

A Comprehensive Framework to Advance Equity, Diversity, and Inclusion in a Forensic Service

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Minority and Indigenous populations have disproportionate representation within forensic mental health services. Social determinants of health and systemic discrimination have contributed to the difficulties these populations have in accessing care, as well as significant differences in care trajectories. In addition, staffing and structural equity, diversity, and inclusion (EDI) challenges permeate forensic systems as in other health care settings. There is little literature to guide forensic mental health services in how best to provide equitable, diverse, and inclusive practices for patients, families, and staff. The forensic service at a major urban center in the Canadian province of Ontario has adapted an EDI framework to describe the processes employed to organize and integrate EDI principles and initiatives within a culture of learning and continuous improvement. This Forensic EDI Framework is composed of six domains: Organizational Commitment, Staff/Workforce Competencies, Service Access and Delivery, Promoting Responsiveness, Community Outreach, and Data Collection. Initiatives within each of these domains form the foundation of a sustainable platform for forensic service EDI practices that will promote lasting change.

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Users of forensic mental health services are disproportionately from minority or Indigenous populations.¹ Service users from these groups are commonly reported to have poor mental health treatment experiences and outcomes.² The Canadian province of Ontario mirrors world experience in this regard, although the development of specific service design to address these challenges is relatively new. Penney *et al.*³ studied the composition of the forensic patient

population in Ontario for more than 30 years and found there was an increase in the ethnic diversity among forensic patients over time. By 2014–2015, 36.3 percent of the Ontario forensic patients were European, 10.8 percent First Nations, 23.5 percent African-Caribbean; and 16.1 percent were of Asian ethnicity.⁴ This change reflects the increasing diversity and migrant population within the densely populated region of the Greater Toronto Area in Ontario over the last three to four decades,³ as well as the rapidly rising incarceration of Canadian Indigenous, Black, and marginalized populations.^{5–7}

Penney *et al.*⁸ studied the profile of migrants in the forensic population in Toronto and found that migrants had a later onset of symptoms of illness and fewer features of abnormal personality but were more socially isolated than Canadian-born patients. There was no difference in the duration of forensic hospitalization or community supervision by migrancy status. The disproportionate representation of migrants,

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particularly forced migrants, in forensic services underlines the complexity of challenges regarding diversity and linguistic and cultural difference in the forensic patient population. Finally, Flora *et al.*⁹ studied the pathways into and through forensic care, comparing persons of African-Caribbean ethnicity with Canadians of European ethnicity in Toronto. They found that the two groups had different community service access prior to being admitted to forensic care (less specialist mental health service involvement for those of African-Caribbean ethnicity), but there were no significant differences between the ethnic groups in their pathways through forensic care.

EDI in Forensic Systems of Care

Equity, Diversity, and Inclusion (EDI) has become a priority area of focus for many major academic institutions,¹⁰ and forensic psychiatry is no exception. Patient equity has been a focus of attention for years in Canada. For example, it has long been established that individuals of Indigenous heritage are significantly overrepresented in both youth and adult correctional settings,¹¹ yet risk assessment tools that guide sentencing and release decisions have often been developed using primarily Caucasian samples, a limitation highlighted in the *Ewert* Supreme Court of Canada decision in 2018.¹² Racial differences in the criminalization of individuals with mental illness have been identified for decades, with visible minorities being sent more often to prisons than to hospitals.^{11,13} Despite this overrepresentation, the integration of culturally responsive forensic assessment and service delivery within a measurement-based framework, has been identified as an area of need in forensic psychiatry.²

The effect of systemic inequity that stems from, for example, colonialism and slavery^{6,14,15} is amplified in the forensic population, as these individuals face not only systemic and structural discrimination, but also the stigma and barriers to care associated with having a mental illness and being involved with the criminal justice system. Therefore, identifying and changing elements of the forensic system that contribute to structural racism are major tasks that require years of education, strategic planning, and acceptance by all stakeholders. Centrally, this requires a willingness on the part of forensic service providers to listen actively to those affected and make iterative changes to service provision.

