

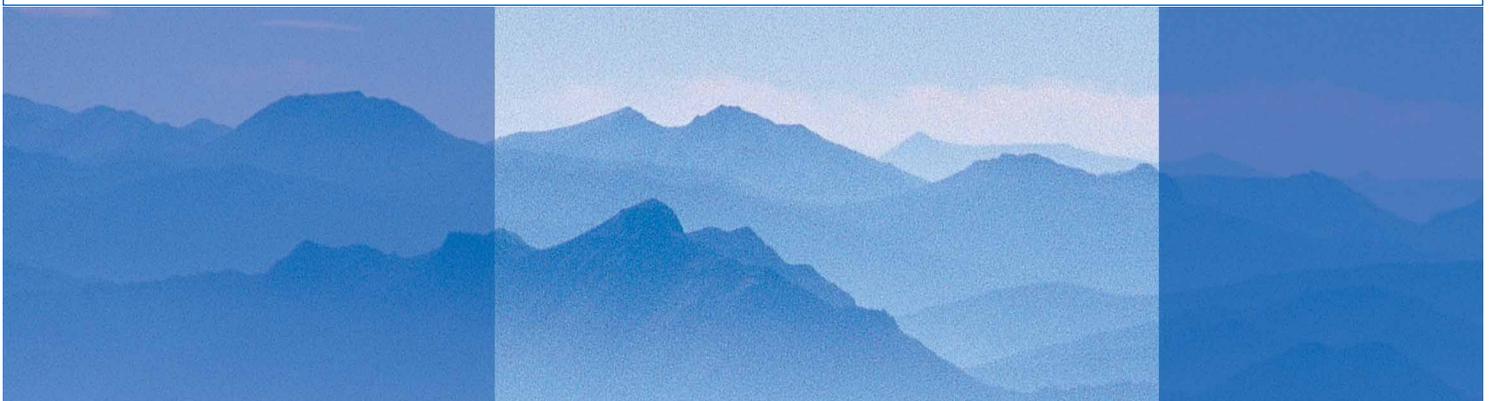


Mental Disorder, Substance Use and Criminal Justice Contact

PART 2

KEY INFORMANT SURVEY

JULY 2004





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Mentally Disordered Offender Services Survey

This Report was commissioned as part of a broader Provincial Strategy by the Government of British Columbia, Canada. The Provincial Strategy is intended to support the development of programs and services for people with mental illness who are within or at risk of entering the criminal justice system. A comprehensive literature review and analysis of administrative databases in BC was also conducted as part of this initiative.

As the term is used in this report, “*mentally disordered offender*” (MDO) refers to the overlap between the offender population and all DSM-IV diagnoses (except anti-social personality disorder), including substance-related disorders, developmental disabilities (IQ below 70), low functioning (IQ above 70 with limited adaptive abilities), brain injury (organic or acquired) and fetal alcohol effects/syndrome. Results of the literature review and data analysis confirmed that these disorders are significantly over-represented among offenders.

To supplement the information provided in the data analysis and literature review, a survey of key informants was conducted. All Canadian Provinces and Territories were surveyed, as well as specific international jurisdictions that are similar in population and culture to British Columbia (i.e., New Zealand, Scotland, Victoria (Australia)). A respondent from the state forensic service in Maryland, USA was also surveyed, given that state’s reputation in this area. Respondents are listed in Appendix A.

Taken together, the Literature Review complements the analysis of linked BC data by allowing for comparison between needs that are apparent in BC and those in other jurisdictions internationally. The present survey was undertaken to clarify the status of needs and practical reforms as perceived by key informants who are responsible for mental health and justice systems in relevant jurisdictions. Ultimately, information from all three of the above serves as a basis for recommendations to improve the efficiency and effectiveness of resources within BC. A copy of the Survey is attached as Appendix B.



I. Service Model Description

Thirteen surveys¹ were returned, covering a range of services for mentally disordered offenders. Despite the small number of respondents and the fact that some areas of the survey were not covered by each respondent, a number of common themes emerged in regard to service models.

