referral services within 60 min.	1.00	0.92, 1.08	**1.11**	**1.04, 1.18**	0.99	0.96, 1.02	-0.02	-0.05, 0.01	1.02	0.99, 1.06
Block 2: Predisposing										
Age	0.99	0.97, 1.02	**0.98**	**0.96, 1.00**	0.99	0.98, 1.00	**-0.01**	**-0.02, -0.00**	**0.98**	**0.98, 0.99**
Female gender	1.56	0.65, 3.71	1.39	0.77, 2.53	1.10	0.77, 1.56	0.04	-0.23, 0.32	**1.67**	**1.13, 2.48**

	OR	95% CI	OR	95% CI	OR	95% CI	β	95% CI	OR	95% CI
Living with a partner, family or friends	**0.53**	**0.33, 0.87**	0.64	0.83, 1.06	**0.73**	**0.59, 0.91**	0.04	-0.17, 0.25	0.89	0.69, 1.16
Criminal history	**2.20**	**1.29, 3.75**	1.15	0.73, 1.81	1.06	0.86, 1.31	-0.07	-0.27, 0.11	**1.29**	**1.01, 1.64**
General practitioner connection	**3.58**	**1.75, 7.36**	0.87	0.52, 1.45	0.82	0.65, 1.04	0.19	-0.06, 0.43	0.95	0.71, 1.26
Block 3 : Need										
NCR history	2.30	0.65, 8.13	**16.3**	**2.16, 123.0**	**1.86**	**1.43, 2.41**	0.13	-0.15, 0.40	**1.77**	**1.08, 2.90**
Psychotic disorder	1.56	0.66, 3.71	**2.29**	**1.12, 4.68**	**1.71**	**1.07, 2.75**	0.21	-0.19, 0.62	0.71	0.44, 1.14
Mood disorder	1.45	0.57, 3.65	1.86	0.88, 3.97	1.45	0.88, 2.38	0.06	-0.35, 0.48	0.65	0.41, 1.06
Other disorders	1.32	0.59, 2.96	0.70	0.35, 1.39	1.24	0.87, 1.77	0.26	-0.26, 0.79	0.77	0.54, 1.08
Concurrent personality disorder	0.76	0.35, 1.65	2.24	0.87, 5.71	1.02	0.77, 1.36	-0.13	-0.41, 0.15	1.31	0.95, 1.81
Concurrent substance use disorder	1.39	0.81, 2.37	2.53	1.39, 4.60	0.85	0.68, 1.07	**0.26**	**0.00, 0.52**	**1.31**	**1.04, 1.66**

Note. Exact p-values of statistically significant variables (bolded) are provided in text. Seeking care: At least one contact with any medical services for mental health reasons. Reaching psychiatric care: At least one contact with a psychiatrist. The model for seeking care used the full sample (n = 753), whereas the models for reaching care and volume of emergency care included those who had sought care (n = 661). The model for receiving – volume of psychiatric care included all those who had reached psychiatric care (n = 555) whereas the model for receiving – continuity of psychiatric care included only those with at least two psychiatric visits (n = 437).

References

1.   Crocker AG, Livingston JD, Leclair MC. Forensic mental health systems internationally. In: Roesch R, Cook AN, editors. Handbook of Forensic Mental Health Services. New York: Routledge; 2017. p. 3–76.

2.   Schneider RD, Crocker AG, Leclair MC. Mental Health Courts and Diversion Programs. In: Chandler JA, Flood CM, editors. Law and Mind: Mental Health Law and Policy in Canada. Toronto: Lexis Nexis Canada; 2016. p. 303–23.

3.   Lafore R. La juridicisation des problèmes sociaux : la construction juridique de la protection sociale. Informations sociales. 2010;n° 157(1):18.

4.   Latimer J, Lawrence A. The review board systems in Canada: Overview of results from the Mentally Disordered Accused Data Collection Study. Ottawa: Department of Justice Canada; 2006.

5.   Jansman-Hart EM, Seto MC, Crocker AG, Nicholls TL, Côté G. International trends in demand for forensic mental health services. International Journal of Forensic Mental Health. 2011;10(4):326–36.

6.   Code criminel canadien. L.R.C. C-46. 1992.

7.   Crocker AG, Nicholls TL, Seto MC, Charette Y, Côté G, Caulet M. The National Trajectory Project of individuals found Not Criminally Responsible on Account of Mental Disorder in Canada. Part 2 - The people behind the label. Canadian Journal of Psychiatry [Internet]. 2015 Mar [cited 2018 Aug 21];60(3):106–16. Available from: http://www.ncbi.nlm.nih.gov/pubmed/25886686

8.   Seto MC, Lalumière ML, Harris GT, Barbaree HE, Hilton NZ, Rice ME, et al. Demands For Forensic Services In The Province Of Ontario. 2001.

9.   Livingston JD, Rossiter KR, Verdun-Jones SN. "Forensic" labelling: An empirical assessment of its effects on self-stigma for people with severe mental illness. Psychiatry Research [Internet]. 2011;188:115–22. Available from: http://dx.doi.org/10.1016/j.psychres.2011.01.018

10.   Martin S, Charette Y, Leclerc C, Seto MC, Nicholls TL, Crocker AG. Not a "Get Out of Jail Free Card": Comparing the Legal Supervision of Persons Found Not Criminally Responsible on Account of Mental Disorder and Convicted Offenders. Frontiers in Psychiatry. 2022;12(January):1–10.

11.   Jacobs P, Moffatt J, Dewa CS, Nguyen T, Zhang T, Lesage AD. Mental health services costs within the Alberta criminal justice system. International Journal of Law and Psychiatry [Internet]. 2016;47:102–8. Available from: http://dx.doi.org/10.1016/j.ijlp.2016.04.008

12.   Gouvernement du Québec. Faire ensemble et autrement: Plan d'action en santé mentale 2015-2020. Québec: Ministère de la Santé et des Services sociaux; 2017. 79 p.

13.   Ministère de la Santé et des Services sociaux. Plan d'action interministériel en santé mentale 2022-2026: S'unir pour un mieux-être collectif. Gouvernement du Québec; 2022.

14.   Mental Health Commission of Canada. Changing directions, changing lives: The mental health strategy for Canada. Mental Health Commission of Canada: Calgary, AB; 2012.

15.   Crocker AG, Nicholls TL, Seto MC, Roy L, Leclair MC, Brink JH, et al. Research priorities in mental health, justice, and safety: A multidisciplinary stakeholder report. International Journal of Forensic Mental Health. 2015;14(3):205–17.

16.   Egede LE, Ruggiero KJ, Frueh BC. Ensuring mental health access for vulnerable populations in COVID era. Journal of Psychiatric Research [Internet]. 2020;129:147–8. Available from: https://doi.org/10.1016/j.jpsychires.2020.07.011

17.   Parrish E. The next pandemic: COVID-19 mental health pandemic. Perspectives in Psychiatric Care. 2020;56(3):485.

18.   Moroz N, Moroz I, D'Angelo MS. Mental health services in Canada: Barriers and cost-effective solutions to increase access. Healthcare Management Forum. 2020;33(6):282–7.

19.   Leclair MC, Charette Y, Caulet M, Crocker AG. Care Pathways, Health Service Use Patterns and Opportunities for Justice Involvement Prevention Among Forensic Mental Health Clients. Canadian Journal of Psychiatry. 2022;1–11.

20.   Canadian Mental Health Association. Ending the healthcare disparity in Canada. 2018;(September):24. Available from: www.cmha.ca

21.   Wise-Harris D, Pauly D, Kahan D, Tan de Bibiana J, Hwang SW, Stergiopoulos V. "Hospital was the Only Option": Experiences of Frequent Emergency Department Users in Mental Health. Administration and Policy in Mental Health and Mental Health Services Research. 2017;44(3):405–12.

22.   Leclair MC, Lemieux AJ, Roy L, Martin MS, Latimer EA, Crocker AG. Pathways to Recovery among Homeless People with Mental Illness: Is Impulsiveness Getting in the Way? Canadian Journal of Psychiatry [Internet]. 2019;706743719885477. Available from: http://www.ncbi.nlm.nih.gov/pubmed/31763933

23.   Roy L, Leclair MC, Côté M, Crocker AG. Itinérance, santé mentale, justice: Expérience et perceptions des utilisateurs de services à Montréal. Criminologie [Internet]. 2020;53(2):359–83. Available from: http://id.erudit.org/iderudit/1074199ar

24.   Schanda H, Stompe T, Ortwein-Swoboda G. Dangerous or merely "difficult"? The new population of forensic mental hospitals. European Psychiatry. 2009;24(6):365–72.

25.   Penney SR, Seto MC, Crocker AG, Nicholls TL, Grimbos T, Darby PL, et al. Changing characteristics of forensic psychiatric patients in Ontario: A population-based study from 1987-2012. Social Psychiatry and Psychiatric Epidemiology. 2019;54(5):627–38.

26.   Statistics Canada. Mental health needs, 2018 [Internet]. 2019. Available from: www.statcan.gc.ca

27.   MacDonald K, Ferrari M, Fainman-Adelman N, Iyer SN. Experiences of pathways to mental health services for young people and their carers: a qualitative meta-synthesis review. Social Psychiatry and Psychiatric Epidemiology [Internet]. 2021;56(3):339–61. Available from: https://doi.org/10.1007/s00127-020-01976-9

28.   Levesque J-F, Harris MF, Russell G. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. International Journal for Equity in

Health [Internet]. 2013 Oct;12(18). Available from: http://www.equityhealthj.com/content/12/1/18

29. Goldberg D, Huxley P. Mental illness in the community. Vol. 6, International Journal of Rehabilitation Research. 1983. 127 p.

30. Ford JA, Wong G, Jones AP, Steel N. Access to primary care for socioeconomically disadvantaged older people in rural areas: A realist review. BMJ Open. 2016;6(5):1–14.

31. Gelberg L, Andersen RM, Leake BD. The Behavioral Model for Vulnerable Populations: Application to Medical Care Use and Outcomes for Homeless People. HSR: Health Services Research. 2000;34(6):1273–302.

32. Andersen RM. National health surveys and the behavioral model of health services use. Medical Care. 2008;46(7):647–53.

33. Andersen RM, Davidson PL. Improving Access to Care in America: Individual and Contextual Indicators. In: Andersen RM, Rice TH, Kominski GF, editors. Changing the US Health Care System: Key Issues in Health Services Policy and Management [Internet]. 3rd editio. San Francisco: Jossey-Bass; 2007. p. 3–31. Available from: https://www.researchgate.net/publication/237675193_Improving_access_to_care_in_America _individual_and_contextual_indicators

34. Crocker AG, Nicholls TL, Seto MC, Côté G, Charette Y, Caulet M. The National Trajectory Project of individuals found Not Criminally Responsible on Account of Mental Disorder in Canada. Part 1 - Context and methods. Canadian Journal of Psychiatry. 2015;60(3):95–105.

35. Gauthier J, INSPQ. Entre adaptabilité et fragilité : les conditions d'accès aux services de santé des communautés rurales et éloignées. 2009. 52 p.

36. RAMQ. Liste des professionnels de la santé non-participants ou désengagés au régime de l'assurance maladie du Québec avec adresse de pratique au Québec [Internet]. 2022. p. 14. Available from: https://www.ramq.gouv.qc.ca/SiteCollectionDocuments/professionnels/facturation/desengage s.pdf

37.   Anderson KK, Fuhrer R, Wynant W, Abrahamowicz M, Buckeridge DL, Malla A. Patterns of health services use prior to a first diagnosis of psychosis: The importance of primary care. Social Psychiatry and Psychiatric Epidemiology. 2013;48(9):1389–98.

38.   Crocker AG, Martin MS, Leclair MC, Seto MC, Nicholls TL. Expanding the early and late starter model of criminal justice involvement for forensic mental health clients. Law and Human Behavior. 2018;42(1):83–93.

39.   Pollack CE, Hussey PS, Rudin RS, Fox DS, Lai J, Schneider EC. Measuring care continuity : A comparison of claims-based methods. Medical Care. 2016;54(5):e30–4.

40.   Institut de la statistique du Québec. Le Québec chiffres en main, Édition 2002. Vol. 148. Québec: Gouvernement du Québec; 2002. 46 p.

41.   Institut national d'excellence en santé et en services sociaux (INESSS). Mécanismes d'accès aux services de proximité – État des connaissances. Québec, Qc: INESSS; 2019. 55 p.

42.   Pampalon R, Raymond G. A deprivation index for health and welfare planning in Quebec. Chronic Diseases in Canada [Internet]. 2000;21(3):104–13. Available from: http://www.phac-aspc.gc.ca/publicat/cdic-mcc/21-3/b_e.html

43.   Breslau N, Reeb KG. Continuity of care in a university based practice. Journal ofMedical Education. 1975;50(10):965–9.

44.   Provost S, Pérez J, Pineault R, Borgès Da Silva R, Tousignant P. An Algorithm Using Administrative Data to Identify Patient Attachment to a Family Physician. International Journal of Family Medicine. 2015;2015:1–11.

45.   Kaufman JS, Kaufman S. Assessment of structured socioeconomic effects on health. Epidemiology. 2001;12(2):157–67.

46.   Simo B, Bamvita JM, Caron J, Fleury M-J. Predictors of mental health service use among individuals with high psychological distress and mental disorders. Psychiatry Research [Internet]. 2018;270(August):1122–30. Available from: https://doi.org/10.1016/j.psychres.2018.10.019

47.   Carr VJ, Johnston PJ, Lewin TJ, Rajkumar S, Carter GL, Issakidis C. Patterns of service use among persons with schizophrenia and other psychotic disorders. Psychiatric Services. 2003;54(2):226–35.

48.   Andersen RM. Revisiting the behavioral model and access to medical care: Does it matter? Journal of Health and Social Behavior. 1995;36(1):1–10.

49.   Institut de la statistique du Québec. Le Québec chiffres en main, Édition 2021 [Internet]. Québec: Gouvernement du Québec; 2021. 73 p. Available from: http://www.stat.gouv.qc.ca/quebec-chiffre-main/pdf/qcm2014_fr.pdf

50.   Fleury M-J. La réforme des soins primaires de santé mentale au Québec et le rôle et les stratégies de coordination des omnipraticiens. Santé mentale au Québec. 2014;39(1):25.

51.   Kravitz RL, Franks P, Feldman M, Meredith LS, Hinton L, Franz C, et al. What drives referral from primary care physicians to mental health specialists? A randomized trial using actors portraying depressive symptoms. Journal of General Internal Medicine. 2006;21(6):584–9.

52.   Anthony JS, Baik SY, Bowers BJ, Tidjani B, Jeffrey Jacobson C, Susnman J. Conditions that influence a primary care clinician's decision to refer patients for depression care. Rehabilitation Nursing. 2010;35(3):113–22.

53.   Imboua A, Fleury M-J. Médecins omnipraticiens : pratiques et intégration des soins en santé mentale au Québec. Sante Mentale au Quebec. 2009;XXXIV(1):55–76.

54.   Newman MW, Hawrilenko M, Jakupcak M, Chen S, Fortney JC. Access and attitudinal barriers to engagement in integrated primary care mental health treatment for rural populations. Journal of Rural Health. 2021;1–7.

55.   Friesen EL. The landscape of mental health services in rural Canada. University of Toronto Medical Journal [Internet]. 2019;96(2):47–52. Available from: https://sophia.stkate.edu/msw_papers/627

56.   Lamberti JS, Weisman RL. Essential Elements of Forensic Assertive Community Treatment. Harvard Review of Psychiatry. 2021;29(4):278–97.

57.   Goulet M-H, Dellazizzo L, Lessard-Deschênes C, Lesage A, Crocker AG, Dumais A. Effectiveness of Forensic Assertive Community Treatment on Forensic and Health Outcomes: A Systematic Review and Meta-Analysis. Criminal Justice and Behavior. 2021;1–15.

58.   Albert M, Becker T, McCrone P, Thornicroft G. Social networks and mental health service utilisation - A literature review. International Journal of Social Psychiatry. 1998;44(4):248–66.

59.   Fleury M-J, Grenier G, Bamvita JM, Perreault M, Caron J. Determinants associated with the utilization of primary and specialized mental health services. Psychiatric Quarterly. 2012;83(1):41–51.

60.   Maulik P, Eaton W, Bradshaw C. The Role of Social Network and Support in Mental Health Service Use: Findings From the Baltimore ECA Study. Psychiatric Services. 2009;60(9).

61.   Reupert A, Gladstone B, Helena Hine R, Yates S, McGaw V, Charles G, et al. Stigma in relation to families living with parental mental illness: An integrative review. International Journal of Mental Health Nursing. 2021;30(1):6–26.

62.   Livingston JD, Rossiter KR, Verdun-Jones SN. "Forensic" labelling: An empirical assessment of its effects on self-stigma for people with severe mental illness. Psychiatry Research [Internet]. 2011;188(1):115–22. Available from: http://dx.doi.org/10.1016/j.psychres.2011.01.018

63.   West ML, Yanos PT, Mulay AL. Triple stigma of forensic psychiatric patients: Mental illness, race, and criminal history. International Journal of Forensic Mental Health. 2014;13(1):75–90.

64.   Leclair M, Crocker AG. Avez-vous dit « dangerosité » ou « dérangerosité »? Analyse d'une prophétie autoréalisatrice en violence et santé mentale. In: Vigneault L, Lecomte T, editors. Préjugés, discrimination et exclusion en santé mentale – Pour en finir avec la stigmatisation. Montréal: Performance édition;

65.   Corrigan PW. How stigma interferes with mental health care. American Psychologist. 2004;59(7):614–25.

66.   Kovandžić M, Chew-Graham C, Reeve J, Edwards S, Peters S, Edge D, et al. Access to primary mental health care for hard-to-reach groups: From "silent suffering" to "making it work." Social Science and Medicine. 2011;72(5):763–72.

67.   Goulet M-H, Pariseau-Legault P, Côté C, Klein A, Crocker AG. Multiple Stakeholders' Perspectives of Involuntary Treatment Orders: A Meta-synthesis of the Qualitative Evidence toward an Exploratory Model. International Journal of Forensic Mental Health [Internet]. 2019;0(0):1–15. Available from: https://www.tandfonline.com/doi/full/10.1080/14999013.2019.1619000

68.   Pariseau-Legault P, Goulet M-H, Crocker AG. Une analyse critique des effets de l'autorisation judiciaire de soins sur la dynamique relationnelle entre la personne visée et ses systèmes de soutien. Aporia. 2019;11(1):41–55.

69.   Fleury M-J, Grenier G, Bonin J-P, Collaborateurs E, Clément M, Nadeau L, et al. État de la situation sur la santé mentale au Québec et réponse du système de santé et de services sociaux. 2012. 243 p.

70.   Islam M, Topp L, Day C, Dawson A, Conigrave K. The accessibility, acceptability, health impact and cost implications of primary healthcare outlets that target injecting drug users: A narrative synthesis of literature. International Journal of Drug Policy. 2012;23(2):94–102.

71.   Government of Ontario. Every Door is the Right Door. 2009;(July):53.

72.   Gronholm PC, Thornicroft G, Laurens KR, Evans-Lacko S. Mental health-related stigma and pathways to care for people at risk of psychotic disorders or experiencing first-episode psychosis: A systematic review. Psychological Medicine. 2017;47(11):1867–79.

73.   Crocker AG, Nicholls TL, Seto MC, Côté G. The National Trajectory Project of Individuals found Not Criminally Responsible on Account of Mental Disorder in Canada. Part 2: The People behind the Label. Canadian Journal of Psychiatry. 2015;60(3):106–16.

74.   Maybery D, Jaffe IC, Cuff R, Duncan Z, Grant A, Kennelly M, et al. Mental health service engagement with family and carers: what practices are fundamental? BMC Health Services Research. 2021;21(1):1–11.

75.   Kaslow NJ, Dunn SE, Henry T, Partin C, Newsome J, O'Donnell C, et al. Collaborative patient- and family-centered care for hospitalized individuals: Best practices for hospitalist care teams. Families, Systems and Health. 2020;38(2):200–8.

76.   Contandriopoulos D, Brousselle A, Breton M, Duhoux A, Hudon C, Vadeboncœur A, et al. Analyse des impacts de la rémunération des médecins sur leur pratique et la performance du système de santé au Québec [Internet]. Programme Actions Concertées. Québec; 2018. Available from:
http://www.frqsc.gouv.qc.ca/documents/11326/448958/2015_D.Contandriopoulos_remun-med_rapport-annexes.pdf/ff739688-c91e-488e-b556-fb0dda7c1efb

77.   Vu T, Anderson KK, Devlin RA, Somé NH, Sarma S. Physician remuneration schemes, psychiatric hospitalizations and follow-up care: Evidence from blended fee-for-service and capitation models. Social Science and Medicine. 2021;268(August 2020).

Chapitre 6 (Article 3) – "*No safe place to call*":

Multistakeholder perspectives on access to mental health

services by people found not criminally responsible on account

of a mental disorder

Leclair, M. C., Roy, L., Dumais Michaud, A.-A., & Crocker, A. G. (soumis). *"No safe place to call": Multistakeholder perspectives on access to mental health services by people found not criminally responsible on account of a mental disorder. BMC Health & Justice.*

Note. Le format des références suit celui exigé par *BMC Health & Justice.*

Background: The growing role of the justice system in the care of individuals with mental illness-related and cognitive disabilities has led to concerns about access to adequate and timely mental health services, particularly for persons with severe mental illness who have behaviours that make them susceptible to justice involvement. The study aims to investigate the perspectives of stakeholders on access to effective and relevant mental health services by people found not criminally responsible on account of mental disorder (NCR) to identify and prioritize opportunities for improving the mental health care system.

Methods: Semi-structured interviews and focus groups were conducted with 16 persons with lived experience as service user, family caregivers, multidisciplinary service providers, community organization workers, and administrators. Data analyses were carried out according to the principles of thematic analysis using the Lévesque and colleagues' conceptual framework of patient-centered access to care.

Results: Seven main themes were identified, spanning all the continuum of access from service gaps during high-risk period to tensions between coercive measures and recovery. The findings highlight how past experiences of stigma, trauma, inefficiency, and discrimination within a hospital-centric system influence service users and caregivers' ability to seek and engage with care. Existing access mechanisms, such as police intervention and emergency rooms, are unacceptable options for service users and their family caregivers and thus often considered as last resorts. As a result, service users enter the healthcare system with complex needs that are challenging to address with the current clinical knowledge.

Conclusions: Findings are discussed in light of structural stigma and implications for policy and service organization are discussed.

In many countries, the justice system has taken an increasingly prominent place in the care of people experiencing mental illness-related and cognitive disabilities (Jansman-Hart et al., 2011; Keown et al., 2018; Lafore, 2010; Priebe et al., 2008; Sheridan Rains et al., 2020). The role of the justice system to leverage access to healthcare is particularly apparent in the case of people who are found to be not criminally responsible on account of a mental disorder (NCR) (Crocker et al., 2017), that is people who committed a crime when their psychiatric symptoms made them "incapable of appreciating the nature and quality of the act [...] or of knowing that it was wrong" (Canadian Criminal Code, 1992, p. section 16). While the vast majority of people found NCR were known to the healthcare system for their mental health problems (Cavney et al., 2012; Crocker et al., 2015, 2018; Hodgins et al., 1990) prior to the offense, recent research shows that their service trajectories are punctuated by service interruptions and that relatively few people received consistent care within the mental health system in the year prior to the offense (Huikko et al., 2023; Leclair, Charette, Caulet, et al., 2022).

Theoretical frameworks of access to health services emphasize that access is not simply the initial contact with services but rather receiving an adequate response to one's health needs. Lévesque and colleagues' patient-centered framework (Lévesque et al., 2013), for example, encompasses recognizing healthcare needs, seeking services, reaching healthcare resources, and receiving services that are relevant and appropriate to the individual's healthcare needs (Lévesque et al., 2013). Consistent with Penchansky & Thomas's (Penchansky & Thomas, 1981) fit model, Lévesque, and colleagues propose that access to healthcare is a function of the fit between system characteristics (approachability, acceptability, availability, affordability, and appropriateness) and service users' capacities (ability to perceive needs, to seek care, to reach care, to pay for care, and to engage with care). It thus allows to take into account the entire experience of service users with the healthcare system, including issues related to initial contact, sustained and continuous care, and the quality and adequacy of the care received.

This patient-centered framework of access may highlight how and why the mental healthcare system fails to meet, in the community, the clinical needs of several people with severe mental illness and who display behaviours that are impulsive, reactive, disruptive, or aggressive. Indeed, research shows that this population experiences greater disruption in care

(Abbott et al., 2017; Adair et al., 2005; Khan et al., 2016; Leclair et al., 2020), stigma and discrimination from service providers (Gronholm et al., 2017; Roy, Leclair, et al., 2020). Health services providers also report feeling pressured to use the criminal justice system to leverage access to specialized and integrated care for their clients (Roy, Crocker, et al., 2020). This pressure is also felt by family caregivers who are unable to access mental healthcare for their loved one by other means (Larose-Hébert, 2020). This situation highlights the importance of better understanding the experienced and perceived barriers and facilitators along pathways to mental healthcare for service users who have a severe mental illness and behaviours perceived as disturbing or dangerous.

