forensic sciences

MDPI

Article

Retrospective Review of the Criminal Code Review Board in Quebec for the Year 2023

Patrycja Myszak [1], Laura Leclair [1], Olivier Khayat [1], Joshua Levy [1], Joseph Abou Jaoude [1], Mathieu Dufour [1,2], Stéphanie Borduas Pagé [1,3] and Alexandre Hudon [1,2,3,4,5,*]

[1] Department of Psychiatry and Addictology, Faculty of Medicine, Université de Montréal, 2900 Bd Édouard-Montpetit, Montréal, QC H3T 1J4, Canada; patrycja.myszak@umontreal.ca (P.M.); laura.leclair@umontreal.ca (L.L.); olivier.khayat@umontreal.ca (O.K.); joshua.levy@umontreal.ca (J.L.); joseph.abou.jaoude@umontreal.ca (J.A.J.); mathieu.dufour.med@ssss.gouv.qc.ca (M.D.); stephanie.borduas-page.cemtl@ssss.gouv.qc.ca (S.B.P.)
[2] Department of Psychiatry, Institut National de Psychiatrie Légale Philippe-Pinel, 10905 Boul Henri-Bourassa E, Montréal, QC H1C 1H1, Canada
[3] Department of Psychiatry, Institut Universitaire en Santé Mentale de Montréal, 7401, Rue Hochelaga, Montréal, QC H1N 3M5, Canada
[4] Centre de Recherche de l'Institut Universitaire en Santé Mentale de Montréal, 7331, Rue Hochelaga, Montréal, QC H1N 3V2, Canada
[5] Groupe Interdisciplinaire de Recherche sur la Cognition et le Raisonnement Professionnel, Université de Montréal, QC H3C 3J7, Canada
* Correspondence: alexandre.hudon.1@umontreal.ca; Tel.: +1-514-251-4000

Abstract

Background/Objectives: The Commission d'examen des troubles mentaux (CETM), under Quebec's Tribunal Administratif du Québec, reviews individuals found not criminally responsible on account of mental disorder (NCRMD). These hearings seek to balance public safety with reintegration, guided largely by treatment team recommendations. Despite the CETM's central role in forensic psychiatry, limited empirical data exist on how its decisions align with clinical advice and which dynamic risk factors influence outcomes. This study aimed to (1) profile the CETM's 2023 caseload, (2) evaluate concordance between CETM dispositions and treatment team recommendations, and (3) examine clinical, social, and legal factors associated with decision-making. **Methods:** We conducted a retrospective review of 1721 judgments issued by the CETM in 2023, retrieved from the publicly accessible Société Québécoise d'information juridique (SOQUIJ) database. Eligible cases included annual NCRMD review hearings, excluding trial fitness assessments and repeated hearings within the same year. A structured coding grid documented sociodemographic, administrative, legal, and clinical information, with emphasis on dynamic risk factors such as treatment adherence, substance use, and recent aggression. Descriptive analyses summarized population characteristics and concordance between clinical recommendations and CETM decisions. **Results:** The cohort was predominantly male (85%) with a mean age of 41 years. Psychotic disorders were the most frequent primary diagnoses (76%), frequently accompanied by substance use and antisocial traits. Most patients (79.6%) had prior psychiatric hospitalizations, while 25.5% had prior incarcerations. Nearly half displayed recent aggression or non-compliance. Treatment teams most often recommended conditional discharge (55%), followed by detention with conditions (21%) and unconditional release (19%). CETM decisions aligned with recommendations in 83.6% of cases; when divergent, rulings were more restrictive (8.6%) than permissive (4.6%). **Conclusions:** This study provides the first large-scale profile of Quebec's CETM. High concordance with clinical teams was observed, but restrictive decisions were more frequent in cases of disagreement. The findings underscore the importance of incorporating standardized risk assessment tools to enhance transparency, consistency, and balance in forensic decision-making.

check for updates

Academic Editor: Stefano Ferracuti

Received: 28 September 2025
Revised: 24 October 2025
Accepted: 2 November 2025
Published: 4 November 2025

Citation: Myszak, P.; Leclair, L.; Khayat, O.; Levy, J.; Abou Jaoude, J.; Dufour, M.; Borduas Pagé, S.; Hudon, A. Retrospective Review of the Criminal Code Review Board in Quebec for the Year 2023. *Forensic Sci.* **2025**, *5*, 59. https://doi.org/10.3390/forensicsci5040059

Copyright: © 2025 by the authors. Licensee MDPI, Basel, Switzerland. This article is an open access article distributed under the terms and conditions of the Creative Commons Attribution (CC BY) license (https://creativecommons.org/licenses/by/4.0/).

Keywords: forensic psychiatry; review boards; risk assessment; psychotic disorders; substance-related disorders; judicial decision-making

1. Introduction

The relationship between violence and mental health is poorly understood within the public [1,2]. Misconceptions stem from highly publicized media events and sensationalized violent crimes [3–5]. However, research has shown that the relationship between mental illness and criminal behavior is weak, and often influenced by the broader social context it is embedded in social determinants (e.g., unemployment, homelessness) [6–8]. Moreover, there has been increasing evidence in support of dynamic risk factors over static risk factors in the prediction of offending behaviors [9]. For example, the relationship between mental health and violent behavior is complex in such that active positive psychotic symptoms predict the risk of criminal behavior, rather than solely having a controlled mental health disorder [10,11]. Additionally, one of the strongest dynamic risk factors of criminal behavior in individuals with mental health disorders remains a substance use disorder [12,13]. Therefore, there is a need to bridge the gap between judicial institutions and mental health services while focusing on specific risk factors related to recidivism, such as antisocial personality and cognition, as well as a lack of prosocial behaviors [14–16].