Addictions Services

Two of the respondents represented Provincial addictions services in Canada (Manitoba and Nova Scotia). It is noteworthy that neither province has a service model *specifically* for mentally disordered offenders. One of the services provides rehabilitation to those with “low to high substance use issues with low mental health issues.” They use a model of *locus of care by problem severity*, which directs patients with high substance use and mental health issues to be treated by mental health services. Considering that substance abuse issues are endemic amongst forensic patients but also somewhat neglected in treatment (see Ogloff, Davis, & Somers, 2004; Ogloff, Lemphers, & Dwyer, 2003), it can be argued that there is a high need for specialized dual diagnosis services within forensic mental health. This does not minimize the crucial work undertaken by specialist addiction services, but does suggest that the dually diagnosed may fail to receive specialized services. Indeed, as noted in Part I of the Key Informant Survey, dual diagnosis (i.e., mental health and substance misuse) services are required to address the complications that arise when a person has both a mental illness and substance use disorder.

Community Corrections

The respondent from community corrections in Newfoundland and Labrador noted that there are “no concerted or organized services to address ... (MDO) ... issues within community corrections.” When such “multi-need” cases are identified, specialized or institutional services are consulted, such as psychiatric hospitals, human resources and employment, and health and community services. However, in cases involving youth and children with “special needs” it was noted that a more formalized memorandum of understanding is signed among several government departments “to provide a

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¹ An additional respondent from addiction services in New Brunswick did not answer this section of the survey (noting that it was not relevant to their field).



I. Service Model Description

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model for the co-ordination of services.” A respondent from community corrections in Saskatchewan noted that a sex offender intervention program (is) offered in eight regions of the province, with Health Districts offering psychological and psychiatric services, and Provincial Corrections offering substance abuse intervention.

Specialist Forensic Services

Nine respondents (five from Canada and one from each of New Zealand, Scotland, Victoria, and Maryland) indicated that they provide specialist services for mentally disordered offenders. Although the respondents varied in their description of services, a common theme was the notion of a “continuum” of care and support consisting of links between the forensic or correctional service and other services such as community mental health centres, local general hospitals, halfway houses, family services, rehabilitation, etc.

The Scottish respondent indicated that “forensic mental health services are well developed in prison and hospital but are much more limited in the community.” Nevertheless, some form of community forensic service is available, and a “managed network of forensic patient care is currently being established.” The respondent from Saskatchewan mentioned several forensic services ranging from a hospital-based, medium-security forensic unit (which includes a maximum-security federal facility for “remand and NCRs that cannot be contained”) to community-based forensic assessments through Mental Health Services. Furthermore, some MDOs are treated with civil psychiatric patients in the rehabilitation unit of the medium-security hospital.

The respondent from Victoria, Australia described an integrated forensic mental health service that includes a wide range of services: court liaison workers (nurses and psychologists) in magistrate courts around the state; intake assessments of all offenders entering jails; psychiatric services in prisons and jails; an acute assessment unit in the state remand jail for mentally disordered offenders; a secure forensic hospital; community-based forensic

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I. Service Model Description

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mental health services; and secondary consultation to area mental health services.

Substance abuse services were a feature of some services, and the need for continuity of care between addiction and mental health services was noted by many respondents (i.e., “most of the time they are the same clients”). Overall, the call for dual diagnosis services has been acknowledged. The forensic service in Victoria, Australia noted the development of systematic assessment and intervention services to identify the needs of patients with both mental illness and substance use disorders. Apparently, research in this jurisdiction has shown that 76% of patients in the secure forensic mental health hospital had a diagnosis of a major mental illness and either a substance abuse or dependence disorder at some time during their life.

The forensic service in Maryland is part of the Department of Health and Mental Hygiene and provides evaluations and treatment of forensic patients. The Mental Hygiene Administration operates a secure psychiatric hospital that accommodates prisoners who become mentally ill and are involuntarily hospitalized. Therefore, specialized forensic services appear to be well-developed in a number of jurisdictions.

Diversion Programs and Mental Health Courts

A respondent from Alberta explicitly noted the creation of a diversion program to provide support and mental health treatment for mentally disordered offenders, and to reduce the burden on the criminal justice system. Another respondent (New Brunswick) noted that a mental health court was being developed, while two other respondents (New Zealand and Victoria, Australia) described links with the court system via court-liaison services. Police and court-based diversion initiatives were also described by Ontario.

Maryland operates a jail-based diversion program that provides social work and occasional psychiatric services to local jails to help identify mentally ill inmates who may be candidates for diversion to mental health treatment in the community.

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I. Service Model Description

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An early psychosis program was being pilot tested in New Brunswick and it was noted that “some of the clients . . . may be at -risk offenders.” Similarly, in Victoria, Australia, an early psychosis program exists to try to identify and treat adolescents who develop psychosis. To some extent, these programs can be seen as early intervention approaches, although it is unclear how much either program targets youth at risk for both psychosis and offending. An early intervention program was also identified by one of the addiction services, which provides awareness and education programs to “children, youth, family, and communities,” as well as targeted programming where appropriate.