EDI Frameworks

Despite the daunting magnitude of EDI needs, and the traditional mindset within forensic psychiatry that emphasizes positions of neutrality (politically and clinically), it is incumbent on forensic services to take a position of advocacy for and commitment to system change. It has been a recognized challenge for mental health service providers, academic institutions, and jurisdictions to respond effectively to these concerns.⁹ Solutions require leadership within forensic services and advocacy with other systems to create care pathways that address inequities arising from structural discrimination.¹⁶ This response is necessary on multiple levels, from patient care, family engagement, and recognition of individualized cultural and identity needs, to creating a diverse workforce and prioritization of EDI-informed policies, practices, and service delivery. Seeleman *et al.*¹⁷ conducted a comparative analysis of how health care systems responded to EDI challenges, identifying six examples from the United States, Australia, and Europe. They identified seven dimensions that were included in these plans; each described effective strategies and initiatives across many aspects of service design and delivery. The seven domains were: organizational commitment (requiring clear policy and leadership to guide responses), empirical evidence of disparities and needs, a competent and diverse workforce, ensuring access for all service users, ensuring responsiveness in care provision, fostering patient and community participation, and actively promoting responsiveness.

More recently, Healey *et al.*¹⁸ performed a systematic review of studies of innovations to address cultural differences in mental health. They found 31 studies that most commonly focused on adaptations of cognitive behavioral interventions or cultural-specific information. Few studies addressed changes in clinicians' behavior. Approximately half the studies showed benefit from the cultural adaptations but there was heterogeneity of findings. There were no studies in forensic contexts. The authors concluded that cultural responsiveness required clinician-level, service-level, and patient-specific procedural change, with careful attention to measuring and tracking the effect of cultural adaptations.

The objective of this article is to describe the procedures undertaken in an urban forensic service to develop a response to meeting the needs of an ethnically diverse clinical population, in a diverse community,

with a diverse staff mix. We adapted the Seeleman *et al.*¹⁷ domains to describe the multilevel approach adopted for the first two years of this project and use this framework to identify areas of strength of our response as well as to identify priorities for future work.

Methodology

Service Context

The Centre for Addiction and Mental Health (CAMH) is situated in a major urban center in Toronto, Canada. CAMH provides one of the largest forensic mental health services in the country, with 190 inpatient beds (across medium and low levels of security) and a large outpatient service serving more than 250 patients. Most patients in the forensic service have been found unfit to stand trial or not criminally responsible because of mental disorder and are subject to the oversight of the provincial Criminal Code Review Board. Other services provided include risk assessments in various spheres (including general and sexual violence), mental health court, and psychiatric services to correctional facilities. Although 15 percent of the total CAMH hospital patient population identify as Black, the forensic population within CAMH has higher representations of Black and visible minorities. In 2020, 31 percent of inpatients and 30 percent of outpatients identified as Black, and 55 percent of inpatients and 51 percent of outpatients identified as a visible minority (Black, Indigenous, Asian, Middle Eastern, or Latin). Ten percent of the inpatient and 16 percent of the outpatient population are female.

The Forensic Service developed an EDI strategy, with an articulated mission to provide a culturally safe milieu for staff and patients, which achieves equity of outcome for forensic patients and ensures psychological safety within team functioning. The concept of cultural safety acknowledges the barriers to clinical effectiveness that arise from power imbalance between provider and patient, with the goal of creating an environment where all people feel respected and safe while they interact with the health care system.¹⁹ It differs from cultural competence, which is an attribute of the clinician, in that cultural safety describes the patient experience of the service delivered, not simply attributes of the provider. This strategy applies to a large forensic service in an

academic mental health hospital, with a commitment to secure recovery and measurement-based design. The strategy development included the expertise of an external agency skilled in ABR and cultural responsiveness work, as well as engagement with key stakeholders that included the voice of forensic patients and a major service user advocacy organization. The strategy was also based on a literature review, and an amalgamation of knowledge and resources from the hospital and broader community. It was developed along with and guided by a hospital-wide initiative to address EDI challenges entitled Fair and Just CAMH.