This study seeks to answer the following question: What are the perspectives of the various stakeholders on access to mental health services by people with a severe mental illness and disruptive or aggressive behaviours? It explores a multiplicity of perspectives, including that of people with lived experience, family caregivers, service providers, community organization workers, and administrators.

Methods

We used a descriptive qualitative design to describe the experience of research participants from their perspective by foregrounding their own discourse. This approach is intended to be less interpretative than other qualitative approaches (Neergaard et al., 2009; Sandelowski, 2010); however it is not solely descriptive, as the researchers provided theoretical insight – in this case, Lévesque et al.'s model of access to care (Lévesque et al., 2013) – in the development of the interview guide and in the interpretation of the data. Ethics board approval was obtained from [blinded for review].

Recruitment and data collection

We recruited family caregivers of persons who received a NCR verdict or were justice-involved, peer support workers with experience of justice involvement, public and community health and social services practitioners, as well as administrators and decision-makers. Recruitment of family caregivers, peer support workers, public and community health and social services practitioners, administrators and decision-makers was done through our existing

110

networks and by emailing various associations, purposefully inviting a diversity of stakeholders. Participants had to be over 18 years of age, able to hold a conversation in French, and – in the case of practitioners, administrators, and decision-makers – have been working for more than a year in their current role. While a specific number of each type of stakeholders was not predetermined, we purposely sought participants from a variety of disciplines (psychiatry, psychology, social work, nursing, law, etc.) and a variety of settings (community mental health, general mental health, forensic mental health, mental health courts, government, etc.).

We held three focus groups (Kitzinger, 1995; Morgan, 2012) of 3 to 6 participants, lasting 90 minutes each. The three groups were respectively made up of (1) health and social services practitioners, (2) administrators of the health and justice system, and (3) family caregivers, peer support workers, and community workers. Three individual semi-structured interviews of 40-60 minutes were also conducted with a senior decision-maker (n = 1), a family caregiver (n = 1), and a service provider (n = 1) to complement the focus groups. This interview format was used for participants who were not available at the agreed-upon time of the focus group, who were not comfortable speaking in a group setting, or whose introduction into a focus group might interfere with the group dynamic (e.g., someone in a position of authority over the other participants). The first author moderated the focus groups and conducted the interviews based on an interview guide developed by the research team. Questions were general prompts about access to mental health services, such as "What can you tell us about access to mental health services for people who have mental disorders and behaviours that make them at risk of justice involvement?" or "If you had a magic wand, what is one concrete action that you would make to improve services for this population?" The audio recording of these interviews were transcribed and then destroyed. Transcripts were denominalized and attached to pseudonyms the participants had chosen. All interviews were conducted in French, and selected quotations were translated in English for the purpose of the present publication.

Data analysis

After a step of familiarisation with the data (through transcribing, relistening to the audio, and reading the transcript multiple times), we conducted the analysis according to the principles

of thematic analysis as described by Paillé & Mucchielli (Paillé & Mucchielli, 2012). Data was systematically synthesized using inductive open-coding to create themes of low inference to describe each section relevant to the research questions. We carefully kept a log of all themes constructed, organized in different sections representing different dimensions on Lévesque and colleagues's continuum of access (1: Approachability of services/Ability of service users to perceive healthcare needs and desire care; 2: Acceptability of services/Ability of service users to seek healthcare needs; 3: Availability of services/Ability of service users to reach services; 4: Affordability of services/Ability of service users to pay; 5: Appropriateness of services/Ability of service users to engage). Because our themes were cross-sectional to those dimensions, we conducted a second analysis moving beyond Lévesque and colleagues' framework. Two analysts coded a portion of the transcripts independently, and any discrepancy in coding was discussed until consensus emerged. After this step, themes were examined for repetition, overlap, contradiction, and complementation across participants and across groups of participants. Themes were then hierarchized in an iterative process such as to construct a thematic tree. This process was validated through consensus meetings between authors. To ensure content validity (Miles et al., 2014), the first author wrote theoretical memos immediately after each focus group or semi-structured interview, as well as after each round of coding. Reflexive team debriefings were also held at regular intervals to examine and discuss the emerging findings.

Findings

In total, we interviewed 16 participants. Of these, five were people with lived experiences (three as family caregivers, two as peer support workers), two were community organization practitioners, five were practitioners in the public health and social services system, and four were administrators and decision-makers in the health (3, all with clinical experience) or justice system (1). All participants had experience as or were involved with long-term mental health service users who had had several hospitalisations and had complex needs (see Table 1).

The analysis revealed 7 themes. Table 2 provides a comprehensive overview of the themes and subthemes, as well as their representation amongst the different groups of participants and the relevant dimensions of access to healthcare. One of the themes was relevant to

"Accessibility/Ability to perceive", 2 to "Acceptability/Ability to seek", 4 to "Availability/Ability to reach", and 5 to "Appropriateness/Ability to engage". None were relevant to "Afforability/Ability to pay".

INSERT TABLES 1-2 HERE

Table 1 – *Participants' status and pseudonyms*

Category	Pseudonym	Role
People with lived experience	Pogo	Peer support worker
	Pito	Peer support worker
	Sam	Family caregiver (brother)
	Tinkerbell	Family caregiver (son)
	Brack	Family caregiver (son)
Service providers	Iris	Nurse
	Ophélie	Social worker
	Pearl	Neuropsychologist
	Rose	Psychiatrist
	Morpheus	Psychiatrist
Community workers	Didi	
	Nuage	
Administrators	Steve	Governmental
	Laure	Health institution
	Maxime	Health institution
	Anne	Justice institution

Table 2 – *Summary of themes*

Themes	Subthemes	Stakeholder representation	Dimensions of access
1 – Tensions in representations of access to care	1.1 *Some things belong to the patient, and some things belong to the system.* 1.2 *Access to services is not just saying, "I'm opening an office with a silver plate, Doctor so-and-so here." That's not it.*	1.1 Administrators, service providers 1.2 Persons with lived experience	Cross-sectional
2 – The hospital grounds as locus of trauma, humiliation, and stigma	2.1 *Getting a kid to set foot on the grounds of the asylum...good luck.* 2.2 *Not just a person who has symptoms.* 2.3 *A ten by ten room, it makes you crazy.*	2.1 All 2.2 Persons with lived experience, community workers 2.3 Persons with lived experience	• Acceptability, ability to seek • Appropriateness, ability to engage
3 – Paradoxical rigidity and hermeticism of services targeted towards people whose needs require flexibility	3.1 *Driving on completely different highways.* 3.2 *You'll never know which door to knock on* 3.3 *You take over a file, you've never seen that patient, he was supposed to show up, he didn't show up, so you close the file.* 3.4 *The chicken and egg*	3.1 Administrators 3.2 All 3.3 People with lived experience, service providers 3.4 People with lived experiences, service providers, administrators	• Availability, capacity to reach • Appropriateness, capacity to engage
4 – Service gaps creating high-risk periods	4.1 *This is where we put ourselves at risk, all of us* 4.2 *Completely out of step* 4.3 *A place for the person to vent*	4.1 Persons with lived experience, service providers, administrators 4.2 Persons with lived experience 4.3 Persons with lived experience	• Accessibility, ability to perceive • Acceptability, capacity to seek • Availability, capacity to reach
5 – The role of family caregivers in the mental health care system	5.1 *I'm part of the care team, the one that didn't bring any service disruptions*	5.1 People with lived experiences	• Acceptability, capacity to reach • Appropriateness, capacity to engage

	5.2 *That's when trouble kicks in.*	5.2 People with lived experience, service providers, administrators	
	5.3 *An extra workload that is really worth it.*	5.3 People with lived experience, service providers, administrators	
6 – Clinical knowledge unable to address the complex needs of service users	6.1 *Not everyone needs to see a psychiatrist.*	6.1 Service providers, administrators	• Availability, capacity to reach
	6.2 *A lot of questions, no answers*		• Appropriateness, capacity to engage
	6.3 *We're just health professionals here... we're not the police, we're not prison guards either*	6.2 Persons with lived experience, service providers	
	6.4 *I have the fantasy of believing that there should be a mobile team*	6.3 Service providers	
		6.4 All	
7 – Tensions between coercive measures and recovery	7.1 *Forcing treatment for these patients... it is quite difficult*	7.1 Service providers, administrators	• Appropriateness, capacity to engage
	7.2 *Yes, the injection was given but at what price?*	7.2 Administrators	
	7.3 *Recovery is possible for everyone*	7.3 People with lived experiences, community workers	

115

Theme 1: Tensions in representations of access to care

    While we did not specifically ask participants to volunteer a definition of access to care, many of them explicitly or implicitly conceptualized access to care. Two representations of access emerged: one where access is conceived as initiating care, and one where access is conceived as the opportunity to have healthcare needs met.

1.1   Some things belong to the patient, and some things belong to the system.

A minority of service providers and administrators defined access in terms of having the possibility to reach services for initial contact. An administrator, for example, regards mental health service access as the capacity to "have a first psychiatric service" within a specific wait time which can be gauged by population statistics.

> When I look at statistics for adults, we have a first [psychiatric] service in 38 days in
> Québec – so there is no lack of access. (Steve, administrator)

In this approach to access, notions of acceptability and appropriateness are not typically considered, and the responsibility to adhere falls solely on the service user: "There is no lack of access. [...] What we have is that patients don't wish to consult, don't want to consult" (Steve, administrator). Because mental health services are construed as widely available, notably through psychiatric emergency services, the fact that many people with mental illness do not seek medical help or fail to show up to their appointments is met with a sense of incomprehension, leading to frustration and ultimately impasse.

1.2 Access to services is not just saying, "I'm opening an office with a silver plate, Doctor so-and-so here." That's not it.

Participants with lived experience offered an alternative interpretation of access. A peer support worker for example dismisses the notion that access to services can be summarized as the availability of medical professionals and facilities. Instead, people with lived experience emphasize that access means receiving appropriate care in a timely manner.

> When I look at the statistics, what always interests me is... OK, but did the person get
> the services they needed? That's what matters to me. (Tinkerbell, family caregiver).

Theme 2 : The hospital grounds as the locus of trauma, humiliation, and stigma

2.1 Getting a kid to set foot on the grounds of the asylum[3]...good luck.

Stigma is reported by individuals with lived experience and community organization workers as the primary barrier to seeking mental health services. What people with lived experiences described as the "fear of being labelled 'mentally ill' " prevents many people from seeking help. Service providers and decision-makers are also aware of this issue and highlight that the current hospital-centered model remains "not a fun experience" of healthcare for patients (Steve, administrator).

2.2 Not just a person who has symptoms.

Participants with extensive service use histories held strong negative views towards the healthcare system due to past encounters, which they described as ineffective, inhumane, and traumatic. They describe a recurring cycle of hospital visits where service users and their families reluctantly seek treatment without seeing improvement and experience stigma from providers, leading to aversion towards hospitals. Participants felt discriminated against, belittled, and dehumanized due to the invasive interactions, intolerance towards occasional substance use, lack of personal connection, and long wait times.

> I feel like I'm at the police station. Because I am getting a police interrogation. Right? Nobody talks to me like I'm a human, nobody talks to me... it's the interrogation. "Did you take your pills? How much? Did you eat? Did you sleep, what did you do?" This is a police interrogation. It's not fun, it's not pleasant. So, you know, I'm not interested in going back there (Pogo, peer support worker).

Participants with lived experience argue that there is no room for forgetfulness or error as a mental health service user, even for errors that are not solely attributable to mental illness and instead part of "human nature", such as forgetting to take medication. This is perceived as unreasonable and condescending, and they advocate instead for an approach based on information and empowerment:

> Can we stop scolding them? Can we? Can we say: "Now, we stop scolding them. It's normal. And here's what to do when you forget." (Pogo, peer support worker)

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[3] Given that this was said by a person with lived experience of severe mental illness who wanted to highlight the stigmatizing experience of the healthcare system, we chose to keep the term "asylum" despite its implications.

117

Participants with lived experience describe how the system's punitive attitudes towards non-compliant service users can negatively impact their health and well-being. For instance, a family caregiver shared that her relative with important cognitive deficits faced an ultimatum from a provider due to difficulties understanding cancer treatment procedures. This ultimatum had negative impacts on his health as he received less than half of the chemotherapy treatments prescribed.

Participants view the biomedical model as central to the current provision of health services, fundamentally disregarding spiritual, sexual and socialization needs of service users.

> Maybe you want to have something more than "how are you doing?" and "are you taking your medication?" and... "How are your positive symptoms?" and "How are your negative symptoms?" It's not just a person who has symptoms, it's a person who wants to live love, who wants to live projects. (Tinkerbell, family caregiver)

There is thus a misalignment between the objectives of patients and that of the healthcare team. Several participants with lived experience and community workers highlighted the need for service users to feel useful to society, to be physically active, and to engage in meaningful activities as part of their recovery. However, for reasons that participants attribute to lack of resources and risk aversiveness, service users often feel useless within institutions. A family caregiver explains how her relative, who "worked 70 hours a week all his life" and is now in long-term care, has difficulty adjusting to the idleness of institutional life.

> Can we use them and make them feel useful because they feel completely useless and they have absolutely nothing to do, except to throw tantrums because they are fed up and sad and they want to kill themselves. (Sam, family caregiver)

She expresses frustration that so very little efforts are made at offering opportunities for service users to engage in meaningful activities in line with "who they were before they got there," such as doing "odd jobs" and "repairs."

2.3 A ten by ten room, it makes you crazy.

Participants explain how healthcare and housing services can be so dehumanizing that it may induce trauma. Pogo, a peer support worker, believes that nearly all people who leave hospitalization must be "treated for the trauma of being hospitalized". Similarly, a family

caregiver notes the negative impact of hospitalization on mental health, emphasizing that "a ten by ten room, it makes you crazy even if you're not crazy to begin with." Participants attribute in large part this situation to the hospital-centered culture, which they describe as risk-averse and dehumanizing. Tinkerbell recounts her experience as a volunteer and how taking patients from a secure unit and bringing them to a less restrictive environment for daily activities was met with reluctance by the service providers and the administration.

> And, câline , just grabbing them from there and taking them to the third floor, it took me some real charm. We weren't even taking them out of the institute... We were just taking them from a secure, ultra-secure floor [...] and bringing them to an environment where they could make some toasts, they could do this... And everything was dangerous. (Tinkerbell, family caregiver)

Theme 3: Paradoxical rigidity and hermeticism of services targeted towards people whose needs require flexibility

3.1 Driving on completely different highways.

Administrators note a lack of intersectoral collaboration between the healthcare system, community organizations, justice system, and public safety due to limited time and resources – akin to "driving on completely separate highways" (Maxime, administrator). They emphasize communication and coordination between sectors as crucial. Because of this lack of communication, justice professionals may make decisions that do not align with current healthcare conditions because they "think that certain things are feasible in the health system, which is not the case, because we don't have the knowledge, we don't have the information" (Anne, administrator). The use of police as a mental health crisis service without coordination with healthcare systems can also cause individuals to be transported to psychiatric emergency rooms located away from their treatment team, ultimately disrupting services.

Additionally, administrators and service providers urged for enhanced communication between treatment teams – more particularly between the team during hospitalization and the team that ensures follow-up after discharge – as well as between justice, public safety, and health sectors. One administrator recommended implementing a police-psychiatric emergency services communication system to promptly notify hospitals of persons in need of psychiatric attention

119

encountered by law enforcement officials. Ongoing collaboration between these two systems would be established to prevent situations from escalating into criminal acts based on systematic transmission of police car screening reports to the emergency department.

3.2 You'll never know which door to knock on.

Nearly all participants highlighted that the healthcare system's organization by program and episode of care leads to an access that is described as arbitrary and requiring to "start anew every time". They explain that mental health programs "operate very, very much in silos" (Rose, service provider), with restrictive criteria that make it difficult for people with multiple diagnoses or comorbidities to find services. Access is thus determined by the clarity, stability, and nature of the diagnosis. People who use substances and are long-time mental health service users are especially likely to be turned away from programs, as their "constant accumulation of diagnoses" makes it so that "there are no more programs for them" (Tinkerbell, family caregiver). Obtaining adequate care is reliant on the discretion of a particular service provider who may "decide to take on the case" (Brack, family caregiver). This can result in service users and their loved ones feeling a sense of powerlessness, as obtaining necessary services is often considered a matter of "luck" rather than certainty.

The healthcare system's organization by program is also a source of frustration for service providers who struggle to connect service users with community-based services. Finding the right service for the right person is described by all types of participants as navigating a heavy, discouraging, and dehumanizing administrative maze – a social worker describes it as "pure hell". The siloed nature of services means that trial and error is often required to find the right service, resulting in a limited understanding among experts regarding the full extent of accessible resources.

> It's like "La maison qui rend fou (the place that sends you mad) " in Astérix, it's super complicated. You call one place, it's not the right number - you call another place... [...] You don't have the right postal code. [...] It's as if everyone is working in their own silo and there is no transversality between our departments. So if you knock on the wrong door, unfortunately, you'll never know which one to knock on. (Laure, administrator)

Administrators highlight the profound and misguided irony that people with mental illness-related and cognitive disabilities are expected to find their way in this administrative maze, given that administrators and service providers themselves are often unable to do so.

> Sometimes *we* are lost, so I can't imagine the person who has committed a crime, the person who has a mental health problem, how do they find their way? (Anne, administrator)

Service providers and administrators argue that while it is important to empower patients and give them responsibility for their care, sometimes they may not have the necessary resources or knowledge to navigate the system and find the appropriate services. This may be especially true for individuals who have a "[justice or forensic] label, which is impossible to remove" (Iris, service provider) because "no community resource wants them afterward." Administrators report that judicial levers are used as an alternative when "it's too complicated to find the right way to directly enter the healthcare system" (Laure, administrator).

3.3 You take over a file, you've never seen that patient, he was supposed to show up, he didn't show up, so you close the file.

Service disruptions tend to recur and stem from various sources, including the lack of a family physician with a comprehensive overview, transitioning between child and adult psychiatry, low patient motivation or engagement levels, multiple caregivers with inadequate communication channels, as well as insufficient medical record information. Family members feel that these disruptions are inevitable, as they occur even when they are anticipated due to the system's lack of flexibility.

Relational continuity was seen as crucial to avoid service disruptions, and what people with lived experience described as "familiar faces" were necessary for building trust to prevent feeling like starting over repeatedly. The importance of a trustworthy service provider, such as a family physician, who has a holistic and historical understanding of the person's needs was emphasized by those with lived experience. Alternatively, certain people prioritize "the trusting relationship" in any service provider over their profession or title, as for them, "when you go to get help, it doesn't matter if it's a psychiatrist, a nurse, a social worker, it doesn't matter." (Pogo, peer support worker)

121

Service providers recognize the insufficient relational continuity and attribute it to the dearth of resources, notably time and staff turnover. Consequently, service providers lose familiarity with patients, contributing to suboptimal care consistency as well as lack of engagement on the part of the service user. The lack of relational continuity can also lead to a nonchalant attitude from service providers when service users miss their appointments.

> It's clear that you end up not knowing [your patient] anymore! They are still numbers, you know, it's very... You see, I say it and then I'm shocked myself, but at the same time, he becomes a number, this gentleman. Because you take over a file, you've never seen that patient, he was supposed to show up, he didn't show up, so you close the file. (Pearl, service provider)

Although similar administrative and governance factors are present in other areas of healthcare, those with personal experience and some service providers emphasize that mental health necessitates "familiar faces" or "a bond" more than physical health. Despite this, participants highlight that they experience lower relational continuity within the mental healthcare system than within the physical healthcare system, where navigators are more common.

According to service providers, insufficient communication and incomplete medical records exacerbate the negative effects of limited relational continuity in healthcare. A dearth of service user history data within and between institutions leads to arbitrary decision-making, hindering patient-centered care. This leads to the follow-up not being "adapted to their real needs".

> This lack of access to relevant medical information means that finally we arrive, we treat, we let go, and then the follow-up is not done, but we don't really know, and it gets lost. (Pearl, service provider).

3.4 The chicken and egg.

Participants from all groups highlight the paradoxical nature of inflexible mental health services, as requiring care suggest symptoms causing dysfunctionality – a conundrum akin to "the chicken and egg" (Morpheus, service provider). Inflexibility is unsuitable for users with complex needs (e.g., cognitive deficits, memory loss), making it challenging for them to access and engage with appropriate services. Standard strategies, such as email reminders and phone calls, are not suitable for all. A family caregiver argues that "the system doesn't work because the person isn't [...] fit to receive that service; you have to go another way."

> The pharmacy was calling every day to get him to take his medication, but he was losing his cell phone. You know, it's all loops all the time. [...] He always lost his cell phone, and he was losing his memory. The appointments with the social worker were written on a big calendar but he didn't think to look at the calendar, so... [...] You know, she would call him but he wouldn't answer the phone. He would forget his appointments; she would call him back. It was kind of a mess. (Sam, family caregiver)

Reaching services "taking God knows what transportation" (Rose, service provider) can be made difficult by ongoing symptoms such as hearing voices or disorganized thinking. Service users also face barriers when they reach services, such as being removed from waiting rooms for lateness or disruptive behavior. Service providers also note that emergency rooms' rapid pace and multi-provider involvement are inappropriate for service users with mental illness and cognitive impairments. A neuropsychologist argues that service users with cognitive deficits need time and thorough explanations to understand their condition and diagnosis. Often patients leave the emergency department with very little information about their illness, having "seen the doctor for maybe three minutes," leading to difficulties or an inability to engage in their care.

While most participants express frustration with the rigidity of the healthcare system, not all share this reading. Some administrators perceive the situation as a lack of engagement on the part of patients, due to "their pathology, but also of what they are, and the behaviors they have." This creates an impasse, as evident in an administrator's response to improving patient engagement: "if you give me this trick, I'll give you an award."

Theme 4: Service gaps creating high-risk periods

4.1 – This is where we put ourselves at risk, all of us.

Several people with lived experience report the absence of adequate services during the high-risk period of progressive, untreated mental health deterioration. Participants note that family and close acquaintances are often the first to recognize a need for mental healthcare, while individuals affected by it may still be in "denial" or unable to perceive their own needs. Peer support workers normalize this period of denial – highlighting that it is also present among people experiencing new physical symptoms – but identify challenges specific to recognizing emerging mental health needs, including internalized stigma and low awareness of mental health needs in the context of limited health literacy which can impact readiness for specialized services.

123

Service providers also identify stigma as an obstacle to mental health literacy, emphasizing that insufficient awareness of early symptoms of psychosis prevents recognition by individuals and their loved ones, contributing to crisis episodes. Lack of insight, a common prodromal symptom, is also highlighted as a significant barrier to perceiving the need for psychiatric care.

The absence of flexible and responsive services creates a "dangerous" period, according to people with lived experience, service providers, and administrators. They argue that this service gap endangers all parties involved, including the affected person, their loved ones and the service providers. A service provider and an administrator, for example, warn that delays in treatment can result in a "window where violent acts may [occur]" (Morpheus, service provider).

4.2 Completely out of step.

Loved ones often refrain from seeking help during such periods due to concerns about endangering themselves, their relative, or their relationship further. Previous encounters with law enforcement that proved counterproductive or compromised trust exacerbate this issue for families as they fear for their safety amid emergencies. A family caregiver, for example, shares how her son reacted negatively and ran away when she called the police, affecting her willingness to call the police again in a future crisis and their sense of security in doing so. She deplores the absence of services that are responsive and that value the safety of the person and their family.

> If we feel that our loved one is in crisis, that they are really in trouble, that they are at risk of acting out, there is no safe place to call without the police headlights coming on to the street [...] without going to the emergency room for four hours and then coming back and not having more services. I think that's really missing. We don't have a place where we feel safe as a parent or as a caregiver or as a loved one, where we can call and say, "Well, there might be momentum." (Brack, family caregiver)

Several participants also emphasized that the services available in a crisis, which most often involve "send[ing] the police" were unacceptable because they were seen as completely "out of step" with their needs (Pito, peer support worker) or were likely to put their loved ones at risk of victimization or traumatization.

4.3 A place for the person to vent.

People with lived experience consistently express a profound inadequacy between the perceived needs in times of crisis and what is offered by existing resources. They describe the needs of a person in crisis often as being as little as "venting," a place for "a little sleep, a little nap, eat a little bit and then leave," while in contrast the available services involve "the full package," that is "sirens," "handcuffs," and "six days of hospitalization." Families report seeking non-police or justice driven, safe emergency response for mental health crises. One participant describes his positive experience with a civilian (non-police) crisis response team, emphasizing that they were "caring" and provided a "safety" that cannot be found through police officers, hospitals, or caregivers.

> [The mental health crisis response team] will make a link with some kind of safety that I could not provide – and that the police can't provide, and that the hospital can't provide. It's like a home visit from people who are caring and who aren't necessarily going to put you in the hospital or in handcuffs or treatments and all that. And just make sure the person is okay. (Pito, peer support worker).