Legislation and Administration of Services

Most of the services described by the survey respondents are administered from a central base. A few are more regionally structured; however, some involvement from more “central” agencies was still noted in these cases. Ontario’s service is maintained by the Ministry of Community Safety and Correctional Services (who also collaborates with the Ministry of the Attorney General on police and court-based diversion). Alberta has a Provincial Forensic Psychiatry Program under the governance of the Alberta Mental Health Board. This is mandated under the authority of the *Criminal Code of Canada*, the *Youth Criminal Justice Act*, the *National Parole Act*, and the Alberta Corrections Act. Addiction services in Nova Scotia are “under the operational guidance of the District Health Authorities” while the Department of Health is responsible for defining core services, policy, and standards.

Services for MDOs in New Brunswick are provided by the Mental Health Services Division. This is headed by an Assistant Deputy Minister who reports to the Deputy Minister of Health and Wellness. Two pieces of legislation are relevant: the *Mental Health Act* and the *Mental Health Services Act*.



I. Service Model Description

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The respondent from Saskatchewan Health reported that mental health services (Community Care Branch, Saskatchewan Health) fund the medium security forensic unit in that jurisdiction. Both the mental health and corrections services are “freestanding organizations.” Nevertheless, the maximum security forensic facility is run by the federal government (Regional Psychiatric Centre in Saskatoon, which is operated by the Correctional Service of Canada). Further, “the Human Services Integration Forum (Department of Learning) has taken a lead role in developing a strategy for complex needs cases.” The respondent from Saskatchewan Community Corrections noted that an interdepartmental committee, comprised of the Departments of Health, Community Resources and Employment, Justice, Corrections and Public Safety, and Education, have been formally working together “to improve services and support to individuals with cognitive disabilities” and behavioural problems.

The Scottish service is centrally based: the State Hospital Board for Scotland organizes high-security services, and all other services fall under local primary care of the National Health Service Trust. Services for MDOs are currently covered by the *Mental Health (Scotland) Act* and the *Criminal Procedure (Scotland) Act*, although the recently passed *Mental Health (Care and Treatment) (Scotland) Act* will be enacted in April 2005.

New Zealand Forensic Mental Health Services are regionally-based, with each regional catchment “accountable to one (lead) District Health Board.” These regional services are autonomous, such that each region may make its own decisions regarding overall policies, admission, and governance, although this is constrained by the law and “common agreement.” Additionally, forensic services, through a National Forensic Advisory Committee, are “an advocacy/advisory instrument via the Ministry of Health.” Addictions services in Nova Scotia are under the direction of the Department of Health, who develop provincial policy. Operational guidance of these services is provided by the District Health Authorities.

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I. Service Model Description

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In Australia, the Victorian Institute of Forensic Mental Health, also known as Forensicare, was established by the Parliament of Victoria as a statutory authority by an amendment to the Mental Health Act. Forensicare is governed by a council that reports to the Minister of Health. The Forensicare council includes representatives from the Attorney General, Corrections Victoria, and the Minister of Health.

Similarly, in Maryland, the Office of Forensic Services is part of the Maryland Mental Hygiene Administration, a division of Maryland's Department of Health and Mental Hygiene.

Therefore, both centrally- and regionally-based services are represented amongst the jurisdictions surveyed; however, in almost all cases, some involvement from central agencies is present.

Summary

The results of the first section of the survey suggest that while there is diversity in services for MDOs, there are also some common themes in regard to models of service. Specialist forensic services appear to be well represented amongst the various jurisdictions. Some of these provide inpatient care in forensic hospitals, while others have specialist units within the prison system. A continuum of care from inpatient to community-based services is also well established, either through specialist services or links to general community psychiatric treatment. An array of allied services is also evident (housing, family services, etc.).

Despite the considerable literature pertaining to mental health courts, they are currently rare in the jurisdictions surveyed, with only New Brunswick reporting a pilot program at this stage. Although Ontario has a mental health court, it was not mentioned by the respondent from Ontario. Omission of this court's services may be due to the fact that it provides rather limited services to individuals who are unfit to stand trial or not

continued ...



I. Service Model Description

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criminally responsible on account of mental disorder. Further information can be found at <http://www.attorneygeneral.jus.gov.on.ca> and www.health.gov.on.ca/index.html

Both New Zealand and Victoria, Australia have court liaison programs that provide both diversionary services as well as assessment and identification of offenders eligible for special consideration as forensic patients (i.e., unfit to stand trial or not criminally responsible on account of mental disorder).