Analytical Approach

We adapted the framework for effective EDI policy change of Seeleman *et al.*¹⁷ to describe the processes used to organize and integrate initiatives within the CAMH Forensic Service, rewording some of the categories to fit our setting but retaining the scope of their framework. The domains were as follows:

- Organizational Commitment (Policy and Leadership)
- Staff/Workforce (Competencies)
- Service Access and Delivery (Provision and Accessibility of Information and Supplemental Services, Resources, or Support)
- Promoting Responsiveness (to the Needs of Patients and Families)
- Community Outreach
- Data Collection (including on Disparities and Needs)

We mapped the initiatives and key processes undertaken in the program against these domains.

We report here progress to date for the first two years of this process. Each area has a data-gathering component. Data are provided where available to date.

Results

Table 1 sets out the domains adapted from Seeleman's framework¹⁷ that we applied to our strategy and maps the activities undertaken against these domains of service change. We describe each of these major domains of work, recognizing that the work is interconnected, and the initiatives are mutually reinforcing.

Organizational Commitment

Organizations must have an explicit commitment to developing culturally responsive care, enabling

Comprehensive Framework to Advance DEI in a Forensic Service

Table 1 Mapping of Forensic Service Initiatives to Domains of Organizational Change (after Seeleman et al.)¹⁶

Domain	Actions
Organizational Commitment (policy and leadership)	Fair and Just CAMH wide Equity, Diversity, and Inclusion (EDI) initiative Clear reporting and investigating process for instances of oppression Mandatory training for existing and on-boarding staff Leadership training to lead and enhance initiatives Equity in hiring and human resource processes Leadership processes for need identification, action, and measurement
Staff/Workforce (competencies)	Implicit Bias and Anti-Black Racism training Cultural and religious awareness training (i.e., San'yas Indigenous Cultural Safety Training Program) Cultural Formulation Interview (CFI) and Culturally Adapted CBT training Adverse Childhood Experiences training Clinical supervision through health equity lens Incident debrief through health equity lens and race-based team conversations
Service Access and Delivery (provision and accessibility of services, resources, and support)	Support patient engagement and empowerment through education and workshops Implementation of the Cultural Formulation Interview and Culturally Adapted CBT Team treatment plans include early access to culture-specific resources and integration of the CFI Forensic Female Pathway Faith-based meals and food practices, including an Indigenous dinner option Culture-specific grooming services Aboriginal Services provide access to traditional healing practices Interpretation services for in-the-moment care Translation of all written materials provided to patients Culture-specific Peer Support
Promoting Responsiveness (to the needs of patients and families)	Family engagement strategy, including family information packages Patient-led experience sharing with teams Leadership and team processes for identification of needs, determining action plans, and measurement of improvement
Community Outreach (education, collaboration, and access to resources)	Community partnerships to build culturally specific resources (legal, social, psychological services) and inform service delivery Promote and disseminate information through provincial and national forensic mental health organizations Communication of cultural formulation in forensic reports and testimony University partnerships to enhance training and improve access and care
Data Collection (what, when, and how to inform continuous improvement)	System for rolling data collection Disaggregated patient data Seclusion and restraint Length of stay Admissions and readmissions Violent incidents Pass usage Program participation Staff incident reports Horizontal violence and oppression data collection Patient and staff satisfaction surveys and focus groups Pre- and post-surveys of training, programs, and service delivery Staff retention and exit survey data Measurement of therapeutic alliance Trainee interest in forensic psychiatry Audit of teaching modalities, documentation, and forensic reports from an EDI lens

initiatives to become structurally embedded rather than individually executed. Fair and Just CAMH is an organization-wide initiative that coordinates and amplifies the efforts to follow through on the overarching hospital commitment to health equity and to a workplace free from prejudice and discrimination.²⁰ Linked to the Fair and Just work are the Office of Health Equity (that provides resources

and conducts education and awareness on initiatives that further the hospital's commitment to EDI needs) and a Horizontal Violence, Anti-Racism, Anti-Oppression Working Group (that focuses on processes to overcome staff-to-staff violence, racism, and oppression).