Under Canadian Law, individuals who committed criminal offenses while mentally ill at the time of the offense come under jurisdiction of provincial and territorial review boards. Under Section 16 of the Canadian Criminal Code, "no person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong" [17]. If the accused meet this criterion, they are deemed Non-Criminally Responsible on account of Mental Disorder (NCRMD). In Quebec, under the aegis of the Tribunal Administratif du Quebec (TAQ), the Commission d'examen des troubles mentaux du Québec (CETM) conducts hearings for cases involving persons NCRMD. The CETM usually reviews decisions annually and render one of three possible decisions: (a) detention (with or without conditions), (b) conditional discharge, or (c) unconditional discharge [18]. The CETM assesses the risk of violence, namely whether the patient represents, because of his mental state, a significant threat to the safety of the public, and must render the necessary and appropriate decision, interpreted as the least onerous and least restrictive disposition. To provide the most accurate risk assessment, the CETM bases their recommendation on the treating psychiatrist's report which provides "a better understanding of the accused's progress, of his condition at the time of the hearing and, consequently, provides an analysis of the threat the accused could pose to public safety" [19]. This system allows for direct communication between judicial boards and mental health professionals to balance the need for public safety with social reintegration.

Recently, there has been a dramatic annual increase in NCRMD cases in Quebec, which already holds a higher number of NCRMD verdicts when compared to the rest of Canada [20–22]. Current evidence places particular emphasis on risk assessment tools that should be systematically used during these reviews, such as the HCR-20 [23]. Evidence shows that dynamic violence risk factors should be used to guide risk assessment recommendations in front of Criminal Code Review Boards [9,24]. However, there is, at this stage, no scientific literature which validates in which way the recommendations of the psychiatric treatment teams are being applied by the review boards during these hearings, and how they help guide the decision-making process.

Therefore, the main objective of this project is to identify the proportion of decisions rendered by the CETM which concur with the recommendations from the psychiatric report, and which dynamic risk factors for violence are correlated to those decisions. In turn, the hope is that this project allows for a better understanding of the demographic portrait of NCRMD cases under the jurisdiction of the CETM in Quebec.

2. Materials and Methods

2.1. Search Strategies

Research was conducted using data from the Société Québécoise d'information juridique (SOQUIJ), an electronic database available on the public domain. Its mandate is to promote research, processing and development of legal information, to improve the quality and accessibility of that information for the benefit of the public. To do so, the SOQUIJ collaborates with *l'Éditeur Officiel du Québec* in the publication of judgements rendered by Quebec's judicial courts. Decisions issued by the Tribunal Administratif du Québec from 1 January through 31 December 2023, were systematically retrieved. However, data extraction was limited by the fact that decisions available on the SOQUIJ database are not comprehensive and therefore only a subset of decisions is available. Considering this information is readily available to the public, there was no need for ethics approbation as per the Ethical Conduct for Research Involving Humans—Tri-Council Policy Statement 2 [25]. Informed consent was not necessary for the review of public mate-rial freely available. In accordance with confidentiality laws, all information from the SOQUIJ database has been de-nominalized. No special filters or keywords were used considering that all judgments available for this time period were assessed.

2.2. NCRMD Annual Review Eligibility Criteria

The objective was to retrieve annual review board decisions concerning NCRMD decisions. Decisions were selected if they responded to the following criterial: (1) Dispositions were issued between 1 January and 31 December 2023; (2) the judgment was issued in French or in English. Decisions concerning ability to withstand trial and court-ordered confinements were eliminated. Additionally, if an individual appeared in front of the review board several times within the selected one-year time frame, the first decision was retained, while subsequent ones were discarded.

2.3. Data Extraction and Analysis

The judgments issued by the CETM for the year 2023 were documented and analyzed using a coding grid in Microsoft Excel (Version 2508). Data was collected from March 2024 to July 2024. The coding framework was developed by the senior investigators (AH, PM). Subsequently, all research assistants and coders (LL, OK, JL, JA) were trained by completing cases alongside the senior investigators. This framework was developed based on static and dynamic factors that could influence risk assessment. Specifically, socio-demographic, medical-administrative, judicial, and clinical history data, as well as clinical presentations in the past year, were collected and categorized according to the coding grid. This approach makes it possible to present various scenarios related to the treatment team's recommendations compared to the decisions rendered by the CETM. The final coding grid can be found in Table 1.

Table 1. Coding grid.

Categories	Information to Collect
Medico-Administrative	Date of the Hearing File Number Administrative Judges Hospital Center Patient Present at the Hearing? Patient Represented by a Lawyer? If Represented, is it Legal Aid? Presence of Family/Friend? Under the review board since When? For What Reasons? Date of the Previous Hearing (if applicable) What was the Verdict at the Previous Hearing? Patient's Lawyer's Request(s) for This Hearing (if applicable)
Sociodemographic Data	Sex Age Children? Lives Alone? Family/Involvement of Relatives? Homelessness? Employment? Hospitalized? If Yes, for How Long? Known to Psychiatry for How Long? History of Previous Hospitalizations? History of Previous Incarcerations? Police Involvement in the Last Year?
Relevant Clinical History	Primary Diagnosis? Other Diagnoses Mentioned Lifestyle Habits: Tobacco? Lifestyle Habits: Alcohol? Lifestyle Habits: Cannabis? Lifestyle Habits: Stimulants? Lifestyle Habits: Other (specify)? Medical History Current Medication (Details in the Judgment) Medication Adherence/Compliance? Attends Follow-Up Appointments?
Symptoms and Signs in the Last Year	Auditory Hallucinations Visual Hallucinations Other Hallucinations (specify) Paranoid Delusion Persecutory Delusion Grandiose Delusion Somatic Delusion Erotomaniac Delusion Other Delusion (specify) Thought Disorder (specify) Aggressiveness Self-Directed Violence (Last Year, Specify if Physical or Verbal) Other-Directed Violence (Last Year, Specify if Physical or Verbal) Self-Criticism (Describe According to Available Information—Good, Partial, Poor, Absent) Judgment (Describe According to Available Information—Good, Partial, Poor, Absent)