A summary of the services available in each of the jurisdictions surveyed can be found in **Table 1**. Gaps in the table reveal areas that were unclear or not covered by respondents. Please note that these descriptions of services relate specifically to areas assessed in the survey, and do not necessarily apply to any other services that may exist in these jurisdictions.

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I. Service Model Description

TABLE 1: SUMMARY OF FORENSIC MENTAL HEALTH SERVICES' SURVEY RESPONSES

	AB	MB (Cor)	NF (Com Cor)	NB	NS (addiction)	ON	SK (Health)	Scotland	Victoria Australia	New Zealand	Maryland USA
Population (Thousands)	3154	1163	520	751	936	12238	995	5200	4823	3831	5172
Specialist Forensic Service	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Hospital (outside prison)	Yes - 2 110 & 20 beds respectively	No	No	Yes - 17 bed unit	Yes - detox services	No (within prison but designated under mental health act - 444 beds)	Yes - 25 med-sec beds w/i general hospital & 200 bed max-sec centre	Yes - Several, 240 high-sec beds, 50 med-sec beds, & several low secure wards	Yes - 120 Bed Secure Forensic Hospital	No?	Yes - Secure Forensic Hospital
Early Intervention Programs	Yes - target pop 12+		M.O.U. for children and youth	a) Early psychosis prog piloted - b) Youth justice serv being established	Yes - youth targets	Yes - targets youth custody system	?		Yes - Early psychosis program		?
Diversion Programs	Yes				No	Yes - police and court-based	No		Court Liaison Services	Court Liaison Services	Yes - Jail-based diversion program
Central or Regional Admin	Alberta Mental Health Board			NB Dept of Health and Wellness	District Health Authorities	Ministry of Community Safety & Correctional Services	Freestanding organizations	Central	Central	Regionally based - accountable to District Health Board	Central
Community Services	Yes	Yes	Yes	Yes - CMHS	Yes	Yes	Yes	Yes	Yes	Yes	No
Mental Health Court	No	No	No	Yes - pilot	No (N/A)	No	No	No	No	No	No



II. Challenges

In addition to providing a general description of the services available in their jurisdictions, the survey asked respondents to identify “the most pressing challenges your jurisdiction faces with respect to the population of mentally disordered offenders, as defined above.”

Participants were also asked to rate the extent to which the identified areas are important and require specialist services. Finally, they were asked to identify additional areas of need that were not identified in the list provided in the survey.

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II. Challenges

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Most Urgent Mentally Disordered Offender Service/Program Needs

Table 2, below, summarizes the results of this section of the survey and will be discussed below.

TABLE 2: MOST URGENT MDO SERVICE/PROGRAM NEEDS

Area of Need Identified	Percentage of Respondents
The need for increased resources for mentally disordered offenders	60%
Increased community services for offenders	50%
Programs for needs of developmentally/cognitively challenged offenders	33%
Diversion programs, such as mental health courts and drug courts	33%
Programs/services for individuals suffering from Fetal Alcohol Effects/Fetal Alcohol Syndrome	32%
Additional services for young offenders with mental disorders	20%
Better collaboration between service providers and criminal justice personnel	20%
Better assessment/diagnostic service to place people in appropriate programs and housing	20%
Increased funding for research and dissemination of information	20%
Need to change public perception of mentally disordered offenders and reduce the stigma of being an MDO	20%
Need for better case management	20%
Coordinating services for dually diagnosed individuals (mental illness and substance abuse) placed in the community	10%
Requirement for high-quality mental health care in prison	10%



II. Challenges

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Of the 13 surveys returned, only 10 respondents completed this section of the survey. The most urgent problem, identified by 60% of respondents, was the need for increased resources for mentally disordered offenders. The urgent need for additional resources was recognized and a number of areas of need were identified, including: (i) increased secure forensic psychiatric beds, as offenders with serious mental illness often remain in correctional institutions for extended periods waiting for an available bed; (ii) better follow up; (iii) more programs for individuals with mental health and substance abuse issues; (iv) sustainable funding for diversion and family violence treatment program initiatives; and (v) funding to ensure continuity of care upon return to the community.