This domain in the forensic EDI strategy notes the importance of synergy between the Forensic

Service and the organization's broader initiatives. Here, we ensure that the Forensic Service is benefiting from organization-wide educational initiatives such as implicit bias and leadership training (in some cases making such training mandatory), hospital-wide practices for reporting and investigating instances of oppression, and equity practices in hiring and human resources. In terms of data collection, there are hospital-wide patient and staff satisfaction surveys that will be supplemented with local forensic focus groups. Further, staff retention and exit survey information can help to inform the resonance, and deficits, of the EDI strategy. Measurements of this domain are somewhat more aligned with broader goals, in that data disaggregated by ethnicity, religion, and gender are collected to track patient outcomes, as well as staff satisfaction and retention.

Staff/Workforce

This domain reflects two variables: diversity among staff members, as well as staff skill and awareness in delivering culturally responsive care. Diversity among staff members is necessary to further cultural responsiveness, highlighting the importance of having a strategy to recruit, retain, and promote diverse staff, and ensure equal opportunities for all. Cultural awareness and humility to improve care delivery may be advanced through training, personal development programs, and adapted policies. Our Forensic Service education initiatives focus on cultural and religious awareness training (i.e., the San'yas Indigenous Cultural Safety Training Program in core mental health, which is a nationally accredited online program that was made available to staff and physicians), implicit bias training, Anti-Black Racism (ABR) training, and training in two specific tools: the Cultural Formulation Interview²¹ (CFI) and Adverse Childhood Experiences²² (ACES). Further, we implemented additional training to equip managers and staff to lead race-based conversations with teams and patients. Both clinical supervision and the discussion around practices that assist teams in debriefing critical incidents are processed through a health equity lens. Additional gender-specific training that addresses female-specific criminogenic profiles and needs has also been implemented. A dialogue about the importance of documentation practices is also a focus, recognizing the effect of words on perpetuating stereotypes.

Measurement of key outcomes in this domain are underway and include data on the diversity of the workforce and leadership composition, monitoring

participation in training, evaluating engagement and concept acquisition, and a measurement of therapeutic alliance (The Essen Climate Evaluation Schema²³). Review and analysis of documentation practices will yield additional outcome variables.

A key training initiative was the requirement that all leadership and staff in the forensic service (317 total participants) undertake ABR training provided by an expert external agency. This initiative was achieved via nine training sessions between July 2020 and February 2021 that examined the origins of ABR and its operation within the mental health and criminal justice sectors. At the point-of-care level, there was an exploration of how ABR affects clinical decision-making and, in turn, may produce inequitable outcomes for Black patients, with a particular focus on use of seclusion and restraint. Identifying and reflecting on the participants' roles in dismantling ABR within their practice was also a key objective of the program. Pre- and post-training evaluations showed a uniform increase in self-reported competence in achieving the goals set out by the program among both staff and management participants. Following ABR training, both staff and leadership requested more opportunities to address concerns that emerged within these sessions. Staff identified the need for such training to occur regularly, and for clinical care discussions to address openly the contribution of racism to individual recovery, decision-making, and critical incident debriefing. Leadership participants also identified the need to focus on tangible actions and increased support in exercising accountability in combating ABR in all practice domains.