However, participants highlight that community-based crisis centers or crisis lines, which do not involve police officers, fail to meet to the demand which endangers the individual in distress and their loved ones. For instance, Tinkerbell recounts how her son was "blacklisted" by a crisis center for frequently seeking help with his suicidal thoughts.

> When he called the crisis center, after three minutes, they hung up the phone. Because he was one of those who were occupying the lines too much. It doesn't work! Yes, this person, in his anxiety and his symptoms... he says it clearly: "Can you be my rock for the next 15 minutes because I don't want to commit suicide?" What more do you have to say to ask for help? "Ah, but you're someone who calls regularly." Yeah, that means I need services regularly. [...] Because despite my symptoms, despite the medication not working, despite the fact that I go to my appointments, despite the fact that I spend six days in hospital, despite the fact that there are periods when I am unstable, really, I am disorganized, I am still at home. I still take care of my apartment. I'm still a good uncle, I'm still my mother and father's son. I still participate in activities, I'm still somebody. But from 5 to 8, I'm overwhelmed with my illness, and that's when I need help. And it's like, it's not possible. (Tinkerbell, family caregiver)

Theme 5: The role of family caregivers in the mental healthcare system

5.1 I'm part of the care team, the one that didn't bring any service disruption.

Participants indicate that individuals' needs for reassurance and connection during mental health crises are not often met by mental health providers (with the notable exception of peer support

125

workers), which can hinder the service users' ability to engage in their own care. It then falls entirely to loved ones and caregivers to provide reassurance and support. Caregivers often face significant burdens, including managing crises as well as household chores like laundry and meal preparation.

> I consider myself to be part of my children's care team, the one that didn't bring any service breakdowns. [...] Quite often, I was the crisis center, and I was the laundromat, and I was also Meals on Wheels... [...] Unfortunately, families have developed enough skills to be just about all the service centers that our loved ones need. (Tinkerbell, family caregiver)

Relatives face a significant burden when addressing their loved one's daily distress, particularly in the absence of available support services. In cases where healthcare systems fail, families must manage associated risks and assume responsibility for care management. Relatives thus play the role of "safety net" to the healthcare system, whereas there are no instances that can play this role when families are unavailable or exhausted. An example of this is when Tinkerbell's son was put on a blacklist for crisis centers (see Theme 4.3) due to excessive calls made by him causing greater distress for his family members seeking respite from caring duties.

When relatives "can't stop working to take care of [the person] full-time" and are unable to "pay a resource that is extremely expensive" (Sam, family caregiver), institutional care is often the only option available. Home care services, such as meal preparation and housekeeping, may not be accessible to everyone due to high costs and yet something that family caregivers would implement.

5.2 That's when trouble kicks in.

The healthcare system delegates caregiving to family, but this role is threatened in hospitals due to patient psychiatric symptoms, confidentiality laws, and power imbalances between health and family caregivers. The paradox of relatives providing daily care yet "not always well accepted" during crises has been noted by those with lived experiences. For instance, healthcare professionals often call upon the family to pick up their loved one upon discharge without "including them in the care protocol," leaving the family feeling undervalued, "not given the place they could have, and not considered" within the system. (Brack, family caregiver). Family

caregivers describe their interactions with service providers as "a lot of negotiations," especially in regard to punitive or control measures. This can in turn erode the family relationships.

Family members face challenges in accessing the healthcare team and often rely on social workers as intermediaries. However, social workers are unable to address medical queries. Family caregivers struggle to obtain information from doctors or psychiatrists due to limited access, restrictive confidentiality laws, and rotating intermediaries with varying communication approaches and personal norms regarding family involvement.

> Right now I'm trying to get [answers]. The social worker says, "You have to ask his psychiatrist" – but the psychiatrist, I don't have access. I can't call him. [...] I talk to the social workers, I leave messages, they call me back sometimes, but everything medical, they say I should talk to the doctors. Yes, but the doctor, I can't talk to him, you're the intermediary, you know, it's the social worker who is the intermediary between me and the medical team and I don't really have an answer. (Sam, family caregiver)

The communication process between treating teams and relatives is deemed "complex" by some service providers and administrators. This complexity stems from various factors such as legal frameworks, relatives' expectations and mental health literacy, insufficient knowledge of healthcare ecosystem, and limited resources.

Several service providers argue that confidentiality laws pose major barriers to family involvement in care. Psychotic symptoms such as delusions and paranoia may also cause service users who previously involved loved ones in healthcare decisions to exclude them during episodes. Psychiatrists can "capture information" (Steve, administrator) from families for evaluation purposes, but this one-sided interaction is experienced highly negatively by some families who cannot reciprocate with their own inquiries. This results in a lack of reassurance for the family members who feel utilized in their relationship with healthcare professionals.

> The resident calls you, you ask, "Did he come to you with lacerations?" He can't tell you, but he is consuming your information like crazy, though. And he wants to know everything. [...] Sometimes it's like: Fuck you! You come to get information and make your diagnosis, and see if you're going to transfer him to the institute, and you're not able to reassure me, as a mother, as to whether my son, at this moment, is in danger or is in trauma from something he did? (Tinkerbell, family caregiver)

This gap in expectations leads to an incomprehension on the part of service providers and administrators, who do not understand why families complain that they cannot "talk with the psychiatrist."

5.3 An extra workload that is really worth it

Service providers and administrators acknowledge that, despite the extra work, involving families has important benefits. By providing psychoeducation and resources, supporting families can prevent worsening of mental health conditions and promote medication compliance. Different solutions to the barriers for the involvement of families in healthcare have been identified by service providers and administrators. Service providers and administrators argue for altering confidentiality laws to enable confidential information sharing among family members and healthcare professionals. Advance directives completed prior to the onset of active symptoms could involve families in a service users' treatment team, even if they resist support during an episode of psychosis. However, some participants note that advance directives are underutilized and may only apply to known patients. Finally, participants identify a need for better explanation and guidance regarding available resources and legal constraints for families navigating the healthcare system.

In contrast, family caregivers advocate for a navigator with whom a relationship of trust can be established, and continuity of care ensured. Although the exact profession of this individual is yet to be determined, it is crucial that they possess the authority and knowledge to convey medical information. This person would have a comprehensive understanding of the patient's care and be able to offer clinical guidance consistently throughout all stages of treatment regardless of diagnosis.

Theme 6: Clinical knowledge unable to address the complex needs of service users

6.1 Not everyone needs to see a psychiatrist.

Service providers and administrators suggest that not all individuals on the waiting list for specialized mental healthcare require such a level of care, leading to unnecessary delays for those who truly need it. Participants highlight that general practitioners struggle with identifying

patients who are in need of specialized services, and that there is thus a need for improved triage processes to properly prioritize service users. Morpheus recommends an evaluation by a specialized mental health worker within 24 hours following a referral from a general practitioner to ensure appropriate prioritization.

6.2 A lot of questions, no answers

People with lived experiences, service providers, and administrators recognize a deficiency in expertise and knowledge when delivering patient- and family-centered services to those with severe mental illness and complex psychosocial or behavioral requirements. When service users finally reach psychiatric care, the complexity of their clinical and psychosocial profile present a challenge due to limited clinical and scientific knowledge. Both individuals with lived experiences and service providers recognize the arbitrary nature of diagnoses in these cases, often resulting in "a constant accumulation of diagnoses" (Tinkerbell) without identifying the underlying issue.

> The diagnoses start adding up - because that's really what it is for some patients, *we don't know*. So we put diagnoses, and diagnoses start adding up. (Pearl, service provider)

Service providers argue that incorrect diagnoses can lead to a revolving door phenomenon, particularly among individuals with concurrent substance use disorder or who resist treatment. Service users are thus repeatedly released and then re-arrested or readmitted due to inadequate care. Sam, a family caregiver describes a similar experience, where her relative was released from hospital and committed a crime shortly thereafter. She attributes this situation to the psychiatrist "no longer knowing what to do with him instead of keeping him in the psychiatric hospital." Service providers highlight how often service providers reach a "therapeutic impasse [where they] don't know what to do with [service users]" (Iris, service provider).

This lack of scientific and medical knowledge adds to the burden of families, who face uncertainty because mental illnesses do not have "predictable probabilities of evolution" (Tinkerbell, family caregiver), unlike most physical illnesses. They describe their experience as "a lot of questions, no answers" (Sam, family caregiver). The uncertainty surrounding the course and outcome of mental illnesses can lead to tensions with service providers, who may view family expectations as unrealistic or even "magical" (Steve, administrator) in nature.

129

6.3 We're just health professionals here... we're not the police, we're not prison guards either.

Service providers report feeling "caught off guard" in addressing behavioral needs and prevent violence, particularly in relation to personality disorders. Treatments that target the risk factors of violence associated with antisocial personality disorder are scarce, and participants believe they should be addressed by the correctional and judicial systems. Healthcare teams are expected to manage not only illness or substance abuse but also personality disorder-related risks; however, this expectation is deemed as not "fair" as healthcare professionals see this as belonging to the sphere of judicial and correctional systems.

> We ask a healthcare team to manage the risk not just related to the illness or the substance abuse, but also the personality disorder. Seriously, sometimes I don't think that's fair. It's like we're... you know, we're just healthcare professionals... we're not the police, we're not prison guards either. (Morpheus, service provider)

Service providers, community workers, and administrators note a lack of expertise in violence prevention within general and specialized mental health services. They assert that these services are organized with a "clear focus on treatment rather than prevention" (Nuage, community worker). Specifically, all deplore the system "[waits] until people commit a crime" and are found NCR to give access to teams specialized in violence prevention instead of working upstream "with people who are more at risk of being violent, but before they have their first violent episode." (Morpheus, psychiatrist). Instead, service providers note that the lack of training results in using some of the violence prevention tools as a checkbox exercise without proper follow-up due to a lack of knowledge about how to manage risks effectively. Participants perceive violence prevention as an important gap in general psychiatry training, especially in contrast to suicide prevention which is extensively covered.

6.4 – I have the fantasy of believing that there should be a mobile team

The current community-based alternatives to institutionalization, such as Assertive Community Treatment teams, are deemed inadequate by participants to address the complex health and psychosocial needs of some individuals, which create the potential for decompensation or judicial involvement. Service providers highlight that, in the absence of the necessary intensity of

services, it is difficult for service providers to perceive the needs of patients when they are unable to express them.

> People often say, "But don't worry, he's on an ACT team." But what does an ACT team mean? You start from a set-up where you're on a closed high security unit, you go out into the community and the ACT teams come to you [...]. "Yes, but we visited him three times a week" – I get that, but last week he was in a 24/7 setting, 365 days a year. So you go from there to there (mimes steps). You can see that the gap is a little bit big between the two steps. [...] Then we ask ourselves questions [when something happens]. "We visited him on Monday, but on Friday when I went back to visit him, his apartment was completely upside down and the neighbors called the police, and they took him to another hospital." But that's totally normal. There was never the intensity that he should have had in leaving an institution for that long. (Maxime, administrator)

The situation that Maxime describes above reflects the experiences of our participants with lived experiences. Thus, administrators and service providers unanimously hope ("dream" or "fantasize") for a mobile team specializing in violence prevention to provide early and flexible services to service users, before they are legally mandated or commit crimes. They recommend integrating various services (such as justice, community organizations, and ACT teams) to provide coordinated service delivery at an appropriate level of intensity. The proposed mobile team should cater to patients who have been identified as presenting a potential risk of violence following hospitalization or emergency visits. Additionally, the team should be trained to evaluate and mitigate risks based on patient requirements rather than legal status for optimal effectiveness in reducing violence and justice involvement.

7 – Tensions between coercive measures and recovery

There is a sense of a double impasse among participants, in that both non-judicial and judicial access mechanisms have failed them.

7.1 – Forcing treatment for these patients... it is quite difficult

Service providers report facing a tension or a "therapeutic clash" (Steve) between respecting their patients' autonomy and their therapeutic interests, especially since psychiatric training emphasizes patient engagement. They thus feel ill-equipped when working with non-voluntary individuals. Service providers point out that strict criteria, long wait times, and administrative burdens hinder treatment for people with severe lack of insight. Psychiatrists are concerned

about professional competence in determining the need for involuntary treatment, which is a responsibility attributed to judges.

> I don't understand that judges are able to determine in ten minutes on the bench that a patient is not dangerous to himself or to others. (Steve, administrator)

They suggest revising civil code to grant physicians greater decision-making authority or establishing an administrative tribunal with specialized judges.

7.2 – Yes, the injection was given but at what price?

Persons with lived experience and community workers describe the model of care as highly paternalistic, providing limited patient choice, with ongoing threats of judicial orders. Some participants argue that judicial leverage can be counterproductive, as it reduces empowerment and care sustainability. They argue that "if you just impose the constraint, you lose them. They're going to be there during the constraint, and after that it's over." (Laure, administrator) However, service providers and administrators sometimes experience tensions as they are expected to enforce some conditions all the while preserving relationships.

> It's written in black and white, "must not consume in the community." But how do you take a notion like that and apply it in the community when you let the client go out... is it necessary to...like punish? Or not? The idea is that if you punish, the impact is too negative on the patient and you can't necessarily move forward in care, you can't have the therapeutic alliance. (Maxime, administrator)

Moreover, judicial leverage can harm the service users' care progress by involving law enforcement or initiating another legal cycle. This may cause disorganization and hinder treatment efforts leading to negative consequences. Although such coercive measures could ensure access to treatment, their implementation might outweigh potential benefits in terms of overall care trajectory.

> We start the delegation, we bring back the patient, who is completely disorganized, he arrives at the emergency room to receive his injection, and I apologize for the term but - he stirs up shit in the ER. And then it ends up involving the police and so on. And whoop, we start another cycle, but we also the impact of having activated the delegation and where it led in terms of the patient's own trajectory. Yeah, the injection was given, but at what cost? (Maxime, administrator)

Instead, they suggest focusing on empowering the service user by using shared decision-making both on treatment modalities and goals as well as establishing a "partnership" with the service user.

> We work together with the legal constraint that is imposed on us, which is "The judge orders me to treat you. Now, you can choose the molecule, you can choose the place of administration, you can choose if you want it by mouth, by injection...if you take it by mouth, do you want it in liquid, do you want it crushed, diluted, or do you want it in a pill?" [...] Everywhere, everywhere where there are constraints, there's also latitude to have some form of choice. I think that's really what it's all about, building a partnership with the patient. (Laure, administrator)

7.3 – Recovery is possible for everyone

People with lived experiences and community workers emphasize the conflict between recovery/rehabilitation best practices and the healthcare system's implicit preference for a biomedical/risk-averse model. Participants deny that mental health services have truly moved towards recovery-oriented approaches, and instead argue that recovery "doesn't come with the healthcare system, it's hard to make the two work together" (Pito, peer support worker).

Participants illustrate this point by highlighting that they feel that service providers' primary focus is on medication and on the diagnosis, instead of being "rooted in the person's needs." This sometimes comes often at the cost of the service user's ability to socialize and integrate their community when side effects include being "all messed up on pills."

> They will medicate him until he has a smile on his face. Even if it's not an intelligent smile, he'll have one. (Sam, family caregiver)

This situation contributes to a sense of dehumanization and may result in a loss of functional abilities. It is especially frustrating for people with lived experience as they feel that these concerns about side effects are unheard, which contributes to eventual unilateral treatment cessation instead of shared decision-making.

Participants argue that the "discourse" of recovery heard within services conflicts with their own experience of these services, where instead "environments are becoming more closed off, adding protective measures" (Tinkerbell, family caregiver). People with lived experience and community

133

workers express disbelief and frustration that evidence-based services are neglected in mental health, highlight the disparity with physical health services.

> It's impossible for a professional to neglect recovery. That's not acceptable. You'll never see that in cancer treatment, nurse practitioners neglecting best practices? Never. It's as if, in mental health, you're allowed to. (Tinkerbell, family caregiver)

They attribute in large part this reluctance to adhere to recovery-oriented approaches as due to the system not being "open to being flexible", with a "highly risk-averse attitude". Brack highlights how flexibility requires taking risks and accepting mistakes – instead "we're in an environment, in every way I think, where mistakes are not possible, where mistakes are always pointed out, where risk taking is always criticized." Participants argue that this culture and these attitudes towards risk stem from a label of "dangerousness," legitimizing coercive measures, including chemical constraints, that are antithetic to a recovery approach. Instead, they argue that recovery should anchor all interventions in mental healthcare, including in institutions and for people who may be at risk of violence or justice involvement.

> When talking about recovery often, what I hear is: "Ah, recovery, that's interesting, but not in tertiary care." "Not for institutionalized clientele." "Not for the elderly." So, in the end, it's as if it's not possible for everyone, while recovery is possible for everyone. (Didi, community worker)

Discussion

The objective of the present study was to examine the experienced and perceived barriers and facilitators encountered by service users with severe mental illness and behaviours perceived as disturbing or dangerous when accessing mental healthcare. The study highlights the significance of previous experiences of stigma, trauma, inefficiency, and discrimination within a predominantly hospital-centric healthcare system as barriers to access to care. Such experiences make mental health services unacceptable to many service users and their family caregivers, leading them to seek alternative, more compassionate, and less dehumanizing strategies to address their needs. Prior research on barriers and facilitators of access to mental health services for people found NCR found that living with a partner or relatives substantially diminished the likelihood of accessing and using such services (Leclair, Charette, Seto, et al., 2022). The present study suggests that families may inadvertently contribute to service interruptions by substituting

themselves for services perceived as ineffective and stigmatizing, which may put them at higher risk of victimisation (Crocker et al., 2015; Tingleff et al., 2022; Vestphal et al., 2023). Access mechanisms that are available in a timely manner, such as police intervention, emergency rooms, or judicial measures, are only seriously considered when other strategies have failed and the person has experienced severe decompensation, possibly involving an offense. As a result, those service users enter the healthcare system with highly complex needs that are challenging to address with current psychiatric and scientific knowledge and available resources. At this point, various types of crises may have already occurred, including breakdowns of relationships, civil rights, housing, finances, health, and trust (Larose-Hébert, 2020). The healthcare system, with its rigid administrative requirements (such as bed pressure, insufficient patient file information, and a healthcare system organized by program, diagnosis, and episodes of care), is ill-equipped to meet those needs. Moreover, coercive strategies, such as restraints, confinement, and mandatory treatment orders, are more likely to be used in this context, reinforcing the negative appraisal of services, and reducing the ability of the service user to engage in care.

The impact of access definitions on these care trajectories is significant. Our findings highlight a strong tension between the conceptualization of access to care held by people with lived experience and those held by some individuals responsible for providing or administering services. The insistence on measuring access through populational statistics terms and considering an initial contact within a month as adequate for access contrasts sharply with the lives and experiences of service users and their loved ones. When service users finally decide to seek help, they require services that are highly responsive and flexible, which is not presently the case. Such definitions of access to care view engagement with services as the sole responsibility of the service user, instead of the result of an adequation between healthcare characteristics and service users' abilities. This results in an inflexibility on the part of the system that hinders adaptation to the needs of individuals and a sense of impasse for all involved. This sense of impasse is what often leads to using the NCR verdict as a lever to services with higher relational continuity, improved coordination, and greater expertise in violence prevention.

While the findings of the present study are based on a relatively small participant group, they align with conclusions drawn from other research on access to mental health services across

135

various populations. A meta-synthesis of qualitative literature focusing on the experiences of individuals under 30 years old seeking mental health services – often for first-episode psychosis – and their family caregivers (MacDonald et al., 2021) emphasized that harbouring negative expectations about services reduces the likelihood of seeking help. Additionally, negative past encounters, especially those leading to perception of ineffectiveness of care, serve as significance barriers for future help seeking. Family caregivers aiding youth with first-episode psychosis also underlined their role as advocates for access to services within a system described as "extremely fractured" (Oruche et al., 2012), owing to factors such as age restrictions, level of functioning, or diagnosis-specific services. In this disjointed system, "Nobody [has] the overall perspective" (Skubby et al., 2015). Similar to our study, navigating these complex pathways is described as frustrating, confusing, traumatic, and dehumanizing (MacDonald et al., 2021). In a qualitative study involving mental health service users with intellectual disability, similar themes were identified. However, this study additionally highlighted that aggressive behaviours stemming from mental illness or cognitive deficits were rejected from multiple services, hindering timely access to care (Whittle et al., 2019). Similar to our study, research exploring the experiences of family caregivers employing legal means to access mental health services for their loved ones also underscored a perception that services are provided in ways that are antithetical to the recovery paradigm. The study noted that resorting to legal measures or "waiting for a crime to occur" (Larose-Hébert, 2020) become the only viable options when care teams and crisis centres fail to respond (Larose-Hébert, 2020).

The lens of stigma as operationalized by Corrigan and colleagues (Corrigan et al., 2014), building on Link & Phelan's conceptualization (Link & Phelan, 2001), may shed a helpful light on the findings from the present study and from the literature. They identify four types of stigma: public stigma, label avoidance, self-stigma, and structural stigma. Public stigma refers to the general population endorsing stereotypes and discriminating against people with mental illness, which can lead to label avoidance as individuals fear being associated with mental health services. Self-stigma, on the other hand, occurs when individuals internalize these negative stereotypes, experiencing diminished self-esteem or self-efficacy as a result. Finally, structural stigma refers to institutional policies and practices that negatively impact the opportunities of people with mental

illness (Link & Phelan, 2001). Following Livingston (Livingston, 2020), we include health service providers' negative attitudes and beliefs within structural stigma. Different types of stigma about severe mental illness may play a role in access to healthcare, creating barriers at the service user-level or at the provider and system-level (Corrigan et al., 2014). Label avoidance and structural stigma are particularly predominant in our findings.

Participants with lived experience explicitly mention stigma in reference to label avoidance, creating personal-level barriers to care. Participants emphasize that label avoidance is one of the main reasons why people experiencing psychiatric symptoms for the first time might avoid seeking services. The literature also highlights how people with lived experience often express fear of stigma and negative reactions as significant factors in not seeking treatment. Four service users out of five report that they delayed seeking care due to concerns that it may harm their employment prospect (83%), that they may no longer be taken seriously (80%), that they may be perceived as weak (80%) or as "crazy" (78%) (Dockery et al., 2015). Of all barriers to seeking help that were identified by service users, the six treatment barriers most frequently reported were all stigma-related (Dockery et al., 2015).

In contrast, structural stigma is not explicitly named as such by participants but nevertheless a pervasive thread throughout our findings. Yet, between 16% and 44% of service users have experienced discrimination within mental healthcare settings (Henderson et al., 2014). This form of stigma is covert, and manifests primarily through provider and system-level barriers to access to care. Livingston (Livingston, 2020) argues that structural stigma reduces access to care through inadequate allocation of resources, lack of intersectoral collaboration and care integration, negative attitudes and practices of healthcare practitioners, and overreliance on coercive approaches. In the following paragraphs, we highlight how these mechanisms are found in the present findings.

In most Western countries, mental health services are underfunded relative to disease burden compared to physical healthcare (Canadian Mental Health Association, 2018; Mental Health Commission of Canada, 2017; Royal College of Psychiatrists, 2013), indicating structural stigma (Corrigan et al., 2014; Henderson et al., 2014; Livingston, 2020; Pugh et al., 2015). This

underfunding contributes to chronic shortage of mental health practitioners (Kakuma et al., 2011), delayed care (Clement et al., 2015), and service user dissatisfaction (Clement et al., 2015). In the present study, family caregivers have repeatedly contrasted their experience in mental health services as opposed to physical health services, highlighting the disparity in resources. One manifestation of structural stigma is the absence of support systems in mental health services that are now commonplace in speciality physical healthcare (e.g., oncology, heart disease), such as a designated nurse navigator (Doerfler-Evans, 2016; Monza et al., 2015). The service user and their family caregivers are thus expected to navigate their way into an increasingly sectorized and siloed mental healthcare system with little to no assistance (Björk Brämberg et al., 2018; Shim & Rust, 2013), resulting in lower odds of reaching and fully engaging with services.

Structural stigma also takes the form of inequitable allocation of resources for mental health research funding (Aoun et al., 2004; Christensen et al., 2011; Corrigan et al., 2014; Lam & El-Guelbaly, 1994), contributing to barriers in accessing high-quality, evidence-based mental health services. Our findings emphasize the deficiency of clinical expertise for addressing complex mental health needs in both primary and specialized mental healthcare. It is estimated that less than half of people with severe mental illness receive adequate treatment in psychiatric services (Wang et al., 2002). The ways in which structural stigma may be perpetuated by some service providers' negative attitudes and resistance to adopting evidence-based practices are discussed below. However, our findings highlight that even when service providers intend to implement these practices, structural constraints prevent them from having the necessary time or resources.

Negative attitudes of healthcare practitioners can hinder the adoption of evidence-based practices (De Hert et al., 2011; Henderson et al., 2014; Nyblade et al., 2019), such as shared decision-making (Pérez-Revuelta et al., 2023). While many healthcare practitioners do not hold stereotyped views of people with severe mental illness (Wahl & Aroesty-Cohen, 2010), the pervasiveness of negative interactions implies that the issue is systemic (Knaak et al., 2017) and possibly reinforced by staff burnout (Henderson et al., 2014). Surveys reveal that up to half of mental health professionals fail to endorse recovery as an outcome for serious mental illness (Magliano et al., 2004). Service users and their loved ones often describe that mental health professionals focus on the disease rather than the person (Godrie & Rivet, 2021; Lee et al., 2006).