The majority of respondents endorsed a need for increased community-based services for offenders. Half of respondents indicated that community services are urgently needed, including: community-based residential support; community settings for inappropriately placed patients; increased safe community accommodation as many clients are on a one-year waiting list for appropriate community housing; and programs for social reintegration of offenders into the community

Programs that specifically address the needs of developmentally/cognitively challenged offenders were seen as urgent by 30% of respondents. No specific program needs were indicated; it was simply stated that these individuals urgently need programs and services. Thirty per cent of respondents indicated that diversion programs such as mental health courts and drug courts were urgently required services, and 30% also responded that programs and services were urgently required for individuals suffering from Fetal Alcohol Effects or Fetal Alcohol Syndrome.

The following program and service needs were also indicated as urgent: more youth services (20%), better collaboration between service providers and criminal justice personnel (20%), better services to place people in appropriate programs and housing (20%), increased funding for research and dissemination of information (20%), the need

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II. Challenges

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to change public perception of mentally disordered offenders and reduce the stigma of being an MDO (20%), and the need for better case management (20%). Only one respondent indicated the need for enhanced mental health services for prisoners (10%), and coordination of services for dually diagnosed individuals (mental illness and substance abuse) placed in the community (10%).

Perception of Importance of Specialist Needs/Services

Thus far, it has been assumed that each one of the seven areas of mental disorder identified in this survey is important and requires services. Partly to validate this assumption, and to determine whether any other areas should be considered, each of the key informants was asked to rate the importance of each of the seven areas and to list any other areas of mental disorder that are relevant to their service(s). Each respondent was asked “To what extent do those with the following illnesses or disabilities require specialist services to prevent them from entering the criminal justice system or to help them become reintegrated into existing or developing service systems upon release from the criminal justice system?” They were then asked “Do you provide services for these populations in your jurisdiction at present?” The results are summarised below in **Table 3**.

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II. Challenges

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TABLE 3: Perceived Need for Specialist Services across Areas of Mental Disorder

Area of Mental Disorder	Extent to which specialist services are required?			Whether such services are available in their jurisdiction?	
	Not at All	Somewhat	Completely	YES	No
Mental Illness	0	2	9	9	2
Substance Use Disorder	0	5	9	9	3
Personality Disorder (not APD)	1	5	4	8	4
Developmental Disabilities (IQ <70)	0	3	7	9	3
Low Functioning (IQ > 70 with limited adaptive abilities)	1	5	3	7	6
Brain Injury (organic or acquired)	1	3	5	4	5
Fetal Alcohol Effects/Syndrome	2	2	5	5	7

Note: Not all respondents replied to each question

As the above results show, most of the respondents found all of the areas to be at least somewhat in need of specialist services to prevent afflicted individuals from entering the criminal justice system, and/or to help them reintegrate into the community upon release. However, the relative need or importance varied by area of impairment. Eighty-two percent of respondents identified people with mental illnesses as “completely” requiring specialist services; whereas, only 33% of respondents felt that people who are “low functioning” (i.e., having an IQ greater than 70 but with limited adaptive abilities) completely require specialist services. Similarly, less than half of the respondents (44%) felt that such services were completely required for people with personality disorders.

With respect to whether such services are available in their jurisdictions, most respondents stated that services were available, although several noted that the services were only available to a limited extent. In particular, all but two of the jurisdictions provide services for those with mental

continued ...



II. Challenges

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illnesses in the criminal justice system. Similarly, most jurisdictions provide services for substance abuse, personality disorders, and developmental or intellectual disability. Fewer jurisdictions provide services for people in the criminal justice system who are low functioning, have acquired brain injuries, or who suffer from Fetal Alcohol Syndrome or Fetal Alcohol Effects.

Surprisingly, two respondents answered that specialist services were not at all required for people with Fetal Alcohol Syndrome or Fetal Alcohol Effects; one respondent similarly replied that services were not required for people with brain injury; and one respondent replied that services were not required for people with low cognitive functioning (IQ greater than 70 but limited adaptive functioning). This is unfortunate, given that, as explained in Part I, research shows that people with Fetal Alcohol Syndrome/ Effects and brain injury/low levels of functioning are at significantly greater risk than those not similarly afflicted to commit offences and to come into contact with the criminal justice system. To indicate that services for these groups are “not at all required” reveals a lack of awareness of the needs of these groups. Finally, one respondent did not believe that any services were required for people with personality disorders.