Table 1. *Cont.*

Categories	Information to Collect
Judicial History	Relevant History In the Last Year (Theft)? In the Last Year (Break-In)? In the Last Year (Drug Sales/Trafficking)? In the Last Year (Runaway)? In the Last Year (Non-Compliance with Rules)? In the Last Year (Assault: If Yes, Specify if Armed)?
Verdict	Request from the Treating Team (Detention/Release) Requested Conditions Risk Factors Considered by the Team Verdict Delegation of Authority

2.4. Quality Assessment of the Judgments

Due to the heterogenous nature of the judgments found on the SOQUIJ platform, it was not possible to conduct a quality assessment of these judgments.

3. Results

A total of 1721 judgments were analyzed, focusing on sociodemographic traits, administrative court information, clinical data, and legal implications.

3.1. Socio-Demographic Data

Socio-demographic data collected is presented in Table 2. It is possible to observe a predominance of men under the aegis of the CETM, specifically 1464 (or 85.07%), compared to 234 women (13.4%), with a comparable average age for both sexes (40.92 years vs. 40.97 years). Interestingly, only 8. 37% (N = 144) of judgements made mention of homelessness.

Table 2. Sociodemographic data.

Characteristic	N	Percentage
Gender		
Males	1464	85.07%
Females	234	13.60%
Not specified	23	1.33%
Children		
Yes	433	25.16%
No	1063	61.77%
Not specified	225	13.07%
Mention of homelessness in the judgment	144	8.37%
Employment status at the time of the session	313	18.19%

3.2. Administrative Data

In terms of court-relevant information, the data can be found in Table 3. A total of 77.22% of patients (N = 1329) were represented by a lawyer, as opposed to 19,58% of patients (N = 337) that had no representation. Among those represented, 56.51% (N = 751) were represented by legal aid. Only a minority of patients (9.24%, N = 159) had a family member present at the audience.

Table 3. Administrative Data.

Characteristic	N	Percentage
Total Present at the Hearing	1710	99.36%
Representation by lawyers		
Yes	1329	77.22%
No	337	19.58%
Not specified	56	3.25%
Proportion Represented by Legal Aid		
Yes (Among those represented by lawyers)	751	56.51%
Presence of a Family Member		
Yes	159	9.24%
No	1562	90.76%

3.3. Legal Context

Table 4 provides an overview of the legal status of patients at the time of the hearing. On average, patients have been under CETM jurisdiction for 4.7 years. Among the cases presented, which were all NCRMD, 17.08% (N = 294) involve initial hearings. In most cases (79.55%, N = 1369), patients had prior psychiatric hospitalizations. Very few (6.45%, N = 111), had none. On average, patients had been known to psychiatry for 14.33 years before the initial verdict. Additionally, 25.52% (N = 439) had prior incarcerations, while 28.18% (N = 485) did not. However, in 46.31% of cases (N = 797), that information was not available. Several individuals have various criminal records, spanning periods from the 1980s to recent years. Common offenses include theft, fraud, assaults, possession of illegal substances, and non-compliance with court orders. Table 5 outlines the offenses associated with the current hearing. Most cases include assault charges (N = 1388), reported in approximately 80% of all cases.

Table 4. Legal context at the time of the hearing.

Characteristic	N	Percentage
First hearing	294	17.08%
Verdict from the Previous Hearing	1427	
Strict Detention	42	2.94%
Detention with conditions	426	29.85%
Release with conditions	956	66.99%
Prior Psychiatric Hospitalizations		
Yes	1369	79.55%
No	111	6.45%
Not Specified	241	14.00%
Prior Incarceration (beyond detention related to the verdict)		
Yes	439	25.51%
No	485	28.18%
Not Specified	797	46.31%

Table 5. Offense at the time of the hearing.

Offense	N
Assault	1388
Threat to cause death or bodily harm	515
Mischief	442
Theft	387

Table 5. *Cont.*

Offense	N
Failure to comply	203
Criminal harassment	187
Aggressive behavior	103
Breaking and entering	89
Carrying a weapon	66
Murder	56
Attempted murder	24
Reckless driving	18
Fraud	8
Negligent use of a weapon	4

Nota bene: A single hearing may address multiple offenses.

3.4. Clinical Presentation

Table 6 depicts primary psychiatric diagnosis at the time of the hearing. Psychotic disorders account for 75.53% of the primary diagnoses (N = 1300), with the majority being schizoaffective disorder (N = 435) and schizophrenia (N = 647). Bipolar disorders make up 11.85% of primary diagnoses (N = 204), with nearly all cases being classified as Bipolar Type 1 (N = 202). 30 cases involved a primary diagnosis of Personality Disorder, almost exclusively all of which were classified as Cluster B personality disorders: Antisocial (n = 10), Borderline (n = 6), and unspecified Cluster B (n = 13). Table 7 highlights the presence of substance use within the current study population. In terms of psychiatric comorbidities, substance use is highly prevalent, with nearly every case involving a substance use disorder, either current or in remission. Moreover, when surveying the cases, there is a very high prevalence of comorbid personality disorders, particularly, a very high occurrence of antisocial personality traits. Finally, certain specific disorders (such as OCD or specific anxiety disorders) appear less often.

Table 6. Clinical presentation.