Negative attitudes among healthcare practitioners contribute to a healthcare culture that permits antitherapeutic, paternalistic practices, making people with lived experience feel infantilized, uninformed, disrespected, and overly medicated (Amsalem et al., 2018; Arboleda-Flórez & Stuart, 2012; González-Torres et al., 2007; Livingston, 2020; Ye et al., 2016). These negative interactions are barriers to seeking and engaging with care (Dockery et al., 2015; Gronholm et al., 2017). It is worth mentioning that this problem extends beyond mental health services and impacts access to physical health services for those with mental illnesses (Cunningham et al., 2013; Koroukian et al., 2012; Moore et al., 2015). For instance, individuals with severe mental illness face higher mortality rates from colorectal cancer (despite similar incidence rates) due to delayed diagnoses and limited access to evidence-based care (Protani et al., 2022).

The lack of resources and negative beliefs held by service providers (particularly regarding dangerousness) (Leclair & Crocker, 2023) contribute to a risk-averse culture that legitimizes an overreliance on punitive and coercive methods. The findings emphasize that such coercive tactics often reduce the acceptability of services for both the service user and their loved ones (Swartz et al., 2003; Thornicroft et al., 2007). Moreover, this culture of coercion may impact the self-stigma experienced by service users, reducing their self-confidence and sense of empowerment, ultimately hindering their ability to engage in treatment (Corrigan et al., 2014; Livingston, 2020).

Implications

The present findings and the literature on the experience of access to mental health services highlight that efforts to address stigma and discrimination related to mental health are essential in improving all aspects of access to care (Clement et al., 2015; Corrigan, 2004; Corrigan et al., 2014; Dockery et al., 2015; Livingston, 2020). Unfortunately, strategies to reduce public stigma and label avoidance (such as public campaigns) may not be effective on the short- to medium-term (Lloyd-Evans et al., 2011). We argue instead that acting on system-level and provider-level barriers may be a more efficient strategy (Corrigan et al., 2014). As the present findings suggest, shifting from hospital-centered to community-based care may be perceived as less stigmatizing and less hostile for potential first-time mental health service users. It is also essential that any transformation of the mental healthcare system strive to dismantle silos. The

Trieste model for mental healthcare, with its "Open door – No restraint" approach (Mezzina, 2014), may inspire other healthcare systems. This model provides holistic, person- and family-centered care in a way that is fundamentally transdiagnostic (with no exclusion criteria), community-based (very little inpatient care), flexible and mobile, and promotes continuity of care (Frances, 2021; Sashidharan, 2022). At the core of the model are found community mental health centers (non-hospital residences) which are operated 24/7 by multidisciplinary teams working in close collaboration with a general hospital psychiatric unit, supported housing facilities, as well as social enterprises (Mezzina, 2014). By supporting strong therapeutic partnerships, empowerment, and social network enhancement, this model yields an antipsychotic medication compliance rate of 75% (Palcic et al., 2011) which is nearly two times as high as other systems (García et al., 2016). There is also growing data that, as suggested by several of our participants, implementing empowerment approaches is the best strategy to nourish the therapeutic relationship and engage the patient in healthcare on a long-term basis (Shepherd et al., 2016). These empowerment strategies can take the form of advance directives or crisis joint plans (Henderson et al., 2009; Swanson et al., 2008) and shared decision-making (Pérez-Revuelta et al., 2023).

A problem highlighted by providers and administrators in the present study is the variability and unpredictability of waiting times, which are in large part dependent on the priority score given by a family physician, who may or may not have a strong expertise in mental health. A model such as Trieste would be a structural solution, as walk-in services are provided to all within 2 hours and immediately when the service user, the family caregiver or the mental health worker consider the problem urgent (Mezzina, 2014). A palliative solution, within the current healthcare system, may be to have a mental health worker (Finn, 2014) meet with the service user within 24 to 48 hours after a referral to speciality mental health services to evaluate the situation and make an appropriate prioritization (Broadbent et al., 2007). To be conducted adequately, this will also require that all patient file information is shared between establishments and updated in a timely manner.

In addition to moving towards community-based care, it appears urgent to address the repeated experience of negative interactions of service users with healthcare providers. Anti-

stigma training among the current and future generation of healthcare providers should be a priority. Concrete suggestions include increasing social contact with people with lived experience, such as hearing firsthand testimonies about personal journeys and recovery outside of a typical provider/user interaction, where power dynamics are reversed and service users act as educators (Agrawal et al., 2016; Knaak et al., 2016; Maranzan, 2016; Pettigrew & Tropp, 2006). This approach has been shows to reduce stereotypes and improve adherence to recovery ideas by practitioners (Agrawal et al., 2016; Maranzan, 2016; Pettigrew & Tropp, 2006). For instance, a program that pairs mental health service users with senior psychiatry residents as advisors has demonstrated a positive impact on the beliefs of future psychiatrists regarding mental health and recovery (Agrawal et al., 2016) . The true effectiveness of such measures require cultural changes within an organization (Sukhera & Knaak, 2022), indicating that it may be strategic to target service providers and administrators who have a large network of formal but more importantly informal influence (Charette et al., 2021). A review found that dismantling mental health structural stigma in healthcare settings required a culture change, where the organization was ready for disruption and a paradigm change, with values aligned across different partners (Sukhera & Knaak, 2022). Most importantly, any anti-stigma training should be thoroughly evaluated as some educational interventions can instead increase blaming attitudes and lower support for government social action and policies (Melro, 2023).

Our findings stress the importance of revising access mechanisms during crises. Police involvement in mental health crises is a barrier to help-seeking (Holt et al., 2023), and is perceived as unsafe by caregivers for both themselves and their loved one. Indeed, involvement of police officers in mental health crises is strongly associated to injuries and deaths among service users (Baker et al., 2020; Saleh et al., 2018). In addition, the present findings suggest that police involvement may disrupt the continuity of care, such as when individuals are brought to an emergency room different from their usual treatment location, due to a lack of intersectoral communication and coordination. In response to several incidents of police violence during mental health crises, Crisis Intervention Teams (CIT) were implemented. However, this police-based model has not effectively reduced arrests, use of force, or improved on-scene crisis call resolutions compared to standard policing (Marcus & Stergiopoulos, 2022). As a result, there is

141

growing recognition of the need to shift away from the CIT model and support the development of alternative, evidence-based approaches that prioritize the lived experience of service users (Marcus & Stergiopoulos, 2022). Civilian (non-police) mental health response teams show promise in terms of care engagement and reduced involvement with the justice system but require further experimental studies to reach conclusive findings (Marcus & Stergiopoulos, 2022). Co-responder models, where mental health providers are integrated into a police officer team to respond to mental health crises, mental health providers are included in a team of police officers, could be reserved for situations with serious concerns about violence (Marcus & Stergiopoulos, 2022). There is growing evidence supporting the reallocation of a portion of the police budget to non-police crisis response programs for nonviolent mental health crises, as long as proper triage by mental health professionals to select the appropriate level of support is conducted (for a live repertoire of existing programs and evaluation, see here https://justmentalhealth.ca).

Mobile teams were highly desired by all participants in our study, as they believe these teams can provide the flexibility, responsiveness, and coordination necessary for service users with high and complex needs. Implementing such teams could play a crucial role in preventing violence and reducing justice system involvement, provided that they can effectively identify individuals at risk of these outcomes. One potential model for adaptation is Forensic Assertive Community Treatment (Goulet et al., 2021; Lamberti & Weisman, 2021); however, its current implementations target those already involved with the justice system. To address this, interventions should be aligned with service users' needs rather than their legal statuses. To achieve this, it is essential to bring expertise in violence risk identification and prevention into non-forensic mental health settings. Participants suggested that peer mentorship and communities of practice, where forensic experts share knowledge with generalists and discuss real case studies, would be an ideal strategy. For those with lower needs, a navigator could significantly improve access and continuity of care. It is worth noting that nurse navigators are already common for many chronic illnesses. As this model expands, prioritizing those living with severe mental illness should be considered.

Finally, the findings highlight the importance of providing support to relatives, who play a critical role in seeking, reaching, and engaging with care (Leclair, Charette, Seto, et al., 2022). A

meta-synthesis of the literature on the experiences of family caregivers in forensic mental health highlighted that caring for their loved one is a great burden of responsibility that takes over their whole lives (Vestphal et al., 2023). As in our findings, collaboration between the family caregivers and service providers is described as difficult, and punctuated by constant negotiations and advocacy (Vestphal et al., 2023). Their systemic exclusion from the care team may be due to system-level barriers such as confidentiality laws, but there is evidence for provider-level barriers as a qualitative study in Sweden showed that healthcare providers perceived most family caregiver behaviours as "getting in the way" (Hörberg et al., 2015). Few interventions to support families have been put in place in forensic mental health (Gatherer et al., 2020). More work should be done in this area to see how best families can be supported, such as co-creating with people with lived experience a capacity-building programs for service providers through an intersectoral, family-centered approach.

Limitations

One significant limitation of this study is the absence of interviews with individuals who have recently received an NCR verdict. There were two primary reasons for this limitation. The first reason was the timing of recruitment, which coincided with the COVID-19 pandemic crisis when research projects in forensic hospitals without a direct benefit to service users were suspended. The second reason was the institutional culture and relatively siloed organization of the institution where recruitment was attempted, which made it challenging to recruit participants. As a result, this study may not provide a complete understanding of the experiences of individuals with NCR verdicts, and future research should aim to address this limitation. To address this limitation, we decided to interview peer support workers and family caregivers, providing valuable insights into the experiences of those who support individuals with NCR verdicts and of those of had experience of judicial levers of access to care. In addition, while saturation was reached among some subgroups of participants, such as people with lived experience, saturation was not reached in others due to the small number of potential participants with experiential knowledge relevant to the topic (e.g., senior administrators).

Conclusion

Structural stigma against people with severe mental illness within the healthcare system creates and upholds significant barriers to accessing adequate care, to recover, and to thrive. This is especially true for people who have behaviors that are perceived as dangerous, disruptive, or violent and that are thus at risk of justice involvement and entry into the forensic mental health system. There is a need to transition towards community-based care and prioritize the lived experience of service users through evidence-based approaches. Promising models such as the Trieste approach, which has been extended in Italy to forensic mental health service users (Ferracuti et al., 2019; Lombardi et al., 2019), and mobile teams offer responsive and coordinated care while reducing involvement with the justice system. Additionally, providing support to caregivers is crucial, as their role is often ignored and belittled by the healthcare system. Reducing structural stigma in mental healthcare is a crucial step in decreasing the justice involvement of people with severe mental illness.

References

Abbott, P., Magin, P., Lujic, S., & Hu, W. (2017). Supporting continuity of care between prison and the community for women in prison: A medical record review. Australian Health Review, 41(3), 268–276. https://doi.org/10.1071/AH16007

Adair, C. E., McDougall, G. M., Mitton, C., Joyce, A. S., Wild, T. C., Gordon, A., Costigan, N., Kowalsky, L., Pasmeny, G., & Beckie, A. (2005). Continuity of care and health outcomes among persons with severe mental illness. Psychiatric Services, 56(9), 1061–1069. https://doi.org/0.1176/appi.ps.56.9.1061

Agrawal, S., Capponi, P., López, J., Kidd, S., Ringsted, C., Wiljer, D., & Soklaridis, S. (2016). From surviving to advising: A novel course pairing mental health and addictions service users as advisors to senior psychiatry residents. Academic Psychiatry, 40(3), 475–480. https://doi.org/10.1007/s40596-016-0533-z

Amsalem, D., Hasson-Ohayon, I., Gothelf, D., & Roe, D. (2018). Subtle ways of stigmatization among professionals: The subjective experience of consumers and their family members. Psychiatric Rehabilitation Journal, 41(3), 163–168. https://doi.org/10.1037/prj0000310

Aoun, S., Pennebaker, D., & Pascal, R. (2004). To what extent is health and medical research funding associated with the burden of disease in Australia? Australian and New Zealand Journal of Public Health, 28(1), 80–86. https://doi.org/10.1111/j.1467-842X.2004.tb00637.x

Arboleda-Flórez, J., & Stuart, H. (2012). From sin to science: Fighting the stigmatization of mental illnesses. Canadian Journal of Psychiatry, 57(8), 457–463. https://doi.org/10.1177/070674371205700803

Baker, D., Pillinger, C., & Baker, D. (2020). ' If You call 911 they are going to kill me ': families ' experiences of mental health and deaths after police contact in the United States mental health and deaths after police contact in the United States. https://doi.org/10.1080/10439463.2019.1581193

Björk Brämberg, E., Torgerson, J., Norman Kjellström, A., Welin, P., & Rusner, M. (2018). Access to primary and specialized somatic health care for persons with severe mental illness: A

qualitative study of perceived barriers and facilitators in Swedish health care. BMC Family Practice, 19(1), 1–11. https://doi.org/10.1186/s12875-017-0687-0

Broadbent, M., Moxham, L., & Dwyer, T. (2007). The development and use of mental health triage scales in Australia. International Journal of Mental Health Nursing, 16(6), 413–421. https://doi.org/10.1111/j.1447-0349.2007.00496.x

Canadian Criminal Code. (1992). L.R.C. C-46.

Canadian Mental Health Association. (2018). Ending the healthcare disparity in Canada. September, 24. www.cmha.ca

Cavney, J., Skipworth, J., Madell, D., & McKenna, B. (2012). Patterns of mental health service contact before and after forensic mental health contact in New Zealand. Australasian Psychiatry, 20(3), 225–227. https://doi.org/10.1177/1039856212437258

Charette, Y., Goossens, I., Seto, M. C., Nicholls, T. L., & Crocker, A. G. (2021). Is Knowledge Contagious? Diffusion of Violence-Risk-Reporting Practices Across Clinicians' Professional Networks. Clinical Psychological Science, 9(2), 284–293. https://doi.org/10.1177/2167702620954797

Christensen, H., Batterham, P. J., Hickie, I. B., McGorry, P. D., Mitchell, P. B., & Kulkarni, J. (2011). Funding for mental health research: The gap remains. Medical Journal of Australia, 195(11), 681–684. https://doi.org/10.5694/mja10.11415

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Morgan, C., Rüsch, N., Brown, J. S. L., & Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. Psychological Medicine, 45(1), 11–27. https://doi.org/10.1017/S0033291714000129

Corrigan, P. W. (2004). How stigma interferes with mental health care. American Psychologist, 59(7), 614–625. https://doi.org/10.1037/0003-066X.59.7.614

Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014). The impact of mental illness stigma on seeking and participating in mental health care. Psychological Science in the Public Interest, Supplement, 15(2), 37–70. https://doi.org/10.1177/1529100614531398

Crocker, A. G., Livingston, J. D., & Leclair, M. C. (2017). Forensic mental health systems internationally. In R. Roesch & A. N. Cook (Eds.), Handbook of Forensic Mental Health Services (pp. 3–76). Routledge.

Crocker, A. G., Martin, M. S., Leclair, M. C., Seto, M. C., & Nicholls, T. L. (2018). Expanding the early and late starter model of criminal justice involvement for forensic mental health clients. Law and Human Behavior, 42(1), 83–93. https://doi.org/10.1037/lhb0000269

Crocker, A. G., Nicholls, T. L., Seto, M. C., Charette, Y., Côté, G., & Caulet, M. (2015). The National Trajectory Project of individuals found Not Criminally Responsible on Account of Mental Disorder in Canada. Part 2 - The people behind the label. Canadian Journal of Psychiatry, 60(3), 106–116. https://doi.org/10.1177/070674371506000305

Cunningham, C., Peters, K., & Mannix, J. (2013). Physical health inequities in people with severe mental illness: Identifying initiatives for practice change. Issues in Mental Health Nursing, 34(12), 855–862. https://doi.org/10.3109/01612840.2013.832826

De Hert, M., Correll, C. U., Bobes, J., Cetkovich-Bakmas, M., Cohen, D. A. N., Asai, I., Detraux, J., Gautam, S., Möller, H. J., Ndetei, D. M., Newcomer, J. W., Uwakwe, R., & Leucht, S. (2011). Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. World Psychiatry, 10(1), 52–77. https://doi.org/10.1002/j.2051-5545.2011.tb00014.x

Dockery, L., Jeffery, D., Schauman, O., Williams, P., Farrelly, S., Bonnington, O., Gabbidon, J., Lassman, F., Szmukler, G., Thornicroft, G., & Clement, S. (2015). Stigma- and non-stigma-related treatment barriers to mental healthcare reported by service users and caregivers. Psychiatry Research, 228(3), 612–619. https://doi.org/10.1016/j.psychres.2015.05.044

Doerfler-Evans, R. E. (2016). Shifting paradigms continued—the emergence and the role of nurse navigator. Journal of Thoracic Disease, 8(S6), S498–S500. https://doi.org/10.21037/jtd.2016.04.03

Ferracuti, S., Pucci, D., Trobia, F., Alessi, M. C., Rapinesi, C., Kotzalidis, G. D., & Del Casale, A. (2019). Evolution of forensic psychiatry in Italy over the past 40 years (1978–2018). International Journal of Law and Psychiatry, 62, 45–49. https://doi.org/10.1016/j.ijlp.2018.10.003

Finn, M. (2014). Emergency Department Mental Health Triage and Consultancy Service: An advanced practice role for mental health nurses. 6178. https://doi.org/10.5172/conu.14.2.138

Frances, A. (2021). Save Trieste's mental health system. The Lancet Psychiatry, 8(9), 744–746. https://doi.org/10.1016/S2215-0366(21)00252-2

García, S., Martínez-Cengotitabengoa, M., López-Zurbano, S., Zorrilla, I., López, P., Vieta, E., & González-Pinto, A. (2016). Adherence to antipsychotic medication in bipolar disorder and schizophrenic patients. Journal of Clinical Psychopharmacology, 36(4), 355–371. https://doi.org/10.1097/JCP.0000000000000523

Gatherer, C., Dickson-Lee, S., & Lowenstein, J. (2020). The forgotten families; a systematic literature review of family interventions within forensic mental health services. Journal of Forensic Psychiatry and Psychology, 31(6), 823–836. https://doi.org/10.1080/14789949.2020.1799054

Godrie, B., & Rivet, C. (2021). Inégalités épistémiques et réduction identitaire : ce que l'entraide en santé mentale fait aux récits de la maladie. Corps, 18(1), 129–140. https://doi.org/10.3917/corp1.018.0129

González-Torres, M. A., Oraa, R., Arístegui, M., Fernández-Rivas, A., & Guimon, J. (2007). Stigma and discrimination towards people with schizophrenia and their family members: A qualitative study with focus groups. Social Psychiatry and Psychiatric Epidemiology, 42(1), 14–23. https://doi.org/10.1007/s00127-006-0126-3

Goulet, M.-H., Dellazizzo, L., Lessard-Deschênes, C., Lesage, A., Crocker, A. G., & Dumais, A. (2021). Effectiveness of Forensic Assertive Community Treatment on Forensic and Health
149

Outcomes: A Systematic Review and Meta-Analysis. Criminal Justice and Behavior, 1–15. https://doi.org/10.1177/00938548211061489

Gronholm, P. C., Thornicroft, G., Laurens, K. R., & Evans-Lacko, S. (2017). Mental health-related stigma and pathways to care for people at risk of psychotic disorders or experiencing first-episode psychosis: A systematic review. Psychological Medicine, 47(11), 1867–1879. https://doi.org/10.1017/S0033291717000344

Henderson, C., Flood, C., Leese, M., Thornicroft, G., Sutherby, K., & Szmukler, G. (2009). Views of service users and providers on joint crisis plans. Social Psychiatry and Psychiatric Epidemiology, 44(5), 369–376. https://doi.org/10.1007/s00127-008-0442-x

Henderson, C., Noblett, J., Parke, H., Clement, S., Caffrey, A., Gale-Grant, O., Schulze, B., Druss, B., & Thornicroft, G. (2014). Mental health-related stigma in health care and mental health-care settings. The Lancet Psychiatry, 1(6), 467–482. https://doi.org/10.1016/S2215-0366(14)00023-6

Hodgins, S., Webster, C. D., Paquet, J., & Zellerer, E. (1990). Canadian Database: Patients Held on Lieutenant Governor Warrants.

Holt, N. R., Botelho, E., Wolford-Clevenger, C., & Clark, K. A. (2023). Previous mental health care and help-seeking experiences: Perspectives from sexual and gender minority survivors of near-fatal suicide attempts. Psychological Services. https://doi.org/10.1037/ser0000745

Hörberg, U., Benzein, E., Erlingsson, C., & Syrén, S. (2015). Engaging with Families Is a Challenge : Beliefs among Healthcare Professionals in Forensic Psychiatric Care. 2015.

Huikko, E., Aalto-Setälä, T., Santalahti, P., Lämsä, R., & Ahlgrén-Rimpiläinen, A. (2023). Lifelong mental health service use among 15–22 years old offenders: a document-based, mixed-methods descriptive study. BMJ Open, 13(3), e065593. https://doi.org/10.1136/bmjopen-2022-065593

Jansman-Hart, E. M., Seto, M. C., Crocker, A. G., Nicholls, T. L., & Côté, G. (2011). International trends in demand for forensic mental health services. International Journal of Forensic Mental Health, 10(4), 326–336. https://doi.org/10.1080/14999013.2011.625591

Kakuma, R., Minas, H., Van Ginneken, N., Dal Poz, M. R., Desiraju, K., Morris, J. E., Saxena, S., & Scheffler, R. M. (2011). Human resources for mental health care: Current situation and strategies for action. The Lancet, 378(9803), 1654–1663. https://doi.org/10.1016/S0140-6736(11)61093-3

Keown, P., Murphy, H., McKenna, D., & McKinnon, I. (2018). Changes in the use of the Mental Health Act 1983 in England 1984/85 to 2015/16. British Journal of Psychiatry, 213(4), 595–599. https://doi.org/10.1192/bjp.2018.123

Khan, S., Chiu, M., Simpson, A. I. F., Guttmann, A., Jembere, N., & Kurdyak, P. (2016). Use of mental health services by youths and young adults before and during correctional custody: A population-based study. Psychiatric Services, 67(7), 790–793. https://doi.org/10.1176/appi.ps.201500085

Kitzinger, J. (1995). Qualitative Research: Introducing focus groups. BMJ, 311, 299–302.

Knaak, S., Karpa, J., Robinson, R., & Bradley, L. (2016). "They are us - We are them": Transformative learning through nursing education leadership. Healthcare Management Forum, 29(3), 116–120. https://doi.org/10.1177/0840470416628880

Knaak, S., Mantler, E., & Szeto, A. (2017). Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions. Healthcare Management Forum, 30(2), 111–116. https://doi.org/10.1177/0840470416679413

Koroukian, S. M., Bakaki, P. M., Golchin, N., Tyler, C., & Loue, S. (2012). Mental illness and use of screening mammography among medicaid beneficiaries. American Journal of Preventive Medicine, 42(6), 606–609. https://doi.org/10.1016/j.amepre.2012.03.002

Lafore, R. (2010). La juridicisation des problèmes sociaux : la construction juridique de la protection sociale. Informations Sociales, n° 157(1), 18. https://doi.org/10.3917/inso.157.0018

Lam, R. D., & El-Guelbaly, N. (1994). Research funding of psychiatric disorders in Canada. Canadian Journal of Psychiatry, 39(3), 141–146. https://doi.org/10.1177/070674379403900301

Lamberti, J. S., & Weisman, R. L. (2021). Essential Elements of Forensic Assertive Community Treatment. Harvard Review of Psychiatry, 29(4), 278–297. https://doi.org/10.1097/HRP.0000000000000299

Larose-Hébert, K. (2020). Judiciarisation de l'accès aux services de santé mentale : le rôle complexe des proches-aidants. Intervention, 151, 47–62.

Leclair, M. C., Charette, Y., Caulet, M., & Crocker, A. G. (2022). Care Pathways, Health Service Use Patterns and Opportunities for Justice Involvement Prevention Among Forensic Mental Health Clients. Canadian Journal of Psychiatry, 1–11. https://doi.org/10.1177/07067437221076723

Leclair, M. C., Charette, Y., Seto, M., Nicholls, T. L., Roy, L., Dufour, M., & Crocker, A. G. (2022). Barriers and facilitators of access and utilization of mental health services among forensic service users along the care pathway. BMC Health Services Research, 22(1), 1495. https://doi.org/10.1186/s12913-022-08848-9

Leclair, M. C., & Crocker, A. G. (2023). Avez-vous dit « dangerosité » ou « dérangerosité »? Analyse d'une prophétie autoréalisatrice en violence et santé mentale. In L. Vigneault & T. Lecomte (Eds.), Préjugés, discrimination et exclusion en santé mentale – Pour en finir avec la stigmatisation. Performance édition.