Other Areas of Illness or Disability Not Covered in the Survey

Few survey respondents reported other areas of illness or disability that they deemed important for consideration. There was no overlap among the different areas of impairment reported; that is, each additional area was indicated by at most one respondent. Respondents who completed this section raised the following areas as important for consideration: elderly offenders; offenders with significant physical disabilities (restricted mobility, those requiring palliative care, blind, deaf, etc.); persons affected by Fetal Alcohol Effects, alcohol related neuro-developmental disorders; and severe behaviour problems (severe aggression, autism, dementia, etc).



III. Strengths

Identification of any Particularly Strong Programs/Services – In Respondents’ Jurisdictions

The final section of the survey asked respondents to provide information about any strength(s) that they believe exist in their jurisdictions with respect to the population of mentally disordered offenders, as defined above.

Due to the varied and specific nature of the responses to the question of strengths of programs in each respondent’s jurisdiction we have summarized the results by jurisdiction.

Alberta. A number of programs were identified as being particularly strong in this jurisdiction. In 2002, the Provincial Forensic Psychiatry program participated in the Canadian Council on Health Services Accreditation Survey in order to identify existing “good practices” programs. *The Phoenix Program* (assessment and treatment of sex offenders), and the *Province Wide Needs Assessment* (to address provincial program needs) were identified as “good practices.” Furthermore, this accreditation process identified provincial priorities for improving programs. These priorities are currently being revised in order to improve and expand various provincial programs. Unfortunately, no further information was provided regarding these priorities, the Phoenix Program, or the Province Wide Needs Assessment.

Currently, the Alberta Mental Health Board and the Mental Health and Justice Deputies Committee are working toward implementing a *provincial diversion framework* to “ensure that, whenever appropriate, adults and adolescents with mental illness who are in conflict with the law receive appropriate care, support and treatment from mental health, social, and support services, thereby reducing reliance on the criminal justice system.” The target population is adults and adolescents with mental illness who are in contact with the law but whose needs may be more appropriately met by mental health

continued . . .



III. Strengths

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and social support services. Minimal information appears to be available about the success of the program as it is still in the implementation stage. More information about this program can be found at www.amhb.ab.ca/programs.

Alberta has also adopted a *Telemental Health Program* that allows for Forensic Psychiatric intervention in regional and outlying communities in a timely and cost effective manner using video conferencing equipment. Priority for this resource is given to individuals on probation, offenders with court-ordered treatment, sexual and violent offenders, and individuals with severe and persistent mental illness.

Another Alberta service is the *Community Geographic Team Resources*, which are dedicated resources developed in partnership with core forensic psychiatry services in Edmonton and Calgary, regional health authorities, community agencies and other stakeholders. This partnership allows sharing of resources in rural areas for persons who have difficulty accessing services due to distance, transportation, and lack of forensic expertise in the community.

Finally, *Turning Point* is an Alberta program specifically for youth charged or sentenced under the federal *Youth Criminal Justice Act*. Youth are remanded for assessments or are admitted for treatment if they have been sentenced under the *Act*.

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III. Strengths

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Ontario. A strength in this jurisdiction is a growing willingness on the part of different services to work together to enhance services provided to mentally disordered offenders. Furthermore, the relevant ministry is in the process of developing a new program to administer the *Intensive Rehabilitation Custody and Supervision Order (IRCS)*, which will be introduced as part of a new *Youth Criminal Justice Act*. The IRCS is a federal initiative intended to address the needs of violent youth who meet a variety of criteria including suffering from a mental illness/disorder, and/or a psychological disorder or emotional disturbance.

Ontario has also established a *secure treatment unit* at the St. Lawrence Valley Correctional Treatment Centre which provides forensic psychiatric services in conjunction with the Ministry of Health and Long-Term Care at the Royal Ottawa Hospital. The reported benefits of this unit include the anticipated improvement in treatment outcomes, the ability to efficiently assess individuals before and after receiving services, pharmacological care, reduced costs of transporting offenders for treatment, and integration of discharge planning with available community resources in the offender's home community. With intensive programming, offenders are held for shorter periods, therefore reducing waiting lists for treatment.

Ontario also has an ongoing initiative to ensure efficient use of resources, consistency in diagnosis and appropriate and effective identification of offenders requiring special services in order to improve standards of care.

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III. Strengths

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Nova Scotia. *CORE (Community Oriented Recovery Environment)*, administered by the Capital Health Addiction Prevention and Treatment Services, was identified as a strong program in this jurisdiction. CORE provides for and encourages flexibility in individual needs, programming, and treatment. CORE provides education on recovery and related issues, offers treatment and discussion groups, and support groups such as Alcoholics Anonymous and Narcotics Anonymous.