Primary Psychiatric Diagnosis	N
Psychotic disorders	1300
Bipolar disorders	204
Major neurocognitive disorder	47
Intellectual disability	40
Personality disorders	30
Mood disorders	13
Autism spectrum disorder	10
Unspecified neurodevelopmental disorder	6
Dissociative disorders	4
Impulse control and conduct disorders	3
Anxiety disorders	2
Sleep disorders	2
Genetic disorders	2
Paraphilia	1
Not specified	57

Table 7. Prevalence of substance use.

Characteristic	N	Percentage
Alcohol		
Yes	626	36.37%
Not specified	1095	63.62%
Cannabis		
Yes	826	48.00%
Not specified	895	52.00%
Stimulants		
Yes	590	34.28%
Not specified	1131	65.72%
Tobacco		
Yes	131	7.61%
Not specified	1590	92.39%
Other		
Yes	390	22.66%
Not specified	1331	77.34%

3.5. Clinical Presentation in the Last Year

Table 8 provides an overview of the clinical presentation in the past year. A total of 30.56% of patients presented with issues related to medication adherence (N = 526). A smaller proportion, 18.25% displayed issues related to follow-up adherence, which includes participation in the care plan. This includes psychiatric follow-up, as well as rehabilitative care plans including other healthcare professionals such as social workers, occupational therapists and nursing staff. When it comes to symptomatology, many cases presented with paranoid/persecutory delusions (N = 769), thought disorders (N = 693) and auditory hallucinations (N = 361) in the past year. In terms of treatment, injectable medications were frequently used, particularly long-acting antipsychotics such as Abilify Maintena, Invega Sustenna, and Clopixol Depot. Clozapine as well was mentioned several times, both for its effectiveness and for patient resistance due to side effects. There are regular mentions of treatment adjustments, suggesting ongoing management and assessment of patient needs, which makes sense considering the large proportion of patients presenting with active psychotic symptoms or the presence of side effects.

Table 8. Clinical presentation in the last year.

Characteristic	N	Percentage
Issues Related to Medication Adherence		
Yes	526	30.56%
No	1068	62.06%
Not specified	127	7.38%
Issues Related to Attending Follow-ups/Participating in the Care Plan		
Yes	314	18.25%
No	136	7.90%
Not specified	1271	73.85%
Hallucinations (mentioned in the judgment)		
Auditory	361	20.98%
Visual	46	3.67%
Other	72	4.18%

Table 8. *Cont.*

Characteristic	N	Percentage
Delusions (mentioned in the judgment)		
Paranoid/Persecutory	769	44.68%
Grandiose	203	11.80%
Erotomanic	42	2.44%
Somatic	35	2.03%
Other	589	34.22%
Thought Disorder (mentioned in the judgment)	693	40.27%

Moreover, Table 9 portrays the prevalence of antisocial behavior in the last year, and Table 10 breaks down the different types of aggressive behaviors in the past year (year 2022). A non-negligeable number of patients exhibited aggressive behavior (N = 751), violence toward others (N = 707) and non-compliance with unit/living environment rules (N = 737).

Table 9. Antisocial behavior in the last year.

Characteristic	N
Theft	79
Breaking and entering	56
Drug Trafficking	29
Escape	149
Non-compliance with Unit/Living Environment Rules	737
Assaults (all forms)	476

Table 10. Aggressive behavior in the last year.

Characteristic	N
Aggressive behavior	81
Self-directed violence	56
Hetero-directed violence	707

3.6. Decisions Rendered

The first section of Table 11 outlines the treatment teams' recommendations, while the second section illustrates the various scenarios that arise when comparing the CETM's decisions to those recommendations. Most treatment teams recommended conditional discharge (N = 948), while detention with conditions (N = 364) and absolute discharge (N = 329) were less frequently suggested. Strict detention (N = 24) was recommended in only a small number of cases. In 83.55% of cases, the decisions rendered by the CETM (N = 1438) were aligned with the recommendations of the treatment teams. 8.59% of the decisions rendered (N = 148) were more restrictive than the recommendations received. In turn, 4.59% of the decisions rendered (N = 79) were more permissive than the recommendations. When analyzing in which cases the decisions rendered were more permissive; cases in which a conditional discharge was recommended, and the decision was absolute discharge (N = 58) was the most often encountered scenario. A summary of the decision concordances is reported in Figure 1.

Table 11. Decisions rendered.

Characteristic	N	Percentage
Recommendations from the Treatment Team		
Strict detention	24	1.39%
Detention with conditions	364	21.15%
Release with conditions	948	55.08%
Unconditional release	329	19.11%
Not specified	56	3.25%
Scenarios of Treatment Team Recommendations (R) versus CETM Decision (D)		
Recommendations = Decisions	1438	83.55%
Recommendations more restrictive than the decision	148	8.59%
Recommendations more permissive than the decision	79	4.59%
• Strict detention (R), Detention with conditions (D)	7	
• Detention with conditions (R), Release with conditions (D)	13	
• Detention with conditions (R), Unconditional release (D)	1	
• Release with conditions (R), Unconditional release (D)	58	
Not specified	56	