Leclair, M. C., Lemieux, A. J., Roy, L., Martin, M. S., Latimer, E. A., & Crocker, A. G. (2020). Pathways to recovery among homeless people with mental illness: Is impulsiveness getting in the way? Canadian Journal of Psychiatry, 65(7), 473–483.

Lee, S., Chiu, M. Y. L., Tsang, A., Chui, H., & Kleinman, A. (2006). Stigmatizing experience and structural discrimination associated with the treatment of schizophrenia in Hong Kong. Social Science & Medicine, 62(7), 1685–1696. https://doi.org/10.1016/j.socscimed.2005.08.016

Lévesque, J.-F., Harris, M. F., & Russell, G. (2013). Patient-centred access to health care: conceptualising access at the interface of health systems and populations. International Journal for Equity in Health, 12(18). http://www.equityhealthj.com/content/12/1/18

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. Annual Review of Sociology, 27, 363–385.

Livingston, J. D. (2020). Structural Stigma in Health-Care Contexts for People with Mental Health and Substance Use Issues: A Literature Review. Mental Health Commission of Canada.

Lloyd-Evans, B., Crosby, M., Stockton, S., Pilling, S., Hobbs, L., Hinton, M., & Johnson, S. (2011). Initiatives to shorten duration of untreated psychosis: Systematic review. British Journal of Psychiatry, 198(4), 256–263. https://doi.org/10.1192/bjp.bp.109.075622

Lombardi, V., Veltri, A., Montanelli, C., Mundo, F., Restuccia, G., Cesari, D., Maccari, M., Scarpa, F., & Sbrana, A. (2019). Sociodemographic, clinical and criminological characteristics of a sample of Italian Volterra REMS patients. International Journal of Law and Psychiatry, 62(September 2018), 50–55. https://doi.org/10.1016/j.ijlp.2018.09.009

MacDonald, K., Ferrari, M., Fainman-Adelman, N., & Iyer, S. N. (2021). Experiences of pathways to mental health services for young people and their carers: a qualitative meta-synthesis review. Social Psychiatry and Psychiatric Epidemiology, 56(3), 339–361. https://doi.org/10.1007/s00127-020-01976-9

Magliano, L., De Rosa, C., Fiorillo, A., Malangone, C., & Maj, M. (2004). Perception of patients' unpredictability and beliefs on the causes and consequences of schizophrenia: A community survey. Social Psychiatry and Psychiatric Epidemiology, 39(5), 410–416. https://doi.org/10.1007/s00127-004-0764-2

Maranzan, K. A. (2016). Interprofessional education in mental health: An opportunity to reduce mental illness stigma. Journal of Interprofessional Care, 30(3), 370–377. https://doi.org/10.3109/13561820.2016.1146878

Marcus, N., & Stergiopoulos, V. (2022). Re-examining mental health crisis intervention: A rapid review comparing outcomes across police, co-responder and non-police models. Health and Social Care in the Community, 30(5), 1665–1679. https://doi.org/10.1111/hsc.13731

Melro, C. (2023). What Works, Why, and How? The Effect of Educational Interventions on Health Professional Learners' Causal Beliefs and Attitudes Towards Indigenous Peoples' Experiences with Historical and Ongoing Colonialism. Dalhousie University.

Mental Health Commission of Canada. (2017). Investing in Canada's Mental Health System : Economic Considerations.

Mezzina, R. (2014). Community Mental Health Care in Trieste and Beyond An "Open Door - No Restraint " System of Care for Recovery and Citizenship. The Journal of Nervous and Mental Disease, 202(6), 440–445. https://doi.org/10.1097/NMD.0000000000000142

Miles, M. B., Huberman, A. M., & Saldana, J. (2014). Qualitative data analysis: A methods sourcebook. SAGE Publications.

Monza, K., Harris, D., & Shaw, C. (2015). The Role of the Nurse Navigator in the Management of the Heart Failure Patient. Critical Care Nursing Clinics of North America, 27(4), 537–549. https://doi.org/10.1016/j.cnc.2015.07.010

Moore, S., Shiers, D., Daly, B., Mitchell, A. J., & Gaughran, F. (2015). Promoting physical health for people with schizophrenia by reducing disparities in medical and dental care. Acta Psychiatrica Scandinavica, 132, 109–121.

Morgan, D. (2012). Planning and Research Design for Focus Groups. In Focus Groups as Qualitative Research (pp. 31–45). https://doi.org/10.4135/9781412984287.n4

Neergaard, M. A., Olesen, F., Andersen, R. S., & Sondergaard, J. (2009). Qualitative description-the poor cousin of health research? BMC Medical Research Methodology, 9(1), 1–5. https://doi.org/10.1186/1471-2288-9-52

Nyblade, L., Stockton, M. A., Giger, K., Bond, V., Ekstrand, M. L., Lean, R. M., Mitchell, E. M. H., Nelson, L. R. E., Sapag, J. C., Siraprapasiri, T., Turan, J., & Wouters, E. (2019). Stigma in health facilities: Why it matters and how we can change it. BMC Medicine, 17(1), 1–15. https://doi.org/10.1186/s12916-019-1256-2

Oruche, U. M., Gerkensmeyer, J., Stephan, L., Wheeler, C. A., & Hanna, K. M. (2012). The Described Experience of Primary Caregivers of Children With Mental Health Needs. Archives of Psychiatric Nursing, 26(5), 382–391. https://doi.org/10.1016/j.apnu.2011.12.006

Paillé, P., & Mucchielli, A. (2012). L'analyse thématique. In L'analyse qualitative en sciences humaines et sociales (pp. 231–314).

Palcic, S., Broussard, P., Pettinelli, A., Giraldi, T., Martinis, E., Furina, C., Bracco, R., Zanello, E., Riolo, A., & Mezzina, R. (2011). Studio comparativo sull'utilizzo dei farmaci antipsicotici nel territorio dell'ASS n. 1 '"Triestina."' https://asugi.sanita.fvg.it/export/sites/aas1/it/documenti/all_dir_san/all_farma/mat_info/farma_congresso_italiano_farmacia_ospedaliera_2009.pdf

Penchansky, R., & Thomas, J. W. (1981). The concept of access: definition and relationship to consumer satisfaction. Medical Care, 19(2), 127–140.

Pérez-Revuelta, J. I., González-Sáiz, F., Pascual-Paño, J. M., Mongil-San Juan, J. M., Rodríguez-Gómez, C., Muñoz – Manchado, L. I., Mestre-Morales, J., Berrocoso, E., & Villagrán Moreno, J. M. (2023). Shared decision making with schizophrenic patients: a randomized controlled clinical trial with booster sessions (DECIDE Study). Patient Education and Counseling, 110(October 2022), 0–3. https://doi.org/10.1016/j.pec.2023.107656

Pettigrew, T. F., & Tropp, L. R. (2006). A meta-analytic test of intergroup contact theory. Journal of Personality and Social Psychology, 90(5), 751–783. https://doi.org/10.1037/0022-3514.90.5.751

Priebe, S., Frottier, P., Gaddini, A., Kilian, R., Lauber, C., Martinez-Leal, R., Munk-Jorgensen, P., Walsh, D., Wiersma, D., & Wright, D. (2008). Mental health care institutions in nine European countries, 2002 to 2006. Psychiatric Services, 59(5), 570–573. https://doi.org/10.1176/appi.ps.59.5.570 [doi]

Protani, M. M., Alotiby, M. K. N., Seth, R., Lawrence, D., Jordan, S. J., Logan, H., Kendall, B. J., Siskind, D., Sara, G., & Kisely, S. (2022). Colorectal cancer treatment in people with severe mental illness: a systematic review and meta-analysis. Epidemiology and Psychiatric Sciences, 31, e82. https://doi.org/10.1017/S2045796022000634

Pugh, T., Hatzenbuehler, M., & Link, B. G. (2015). Structural stigma and mental illness: Commissioned paper for Committee on the Science of Changing Behavioral Health Social Norms.

155

Columbia University, August. https://sites.nationalacademies.org/cs/groups/dbassesite/documents/webpage/dbasse_170045.pdf

Roy, L., Crocker, A. G., Hurtubise, R., Latimer, E., Côté, M., Billette, I., & Boissy, F. (2020). Reducing criminal justice involvement of individuals experiencing homelessness and mental illness: Perspectives of frontline practitioners. Canadian Journal of Criminology and Criminal Justice, 62(2), 1–21. https://doi.org/10.3138/cjccj.2019-0056

Roy, L., Leclair, M. C., Côté, M., & Crocker, A. G. (2020). Itinérance, santé mentale, justice: Expérience et perceptions des utilisateurs de services à Montréal. Criminologie, 53(2), 359–383. https://doi.org/10.7202/1074199ar

Royal College of Psychiatrists. (2013). From rhetoric to reality Achieving parity between mental and physical health Summary Royal College of Psychiatrists. March 2013, 1-12. [Accessed 12 November 2022]. https://clahrc-cp.nihr.ac.uk/wp-content/uploads/2013/04/RCP_reporton-parity.pdf. [Accessed 12 November 2022]

Saleh, A. Z., Appelbaum, P. S., Liu, X., Scott Stroup, T., & Wall, M. (2018). Deaths of people with mental illness during interactions with law enforcement. International Journal of Law and Psychiatry, 58, 110–116. https://doi.org/10.1016/j.ijlp.2018.03.003

Sandelowski, M. (2010). What's in a name? Qualitative description revisited. Research in Nursing and Health, 33(1), 77–84. https://doi.org/10.1002/nur.20362

Sashidharan, S. P. (2022). Why Trieste matters. 52–53. https://doi.org/10.1192/bjp.2021.149

Shepherd, A., Doyle, M., Sanders, C., & Shaw, J. (2016). Personal recovery within forensic settings - Systematic review and meta-synthesis of qualitative methods studies. Criminal Behaviour and Mental Health, 26(1), 59–75. https://doi.org/10.1002/cbm.1966

Sheridan Rains, L., Weich, S., Maddock, C., Smith, S., Keown, P., Crepaz-Keay, D., Singh, S. P., Jones, R., Kirkbride, J., Millett, L., Lyons, N., Branthonne-Foster, S., Johnson, S., & Lloyd-Evans, B.

(2020). Understanding increasing rates of psychiatric hospital detentions in England: development and preliminary testing of an explanatory model. BJPsych Open, 6(5), 1–13. https://doi.org/10.1192/bjo.2020.64

Shim, R., & Rust, G. (2013). Primary care, behavioral health, and public health: Partners in reducing mental health stigma. American Journal of Public Health, 103(5), 774–776. https://doi.org/10.2105/AJPH.2013.301214

Skubby, D., Bonfine, N., Tracy, H., Knepp, K., & Munetz, M. R. (2015). The Help-Seeking Experiences of Parents of Children with a First-Episode of Psychosis. Community Mental Health Journal, 51(8), 888–896. https://doi.org/10.1007/s10597-015-9877-1

Sukhera, J., & Knaak, S. (2022). A realist review of interventions to dismantle mental health and substance use related structural stigma in healthcare settings. SSM - Mental Health, 2(November), 100170. https://doi.org/10.1016/j.ssmmh.2022.100170

Swanson, J. W., Swartz, M. S., Elbogen, E. B., Van Dorn, R. A., Wagner, H. R., Moser, L. A., Wilder, C., & Gilbert, A. R. (2008). Psychiatric advance directives and reduction of coercive crisis interventions. Journal of Mental Health, 17(3), 255–267. https://doi.org/10.1080/09638230802052195

Swartz, M. S., Swanson, J. W., & Hannon, M. J. (2003). Does fear of coercion keep people away from mental health treatment? Evidence from a survey of persons with schizophrenia and mental health professionals. Behavioral Sciences & the Law, 21(4), 459–472. https://doi.org/10.1002/bsl.539

Thornicroft, G., Rose, D., & Kassam, A. (2007). Discrimination in health care against people with mental illness. International Review of Psychiatry, 19(2), 113–122. https://doi.org/10.1080/09540260701278937

Tingleff, E. B., Rowaert, S., Vinding, S., Vestphal, T. K., Wilson, R., & Gildberg, F. A. (2022). "It's still our child". A qualitative interview study with parent carers in forensic mental health. Archives of Psychiatric Nursing, 41(July), 124–131. https://doi.org/10.1016/j.apnu.2022.07.017

Vestphal, T. K., Gildberg, F. A., Jørgensen, R., Rowaert, S., & Tingleff, E. B. (2023). Experiences of family caregivers in forensic mental health care - A qualitative evidence synthesis. Journal of Psychiatric and Mental Health Nursing, August 2022, 1–16. https://doi.org/10.1111/jpm.12910

Wahl, O., & Aroesty-Cohen, E. (2010). Attitudes of mental health professionals about mental illness: a review of the recent literature. Journal of Community Psychology, 38(1), 49–62. https://doi.org/10.1002/jcop.20351

Wang, P. S., Demler, O., & Kessler, R. C. (2002). Adequacy of treatment for serious mental illness in the United States. American Journal of Public Health, 92(1), 92–98. https://doi.org/10.2105/AJPH.92.1.92

Whittle, E. L., Fisher, K. R., Reppermund, S., & Trollor, J. (2019). Access to mental health services: The experiences of people with intellectual disabilities. Journal of Applied Research in Intellectual Disabilities, 32(2), 368–379. https://doi.org/10.1111/jar.12533

Ye, J., Chen, T. F., Paul, D., McCahon, R., Shankar, S., Rosen, A., & O'Reilly, C. L. (2016). Stigma and discrimination experienced by people living with severe and persistent mental illness in assertive community treatment settings. International Journal of Social Psychiatry, 62(6), 532–541. https://doi.org/10.1177/0020764016651459

Chapitre 7 – Discussion générale et directions futures

Les trois articles qui composent cette thèse permettent, ensemble, de mieux comprendre les trajectoires de services de santé mentale, ainsi que les facteurs qui les modulent, par les personnes qui commettront éventuellement un délit les menant à un verdict NCR. Le premier article permet de décrire la nature et l'étendue des services utilisés, en faisant notamment ressortir que la majorité de ces personnes étaient connues du système de santé pour leurs troubles mentaux, mais que leur trajectoire était ponctuée d'interruptions de services dans les mois précédant le délit. Le deuxième article a permis d'identifier les facteurs qui rendaient les usagers plus susceptibles d'accéder à différentes étapes du continuum d'accès aux services de santé de Lévesque et collègues. Finalement, le troisième article permet d'expliquer les mécanismes derrière ces facteurs, permettant au final d'identifier des pistes de solution pour pallier les problèmes d'accès pour cette population.

Principales conclusions

Le premier article avait pour objectif d'examiner les parcours de soins de plus de 1 000 personnes déclarées NCR au Québec à partir de leurs données administratives en santé. Cette analyse montre que les personnes NCR sont nombreuses à avoir eu des contacts sporadiques avec le système de santé pour leur santé mentale, mais les interruptions de services caractérisent les derniers mois précédant un délit. Malgré le fait que 71 % des personnes NCR étaient connues des services de santé mentale dans l'année avant le délit, moins de la moitié bénéficiaient d'un véritable suivi pour leur santé mentale pendant cette période. Par exemple, plusieurs patients ont reçu leur congé d'une hospitalisation psychiatrique sans qu'un rendez-vous de suivi n'ait lieu par la suite. Notre analyse fait également ressortir qu'une personne sur cinq a commis l'infraction dans la semaine suivant un contact avec les services de santé mentale, contact qui avait souvent lieu aux urgences.

Ces résultats faisaient ressortir une question essentielle : quels facteurs, contextuels ou individuels, contribuaient à ces interruptions de service? Pour le deuxième article de la

dissertation, nous avons donc mobilisé les données de la santé, de la justice, de la sécurité publique, ainsi que des données à un niveau contextuel issu de l'INSPQ, etc. pour identifier les barrières et les facteurs facilitants l'accès aux services dans cette population. Nous avons utilisé le modèle d'accès centré sur le patient de Lévesque et collègues pour définir l'accès et structurer notre analyse (Lévesque et al., 2013). Nous avons donc défini l'accès comme avoir l'occasion de voir ces besoins en termes de santé répondus en fonction de la possibilité de chercher, rejoindre et recevoir des services de santé mentale spécialisés (Lévesque et al., 2013). Bien que la taille de l'effet des facilitateurs et des barrières différait pour chaque niveau de soins, des tendances générales se sont dégagées : la situation de vie de la personne, tant sur le plan géographique que sur celui des cohabitants, avait une influence majeure sur les services auxquels elle avait accès et qu'elle utilisait, même en tenant compte des variables liées aux besoins, tels que les diagnostics primaires et concomitants. Contrairement aux modèles théoriques d'accès aux services ainsi que contrairement à nos hypothèses, vivre avec des proches, soit des membres de la famille, des amis ou un ou une partenaire de vie, réduisait les probabilités d'accéder et d'utiliser les soins spécialisés en santé mentale, et ce, à presque chaque étape du continuum d'accès. Dans le cadre de la discussion de ce deuxième article, nous avons avancé différentes hypothèses pour expliquer ce résultat inattendu. Le troisième et dernier article de cette dissertation a permis, entre autres, de vérifier les mécanismes derrière cette association.

Le troisième article repose sur l'analyse qualitative d'entretiens avec des parties prenantes, dont des pairs aidants, des membres de la famille, des cliniciens et des décideurs. L'objectif de cette étude était de décrire l'expérience des usagers dans leur recherche de soins, ainsi que les barrières perçues par les différents acteurs. Cet article a mis en lumière les difficultés pour les usagers de s'engager dans leurs soins dans un contexte où les expériences passées dans le système de santé sont marquées par la stigmatisation, les traumatismes, l'inefficacité et la discrimination. Ces expériences ont sévèrement diminué l'acceptabilité des services de santé mentale pour de nombreux usagers et leurs proches aidants, les poussant à chercher des

160

alternatives plus compatissantes et moins déshumanisantes pour répondre aux besoins de santé mentale, dont le soutien des proches. Les résultats soulignent ainsi le rôle crucial des familles dans les trajectoires de soins, qui peuvent malgré elles contribuer aux interruptions de services en se substituant à des services jugés stigmatisants et inefficaces. De plus, en période de crise, les mécanismes d'accès disponibles, tels que l'intervention policière, les salles d'urgence ou les mesures judiciaires, ne sont envisagés sérieusement que lorsque les autres stratégies ont échoué et que la personne a subi une décompensation sévère, impliquant possiblement un délit ou un incident de violence. Ces usagers entrent donc dans le système de santé avec des besoins complexes difficiles à aborder avec les connaissances actuelles en psychiatrie générale, requérant parfois un niveau de soins disponibles uniquement en psychiatriqe légale. Le système de santé, avec ses exigences administratives rigides, est mal équipé pour répondre à ces besoins, et des stratégies coercitives sont plus susceptibles d'être utilisées, renforçant l'évaluation négative des services et réduisant la capacité des usagers à s'engager dans les soins.

Implications

Cette section se centre sur les implications des résultats, particulièrement en termes de solutions aux barrières à l'accès aux services de santé mentale identifiés dans le cadre des deuxième et troisième articles. Les barrières et les solutions sont résumées dans le tableau 1.

Accessibilité et capacité à percevoir des besoins et souhaiter des soins

Notre premier article suggère que la vaste majorité des personnes déclarées NCR avait déjà eu un contact initial avec les services de santé mentale, et un de nos précédents articles suggère que les personnes n'ayant jamais eu un contact initial avec les services de santé mentale avant l'incident menant à un verdict NCR vivaient possiblement un premier épisode psychotique (Crocker et al., 2018). Cela suggère que les principales barrières à l'accès pour cette population ne se situent probablement pas au niveau de l'accessibilité des services et de la capacité à percevoir des besoins et à souhaiter des soins pour répondre aux besoins.

161

Les participants dans les cadres des entretiens qualitatifs ont toutefois fait ressortir deux barrières principales à la perception des besoins en santé mentale et la recherche de services pour un premier épisode de soins : le manque de littéracie en santé mentale et la volonté d'éviter l'étiquette « maladie mentale ».

Littéracie en santé mentale. En effet, la littérature – et nos participants – souligne que les idées délirantes ou le discours désorganisé sont rarement identifiés par les personnes ayant des troubles mentaux graves et leurs proches comme faisant partie de symptômes requérant des soins (López et al., 2018). Une étude récente en Norvège suggère que la littéracie en santé mentale, et plus particulièrement la capacité à reconnaître des symptômes psychotiques, avait un effet petit mais robuste sur la durée d'un épisode psychotique non traité (Takizawa et al., 2021). Dans une étude basée sur des vignettes, les participants qui reconnaissaient la vignette comme présentant des symptômes d'un trouble mental grave – sans nécessairement formuler une hypothèse sur le diagnostic spécifique – étaient trois fois plus susceptibles de recommander le recours à un professionnel de la santé (López et al., 2018). Une récente méta-synthèse fait ressortir que la littéracie en santé mentale est un thème commun dans les trajectoires d'accès aux soins. Pour les jeunes adultes et leurs proches, les comportements ou la détresse sont souvent attribués à un stade développemental transitoire plutôt qu'à un besoin en santé (MacDonald et al., 2021). Les participants de notre étude qualitative ont noté que les campagnes de sensibilisation et de déstigmatisation négligeaient souvent les troubles mentaux graves, ce qui nuisait aux connaissances du public et à la reconnaissance des besoins en santé. L'effet des interventions pour améliorer la littéracie liée à la psychose sur l'accès aux soins n'est toutefois pas démontré, avec des effets mixtes (Calderon et al., 2022; Lloyd-Evans et al., 2011). Bien qu'il puisse être louable d'accroître la visibilité des troubles mentaux graves dans les campagnes de déstigmatisation, cette initiative n'est probablement pas suffisante pour avoir un effet significatif sur l'accès.

162

Évitement de l'étiquette « maladie mentale ». Des solutions structurelles agissant sur les obstacles au niveau du système et des prestataires pourrait être une stratégie plus efficace pour réduire les effets du stigma sur le souhait de soins (Corrigan et al., 2014). La littérature souligne également que la peur de la stigmatisation et des réactions négatives sont nommés par les personnes ayant de l'expérience vécue comme des facteurs importants les incitant à ne pas chercher de traitement. (Dockery et al., 2015). Comme le suggèrent les résultats du troisième article, passer d'une prise en charge en contexte hospitalo-centrique à des soins en communauté pourrait être perçu comme moins stigmatisant et moins hostile pour les personnes qui utilisent les services de santé mentale pour la première fois. Le modèle de Trieste pour les soins de santé mentale, avec son approche des « portes ouvertes » (Mezzina, 2014), peut inspirer d'autres systèmes de soins de santé. Au Québec, l'initiative des Aires ouvertes, où des points de services accueillent des jeunes de 12 à 25 ans gratuitement, sans rendez-vous et avec un horaire flexible, pourraient également être un modèle étendu à des populations adultes et aux besoins psychosociaux plus complexes, comme c'est le cas à Trieste.

Acceptabilité/Capacité à chercher des soins

Les résultats de nos deux premiers articles montrent que la vaste majorité des personnes déclarées NCR avaient cherché des soins dans les années précédant l'incident. Nos résultats du deuxième article indiquent que les personnes qui n'avaient pas cherché des soins en santé mentale étaient plus susceptibles de vivre avec de la famille ou des amis, de ne pas avoir de dossier criminel et de ne pas avoir de médecin de famille. Il est possible que ce résultat pointent indirectement vers les personnes dont l'incident menant à un verdict NCR concordait avec un premier épisode de symptômes – des personnes qui étaient plus susceptibles d'avoir une vie familiale stable, sans antécédents judiciaires (Crocker et al., 2018) – plutôt que de réelles barrières à la capacité à chercher des soins pour une prise en charge initiale.

Les données qualitatives ont fait ressortir que l'inacceptabilité des services est ressortie comme une barrière majeure à l'accès aux soins pour les personnes ayant déjà eu des contacts avec le système, et explique sans doute en grande partie les interruptions de services qui ont été remarquées dans le premier article. Bien qu'il y ait des recoupements majeurs étant donné la chronicité des troubles mentaux graves, avec la capacité à s'engager, nous discutons de la capacité à chercher ici lorsqu'il s'agit soit d'un premier épisode de soins, lorsqu'il s'agit de débuter un nouvel épisode de soins ou lorsqu'il s'agit d'un épisode de crise. La capacité à s'engager fait davantage référence à la capacité à se présenter aux rendez-vous de suivi ou à prendre la médication comme prescrite, et est discutée plus loin.

Trois barrières majeures sont ressorties : l'absence de mécanismes d'accès acceptables en période de crise, l'inadéquation des services en période de crise avec les besoins, ainsi que la crainte d'une expérience déshumanisante, stigmatisante et traumatique. Ces craintes étaient bien basées sur les expériences passées, remettant ainsi en question la qualité technique et relationnelle des soins précédemment reçus. Les implications pour cette barrière est donc discutée plus loin.