Saskatchewan. The forensic unit at the North Battleford Hospital works closely with corrections and Public Safety and Mental Health Services in the pre- and post-disposition process, ensuring coordinated treatment strategies between corrections and mental health services. The “*Complex Needs Strategy*” improves services by encouraging those departments with necessary resources to work together to aid individuals with special needs. Specialist services for low functioning sex offenders, offered by corrections staff, and addictions treatment are also offered throughout the province.

Scotland. Within the state hospitals there are specific programs for substance abuse education and relapse prevention, anger management, sex offenders, reasoning and rehabilitation, problem solving skills training, and fire setting. Other Scottish programs and services are outlined in the Scottish Offices document and include: Diversion from Prosecution, which was being evaluated at the time of writing of the Scottish Offices document, and court-based services in which staff can give immediate assistance to MDOs in the court room. For offenders with learning disabilities, there are services that provide specialized assessment and treatment within the prison system and subsequent treatment may be accessed through social services in the community.

continued ...



III. Strengths

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New Brunswick. Strengths in this jurisdiction include a mental health court, a Concurrent Disorders Protocol, Cross Training Initiatives with Mental Health and Public Safety, a Continuity of Care Protocol, and a protocol for discharge planning and delivery of mental health services to offenders being released from federal and provincial correctional institutions.

Under the Release Protocol Corrections Services Of Canada (CSC) and New Brunswick Community Corrections Services (NBCCS), case managers work with mental health services in discharge planning for MDOs being released from prison, intake assessment and mental health support is afforded individuals in an appropriate and timely manner, there is collaboration between service providers and frontline staff, and as clients near the end of their parole they are transferred for service from the parole office to community mental health services.

New Brunswick also has programs for the education of frontline staff in terms of the correctional system's current philosophies and approaches, available community supervision, and reintegration of incarcerated individuals. Furthermore, in collaboration with community health services, correctional mental health services are developing a standard provincial referral form which will include space for the referral source, the degree of violent re-offending, and the urgency of the situation.

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III. Strengths

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Victoria, Australia. Two unique programs were identified in this jurisdiction. First, *Forensicare* has developed a comprehensive program to provide dual diagnosis services to mentally ill offenders as well as services that address behavioural issues that are not captured by mental illness. This program is unique insofar as most forensic mental health services provide psychiatric services in response to imminent needs, but do not systematically address the criminogenic risks and needs that relate to offending.

A second innovation in Victoria includes Parliament passing the *Human Services (Complex Needs) Act* in 2003. The Act provides a legislative framework for the Multiple and Complex Needs (MACN) Initiative which targets a relatively small number (approximately 220) of Victorians with complex needs – including at least two of: mental illness, severe personality disorder, intellectual impairment, acquired brain injury, substance use disorder – who have essentially failed in the system. Background research for the legislation showed that the cost of maintaining people through MACN is approximately \$28,000,000 (AUD) per year (average of \$129,000 per person). This cost includes everything from hospital bed stay to incarceration and intensive supervision. Despite such expense, the targeted people have failed in the community. The MACN Initiative consists of three components: Careplan Assessments Victoria; the MACN Panel; and the MACN Intensive Case Management Service.

Directors of the relevant health region make referrals to the MACN Initiative Panel, which has the authority to decide whether the person referred requires the services of the MACN Initiative. If accepted, the case is referred to Careplan Assessments Victoria, the assessment service for the Initiative. Careplan Assessments Victoria is operated by the state forensic service (*Forensicare*) and a non-governmental agency with expertise in community-based transitional services for mentally disordered offenders. The assessment service is provided with all of the prior assessment reports and file material for the case (the legislation allows for sharing of such information among agencies). A comprehensive assessment

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III. Strengths

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is conducted by the assessment team, which is comprised of a psychiatrist, senior psychologist, senior social worker, and mental health worker. If necessary, additional assessment services can be purchased on a case-by-case basis. A care plan is also developed, drawing upon services in the state.

The assessment and care plan is then submitted to the Panel for approval. If approved, the Panel endorses the care plan and brokers required services. The case is managed by the intensive case management service that is part of the MACN Initiative. At any point, the case can be referred back to the Panel if services cannot be obtained. As the MACN Initiative is just being implemented, evaluative information is not available. It should be noted, though, that part of the funding for the MACN Initiative includes approximately \$600,000 to assess the initiative over a three year period.