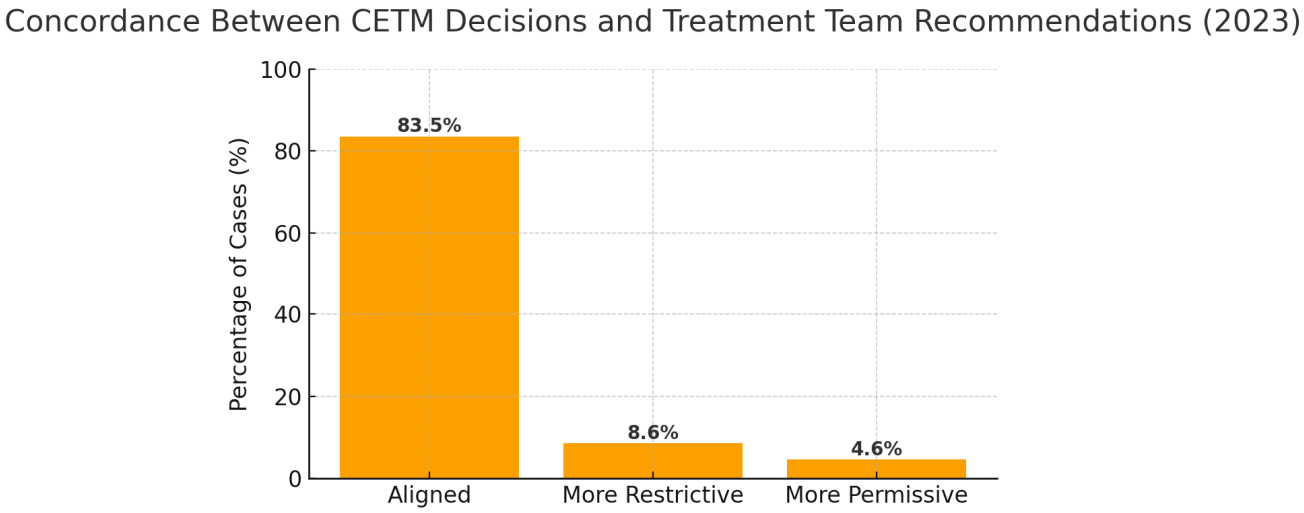

Figure 1. Concordance between CETM and treatment team recommendations for the year 2023.

4. Discussion

In this study, we analyzed 1721 judgments from the TAQ in 2023 to establish a demographic profile of the population under the CETM's jurisdiction. Findings indicate a predominantly male population (85.07%) with an average jurisdiction duration of 4.7 years, and a high prevalence of psychotic disorders (75.53%) often accompanied by substance use and personality disorders. Notably, 83.55% of CETM decisions aligned with treatment team recommendations; when discrepancies occurred, permissive decisions were approximately twice as common as restrictive ones.

The first matter to be discussed is the disproportionate number of cases (n = 1721) under the jurisdiction of the CETM in Quebec compared to the rest of Canada. Moreover, the number of judgments retrieved underestimates the number of cases in Québec since data extraction was limited to the subset of decisions available in the SOQUIJ database. Yet, it remains higher than in the rest of Canada proportionally to the population. A similar study depicting a population-based overview of the Ontario forensic mental health system collected data from 1240 subjects under the jurisdiction of the Ontario Review Board over the span of two years, 2014–2015 [26]. Even when taking into the account the increasing number of cases under the jurisdiction of review board, there is a significant difference between the number of cases in Quebec compared to Ontario. The National Trajectory Project study presented comparable results, showing that "Quebec had 6.4 times

the number of cases diverted to the RB system than Ontario, and 5 times that of British Columbia" [27]. The rise in NCRMD verdicts and variations in applying federal law across provinces highlight the need to implement standardized risk assessment tools as well as better pre-arrest mental health services for minor offenses.

A notable proportion of individuals (19.58%) lacked legal representation, and even fewer had family or friends present at their hearings. Exploring whether the absence of representation influences decisions could provide valuable insights. The absence of a support system for individuals with mental illness increases their vulnerability, potentially leading to prolonged supervision under the oversight of the TAQ. Conversely, a stable support system is frequently associated with shorter stays in forensic psychiatric hospitals, highlighting its importance as a factor in risk management [28].

When examining drawbacks in the system, one key issue stands out: 79.55% of individuals had prior hospitalizations before the index offense, compared to only 25.51% with prior incarcerations. This underscores the need to prioritize violence risk assessment and interventions within psychiatric services to prevent further mental health deterioration and reduce the risk of criminal behavior. Moreover, it contrasts the skewed portrayal of individuals declared NCRMD in Canadian media, which highlights criminality and violence rather than treatment and rehabilitation [29].

Serious offenses such as murder (N = 56) and attempted murder (N = 24) are significantly less common compared to minor offenses like theft (N = 387), mischief (N = 442), and failure to comply (N = 203). However, assaults are the most frequent offense. It would be valuable to further analyze assaults based on their severity to determine whether they are predominantly minor or major. One hypothesis suggests that Quebec has a higher number of NCRMD cases because it is less likely to restrict NCRMD defenses to more severe offenses compared to British Columbia or Ontario [27]. This hypothesis is supported by the fact that criteria for involuntary hospitalization in Quebec are the most restrictive ones in Canada, allowing compulsive admissions only for patients who present an acute risk of violence and not a need for treatment or to prevent a mental health deterioration like most other provinces. Forensic psychiatry system is seldom used to treat these patients who may not present a high risk of violence but cannot be treated properly given the restrictive nature of civil mental health legislations in Quebec.

Most cases involved individuals with psychotic disorders (N = 1300), consistent with prior research identifying psychotic spectrum disorders as the most common diagnosis [27]. Substance use and personality disorders, particularly cluster B disorders, are also highly prevalent. Alcohol and cannabis use contribute to disinhibition, exacerbate psychiatric symptoms and increase the risk of aggression and criminal behavior [12,30–32]. Antisocial personality traits include lack of remorse, pleasure-seeking, impulsivity, and a tendency to ignore laws and social norms [22]. These traits contribute to a chronic risk of criminal behavior and aggression and may serve as negative predictors for discharge. Interestingly, diagnosis has shown mixed results in predicting outcomes [33]. For instance, one study found psychotic patients had higher discharge rates from forensic hospitals compared to those with personality disorders [34]. However, Crocker et al. (2014) reported that psychotic diagnoses reduced the likelihood of receiving an absolute discharge, while personality disorders decreased conditional discharge likelihood but increased chances of absolute discharge [35]. Thus, diagnosis may be more effective as a dynamic predictor based on recent clinical presentations. Risk-Need-Responsivity models also emphasized the criminogenic factors other than the mental disorders in the risk assessment and should therefore be part of any risk management plan.