Service Access and Delivery

Barriers to receiving services in the forensic system need to be identified and managed, including providing understandable information that facilitates accessibility, engaging those entitled to care in the forensic system, and helping those not eligible to find care elsewhere.¹ This management may occur through modification of the content of materials to include racial or cultural facts, values, or images, or changes to the process or structure of service delivery.¹⁹ Our key processes in this domain are the introduction of culture-specific assessment and therapeutics.

To better address culture, faith, and identity, we introduced life course narratives as routine practice, aided by the CFI and ACES tools. These tools are now embedded in routine use in our Model of Care

and were chosen to expand discussion regarding aspects of a person's identity that existing forensic assessment or treatment tools do not explicitly include. The addition of a cultural formulation to a patient's overall case formulation is designed to address this gap and expand understanding and engagement.

The educational components in this domain focus on creating opportunities and developing skills for patient empowerment and engagement. For some patients this may involve formal learning through educational activities, and for others this may consist of engagement in creative projects or leisure activities such as photography, art, music, or sport. Peer-led workshops can be venues to promote dialogue and the formulation of ideas to stimulate change. Easy access to interpretation and translation services is imperative to enable accessible service provision.

Faith-based meals and food practices, including an Indigenous dinner option, and culturally appropriate grooming services were identified and made available to patients. Aboriginal Services at CAMH provides access to traditional healing practices such as smudging ceremonies. Culturally adapted CBT²⁴ and a female-specific pathway have been implemented to facilitate engagement in services provided.

Measurement of this domain is focused on several factors, including evaluation of the implementation of the CFI and measures of therapeutic engagement. Further, as will be discussed in the Data Collection domain, rates of seclusion and restraint events, among other metrics, are monitored.

Promoting Responsiveness

Opportunities to share experiences are integral to promoting cultural responsiveness to the needs of patients and families. Initiatives within this domain include patients having structured opportunities to talk about their experiences with their teams, as well as a family engagement and education strategy. Essential to the efficacy of such initiatives are processes by which teams and leadership identify patient and family needs, develop plans of action, and monitor for improvement.

Community Outreach

Community engagement can often be the foundation upon which culturally informed care practices are developed.¹⁸ The care that is provided to patients must be responsive to their needs and enable patient participation (including shared decision-making) in

the care process and service development.¹ In our forensic service, community engagement is essential, given the involvement of multiple systems outside of health care. Community stakeholders identified as playing key roles in the trajectories of our patients include: the criminal justice system, police services, legal services, housing partnerships, and university training programs. This strategy includes expanding education of EDI principles to our community partners, systems outside of psychiatry, and learners within the forensic system. Further, to demonstrate our commitment to the EDI strategy and enable organizations to learn from one another, it is important to promote and disseminate information through provincial and national forensic mental health organizations. To this end, we engaged in community consultation with legal services to explore the potential for culturally specific legal resources for patients. We also shared this framework for critique by diverse stakeholders representing many special interest groups within the community.

Data Collection

Each component described above required a data collection framework to enable us to measure and report on progress. Some of these components are process measures (not outcome measures), such as the number of persons completing training, or the rate of completion of tools such as the CFI and ACES that have been introduced into our care pathway. These process measures fit with our service-wide commitment to measurement-based care.²⁵ Outcome measures, disaggregated by ethnicity, religion, and gender, must span staff-related as well as patient-related variables. Staff-related measures include staff satisfaction surveys, focus groups, staff retention and exit survey data, incident reports, horizontal violence and oppression reports, and pre- and post-surveys of training. Other measurements include trainee interest in forensic psychiatry and audit of teaching modalities and forensic reports that incorporate cultural considerations. Patient-related variables include length of stay, admissions and readmissions, seclusion and restraint events, incidents of violence, pass usage on hospital grounds and in the community, and attendance at programs and therapeutic activities.

A working group was assembled to ensure accuracy and relevance of the data that are to be collected on a quarterly basis. This group also determines how this data can improve this EDI strategy as well as to inform point of care practice. Data are collected

through a research and analytics team within the organization, which is responsive to this working group's requests for data refinement.