Absence de mécanismes d'accès acceptables en période de crise. Nos résultats soulignent l'importance de revoir les mécanismes d'accès pendant les crises. L'intervention de la police dans les crises de santé mentale est un obstacle à la recherche d'aide (Holt et al., 2023) et est perçue comme dangereuse par les aidants, tant pour eux-mêmes que pour leur proche. En effet, l'implication des policiers dans les crises de santé mentale est fortement associée à des blessures et à des décès parmi les utilisateurs de services (Baker et al., 2020; Saleh et al., 2018). En réponse à plusieurs incidents de violence policière lors de crises de santé mentale, des équipes d'intervention en cas de crise (CIT) ont été mises en place. Toutefois, ce modèle policier n'a pas permis de réduire efficacement les arrestations et le recours à la force, ni d'améliorer la résolution des appels de crise sur place par rapport aux services de police classiques (Marcus & Stergiopoulos, 2022). Par conséquent, on reconnaît de plus en plus la nécessité de s'éloigner du

164

modèle CIT et de soutenir le développement d'approches alternatives, fondées sur des preuves, qui donnent la priorité à l'expérience vécue par les utilisateurs de services (Marcus & Stergiopoulos, 2022). Les équipes civiles (non policières) d'intervention en santé mentale sont prometteuses en termes d'engagement dans les soins et de réduction de l'implication dans le système judiciaire, mais des études expérimentales supplémentaires sont nécessaires pour parvenir à des résultats concluants (Marcus & Stergiopoulos, 2022). Les modèles de co-répondants, où les prestataires de santé mentale sont intégrés dans une équipe de policiers pour répondre aux crises de santé mentale, les prestataires de santé mentale sont inclus dans une équipe de policiers, pourraient être réservés aux situations où il y a de sérieuses inquiétudes concernant la violence (Ghelani et al., 2023; Marcus & Stergiopoulos, 2022). Il existe de plus en plus de preuves en faveur de la réaffectation d'une partie du budget de la police à des programmes d'intervention d'urgence non policiers pour les crises de santé mentale non violentes, à condition qu'un triage adéquat soit effectué par un professionnel de la santé mentale afin de sélectionner le niveau de soutien approprié (Ghelani et al., 2023; Marcus & Stergiopoulos, 2022).

Inadéquation des services en période de crise avec les besoins. Ces équipes civiles pourraient également améliorer l'adéquation des services avec les besoins. Présentement, les participants font ressortir que les réponses sont souvent disproportionnées aux besoins. Alors que les besoins sont décrits comme « un p'tit break » (soit un moment pour se poser, recevoir un soutien rassurant, offrir aux proches un moment de sécurité et de répit), les réponses sont contreproductives et décrites comme « le gros kit » (soit gyrophares, menottes, hospitalisation involontaire, etc.). Des équipes civiles de réponse aux épisodes de crise pourraient répondre à ces besoins et offrir des recommandations à la famille et à la personne quant au niveau de soins requis – soit s'il est pertinent de se rendre aux urgences, s'il est pertinent d'appeler son équipe de soins pour prendre un rendez-vous, ou si la situation peut être résolue sur place. La mise en place d'un modèle communautaire de "portes ouvertes", comme celui de Trieste, offre

165

également la possibilité d'offrir ce moment de répit qui est demandé par les personnes ayant de l'expérience vécue. À Trieste, par exemple, le modèle est orienté sur des résidences non-hospitalières qui sont ouvertes 24h sur 24h, 7 jours sur 7 (Mezzina, 2014). Ce modèle permet effectivement d'offrir une zone de calme en situation de crise – près de la moitié des personnes qui font appel aux services de santé dans une période de crise profite d'une période « d'hospitalité » pour une moyenne de 7.9 jours (Mezzina & Vidoni, 1995). Ce séjour ne se fait pas en hôpital, mais plutôt dans cette résidence où sont situés les soins communautaires. Le modèle se traduit par des résultats positifs (World Health Organisation, 2021) en termes de fonctionnement en communauté (Kemali et al., 1989), de continuité des soins (Mezzina & Vidoni, 1995) et d'engagement dans les soins (Palcic et al., 2011), de résolution de crise (Mezzina et al., 2005), de réduction des idées délirantes (Fascì et al., 2018), de diminution du risque de suicide (Fascì et al., 2018) et de réduction des comportements hostiles (Fascì et al., 2018). Ces résultats encourageants sont à l'origine de la transformation du système de psychiatrie légale en Italie vers un modèle presqu'entièrement communautaire (Di Lorito et al., 2017; Ferracuti et al., 2019), modèle dont l'évaluation complète n'a pas encore été mené.

Disponibilité/Capacité à atteindre les soins

Les résultats de l'article 2 suggèrent que les facteurs géographiques peuvent jouer un rôle important dans la capacité à rejoindre les services de santé mentale. Spécifiquement, la proximité aux hôpitaux offrant des services de référence (dont des services de psychiatrie) et le nombre de médecins par capita influencent la probabilité de rejoindre les services. Les entretiens qualitatifs ont fait ressortir d'autres barrières : le temps d'attente hautement variable pour une évaluation et une prise en charge; des soins offerts dans des endroits excentrés, souvent difficiles d'accès; et l'organisation du système par programmes.

Temps d'attente hautement variable pour une évaluation et une prise en charge. Le temps d'attente hautement variable pour une prise en charge à travers le guichet d'accès en santé

mentale a été attribué par les participants à un manque de littéracie en santé mentale des omnipraticiens. Dans le deuxième article, nos analyses ont fait ressortir qu'avoir un médecin de famille multipliait par 3.6 fois les chances que l'on ait cherché des services, mais n'influait pas la probabilité de rejoindre les services spécialisés en santé mentale. Les difficultés pour les omnipraticiens à reconnaître les profils cliniques requérant une prise en charge psychiatrique à travers une demande au guichet d'accès en santé mentale et ceux pouvant être traités en première ligne ont été soulevés par plusieurs cliniciens et décideurs, avec pour effet d'allonger de façon importante les listes d'attente. Les omnipraticiens étant également responsables d'accorder une cote de priorité, cela crée une grande variabilité dans les délais d'attente et nuit au triage optimal. Deux fronts sont possibles pour répondre à cette faiblesse : 1) améliorer la littéracie en santé mentale des médecins; et 2) améliorer le triage pour une prise en charge en psychiatrie.

Une revue systématique s'est intéressée aux initiatives pour diminuer la durée d'un épisode psychotique non traité (Lloyd-Evans et al., 2011), dont des campagnes d'éducation des omnipraticiens. Ces campagnes impliquaient des présentations vidéo, la distribution de dépliants de façon à sensibiliser les omnipraticiens sur les premiers signes et symptômes des premiers épisodes de psychose afin de les encourager à référer rapidement aux services appropriés. Toutefois, ces études n'ont pas trouvé que ces campagnes entraînaient une réduction du temps avant une prise en charge psychiatriques, ni une augmentation du nombre d'usagers avec un premier épisode de psychose référés aux services (Lester et al., 2009; Power et al., 2007). Des efforts pour améliorer le triage sont donc nécessaires. Les cliniciens et les administrateurs rencontrés suggèrent qu'une évaluation initiale soit faite par un membre d'une équipe multidisciplinaire de façon à apposer une cote de priorité adéquate. Cela est par ailleurs cohérent avec les recommandations qui avaient été formulées en 2019 par l'Association des médecins psychiatres du Québec, avant la mise en place du Guichet d'accès en santé mentale (Association

des médecins psychiatres du Québec (AMPQ) & Centre national d'excellence en santé mentale (CNESM), 2019).

Soins offerts dans des endroits excentrés, souvent difficiles d'accès. Les cliniciens et les administrateurs font également ressortir que la distribution géographique des services sur le territoire peut être un frein à la disponibilité des services et donc à la capacité des usagers à atteindre les services. Il est toutefois à noter qu'aucune personne ayant de l'expérience vécue a fait ressortir la localisation géographique comme une barrière. Encore une fois, des modèles de prestation de services qui sont intégrés à la communauté, dans des services de proximité, sont à privilégier en opposition aux modèles hospitalo-centriques qui sont souvent situés de façon excentrée. Pour les usagers connus, une équipe mobile peut également contribuer à réduire les barrières liées au transport et à la mobilité.

Organisation du système par programme. La plus grande barrière à l'atteinte des services, qui est nommée de façon unanime par tous les acteurs rencontrés dans les entretiens, est l'organisation du système de santé par programme ou par « silos ». À court terme, il apparaît nécessaire de mettre en œuvre une solution « palliative » en attendant que de réels changements structurels soient mis en place. Cette solution palliative pourrait passer à travers une cartographie des services qui serait rendue disponible aux utilisateurs, aux intervenants et aux proches par une instance qui a un portrait d'ensemble et qui peut aiguiller usagers, intervenants, proches vers les ressources adéquates. En parallèle, des solutions structurelles qui répondent aux barrières qui se situent au niveau du prestataire et du système doivent être mises en place. Dans un premier temps, l'organisation du système par programme promeut la multiplication des critères d'exclusion basés sur les diagnostics, qui n'est pas aligné avec les besoins des usagers dont les longues trajectoires de soins se traduisent bien souvent par l'accumulation de diagnostics concomitants. Différentes croyances de la part des prestataires (Wakida et al., 2018) sur des diagnostics – comme ceux liés à l'usage de substances ou aux troubles de la personnalité – peuvent freiner l'intégration des services. Des parcours de formation en silos, par discipline, avec

168

des paradigmes radicalement différents (psychiatres vs. travailleurs sociaux, p. ex.) peuvent également contribuer au manque de transversalité dans les services (Rhodes et al., 2016). Les modèles de soins partagés sont également une avenue intéressante. Il s'agit d'une structure visant à intégrer les soins entre différents prestataires et services, à tous les niveaux de spécialisation. Ils permettent de créer une entente sur la nature des soins et les responsabilités de chaque prestataire, tant du côté communautaire que du côté hospitalier (B. J. Kelly et al., 2011; Lester, 2005). Pour mettre en place un tel modèle de soins partagés, plusieurs éléments clés doivent être pris en compte. Tout d'abord, il est important d'utiliser un modèle de traitement éprouvé et fondé sur des données probantes. Ensuite, il est nécessaire d'obtenir un consensus entre les prestataires de soins sur le cheminement clinique à suivre et de surveiller les résultats obtenus. Il est également important de veiller aux ressources humaines et cliniques nécessaires pour mettre en œuvre ce cheminement clinique. Pour cela, un soutien au développement des capacités cliniques et au maintien du modèle de traitement est essentiel. Enfin, un modèle de gouvernance clinique bien établi est indispensable pour assurer la qualité et la continuité des soins (Byng et al., 2008; B. J. Kelly et al., 2011). Contrairement à la littérature sur les modèles de soins partagés pour les usagers ayant des troubles anxieux ou dépressifs, la littérature examinant les résultats de ce modèle chez les personnes ayant des troubles mentaux graves est plus mince, bien que prometteuse (B. J. Kelly et al., 2011).

Pertinence/Capacité à s'engager dans les soins

Les barrières liées à la pertinence et à la capacité à s'engager dans les soins identifiées dans le cadre de cette thèse sont nombreuses. On identifie principalement : l'expérience répétée d'interactions déshumanisantes, stigmatisantes et traumatiques au sein du système de santé, l'inflexibilité du système par rapport aux besoins et aux capacités de ses usagers, un manque de soutien aux proches aidants, le manque d'expertise en prévention de la violence, ainsi que le refus implicite et systémique d'adhérer aux principes de rétablissement en faveurs d'approches biomédicales et coercitives.

Expérience répétée d'interactions déshumanisantes, stigmatisantes et traumatiques au sein du système de santé. Il est urgent de s'attaquer à l'expérience répétée d'interactions négatives entre les usagers de services de santé mentale et les prestataires de soins. En effet, selon les personnes ayant de l'expérience vécue, il s'agit de la principale barrière à l'engagement dans les soins et à la recherche de services lors d'un nouvel épisode ou d'une période de crise. La formation anti-stigmatisation devrait être une priorité pour les professionnels de la santé actuels et futurs (Agrawal et al., 2016; Knaak et al., 2017; Maranzan, 2016; Pettigrew & Tropp, 2006). La véritable efficacité de telles mesures nécessite des changements culturels au sein d'une organisation (Sukhera & Knaak, 2022), ce qui indique qu'il peut être stratégique de cibler les cliniciens et les administrateurs qui ont un grand réseau d'influence informelle (Charette et al., 2021). Une recension des écrits a révélé que le démantèlement de la stigmatisation structurelle en santé mentale dans les milieux de soins de santé nécessitait un changement de culture, où l'organisation était prête pour la perturbation et un changement de paradigme, avec des valeurs alignées entre différents partenaires (Sukhera & Knaak, 2022). Il est également important de surveiller systématiquement ces résultats dans nos services en tant qu'indicateur de performance, en utilisant des données collectées de manière routinière et des enquêtes auprès des personnes ayant des expériences vécues et des prestataires de services (Livingston, 2021). Cette approche peut également être intégrée dans les processus d'amélioration de la qualité pour identifier et suivre systématiquement la stigmatisation structurelle. Un exemple de cela est le National Stigma Report Card en Australie, qui intègre différentes échelles validées sur la stigmatisation pour formuler des indicateurs (Groot et al., 2020). Un moment pour le faire pourrait être lors de l'agrément, un processus par lequel les organismes évaluent leurs services et en améliorent la qualité de façon à ce qu'elles répondent à des normes nationales établies.

Inflexibilité du système par rapport aux besoins et aux capacités de ses usagers. L'inflexibilité du système de santé mentale par rapport aux besoins et aux capacités de ses usagers est une préoccupation importante et nuit à la continuité des soins et à l'adhérence. Pour répondre

à ce problème, il est nécessaire de développer la tolérance du système et de ses prestataires de soins envers ce qu'un de nos participants a appelé « les éléments délictuels » des usagers – les retards, les oublis de rendez-vous, la non-possession d'une carte d'assurance maladie, ainsi que les manifestations d'impatience ou de frustration. Le milieu d'intervention en itinérance possède des savoirs qu'il pourrait être intervention de partager avec le milieu de la santé mentale. Le Centre de recherche de Montréal sur les inégalités sociales (mieux connu sous son acronyme CREMIS) a développé une boîte à outils pour les intervenants comprenant des récits de pratique pour distinguer les comportements dérangeants de ceux dangereux (Hurtubise & Rose, 2013).

Pour trouver des modèles de soins plus flexibles, nous pouvons nous inspirer du modèle de Trieste pour les soins de santé mentale, avec son approche "Porte ouverte - Sans contrainte" (Frances, 2021; Mezzina, 2014; Mezzina & Vidoni, 1995; Sashidharan, 2022). Ce modèle offre des soins holistiques centrés sur la personne et la famille de manière fondamentalement transdiagnostique (sans critères d'exclusion), basée sur la communauté (très peu de soins hospitaliers), flexible et mobile, et favorise la continuité des soins. Au cœur de ce modèle, on trouve des centres de santé mentale communautaires (résidences non hospitalières) qui sont gérés 24 heures sur 24 par des équipes multidisciplinaires travaillant en étroite collaboration avec une unité psychiatrique d'un hôpital général, des installations de logement avec soutien, ainsi que des entreprises sociales (Mezzina, 2014). En soutenant des partenariats thérapeutiques solides, l'autonomisation et l'amélioration du réseau social, ce modèle donne un taux de conformité aux médicaments antipsychotiques de 75 % (Palcic et al., 2011), soit presque deux fois plus élevé que dans d'autres systèmes (García et al., 2016). Il y a également des données croissantes indiquant que, comme le suggèrent plusieurs de nos participants, la mise en œuvre d'approches d'autonomisation est la meilleure stratégie pour nourrir la relation thérapeutique et engager le patient dans les soins de santé à long terme (Shepherd et al., 2016). Ces stratégies d'autonomisation peuvent prendre la forme de directives anticipées ou de plans de crise conjoints

(Cournos & Goldfinger, 2009; Henderson et al., 2009; Swanson et al., 2008; Tinland et al., 2019) et de prise de décision partagée (Pérez-Revuelta et al., 2023).

Manque de soutien aux proches aidants. Les résultats soulignent l'importance de fournir un soutien aux proches qui jouent un rôle critique dans l'engagement dans les soins. Une méta-synthèse de la littérature sur les expériences des aidants familiaux en santé mentale légale a montré que prendre soin de leur proche représente un grand fardeau de responsabilité qui prend toute leur vie (Vestphal et al., 2023). Comme dans nos résultats, la collaboration entre les aidants familiaux et les prestataires de services est décrite comme difficile et ponctuée de négociations constantes et d'actions de plaidoyer (Vestphal et al., 2023). Leur exclusion systémique de l'équipe de soins peut être due à des obstacles au niveau du système, tels que les lois sur la confidentialité, mais il existe également des obstacles au niveau des prestataires, comme l'a montré une étude qualitative en Suède où les professionnels de santé ont perçu la plupart des comportements des aidants familiaux comme "gênants" (Hörberg et al., 2015). Peu d'interventions ont été mises en place pour soutenir les familles en santé mentale légale (Gatherer et al., 2020). Il conviendrait de poursuivre les travaux dans ce domaine pour voir comment les familles peuvent être soutenues au mieux, notamment en co-créant avec les personnes ayant une expérience vécue des programmes de renforcement des capacités pour les prestataires de services, grâce à une approche familiale et intersectorielle. Les présents résultats font ressortir que les proches aidants souhaitent bénéficier du soutien d'un intervenant pivot apte à transmettre des informations cliniques, ce qui peut requérir des directives anticipées de traitement (Swanson et al., 2008; Tinland et al., 2019). La littérature indique également un besoin d'éducation et de sensibilisation des prestataires de soins sur les bénéfices d'impliquer les familles (Hörberg et al., 2015) ainsi que sur les lois sur la confidentialité (Morin et al., 2021). Les modèles pairs aidants famille sont également une avenue prometteuse à explorer.

172

Le manque d'expertise en prévention de la violence. La recherche met en évidence le manque d'expertise et d'investissements en matière de prévention de la violence dans le système de santé. Cela est reflété, entre autres, par le fait qu'une personne NCR sur cinq a commis son délit dans la semaine suivant son dernier contact avec les services de santé mentale. Les ressources sont actuellement concentrées dans les services de santé mentale légale hautement spécialisés, qui ne sont accessibles qu'après la commission d'une infraction. Pour répondre aux besoins des patients atteints de troubles mentaux graves et de comportements agressifs de manière plus rapide, il est nécessaire d'envisager une approche proactive plutôt que réactive. Actuellement, l'expertise et les investissements en prévention de la violence et de la criminalité sont concentrés dans des services de santé mentale forensique hautement spécialisés, qui ne sont accessibles aux usagers qu'après un acte criminel. Les services de santé mentale forensique sont traditionnellement conçus comme un système de soins tertiaires, mais il y a un argument à faire pour un continuum de soins équilibré, avec des services communautaires de faible intensité (Crocker et al., 2017, 2022). Cela nécessiterait de partager les connaissances en amont et d'offrir une formation supplémentaire aux médecins généralistes, aux infirmières et aux psychiatres, particulièrement en termes de gestion du risque. Les participants ont suggéré que la formation continue, à travers le mentorat par les pairs et les communautés de pratique, où les experts en médecine légale partagent leurs connaissances avec les généralistes et discutent de cas réels, seraient des stratégies idéales. Nos résultats mettent en évidence l'opportunité d'une plus grande implication des intervenants des soins primaires et des services de psychiatrie générale dans la prévention d'un passage à l'acte et d'une judiciarisation subséquente. Il est nécessaire de mener une enquête approfondie sur les stratégies visant à les impliquer et à les soutenir dans ce rôle clé.

Des équipes mobiles, désectorialisées et spécialisées en prévention de la violence ont été fortement souhaitées par plusieurs participants de notre étude, qui estiment que ces équipes peuvent offrir la flexibilité, la réactivité et la coordination nécessaires aux usagers de services ayant des besoins élevés et complexes. La mise en place de telles équipes pourrait jouer un rôle

crucial dans la prévention de la violence et la réduction de l'implication du système de justice, à condition qu'elles puissent identifier efficacement les individus à risque de ces résultats. Étant donné que près de la moitié des personnes ayant un verdict de NCRMD avaient un antécédent de contact avec la justice pénale, il y a une opportunité de mettre en place des équipes de suivi intensif dans la communauté qui intègrent les connaissances forensiques (*Forensic Assertive Community Treatment*) (Goulet et al., 2021; Lamberti & Weisman, 2021). Ces équipes de traitement communautaire assertives en milieu judiciaire peuvent également être offertes aux personnes ayant des troubles mentaux graves qui ne sont pas impliquées dans le système judiciaire mais qui sont considérées à risque de violence ou d'implication dans le système judiciaire. En effet, les interventions doivent être alignées sur les besoins des usagers plutôt que sur leur statut juridique.

Limites

La thèse comporte certaines limites. De prime à bord, la nature des données utilisées pour les deux premiers articles, soit des données administratives datant d'une vingtaine d'années, limite la portée des conclusions qu'il est possible de tirer. Dans un premier temps, ces données se limitent aux services offerts par des médecins, omnipraticiens ou spécialistes, et omettent les services psychosociaux qui peuvent jouer un rôle clé dans l'évaluation et la prise en charge des personnes qui ont des troubles mentaux graves. Dans un deuxième temps, ces données datent d'une vingtaine d'années – les résultats doivent donc être interprétés à la lumière des changements apportés au système de santé dans les dernières années. Cela dit, les principales conclusions – comme le fait que les familles peuvent malgré elles freiner l'accès aux services en se substituant à des services perçus comme stigmatisants ou inefficaces – ont pu être validées par les résultats qualitatifs. La disponibilité des données administratives en santé a également limité l'analyse aux données issues du Québec. Comme discuté dans l'introduction, le Québec est une juridiction unique au Canada lorsqu'il s'agit de l'application du verdict de NCRTM. Certains

résultats pourraient donc ne pas être généralisables ailleurs au Canada. L'article qualitatif comporte également certaines limites, dont l'absence d'entrevues avec des personnes ayant récemment reçu un verdict de NCRTM. De plus, l'échantillon de convenance limite la possibilité de généraliser les résultats. La saturation n'a également pas été atteinte dans certains sous-groupes, comme les administrateurs seniors. Étant donné le faible nombre de participants potentiels œuvrant dans le milieu, il n'a pas été possible de recruter davantage de participants dans ce sous-groupe.

Tableau 1. – *Principales barrières à l'accès identifiées et recommandations*

Barrières	Solutions potentielles		
	Usager/Populationnel	**Prestataire**	**Système**
Accessibilité et capacité à percevoir des besoins et souhaiter des soins			
Manque de littéracie en santé mentale	• Accroître la visibilité des troubles mentaux graves dans les campagnes de déstigmatisation et de sensibilisation.		
Volonté d'éviter l'étiquette « maladie mentale »			• Adopter des modèles alternatifs et moins stigmatisants, en communauté.
Acceptabilité/Capacité à chercher des soins			
Absence de mécanismes d'accès acceptables en période de crise			• Réduire l'implication des services policiers dans la réponse de crise de santé mentale en faveur des équipes civiles ou de co-répondants si le niveau de risque l'exige.
Inadéquation des services en période de crise avec les besoins			• Implanter des réponses de crise de santé mentale incluant des intervenants. • Implanter un modèle communautaire de « portes ouvertes ».
Disponibilité/Capacité à atteindre les soins			

Temps d'attente hautement variable pour une évaluation et une prise en charge	• Accroître la formation des omnipraticiens quant aux troubles mentaux graves.	• Améliorer le triage pour une prise en charge en psychiatrie, par exemple par une évaluation multidisciplinaire pour établir une cote de priorisation.
Soins offerts dans des endroits excentrés, difficiles d'accès		• Implanter des modèles de services en communauté. • Pour les usagers connus, implanter des équipes mobiles.
Organisation par programmes	• Accroître la formation transdisciplinaire des prestataires et leur formation sur les principaux diagnostics concomitants.	• Créer des ressources qui ont une connaissance de tout l'écosystème pour l'aiguillage. • Implanter des modèles de soins partagés.
Coût abordable/Capacité à payer pour les soins		
L'État délègue aux familles la responsabilité des soins quotidiens		• Accroître la disponibilité des ressources de soutien à domicile. • Accroître le nombre de places en ressources intermédiaires et en appartements supervisés.

Pertinence/Capacité à s'engager dans les soins		
Expérience répétée d'interactions déshumanisantes, stigmatisantes et traumatiques	• Formation anti-stigmatisation pour les prestataires	• Intégration d'indicateurs liés au stigma lors du processus d'agrément des établissements
Inflexibilité du système par rapport aux besoins et aux capacités de ses usagers	• Bâtir la tolérance envers les retards, oublis, manifestations de frustration en s'inspirant des pratiques en itinérance	• Implanter un modèle de soins flexible, comme celui de Trieste • Maximiser les stratégies d'autonomisation
Absence de soutien aux proches aidants	• Sensibilisation des prestataires quant aux bénéfices d'impliquer les familles • Éducation sur les lois sur la confidentialité	• Intervenant pivot apte à transmettre des informations cliniques • Directives anticipées de traitement • Explorer le potentiel du pair aidant famille
Le manque d'expertise en prévention de la violence	• Formation continue des prestataires à travers le mentorat par les pairs et	• Équipes mobiles spécialisées en prévention de la violence

Conclusion

Peu d'enjeux liés à la santé mentale suscitent autant d'intérêt public et médiatique, et génèrent autant de controverses, que les événements tragiques où des personnes vivant avec des troubles mentaux graves entrent en contact avec le système de justice. Tristement, la situation liée à la pandémie de la COVID-19 a exacerbé ces enjeux, entraînant une fragilisation accrue de certains groupes et une dégradation de l'accessibilité aux services (Newbronner et al., 2022). En date du dépôt de la thèse, cinq parricides (meurtre du père ou de la mère) pour lesquels l'on soupçonne une personne ayant un problème grave de santé mentale ont eu lieu sur le territoire de Montréal depuis le début de l'année 2023.