Many individuals experienced psychotic symptoms within the past year. Adherence issues were frequently observed, highlighting a common challenge in psychiatric care.

Adherence issues are an even greater challenge in Quebec due to the difficulty in obtaining court-ordered involuntary treatment. Since Quebec's legal system strongly prioritizes patient autonomy, forcing treatment requires judicial authorization, making interventions slower and more complex. This legal barrier means that individuals who refuse treatment (especially those with severe mental illness) may continue to deteriorate without timely medical intervention. In contrast, Ontario's Mental Health Act allows for Community Treatment Orders and physician-led decisions, enabling earlier intervention and better enforcement of treatment plans. As a result, in Quebec, non-adherence can lead to prolonged untreated illness, increased hospitalizations, and increased reliance on verdicts of NCRMD to impose legal barriers and enforce treatment. This means that legal intervention often comes only after a criminal offense has occurred, rather than through proactive medical measures, exacerbating the risks associated with non-adherence. Psychosis combined with non-adherence to medication increases the risk of aggressive behavior [36]. Therefore, it is crucial to assess dynamic factors, such as compliance with treatment and institutional rules, clinical instability, and worsening symptoms, as these factors are strong predictors of provisional discharge failure [37]. However, in addition to treatment response, substance use disorder and violent behavior since the last hearing were found to be important variables predicting discharge [27,38]. Regularly reviewing changes in dynamic risk factors helps evaluate the effectiveness of risk mitigation strategies and determine whether the individual is stabilizing for discharge [39].

This study demonstrates that, in most cases, the decisions made by the CETM align with the treatment team's recommendations. Notably, when discrepancies occur, the CETM is more likely to be restrictive (N = 148) than permissive (N = 79), with restrictive decisions occurring approximately twice as often. One possible hypothesis is that Quebec's significantly higher number of cases processed through the RB system compared to the rest of Canada may be due to the inclusion of a larger proportion of minor offenses [27]. This increase in minor cases could explain the tendency toward more restrictive rather than permissive verdicts within the system. Considering the multitude of dynamic and static risk factors, each with varying degrees of significance, the rising number of NCRMD verdicts in Quebec has made it increasingly challenging to provide risk assessment recommendations that effectively target the most pertinent elements. This study further highlights significant variability in risk assessment approaches. Future research should explore the types and strengths of risk factors identified by clinicians and determine which factors hold greater influence in the decision-making process of the review board.

Limitations

Notably, SOQUIJ does not have access to all judgments rendered by the Superior Court of Quebec. The data collected in this study was limited to the information provided in the judgments available, as there was no access to reports from the treating teams for comparison. This constraint can affect the external validity of the clinical data identified.

5. Conclusions

This study provides the first comprehensive, population-level analysis of the CETM in Quebec for the year 2023, offering novel insights into both its caseload and the decision-making processes. The findings highlight a population characterized by a predominance of psychotic disorders, high rates of comorbid substance use, and recurrent social disadvantage, factors that complicate both treatment and risk management. Importantly, CETM decisions were largely aligned with treatment team recommendations, supporting the central role of clinical expertise in guiding judicial outcomes. However, when divergences occurred, restrictive dispositions were more frequent than permissive ones, suggesting a

cautious approach when balancing public safety with reintegration. The results further underscore the vulnerability of individuals appearing before the CETM, as many lacked legal representation or familial support during hearings. These systemic disparities raise critical questions about procedural fairness and equity within the forensic psychiatric system. The overrepresentation of minor offenses in the Quebec cohort, compared to other provinces, may partially explain the higher number of NCRMD verdicts and the inclination toward restrictive rulings. Taken together, these observations reveal a system under strain, tasked with managing a growing and complex population while maintaining the least onerous restrictions mandated by law. The study highlights the urgent need for standardized risk assessment tools, such as the HCR-20, to improve the consistency and transparency of decisions. By integrating evidence-based practices, strengthening clinical-judicial collaboration, and addressing gaps in representation and support, review boards can enhance both patient recovery and public safety in a more equitable manner.

Author Contributions: Conceptualization, A.H.; methodology, A.H.; validation, P.M.; formal analysis, P.M., L.L., O.K., J.L. and J.A.J.; investigation, P.M., L.L., O.K., J.L. and J.A.J.; resources, A.H.; data curation, P.M., L.L., O.K., J.L. and J.A.J.; writing—original draft preparation, P.M. and A.H.; writing—review and editing, all authors.; visualization, P.M.; supervision, S.B.P., M.D. and A.H.; project administration, A.H. All authors have read and agreed to the published version of the manuscript.

Funding: This research was funded indirectly by the Fondation de l'Insititut universitaire en santé mentale de Montréal and IVADO operational funds of Dr. Hudon.

Institutional Review Board Statement: Considering this information is readily available to the public, there was no need for ethics approbation as per the Ethical Conduct for Research Involving Humans—Tri-Council Policy Statement 2.

Informed Consent Statement: Informed consent was not necessary for the review of public material freely available. In accordance with confidentiality laws, all information from the SOQUIJ database has been anonymized.

Data Availability Statement: Restrictions apply to the availability of these data. Data were obtained from the open-access registry of the Société québécoise d'information juridique (SOQUIJ) and are available at https://soquij.qc.ca/ with the permission of SOQUIJ.

Conflicts of Interest: The authors declare no conflicts of interest.