Discussion

Current literature identifies the need for health care institutions to adopt a comprehensive EDI strategy that addresses the multidimensional nature of the concern.^{10,12} Forensic psychiatry has long recognized that inequities specific to this population are rooted in systemic problems that extend well beyond health care organizations. The framework described above for an urban forensic service recognizes the scope, depth, and complexity of the challenges faced by patients, families, and staff. In addition to being founded on an explicitly stated goal of equity of care and outcomes, this EDI approach springs from a broader duty to ensure state agencies like forensic services are responsive to the population they serve. Such principles must inform and guide the development and implementation of models of care.²⁶ This framework emphasizes the importance of leadership and training to inform service delivery, innovation in care provision, the necessity for community stakeholder engagement, and measurement of key outputs and outcomes. We cannot find a similar EDI framework in forensic literature. We have attempted to embed evidence-based practices from the health services research literature matched to the needs of a forensic patient population. Further, the scope of the strategy is multilevel, and utilizes metrics to inform, evaluate, and enhance implementation, but at this point of the project we have limited data to report on effect.

In our current development of the framework, each domain is at a different stage of progress, with some initiatives having been implemented and evaluated (e.g., ABR and implicit bias training), and others representing works in progress. For each initiative and for the framework more broadly, the program has assumed a stance of openness and humility, as there is a deep awareness of the continuous state of learning and growth in this area that will require responsiveness and refinement of the strategy over time. We anticipate that some of the work will prove vital, and other areas less so or needing adaptation to meet the goals we set for them.

Several questions emerged in the evolution of this framework. The complexity and multidimensional nature of the EDI matters that encompass institutions, policies, and structures beyond any one organization create challenges in measuring effect of any individual

initiative on the broader goal of establishing real and sustainable equitable practices and patient outcomes. Further, increasing education and enabling conversations about EDI is expected to unveil the magnitude of these challenges, resulting in the metrics showing worsening of experiences before improvement is noted. It is also unclear how to apply population-based research on systemic discrimination to an individual forensic risk assessment.

The implementation of this strategy has met with some challenges. First, the size of the initiative that spans a large organization requires widespread communication, as well as collaboration and coordination across multiple groups with overlapping mandates. The collection and use of quality data has been identified as a systemic challenge that is actively being addressed through data-analytic resources within the institution, with significant lead times for implementation. Operationally, there has been no fixed budget for this work, and the government was not involved.

Another challenge has been to help staff develop the skills to have difficult conversations about these topics with patients and colleagues. We have had to continuously incorporate feedback in adapting our practice, both at the individual level and for the strategy as a whole. Maintaining engagement and ensuring sustainability of each initiative, given the competing demands and pressures among health care staff, has been noted as another implementation challenge.

A notable limitation of this work to date is that we do not yet have measures of the effect of these changes on patient experience and engagement, incident rates, treatment effectiveness, and acceptability of care. We will report on these measures in the forthcoming years. Evidence-based EDI frameworks for health care institutions are still in the development stage, and especially so within the field of forensic psychiatry. When measuring progress, it may be apparent that the goal of correcting the disproportional representation of racialized individuals in the forensic system is a long-term outcome dependent on variables beyond the scope of forensic mental health services.¹⁴ Therefore, proxies of progress and change are utilized, given there will be no one-to-one correlation between an intervention and an overarching concern of this magnitude.

We are likely to have made missteps in this work, but hope to learn from these to guide further innovation. We share this EDI strategy to contribute an approach that other services may find helpful, to

share successes and challenges, and to advance equitable workplaces and provision of care to all persons, less impaired by the unconscious and conscious biases that affect the forensic psychiatry community.

Forensic mental health services do not function in isolation, but rather as one component of a complex mental health and criminal justice enterprise. Changing this complex system requires partnerships and growth at a multisystemic level.

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