Les termes « violence » et « santé mentale » nous amènent bien souvent à regarder du côté de la violence commise par les personnes ayant un trouble mental. Bien que cet enjeu soit important, il fait souvent ombre à un phénomène de violence beaucoup plus pernicieux.

Les personnes qui vivent avec un trouble mental sont l'objet tout au long de leur vie d'une violence institutionnelle qui fait l'objet de trop peu de recherche. Cette thèse met en lumière le rôle du système de santé mentale dans l'expression de cette violence. Dans un texte précurseur, John Galtung définissait la violence comme étant « la cause de la différence entre le potentiel et le réel » (traduction libre, 1969, p. 168). Le stigma structurel envers les personnes ayant des troubles mentaux au sein du système de santé amenuise leurs opportunités de recevoir des soins adéquats et basés sur des données probantes, d'être traités avec respect et humanité, de se rétablir et de s'épanouir.

Dans la très grande majorité des cas, la violence chez les personnes vivant avec un trouble mental n'est pas attribuable à la maladie elle-même, mais plutôt à la façon dont la société traite ces personnes et interprète leur comportements (Kelly, 2005). Elle est une conséquence de la façon dont nous décidons collectivement de traiter la différence et de punir les personnes qui s'éloignent de ce qui est considéré comme la norme, incluant dans nos systèmes de santé et de services sociaux. En d'autres mots, elle est la conséquence de la violence structurelle envers les personnes qui dérangent.

Prévenir la violence doit reposer sur des politiques diminuant les stigmatisations structurelle et sociale vécues par plusieurs membres de notre société, dont les personnes ayant un trouble mental. Cette stigmatisation se manifeste dans les interactions sociales, dans la discrimination vécue auprès des services sociaux et de santé, dans un manque d'attention aux demandes d'aide et dans notre difficulté à repenser les services. La stigmatisation est une barrière à l'accès aux ressources vitales, dont un emploi stimulant, des activités porteuses de sens et un réseau social solide, qui permettent de s'épanouir au sein d'une communauté. Il faut donc offrir des contextes de vie adéquats, dont des logements abordables et un revenu offrant un minimum de dignité. L'inclusion sociale est un rempart contre la violence.

Références bibliographiques

Agrawal, S., Capponi, P., López, J., Kidd, S., Ringsted, C., Wiljer, D., & Soklaridis, S. (2016). From surviving to advising: A novel course pairing mental health and addictions service users as advisors to senior psychiatry residents. *Academic Psychiatry*, *40*(3), 475–480. https://doi.org/10.1007/s40596-016-0533-z

Ambrosini, D. L., & Joncas, L. (2013). Civil commitment: A cross Canada checkup. In R. D. Schneider & H. Bloom (Eds.), *Law and Mental Disorder: A Comprehensive and Practical Approach* (pp. 1029–1061). Irwin Law.

Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior*, *36*(1), 1–10.

Andersen, R. M. (2008). National health surveys and the behavioral model of health services use. *Medical Care*, *46*(7), 647–653. https://doi.org/10.1097/MLR.0b013e31817a835d

Andersen, R. M., & Davidson, P. L. (2007). Improving Access to Care in America: Individual and Contextual Indicators. In R. M. Andersen, T. H. Rice, & G. F. Kominski (Eds.), *Changing the US Health Care System: Key Issues in Health Services Policy and Management* (3rd editio, pp. 3–31). Jossey-Bass. https://www.researchgate.net/publication/237675193_Improving_access_to_care_in_America_individual_and_contextual_indicators

Arseneault, L., Moffitt, T. E., Caspi, A., Taylor, P. J., & Silva, P. A. (2000). Mental disorders and violence in a total birth cohort: Results from the Dunedin Study. *Archives of General Psychiatry*, *57*(10), 979. https://doi.org/10.1001/archpsyc.57.10.979

Association des médecins psychiatres du Québec (AMPQ), & Centre national d'excellence en santé mentale (CNESM). (2019). *Guide GASMA*.

Baker, D., Pillinger, C., & Baker, D. (2020). *' If You call 911 they are going to kill me ': families ' experiences of mental health and deaths after police contact in the United States mental*

health and deaths after police contact in the United States.
https://doi.org/10.1080/10439463.2019.1581193

Bandara, S. N., Daumit, G. L., Kennedy-Hendricks, A., Linden, S., Choksy, S., & McGinty, E. E. (2018). Mental health providers' attitudes about criminal justice–Involved clients with serious mental illness. *Psychiatric Services*, *69*(4), 472–475. https://doi.org/10.1176/appi.ps.201700321

Brennan, P. A., Mednick, S. A., & Hodgins, S. (2000). Major mental disorders and criminal violence in a Danish birth cohort. *Archives of General Psychiatry*, *57*(5), 494–500. https://doi.org/10.1001/archpsyc.57.5.494

Butler, A., Nicholls, T., Samji, H., Fabian, S., & Lavergne, M. R. (2022). Prevalence of Mental Health Needs, Substance Use, and Co-occurring Disorders Among People Admitted to Prison. *Psychiatric Services (Washington, D.C.)*, *73*(7), 737–744. https://doi.org/10.1176/appi.ps.202000927

Byng, R., Norman, I., Redfern, S., & Jones, R. (2008). Exposing the key functions of a complex intervention for shared care in mental health: Case study of a process evaluation. *BMC Health Services Research*, *8*, 1–10. https://doi.org/10.1186/1472-6963-8-274

Calderon, V., Cain, R., Torres, E., & Lopez, S. R. (2022). Evaluating the message of an ongoing communication campaign to reduce the duration of untreated psychosis in a Latinx community in the United States. *Early Intervention in Psychiatry*, *16*(2), 147–152. https://doi.org/10.1111/eip.13140

Canadian Mental Health Association. (2018). *Ending the healthcare disparity in Canada*. *September*, 24. www.cmha.ca

Carr, V. J., Johnston, P. J., Lewin, T. J., Rajkumar, S., Carter, G. L., & Issakidis, C. (2003). Patterns of service use among persons with schizophrenia and other psychotic disorders. *Psychiatric*

Services, *54*(2), 226–235. https://doi.org/10.1176/appi.ps.54.2.226

Cavney, J., Skipworth, J., Madell, D., & McKenna, B. (2012). Patterns of mental health service contact before and after forensic mental health contact in New Zealand. *Australasian Psychiatry*, *20*(3), 225–227. https://doi.org/10.1177/1039856212437258

Charette, Y., Crocker, A. G., & Billette, I. (2014). Police Encounters Involving Citizens With Mental Illness: Use of Resources and Outcomes. *Psychiatric Services*, *65*(4), 511–516. https://doi.org/10.1176/appi.ps.201300053

Charette, Y., Goossens, I., Seto, M. C., Nicholls, T. L., & Crocker, A. G. (2021). Is Knowledge Contagious? Diffusion of Violence-Risk-Reporting Practices Across Clinicians' Professional Networks. *Clinical Psychological Science*, *9*(2), 284–293. https://doi.org/10.1177/2167702620954797

Code criminel canadien. (1992). *L.R.C. C-46*.

Commaille, J., & Dumoulin, L. (2009). Heurs et malheurs de la légalité dans les sociétés contemporaines. Une sociologie politique de la "judiciarisation." *L'Année Sociologique*, *59*, 63–107.

Copeland, D. A., & Heilemann, M. V. (2011). Choosing "the best of the hells": Mothers face housing dilemmas for their adult children with mental illness and a history of violence. *Qualitative Health Research*, *21*(4), 520–533. https://doi.org/10.1177/1049732310387936

Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014). The impact of mental illness stigma on seeking and participating in mental health care. *Psychological Science in the Public Interest, Supplement*, *15*(2), 37–70. https://doi.org/10.1177/1529100614531398

Cournos, F., & Goldfinger, S. M. (2009). From psychiatric advance directives to the joint crisis plan. *Psychiatric Services*, *60*(10), 1390–1391. https://doi.org/10.1176/appi.ps.72601

Crocker, A. G., Kahlaoui, K., Luigi, M., & Leclair, M. (2023). Troubles mentaux et comportements violents. In *Manuel de réadaptation psychiatrique 3e édition* (pp. 647–676). Presses de l'Université du Québec.

Crocker, A. G., Leclair, M. C., Bélanger, F. A., & Livingston, J. (2022). Survol de l'organisation des services de santé mentale forensique à travers le monde : vers un modèle hiérarchisé-équilibré. *Santé Mentale Au Québec*, *47*(1), 181. https://doi.org/10.7202/1094150ar

Crocker, A. G., Livingston, J. D., & Leclair, M. C. (2017). Forensic mental health systems internationally. In R. Roesch & A. N. Cook (Eds.), *Handbook of Forensic Mental Health Services* (pp. 3–76). Routledge.

Crocker, A. G., Martin, M. S., Leclair, M. C., Seto, M. C., & Nicholls, T. L. (2018). Expanding the early and late starter model of criminal justice involvement for forensic mental health clients. *Law and Human Behavior*, *42*(1), 83–93. https://doi.org/10.1037/lhb0000269

Crocker, A. G., Nicholls, T. L., Seto, M. C., Charette, Y., Côté, G., & Caulet, M. (2015). The National Trajectory Project of individuals found Not Criminally Responsible on Account of Mental Disorder in Canada. Part 2 - The people behind the label. *Canadian Journal of Psychiatry*, *60*(3), 106–116. https://doi.org/10.1177/070674371506000305

Crocker, A. G., Nicholls, T. L., Seto, M. C., & Côté, G. (2015). The National Trajectory Project of Individuals found Not Criminally Responsible on Account of Mental Disorder in Canada. Part 2: The People behind the Label. *Canadian Journal of Psychiatry*, *60*(3), 106–116.

Crocker, A. G., Nicholls, T. L., Seto, M. C., Côté, G., Charette, Y., & Caulet, M. (2015). The National Trajectory Project of individuals found Not Criminally Responsible on Account of Mental Disorder in Canada. Part 1 - Context and methods. *Canadian Journal of Psychiatry*, *60*(3), 95–105.

Cusack, K. J., Morrissey, J. P., Cuddeback, G. S., Prins, A., & Williams, D. M. (2010). Criminal justice

involvement, behavioral health service use, and costs of forensic assertive community treatment: A randomized trial. *Community Mental Health Journal*, *46*(4), 356–363. https://doi.org/10.1007/s10597-010-9299-z

Cutcliffe, J. R., & Riahi, S. (2013). Systemic perspective of violence and aggression in mental health care: Towards a more comprehensive understanding and conceptualization: Part 1. *International Journal of Mental Health Nursing*, *22*(6), 558–567. https://doi.org/10.1111/inm.12029

Davison, S. E. (2005). The management of violence in general psychiatry. *Advances in Psychiatric Treatment*, *11*(5), 362–370. https://doi.org/10.1192/apt.11.5.362

De Hert, M., Correll, C. U., Bobes, J., Cetkovich-Bakmas, M., Cohen, D. A. N., Asai, I., Detraux, J., Gautam, S., Möller, H. J., Ndetei, D. M., Newcomer, J. W., Uwakwe, R., & Leucht, S. (2011). Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry*, *10*(1), 52–77. https://doi.org/10.1002/j.2051-5545.2011.tb00014.x

Deveaux, F., Lemieux, A. J., Beauchamp, É., Goulet, M.-H., & Crocker, A. G. (2018). A scoping review of prearrest diversion programs for individuals with mental illness. *Poster Session Presented at the Annual International Association of Forensic Mental Health Services Conference*.

Di Lorito, C., Castelletti, L., Lega, I., Gualco, B., Scarpa, F., & Völlm, B. (2017). The closing of forensic psychiatric hospitals in Italy: Determinants, current status and future perspectives. A scoping review. *International Journal of Law and Psychiatry*, *55*, 54–63. https://doi.org/10.1016/j.ijlp.2017.10.004

Dockery, L., Jeffery, D., Schauman, O., Williams, P., Farrelly, S., Bonnington, O., Gabbidon, J., Lassman, F., Szmukler, G., Thornicroft, G., & Clement, S. (2015). Stigma- and non-stigma-

related treatment barriers to mental healthcare reported by service users and caregivers. *Psychiatry Research*, *228*(3), 612–619. https://doi.org/10.1016/j.psychres.2015.05.044

Donabedian, A. (1973). *Aspects of Medical Care Administration*. Harvard University Press.

Dumais, A., Côté, G., Larue, C., Goulet, M.-H., & Pelletier, J.-F. (2014). Clinical characteristics and service use of incarcerated males with severe mental disorders: A comparative case-control study with patients found not criminally responsible. *Issues in Mental Health Nursing*, *35*(8), 597–603. https://doi.org/10.3109/01612840.2013.861885

Estroff, S. E. (1981). *Making it Crazy: An Ethnography of Psychiatric Clients in an American Community*. University of California Press.

Fascì, A., Botter, V., Pascolo-Fabrici, E., Wolf, E., & Mezzina, R. (2018). Il progetto di cura personalizzato orientato alla recovery. Studio di follow up a 5 anni su persone con bisogni complessi a Trieste. *Nuova Rassegna Di Studi Psichiatrici.*, *16*.

Fazel, S., & Danesh, J. (2002). Serious mental disorder in 23 000 prisoners: A systematic review of 62 surveys. *The Lancet*, *359*, 545–550. https://doi.org/10.1016/S0140-6736(02)07740-1

Fazel, S., Langström, N., Hjern, A., Grann, M., & Lichtenstein, P. (2009). Schizophrenia, substance abuse, and violent crimes. *JAMA*, *301*(19), 2016–2023.

Fazel, S., Smith, E. N., Chang, Z., & Geddes, J. R. (2018). Risk factors for interpersonal violence: an umbrella review of meta-analyses. *British Journal of Psychiatry*, *213*(4), 609–614. https://doi.org/10.1192/bjp.2018.145

Ferracuti, S., Pucci, D., Trobia, F., Alessi, M. C., Rapinesi, C., Kotzalidis, G. D., & Del Casale, A. (2019). Evolution of forensic psychiatry in Italy over the past 40 years (1978–2018). *International Journal of Law and Psychiatry*, *62*, 45–49. https://doi.org/10.1016/j.ijlp.2018.10.003

Fleury, M.-J., & Grenier, G. (2004). Historique et enjeux du système de santé mentale québécois. *Rupture*, *10*(1), 21–38.

Fleury, M.-J., Grenier, G., Bamvita, J., & Caron, J. (2014). Determinants and patterns of service utilization and recourse to professionals for mental health reasons. *BMC Health Services Research*, *14*(161), 1–14.

Fleury, M.-J., Grenier, G., Bamvita, J. M., & Caron, J. (2011). Mental health service utilization among patients with severe mental disorders. *Community Mental Health Journal*, *47*(4), 365–377. https://doi.org/10.1007/s10597-010-9320-6

Fleury, M.-J., Grenier, G., Bonin, J.-P., Collaborateurs, E., Clément, M., Nadeau, L., Rousseau, C., Renaud, J., Dumitrescu, L., Whitley, R., Nieuwenhuyse, H. Van, Bélanger, J.-F., Dumas, M.-E., Bélanger, S., Guay, P., Édition, G., Labbé, A.-M., & Fortin, M.-A. (2012). *État de la situation sur la santé mentale au Québec et réponse du système de santé et de services sociaux*.

Frances, A. (2021). Save Trieste's mental health system. *The Lancet Psychiatry*, *8*(9), 744–746. https://doi.org/10.1016/S2215-0366(21)00252-2

Frenk, J. (1992). Concept and measurement of accessibility. In K. White, J. Frenk, C. Ordonez, J. Paganini, & B. Starfield (Eds.), *Health Services Research: An Anthology* (pp. 842–855). Pan American Health Organization.

Galtung, J. (1969). Violence, peace and peace research. *Journal of Peace Research*, *6*(3), 167–191.

Gannon, M. (2006). Crime statistics in Canada, 2005. In *Juristat: Canadian Centre for Justice Statistics* (Vol. 26, Issue 4).

García, S., Martínez-Cengotitabengoa, M., López-Zurbano, S., Zorrilla, I., López, P., Vieta, E., & González-Pinto, A. (2016). Adherence to antipsychotic medication in bipolar disorder and schizophrenic patients. In *Journal of Clinical Psychopharmacology* (Vol. 36, Issue 4, pp. 355–

371). https://doi.org/10.1097/JCP.0000000000000523

Gatherer, C., Dickson-Lee, S., & Lowenstein, J. (2020). The forgotten families; a systematic literature review of family interventions within forensic mental health services. *Journal of Forensic Psychiatry and Psychology*, *31*(6), 823–836. https://doi.org/10.1080/14789949.2020.1799054

Gelberg, L., Andersen, R. M., & Leake, B. D. (2000). The Behavioral Model for Vulnerable Populations: Application to Medical Care Use and Outcomes for Homeless People. *HSR: Health Services Research*, *34*(6), 1273–1302. https://doi.org/10.1016/0277-9536(92)90304-9

Ghelani, A., Douglin, M., & Diebold, A. (2023). Effectiveness of Canadian police and mental health co-response crisis teams: A scoping review. *Social Work in Mental Health*, *21*(1), 86–100. https://doi.org/10.1080/15332985.2022.2074283

Goulet, M.-H., Dellazizzo, L., Lessard-Deschênes, C., Lesage, A., Crocker, A. G., & Dumais, A. (2021). Effectiveness of Forensic Assertive Community Treatment on Forensic and Health Outcomes: A Systematic Review and Meta-Analysis. *Criminal Justice and Behavior*, 1–15. https://doi.org/10.1177/00938548211061489

Gronfein, W. (1985). Psychotropic Drugs and the Origins of Deinstitutionalization. *Social Problems*, *32*(5), 437–454. https://doi.org/10.2307/800774

Groot, C., Rehm, I., Andrews, C., Hobern, B., Morgan, R., Green, H., Sweeney, L., & Blanchard, M. (2020). National Stigma Report Card: Report on Findings from the Our Turn to Speak Survey - Understanding the Impact of Stigma and Discrimination on People Living with Complex Mental Health Issues. *Anne Deveson Research Centre, SANE Australia*, 1–385. https://www.nationalstigmareportcard.com.au/data/legal

Hamilton, S., Lewis-Holmes, E., Pinfold, V., Henderson, C., Rose, D., & Thornicroft, G. (2014).

Discrimination against people with a mental health diagnosis: Qualitative analysis of reported experiences. *Journal of Mental Health*, *23*(2), 88–93. https://doi.org/10.3109/09638237.2014.880408

Hébert, G., Sully, J.-L., & Nguyen, M. (2017). *L'allocation des ressources pour la santé et les services sociaux au Québec: État de la situation et propositions alternatives*.

Henderson, C., Flood, C., Leese, M., Thornicroft, G., Sutherby, K., & Szmukler, G. (2009). Views of service users and providers on joint crisis plans. *Social Psychiatry and Psychiatric Epidemiology*, *44*(5), 369–376. https://doi.org/10.1007/s00127-008-0442-x

Henderson, C., Noblett, J., Parke, H., Clement, S., Caffrey, A., Gale-Grant, O., Schulze, B., Druss, B., & Thornicroft, G. (2014). Mental health-related stigma in health care and mental health-care settings. *The Lancet Psychiatry*, *1*(6), 467–482. https://doi.org/10.1016/S2215-0366(14)00023-6

Hiday, V. A. (1995). The social context of mental illness and violence. *Journal of Health and Social Behavior*, *36*(2), 122–137.

Hiday, V. A., & Wales, H. W. (2011). The criminalization of mental illness. In E. R. Vingilis & S. A. State (Eds.), *Applied Research and Evaluation in Community Mental Health Services: An update of key research domains* (Issue May 2018, pp. 80–93). McGill-Queen's University Press.

Hodgins, S., Cree, A., Khalid, F., Patel, K., Sainz-Fuentes, R., Shortt, M., Mak, T., & Riaz, M. (2009). Do community mental health teams caring for severely mentally ill patients adjust treatments and services based on patients' antisocial or criminal behaviours? *European Psychiatry*, *24*(6), 373–379. https://doi.org/10.1016/j.eurpsy.2009.07.009

Hodgins, S., Mednick, S. A., Brennan, P. A., Schulsinger, F., & Engberg, M. (1996). Mental disorder and crime: Evidence from a Danish birth cohort. *Archives of General Psychiatry*, *53*(6), 489–

496. https://doi.org/10.1001/archpsyc.1996.01830060031004

Hodgins, S., Webster, C. D., Paquet, J., & Zellerer, E. (1990). *Canadian Database: Patients Held on Lieutenant Governor Warrants*.

Holt, N. R., Botelho, E., Wolford-Clevenger, C., & Clark, K. A. (2023). Previous mental health care and help-seeking experiences: Perspectives from sexual and gender minority survivors of near-fatal suicide attempts. *Psychological Services*. https://doi.org/10.1037/ser0000745

Hörberg, U., Benzein, E., Erlingsson, C., & Syrén, S. (2015). *Engaging with Families Is a Challenge : Beliefs among Healthcare Professionals in Forensic Psychiatric Care*. *2015*.

Hunt, G. E., Large, M. M., Cleary, M., Lai, H. M. X., & Saunders, J. B. (2018). Prevalence of comorbid substance use in schizophrenia spectrum disorders in community and clinical settings, 1990–2017: Systematic review and meta-analysis. *Drug and Alcohol Dependence*, *191*(July), 234–258. https://doi.org/10.1016/j.drugalcdep.2018.07.011

Hurtubise, R., & Rose, M.-C. (2013). Dérangeant ou dangereux? Repartir à neuf et évaluation des risques. In *Récit de pratique en itinérance, Projet Chez Soi* (pp. 1–10). Centre de recherche de Montréal sur les inégalités sociales (CREMIS).

Jacobs, P., Moffatt, J., Dewa, C. S., Nguyen, T., Zhang, T., & Lesage, A. D. (2016). Mental health services costs within the Alberta criminal justice system. *International Journal of Law and Psychiatry*, *47*, 102–108. https://doi.org/10.1016/j.ijlp.2016.04.008

Jaimes, A., Crocker, A. G., Bédard, É., & Ambrosini, D. L. (2020). *Santé mentale au Québec Les Tribunaux de santé mentale : déjudiciarisation et jurisprudence thérapeutique Mental health courts : Therapeutic jurisprudence in action Los Tribunales de Salud Mental : desjudicialización y jurisprudencia terapéutica Tribunais*.

Jansman-Hart, E. M., Seto, M. C., Crocker, A. G., Nicholls, T. L., & Côté, G. (2011). International

trends in demand for forensic mental health services. *International Journal of Forensic Mental Health*, *10*(4), 326–336. https://doi.org/10.1080/14999013.2011.625591

Jennings, J. L. (2009). Does Assertive Community Treatment Work with Forensic Populations? Review and Recommendations. *The Open Psychiatry Journal*, *3*, 13–19. https://doi.org/10.2174/1874354400903010013

Kelly, B. D. (2005). Structural violence and schizophrenia. *Social Science and Medicine*, *61*(3), 721–730. https://doi.org/10.1016/j.socscimed.2004.12.020

Kelly, B. J., Perkins, D. A., Fuller, J. D., & Parker, S. M. (2011). Shared care in mental illness: A rapid review to inform implementation. *International Journal of Mental Health Systems*, *5*, 1–12. https://doi.org/10.1186/1752-4458-5-31

Kemali, D.-, Maj, M., Carpiniello, B., Giurazza, R. D., Impagnatiello, M., Lojacono, D., Martini, P., & Morandini, G. (1989). Patterns of care in Italian psychiatric services and psychosocial outcome of schizophrenic patients. A three-year prospective study. *Psychiatry and Psychobiology*, *4*(1), 23–31. https://doi.org/10.1017/S0767399X00004090

Keown, P., Murphy, H., McKenna, D., & McKinnon, I. (2018). Changes in the use of the Mental Health Act 1983 in England 1984/85 to 2015/16. *British Journal of Psychiatry*, *213*(4), 595–599. https://doi.org/10.1192/bjp.2018.123

Kim, D. Y. (2016). Psychiatric Deinstitutionalization and Prison Population Growth: A Critical Literature Review and Its Implications. *Criminal Justice Policy Review*, *27*(1), 3–21. https://doi.org/10.1177/0887403414547043

Knaak, S., Mantler, E., & Szeto, A. (2017). Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions. *Healthcare Management Forum*, *30*(2), 111–116. https://doi.org/10.1177/0840470416679413

Kurdyak, P., Friesen, E. L., Young, J. T., Borschmann, R., Iqbal, J., Huang, A., & Kouyoumdjian, F. (2021). Prevalence of Mental Health and Addiction Service use Prior to and During Incarceration in Provincial Jails in Ontario, Canada: A Retrospective Cohort Study: Prévalence de l'utilisation des services de santé mentale et de dépendance avant et durant l'inca. *Canadian Journal of Psychiatry*, 1–11. https://doi.org/10.1177/07067437211055414

Kvrgic, S., Cavelti, M., Beck, E. M., Rüsch, N., & Vauth, R. (2013). Therapeutic alliance in schizophrenia: The role of recovery orientation, self-stigma, and insight. *Psychiatry Research*, *209*(1), 15–20. https://doi.org/10.1016/j.psychres.2012.10.009

L.R.Q., c. P-38.001, (1997).