Abbreviations

The following abbreviations are used in this manuscript:

CETM	Commission d'examen des troubles mentaux
TAQ	Tribunal Administratif du Québec
NCRMD	Not Criminally Responsible on account of Mental Disorder
SOQUIJ	Société Québécoise d'information juridique
HCR-20	Historical Clinical Risk Management-20
DSM	Diagnostic and Statistical Manual of Mental Disorders

References

1. Ahonen, L.; Loeber, R.; Brent, D.A. The association between serious mental health problems and violence: Some common assumptions and misconceptions. *Trauma Violence Abus.* **2019**, *20*, 613–625. [CrossRef]
2. Horgoș, B.-M.; Ungureanu, D.; Crișan, C.-A. Insight and Violence: An Overview of the Possible Link and Treatment Options in Forensic Psychiatric Settings. *Psychiatry Int.* **2024**, *5*, 975–998. [CrossRef]
3. Battaglia, A.M.; Mamak, M.; Goldberg, J.O. The impact of social media coverage on attitudes towards mental illness and violent offending. *J. Community Psychol.* **2022**, *50*, 2938–2949. [CrossRef] [PubMed]

4. Zhang, H.; Firdaus, A. What Does Media Say about Mental Health: A Literature Review of Media Coverage on Mental Health. *J. Med.* **2024**, *5*, 967–979. [CrossRef]
5. Graham, M.; Morgan, A.; Paton, E.; Ross, A. Examining the quality of news media reporting of complex mental illness in relation to violent crime in Australia. *Int. J. Soc. Psychiatry* **2023**, *69*, 2110–2120. [CrossRef]
6. Edwards, L.M.; Chang, S.; Zeki, R.; Jamieson, S.K.; Bowman, J.; Cooper, C.; Sullivan, E. The associations between social determinants of health, mental health, substance-use and recidivism: A ten-year retrospective cohort analysis of women who completed the connections programme in Australia. *Harm Reduct. J.* **2024**, *21*, 2. [CrossRef]
7. Xu, K.Y.; Gold, J.A.; Szlyk, H.S.; Rolin, S.A.; Shields, M.C. Mental Illness and Violence Among People Experiencing Homelessness: An Evidence-Based Review. *Mo. Med.* **2024**, *121*, 14–20. [CrossRef] [PubMed]
8. Armstead, T.L.; Wilkins, N.; Nation, M. Structural and social determinants of inequities in violence risk: A review of indicators. *J. Community Psychol.* **2021**, *49*, 878–906. [CrossRef] [PubMed]
9. Cheng, J.; Olver, M.E.; Haag, A.M.; Wormith, J.S. Static and dynamic predictors of forensic mental health decision-making. *Psychol. Serv.* **2023**, *20*, 899–907. [CrossRef]
10. Beaudoin, M.; Potvin, S.; Dellazizzo, L.; Luigi, M.; Giguère, C.E.; Dumais, A. Trajectories of dynamic risk factors as predictors of violence and criminality in patients discharged from mental health services: A longitudinal study using growth mixture modeling. *Front. Psychiatry* **2019**, *10*, 301. [CrossRef]
11. Lin, R.; Li, Q.; Liu, Z.; Zhong, S.; Huang, Y.; Cao, H.; Zhang, X.; Zhou, J.; Wang, X. Risk factors for violent crime in patients with schizophrenia: A retrospective study. *PeerJ* **2024**, *12*, e18014. [CrossRef]
12. Whiting, D.; Gulati, G.; Geddes, J.R.; Fazel, S. Association of Schizophrenia Spectrum Disorders and Violence Perpetration in Adults and Adolescents From 15 Countries: A Systematic Review and Meta-analysis. *JAMA Psychiatry* **2022**, *79*, 120–132. [CrossRef]
13. Lagerberg, T.; Lambe, S.; Paulino, A.; Yu, R.; Fazel, S. Systematic review of risk factors for violence in psychosis: 10-year update. *Br. J. Psychiatry* **2025**, *226*, 100–107. [CrossRef]
14. Noland, E.; Strandh, M.; Klötz Logan, F. The reconvictions of mentally disordered offenders-how, when, and where? *BMC Psychiatry* **2022**, *22*, 264. [CrossRef]
15. Morgan, R.D.; Scanlon, F.; Van Horn, S.A. Criminogenic risk and mental health: A complicated relationship. *CNS Spectr.* **2020**, *25*, 237–244. [CrossRef]
16. Van Deinse, T.B.; Cuddeback, G.S.; Wilson, A.B.; Edwards, D., Jr.; Lambert, M. Variation in Criminogenic Risks by Mental Health Symptom Severity: Implications for Mental Health Services and Research. *Psychiatr. Q.* **2021**, *92*, 73–84. [CrossRef] [PubMed]
17. Jansman-Hart, E.M.; Seto, M.C.; Crocker, A.G.; Nicholls, T.L.; Côté, G. International trends in demand for forensic mental health services. *Int. J. Forensic Ment. Health* **2011**, *10*, 326–336. [CrossRef]
18. Salem, L.; Crocker, A.G.; Charette, Y.; Seto, M.C.; Nicholls, T.L.; Côté, G. Supportive housing and forensic patient outcomes. *Law Hum. Behav.* **2015**, *39*, 311–320. [CrossRef] [PubMed]
19. La Commission d'Examen des Troubles Mentaux du Québec (CETM): Guide Québec: Tribunal Administratif du Québec. 2016. Available online: https://www.taq.gouv.qc.ca/fileadmin/user_upload/Guide_CETM_Francais_2021.pdf (accessed on 3 January 2024).
20. Crocker, A.G.; Nicholls, T.L.; Seto, M.C.; 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. *Can. J. Psychiatry. Rev. Can. Psychiatr.* **2015**, *60*, 98–105. [CrossRef] [PubMed]
21. Leclair, M.C.; Charette, Y.; Caulet, M.; Crocker, A.G. Care pathways, health service use patterns and opportunities for justice involvement prevention among forensic mental health clients. *Can. J. Psychiatry* **2022**, *67*, 907–917. [CrossRef]
22. Martin, S.; Charette, Y.; Leclerc, C.; Seto, M.C.; Nicholls, T.L.; Crocker, A.G. 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. *Front. Psychiatry* **2022**, *12*, 775480. [CrossRef] [PubMed]
23. Côté, G.; Crocker, A.G.; Nicholls, T.L.; Seto, M.C. Risk assessment instruments in clinical practice. *Can. J. Psychiatry. Rev. Can. Psychiatr.* **2012**, *57*, 238–244. [CrossRef] [PubMed]
24. Crocker, A.G.; Braithwaite, E.; Côté, G.; Nicholls, T.L.; Seto, M.C. To detain or to release? Correlates of dispositions for individuals declared not criminally responsible on account of mental disorder. *Can. J. Psychiatry. Rev. Can. Psychiatr.* **2011**, *56*, 293–302. [CrossRef]
25. Conseil de Recherches en Sciences Humaines du Canada, Conseil de Recherches en Sciences Naturelles et en Génie du Canada, Instituts de Recherche en Santé du Canada. Énoncé de Politique des Trois Conseils Éthique de la Recherche avec des êtres Humains. December 2022. Available online: https://ethics.gc.ca (accessed on 17 June 2024).
26. Chaimowitz, G.; Moulden, H.; Upfold, C.; Mullally, K.; Mamak, M. The Ontario forensic mental health system: A population-based review. *Can. J. Psychiatry. Rev. Can. Psychiatr.* **2022**, *67*, 481–489. [CrossRef]

27. Crocker, A.G.; Nicholls, T.L.; Seto, M.C.; 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. *Can. J. Psychiatry. Rev. Can. Psychiatr.* **2015**, *60*, 106–116. [CrossRef]
28. Sebalo, I.; Sebalo Vňuková, M.; Anders, M.; Ptáček, R.; Páv, M. Markers of predicting discharge from forensic psychiatric hospitals in Czechia. *Int. J. Soc. Psychiatry* **2024**, *70*, 1075–1082. [CrossRef] [PubMed]
29. Whitley, R.; Berry, S. Trends in newspaper coverage of mental illness in Canada: 2005–2010. *Can. J. Psychiatry. Rev. Can. Psychiatr.* **2013**, *58*, 107–112. [CrossRef]
30. Kraan, T.; Velthorst, E.; Koenders, L.; Zwaart, K.; Ising, H.K.; van den Berg, D.; de Haan, L.; van der Gaag, M. Cannabis use and transition to psychosis in individuals at ultra-high risk: Review and meta-analysis. *Psychol. Med.* **2016**, *46*, 673–681. [CrossRef]
31. Moulin, V.; Framorando, D.; Gasser, J.; Dan-Glauser, E. The Link Between Cannabis Use and Violent Behavior in the Early Phase of Psychosis: The Potential Role of Impulsivity. *Front. Psychiatry* **2022**, *13*, 746287. [CrossRef]
32. Sontate, K.V.; Rahim Kamaluddin, M.; Naina Mohamed, I.; Mohamed, R.M.P.; Shaikh, M.F.; Kamal, H.; Kumar, J. Alcohol, aggression, and violence: From public health to neuroscience. *Front. Psychol.* **2021**, *12*, 699726. [CrossRef]
33. Fisher, K.A.; Torrico, T.J.; Hany, M. Antisocial Personality Disorder. In *StatPearls*; StatPearls Publishing: Treasure Island, FL, USA, 2025. Available online: https://www.ncbi.nlm.nih.gov/books/NBK546673/ (accessed on 29 February 2024).
34. Ross, T.; Querengässer, J.; Fontao, M.I.; Hoffmann, K. Predicting discharge in forensic psychiatry: The legal and psychosocial factors associated with long and short stays in forensic psychiatric hospitals. *Int. J. Law Psychiatry* **2012**, *35*, 213–221. [CrossRef] [PubMed]
35. Crocker, A.G.; Nicholls, T.L.; Charette, Y.; Seto, M.C. Dynamic and static factors associated with discharge dispositions: The national trajectory project of individuals found not criminally responsible on account of mental disorder (NCRMD) in Canada. *Behav. Sci. Law* **2014**, *32*, 577–595. [CrossRef] [PubMed]
36. Li, Y.; Wen, H.; Xiong, C.; Lin, C.; Yang, X.; Wang, D.; Fan, R.; Liu, J.; Zhao, X.; Liu, Y.; et al. Medication nonadherence and risk of violence to others among patients with schizophrenia in Western China. *JAMA Netw. Open* **2023**, *6*, e235891. [CrossRef]
37. Kastner, R.M.; Vitacco, M.J.; Anderson, K.; Batastini, A.B. Risk assessment and provisional discharge: Predictive utility of the HCR-20. *Psychol. Public Policy Law* **2022**, *28*, 332–343. [CrossRef]
38. McDermott, B.E.; Quanbeck, C.D.; Busse, D.; Yastro, K.; Scott, C.L. The accuracy of risk assessment instruments in the prediction of impulsive versus predatory aggression. *Behav. Sci. Law* **2008**, *26*, 759–777. [CrossRef]
39. Hogan, N.R.; Olver, M.E. Static and dynamic assessment of violence risk among discharged forensic patients. *Crim. Justice Behav.* **2019**, *46*, 923–938. [CrossRef]

Disclaimer/Publisher's Note: The statements, opinions and data contained in all publications are solely those of the individual author(s) and contributor(s) and not of MDPI and/or the editor(s). MDPI and/or the editor(s) disclaim responsibility for any injury to people or property resulting from any ideas, methods, instructions or products referred to in the content.