Lafore, R. (2010). La juridicisation des problèmes sociaux : la construction juridique de la protection sociale. *Informations Sociales*, *n° 157*(1), 18. https://doi.org/10.3917/inso.157.0018

Lamberti, J. S., & Weisman, R. L. (2021). Essential Elements of Forensic Assertive Community Treatment. *Harvard Review of Psychiatry*, *29*(4), 278–297. https://doi.org/10.1097/HRP.0000000000000299

Lamberti, J. S., Weisman, R. L., Cerulli, C., Williams, G. C., Jacobowitz, D. B., Mueser, K. T., Marks, P. D., Strawderman, R. L., Harrington, D., Lamberti, T. A., & Caine, E. D. (2017). A Randomized Controlled Trial of the Rochester Forensic Assertive Community Treatment Model. *Psychiatric Services*, *68*(10), 1016–1024. https://doi.org/10.1176/appi.ps.201600329

Large, M. M., Ryan, C. J., Singh, S. P., Paton, M. B., & Nielssen, O. B. (2011). The predictive value of risk categorization in schizophrenia. *Harvard Review of Psychiatry*, *19*(1), 25–33. https://doi.org/10.3109/10673229.2011.549770

Latimer, J., & Lawrence, A. (2006). *The review board systems in Canada: Overview of results from the Mentally Disordered Accused Data Collection Study*. Department of Justice Canada.

Laursen, T. M., Nordentoft, M., & Mortensen, P. B. (2014). Excess Early Mortality in Schizophrenia. *Annual Review of Clinical Psychology*, *10*(1), 425–448. https://doi.org/10.1146/annurev-clinpsy-032813-153657

Leclair, M. C., Lemieux, A. J., Roy, L., Martin, M. S., Latimer, E. A., & Crocker, A. G. (2020a). Pathways to recovery among homeless people with mental illness: Is impulsiveness getting in the way? *Canadian Journal of Psychiatry*, *65*(7), 473–483.

Leclair, M. C., Lemieux, A. J., Roy, L., Martin, M. S., Latimer, E. A., & Crocker, A. G. (2020b). Recovering with impulsiveness : organizing services for improvement in hope and mental health. *Canadian Psychological Association*.

Lemming, M. R., & Calsyn, R. J. (2004). Utility of the behavioral model in predicting service utilization by individuals suffering from severe mental illness and homelessness. *Community Mental Health Journal*, *40*(4), 347–364. https://doi.org/10.1023/B:COMH.0000035229.20557.5c

Lesage, A. D., Morissette, R., Fortier, L., Reinharz, D., & Contandriopoulos, A.-P. (2000). Downsizing psychiatric hospitals: Needs for care and services of current and discharged long-stay inpatients. *Canadian Journal of Psychiatry*, *45*(6), 526–531. https://doi.org/10.1177/070674370004500602

Lester, H. (2005). Shared care for people with mental illness: A GP's perspective. *Advances in Psychiatric Treatment*, *11*(2), 133–138. https://doi.org/10.1192/apt.11.2.133

Lester, H., Birchwood, M., Freemantle, N., Michail, M., & Tait, L. (2009). REDIRECT: Cluster randomised controlled trial of GP training in first-episode psychosis. *British Journal of General Practice*, *59*(563), 403–408. https://doi.org/10.3399/bjgp09X420851

Lévesque, J.-F., Harris, M. F., & Russell, G. (2013). Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *International*

Journal for Equity in Health, *12*(18). http://www.equityhealthj.com/content/12/1/18

Livingston, J. D. (2020). *Structural Stigma in Health-Care Contexts for People with Mental Health and Substance Use Issues: A Literature Review*. Mental Health Commission of Canada.

Livingston, J. D., Rossiter, K. R., & Verdun-Jones, S. N. (2011a). "Forensic" labelling: An empirical assessment of its effects on self-stigma for people with severe mental illness. *Psychiatry Research*, *188*, 115–122. https://doi.org/10.1016/j.psychres.2011.01.018

Livingston, J. D., Rossiter, K. R., & Verdun-Jones, S. N. (2011b). "Forensic" labelling: An empirical assessment of its effects on self-stigma for people with severe mental illness. *Psychiatry Research*, *188*(1), 115–122. https://doi.org/10.1016/j.psychres.2011.01.018

Livingston, J. D., Wilson, D., Tien, G., & Bond, L. (2003). A follow-up study of persons found not criminally responsible on account of mental disorder in British Columbia. *Canadian Journal of Psychiatry*, *48*(6), 408–415. https://ww1.cpa-apc.org/Publications/Archives/CJP/2003/july/livingston.pdf

Lloyd-Evans, B., Crosby, M., Stockton, S., Pilling, S., Hobbs, L., Hinton, M., & Johnson, S. (2011). Initiatives to shorten duration of untreated psychosis: Systematic review. *British Journal of Psychiatry*, *198*(4), 256–263. https://doi.org/10.1192/bjp.bp.109.075622

López, S. R., Gamez, D., Mejia, Y., Calderon, V., Lopez, D., Ullman, J. B., & Kopelowicz, A. (2018). Psychosis literacy among Latinos with first-episode psychosis and their caregivers. *Psychiatric Services*, *69*(11), 1153–1159. https://doi.org/10.1176/appi.ps.201700400

Lukassen, J., & Miladinovic, Z. (2014). *Verdicts of not criminally responsible on account of mental disorder in adult criminal courts, 2005/2006-2011/2012*. Statistics Canada. https://www150.statcan.gc.ca/n1/pub/85-002-x/2014001/article/14085-eng.htm

MacDonald, K., Ferrari, M., Fainman-Adelman, N., & Iyer, S. N. (2021). Experiences of pathways

to mental health services for young people and their carers: a qualitative meta-synthesis review. *Social Psychiatry and Psychiatric Epidemiology*, *56*(3), 339–361. https://doi.org/10.1007/s00127-020-01976-9

Maranzan, K. A. (2016). Interprofessional education in mental health: An opportunity to reduce mental illness stigma. *Journal of Interprofessional Care*, *30*(3), 370–377. https://doi.org/10.3109/13561820.2016.1146878

Marcus, N., & Stergiopoulos, V. (2022). Re-examining mental health crisis intervention: A rapid review comparing outcomes across police, co-responder and non-police models. *Health and Social Care in the Community*, *30*(5), 1665–1679. https://doi.org/10.1111/hsc.13731

Markowitz, F. E. (2011). Mental illness, crime, and violence: Risk, context, and social control. *Aggression and Violent Behavior*, *16*(1), 36–44. https://doi.org/10.1016/j.avb.2010.10.003

Markowitz, F. E. (2014). Mental Illness and Labeling Theory. *The Wiley Blackwell Encyclopedia of Health, Illness, Behavior, and Society*, *October*, 1582–1587. https://doi.org/10.1002/9781118410868.wbehibs328

Marquant, T., Sabbe, B., Van Nuffel, M., & Goethals, K. (2016). Forensic Assertive Community Treatment: A Review of the Literature. *Community Mental Health Journal*, *52*(8), 873–881. https://doi.org/10.1007/s10597-016-0044-0

Martin, S., Charette, Y., Leclerc, C., Seto, M. C., Nicholls, T. L., & Crocker, A. G. (2022). Not a "Get Out of Jail Free Card": Comparing the Legal Supervision of Persons Found Not Criminally Responsible on Account of Mental Disorder and Convicted Offenders. *Frontiers in Psychiatry*, *12*(January), 1–10. https://doi.org/10.3389/fpsyt.2021.775480

Mezzina, R. (2014). Community Mental Health Care in Trieste and Beyond An "Open Door - No Restraint " System of Care for Recovery and Citizenship. *The Journal of Nervous and Mental Disease*, *202*(6), 440–445. https://doi.org/10.1097/NMD.0000000000000142

Mezzina, R., & Vidoni, D. (1995). Beyond the Mental Hospital: Crisis Intervention and Continuity of Care in Trieste. A Four Year Follow-Up Study in a Community Mental Health Centre. *International Journal of Social Psychiatry*, *41*(1), 1–20. https://doi.org/10.1177/002076409504100101

Mezzina, R., Vidoni, D., Miceli, M., Interlandi, G., Accetta, A., & Crusiz, C. (2005). Gli interventi territoriali a 24 ore dalla crisi sono basati sull'evidenza? *Psichiatria Di Comunità*, *4*(4), 200–217.

Ministère de la Santé et des Services sociaux. (1998). *Plan d'action pour la transformation des services de santé mentale*.

Ministère de la Santé et des Services sociaux. (2005). *Plan d'action en santé mentale 2005-2010: la force des liens*.

Mitchell, A. J., Vancampfort, D., Sweers, K., Van Winkel, R., Yu, W., & De Hert, M. (2013). Prevalence of metabolic syndrome and metabolic abnormalities in schizophrenia and related disorders-a systematic review and meta-analysis. In *Schizophrenia Bulletin* (Vol. 39, Issue 2, pp. 306–318). https://doi.org/10.1093/schbul/sbr148

Moore, S., Shiers, D., Daly, B., Mitchell, A. J., & Gaughran, F. (2015). Promoting physical health for people with schizophrenia by reducing disparities in medical and dental care. *Acta Psychiatrica Scandinavica*, *132*, 109–121.

Morin, M., Bergeron, A., Levasseur, M. A., Iyer, S. N., & Roy, M. (2021). Les approches familiales en intervention précoce : repères pour guider les interventions et soutenir les familles dans les programmes d'intervention pour premiers épisodes psychotiques (PPEP). *Santé Mentale Au Québec*, *46*(2), 139. https://doi.org/10.7202/1088181ar

Moroz, N., Moroz, I., & D'Angelo, M. S. (2020). Mental health services in Canada: Barriers and cost-effective solutions to increase access. *Healthcare Management Forum*, *33*(6), 282–287.

https://doi.org/10.1177/0840470420933911

Nakash, O., Nagar, M., & Levav, I. (2015). Predictors of mental health care stigma and its association with the therapeutic alliance during the initial intake session. *Psychotherapy Research*, *25*(2), 214–221. https://doi.org/10.1080/10503307.2014.885147

Newbronner, E., Spanakis, P., Wadman, R., Crosland, S., Heron, P., Johnston, G., Walker, L., Gilbody, S., & Peckham, E. (2022). Exploring Access to Mental Health and Primary Care Services for People With Severe Mental Illness During the COVID-19 Restrictions. *Frontiers in Psychiatry*, *12*(January), 1–8. https://doi.org/10.3389/fpsyt.2021.799885

Ouellet, G. (2017). *L'individu dans les rouages de l'objectivation : Déficience intellectuelle, justice pénale et travail en réseau*. Université de Montréal.

Palcic, S., Broussard, P., Pettinelli, A., Giraldi, T., Martinis, E., Furina, C., Bracco, R., Zanello, E., Riolo, A., & Mezzina, R. (2011). *Studio comparativo sull'utilizzo dei farmaci antipsicotici nel territorio dell'ASS n. 1 '"Triestina."'* https://asugi.sanita.fvg.it/export/sites/aas1/it/documenti/all_dir_san/all_farma/mat_info/farma_congresso_italiano_farmacia_ospedaliera_2009.pdf

Pedersen, E. R., & Paves, A. P. (2014). Comparing perceived public stigma and personal stigma of mental health treatment seeking in a young adult sample. *Psychiatry Research*, *219*(1), 143–150. https://doi.org/10.1016/j.psychres.2014.05.017

Penchansky, R., & Thomas, J. W. (1981). The concept of access: definition and relationship to consumer satisfaction. *Medical Care*, *19*(2), 127–140.

Penney, S. R., Seto, M. C., Crocker, A. G., Nicholls, T. L., Grimbos, T., Darby, P. L., & Simpson, A. I. F. (2019). Changing characteristics of forensic psychiatric patients in Ontario: A population-based study from 1987-2012. *Social Psychiatry and Psychiatric Epidemiology*, *54*(5), 627–638. https://doi.org/10.1007/s00127-018-1619-6

Pérez-Revuelta, J. I., González-Sáiz, F., Pascual-Paño, J. M., Mongil-San Juan, J. M., Rodríguez-Gómez, C., Muñoz – Manchado, L. I., Mestre-Morales, J., Berrocoso, E., & Villagrán Moreno, J. M. (2023). Shared decision making with schizophrenic patients: a randomized controlled clinical trial with booster sessions (DECIDE Study). *Patient Education and Counseling*, *110*(October 2022), 0–3. https://doi.org/10.1016/j.pec.2023.107656

Peterson, J. K., Skeem, J. L., Kennealy, P., Bray, B., & Zvonkovic, A. (2014). How often and how consistently do symptoms directly precede criminal behavior among offenders with mental illness? *Law and Human Behavior*, *38*(5), 439–449. https://doi.org/10.1037/lhb0000075

Pettigrew, T. F., & Tropp, L. R. (2006). A meta-analytic test of intergroup contact theory. *Journal of Personality and Social Psychology*, *90*(5), 751–783. https://doi.org/10.1037/0022-3514.90.5.751

Power, P., Iacoponi, E., Reynolds, N., Fisher, H., Russell, M., Garety, P., McGuire, P. K., & Craig, T. (2007). The Lambeth Early Onset Crisis Assessment Team Study: General practitioner education and access to an early detection team in first-episode psychosis. *British Journal of Psychiatry*, *191*(SUPPL. 51), 3–9. https://doi.org/10.1192/bjp.191.51.s133

Priebe, S., Frottier, P., Gaddini, A., Kilian, R., Lauber, C., Martinez-Leal, R., Munk-Jorgensen, P., Walsh, D., Wiersma, D., & Wright, D. (2008). Mental health care institutions in nine European countries, 2002 to 2006. *Psychiatric Services*, *59*(5), 570–573. https://doi.org/10.1176/appi.ps.59.5.570 [doi]

Protani, M. M., Alotiby, M. K. N., Seth, R., Lawrence, D., Jordan, S. J., Logan, H., Kendall, B. J., Siskind, D., Sara, G., & Kisely, S. (2022). Colorectal cancer treatment in people with severe mental illness: a systematic review and meta-analysis. *Epidemiology and Psychiatric Sciences*, *31*, e82. https://doi.org/10.1017/S2045796022000634

Rhodes, J., Winder, P., Stratheran, M., McMillan, M., Richter, K., & McLeod, M. (2016). Breaking

down educational silos. *Nursing New Zealand (Wellington, N.Z. : 1995)*, *22*(1), 16–17.

Ricketts, T. C., & Goldsmith, L. J. (2005). Access in health services research: The battle of the frameworks. *Nursing Outlook*, *53*(6), 274–280. https://doi.org/10.1016/j.outlook.2005.06.007

Roy, L., Crocker, A. G., Hurtubise, R., Latimer, E., Côté, M., Billette, I., & Boissy, F. (2020). Reducing criminal justice involvement of individuals experiencing homelessness and mental illness: Perspectives of frontline practitioners. *Canadian Journal of Criminology and Criminal Justice*. https://doi.org/10.3138/cjccj.2019-0056

Roy, L., Leclair, M. C., Côté, M., & Crocker, A. G. (2020). Itinérance, santé mentale, justice: Expérience et perceptions des utilisateurs de services à Montréal. *Criminologie*, *53*(2), 359–383. https://doi.org/10.7202/1074199ar

Rutherford, M., & Duggan, S. (2009). Meeting complex health needs in prisons. *Public Health*, *123*, 415–418.

Saleh, A. Z., Appelbaum, P. S., Liu, X., Scott Stroup, T., & Wall, M. (2018). Deaths of people with mental illness during interactions with law enforcement. *International Journal of Law and Psychiatry*, *58*, 110–116. https://doi.org/10.1016/j.ijlp.2018.03.003

Sashidharan, S. P. (2022). *Why Trieste matters*. 52–53. https://doi.org/10.1192/bjp.2021.149

Saunders, J. C. (2003). Families living with severe mental illness: A literature review. *Issues in Mental Health Nursing*, *24*(2), 175–198. https://doi.org/10.1080/01612840305301

Schanda, H., Stompe, T., & Ortwein-Swoboda, G. (2009). Dangerous or merely "difficult"? The new population of forensic mental hospitals. *European Psychiatry*, *24*(6), 365–372. https://doi.org/10.1016/j.eurpsy.2009.07.006

Schneider, R. D., Crocker, A. G., & Leclair, M. C. (2016). Mental Health Courts and Diversion

Programs. In J. A. Chandler & C. M. Flood (Eds.), *Law and Mind: Mental Health Law and Policy in Canada* (pp. 303–323). Lexis Nexis Canada.

Sealy, P. A. (2012). The impact of the process of deinstitutionalization of mental health services in Canada: An increase in accessing of health professionals for mental health concerns. *Social Work in Public Health*, *27*(3), 229–237. https://doi.org/10.1080/19371911003748786

Sealy, P. A., & Whitehead, P. C. (2004). Forty years of deinstitutionalization of psychiatric services in Canada: An empirical assessment. *Canadian Journal of Psychiatry*, *49*(4), 249–257. https://doi.org/10.1177/070674370404900405

Shepherd, A., Doyle, M., Sanders, C., & Shaw, J. (2016). Personal recovery within forensic settings - Systematic review and meta-synthesis of qualitative methods studies. *Criminal Behaviour and Mental Health*, *26*(1), 59–75. https://doi.org/10.1002/cbm.1966

Sheridan Rains, L., Weich, S., Maddock, C., Smith, S., Keown, P., Crepaz-Keay, D., Singh, S. P., Jones, R., Kirkbride, J., Millett, L., Lyons, N., Branthonne-Foster, S., Johnson, S., & Lloyd-Evans, B. (2020). Understanding increasing rates of psychiatric hospital detentions in England: development and preliminary testing of an explanatory model. *BJPsych Open*, *6*(5), 1–13. https://doi.org/10.1192/bjo.2020.64

Simo, B., Bamvita, J. M., Caron, J., & Fleury, M.-J. (2018). Predictors of mental health service use among individuals with high psychological distress and mental disorders. *Psychiatry Research*, *270*(August), 1122–1130. https://doi.org/10.1016/j.psychres.2018.10.019

Statistics Canada. (2019). *Mental health needs, 2018*. www.statcan.gc.ca

Stein, J. A., Andersen, R. M., & Gelberg, L. (2007). Applying the Gelberg-Andersen behavioral model for vulnerable populations to health services utilization in homeless women. *Journal of Health Psychology*, *12*(5), 791–804. https://doi.org/10.1177/1359105307080612

Stilo, S. A., & Murray, R. M. (2019). Non-Genetic Factors in Schizophrenia. *Current Psychiatry Reports*, *21*(10), 100. https://doi.org/10.1007/s11920-019-1091-3

Sukhera, J., & Knaak, S. (2022). A realist review of interventions to dismantle mental health and substance use related structural stigma in healthcare settings. *SSM - Mental Health*, *2*(November), 100170. https://doi.org/10.1016/j.ssmmh.2022.100170

Swanson, J. W., Holzer, C. E., Ganju, V. K., & Jono, R. T. (1990). Violence and psychiatric disorder in the community: evidence from the Epidemiologic Catchment Area surveys. *Hospital and Community Psychiatry*, *41*(7), 761–770. https://doi.org/10.1176/ps.41.7.761

Swanson, J. W., Swartz, M. S., Elbogen, E. B., Van Dorn, R. A., Wagner, H. R., Moser, L. A., Wilder, C., & Gilbert, A. R. (2008). Psychiatric advance directives and reduction of coercive crisis interventions. *Journal of Mental Health*, *17*(3), 255–267. https://doi.org/10.1080/09638230802052195

Swanson, J. W., Swartz, M. S., van Dorn, R., Elbogen, E. B., Wagner, H. R., Rosenheck, R. A., Stroup, T. S., McEvoy, J. P., & Lieberman, J. A. (2006). A national study of violent behavior in persons with schizophrenia. *Archives of General Psychiatry*, *63*(5), 490–499. https://doi.org/10.1001/archpsyc.63.5.490

Tabita, B., de Santi, M. G., & Kjellin, L. (2012). Criminal recidivism and mortality among patients discharged from a forensic medium secure hospital. *Nordic Journal of Psychiatry*, *66*(4), 283–289. https://doi.org/10.3109/08039488.2011.644578

Takizawa, N., Melle, I., Barrett, E. A., Nerhus, M., & Ottesen, A. A. (2021). The Influence of Mental Health Literacy, Migration, and Education on the Duration of Untreated Psychosis. *Frontiers in Public Health*, *9*(July), 1–9. https://doi.org/10.3389/fpubh.2021.705397

Thornicroft, G. (2008). Stigma and discrimination limit access to mental health care. *Epidemiologia e Psichiatria Sociale*, *17*(1), 14–19.

https://doi.org/10.1017/S1121189X00002621

Tiihonen, J., Isohanni, M., Räsänen, P., Koiranen, M., & Moring, J. (1997). Specific major mental disorders and criminality: A 26-year prospective study of the 1996 Northern Finland Birth Cohort. *The American Journal of Psychiatry*, *154*(6), 840–845. https://doi.org/http://dx.doi.org/10.1176/ajp.154.6.840

Tinland, A., Leclerc, L., Loubière, S., Mougeot, F., Greacen, T., Pontier, M., Franck, N., Lançon, C., Boucekine, M., & Auquier, P. (2019). Psychiatric advance directives for people living with schizophrenia, bipolar I disorders, or schizoaffective disorders: Study protocol for a randomized controlled trial-DAiP study. *BMC Psychiatry*, *19*(1), 1–13. https://doi.org/10.1186/s12888-019-2416-9

Tribunal administratif du Québec. (2012). *Rapport annuel de gestion 2011-2012*.

Üçok, A., Brohan, E., Rose, D., Sartorius, N., Leese, M., Yoon, C. K., Plooy, A., Ertekin, B. A., Milev, R., & Thornicroft, G. (2012). Anticipated discrimination among people with schizophrenia. *Acta Psychiatrica Scandinavica*, *125*(1), 77–83. https://doi.org/10.1111/j.1600-0447.2011.01772.x

Vanasse, A., Courteau, J., Courteau, M., Roy, M. A., Stip, E., Fleury, M.-J., Lesage, A., & Brodeur, S. (2022). Multidimensional analysis of adult patients' care trajectories before a first diagnosis of schizophrenia. *Schizophrenia*, *8*(1), 1–10. https://doi.org/10.1038/s41537-022-00256-6

Vérificateur général du Québec. (2003). *Rapport à l'Assemblée nationale pour l'année 2002-2003, tome II: Services de santé mentale*.

Vestphal, T. K., Gildberg, F. A., Jørgensen, R., Rowaert, S., & Tingleff, E. B. (2023). Experiences of family caregivers in forensic mental health care - A qualitative evidence synthesis. *Journal of Psychiatric and Mental Health Nursing*, *August 2022*, 1–16.

https://doi.org/10.1111/jpm.12910

Wakida, E. K., Talib, Z. M., Akena, D., Okello, E. S., Kinengyere, A., Mindra, A., & Obua, C. (2018). Barriers and facilitators to the integration of mental health services into primary health care: A systematic review. *Systematic Reviews*, *7*(1), 1–13. https://doi.org/10.1186/s13643-018-0882-7

Walker, E. R., McGee, R. E., & Druss, B. G. (2015). Mortality in mental disorders and global disease burden implications: A systematic review and meta-analysis. *JAMA Psychiatry*, *72*(4), 334–341. https://doi.org/10.1001/jamapsychiatry.2014.2502

West, M. L., Yanos, P. T., & Mulay, A. L. (2014). Triple stigma of forensic psychiatric patients: Mental illness, race, and criminal history. *International Journal of Forensic Mental Health*, *13*(1), 75–90. https://doi.org/10.1080/14999013.2014.885471

Williams, A., Moore, E., Adshead, G., McDowell, A., & Tapp, J. (2011). Including the excluded: High security hospital user perspectives on stigma, discrimination, and recovery. *The British Journal of Forensic Practice*, *13*, 197–204.

Winick, B. J. (1997). The jurisprudence of therapeutic jurisprudence. *Psychology, Public Policy, and Law*, *3*(1), 184–206. https://doi.org/10.1037/1076-8971.3.1.184

World Health Organisation. (2021). *Guidance on Community Mental Health Services*. https://www.who.int/publications/i/item/9789240025707