Maryland. This state operates excellent facility-based forensic mental health evaluations and treatment programs particularly at its maximum security facility, the Clifton T. Perkins Hospital Center. Staff members who conduct evaluations for the courts complete a three day training program coordinated by the Office of Forensic Services. In-service training and an annual forensic symposium are also offered.

Another strength noted in Maryland is the conditional release program for people found not criminally responsible (not guilty by reason of insanity). Conditional release monitors work closely with providers who serve individuals on conditional release in the community. It is noteworthy that the re-arrest rate (under 3%) is lower than the general arrest rate in Maryland.

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III. Strengths

... continued ...

Diversion programs and metal health courts. In terms of these specialized services, only the respondents from Alberta, Victoria, Scotland, and Maryland provided information. New Brunswick indicated that they have a mental health court but minimal information was supplied. The document provided from Alberta appears to be quite informative and can be viewed in further detail at the URL indicated above. More information for the Scottish diversion program can be obtained from the Scottish Office document (1998). In Victoria, Australia, six of the magistrate's courts have a mental health professional (i.e., psychiatric nurse or psychologist) on site to identify the need for services and to make referrals for offenders with mental illnesses who come into contact with the courts. The court liaison workers are employed by either the forensic mental health service or an area (regional?) mental health service. As such, the court liaison workers are able to assist with the diversion of mentally ill offenders to appropriate services. For those offenders who have been charged with committing more serious crimes, they can ensure that mental health services are made available to the accused either in a secure forensic hospital or in prison, as appropriate. The Maryland jail-based diversion programs are nationally recognized in the USA and are a significant strength of their system.

From the results of the survey, it appears that there are a number of new and innovative programs across Canada and in the other jurisdictions surveyed. Although not all respondents commented on the strengths of their programs, those who did provided a number of program and service descriptions and contact information for organizations that may be helpful in stimulating further innovations to address the complex needs of individuals with mental illness who come into contact with the justice system.

continued ...



III. Strengths

. . . continued . . .

Identification of any Particularly Strong Programs/Services – In Other Jurisdictions

New Brunswick also has innovative school-based outpatient programs for youth with addictions, and outcome indicators have demonstrated positive results (no contact or program names given). In addition, St. John, New Brunswick has a mental health court although, again, no details were provided.

In Calgary, Alberta there is a program that integrates mental health, police, and corrections in dealing with the needs of mentally disordered offenders. This program attempts to divert mentally disordered offenders towards treatment and away from the criminal justice system.

In Saskatchewan, the Community Living Division Skills Project is a demonstration project for development of community based, specialized assessment and treatment services to adult men with intellectual disabilities and sexually offensive behaviors.

Mention was made of the consolidated mental health courts that have been established in Toronto. These deal more effectively with mentally disordered offenders than does the regular court system. They bring together the expertise of mental health specialists, community agencies and treatment institutions in conjunction with specially trained crown attorneys, duty counsel, court security and judges. Other courts have now been established in Peel and Sudbury. As noted above, further information can be found at <http://www.attorneygeneral.jus.gov.on.ca> and www.health.gov.on.ca/index.html

continued . . .



III. Strengths

... continued ...

The Manitoba survey mentioned two organizations that may possibly have relevant information:

Sara Riel Inc.

210 Kenny St.
Winnipeg, MB
R2H 2E4
Ph: 237-9263
www.sararielinc.com

El Dad Ranch

Box 9, Group 3, RR1
Stienbach, MB
R5G 1L9
Ph: 1-888-622-6337
www.mcc.org\mb\eldad

In terms of federal programs, Correctional Services of Canada offers in-patient mental health intervention, primarily through their treatment/psychiatric centres, assessments of risk, and community based treatment and relapse prevention programs. Dialectical Behaviour Therapy (DBT) is a treatment model used in some women's programs and is beginning in programs for men. DBT appears to be a promising approach for working with offenders with severe emotional dysregulation. There are four models of DBT used in the correctional system: Comprehensive (for inmates in mental health units); General (for inmates in the general prison population); Secure (for maximum security inmates); and Community (to support offenders upon release)

CSC has also proposed a number of additional programs: see the document Effective Corrections Proposal Table-Approved in the Appendices pertaining to CSC.

New Brunswick is also planning to cross-train mental health and addictions providers to better serve people with concurrent illnesses and to cross-train mental health and correctional staff to support the operationalization of their Continuity of Care protocol.

The conditional release programs in California and Connecticut were identified as being strong, although these jurisdictions were not part of the current survey. Similarly, New York and Massachusetts were identified as having excellent re-entry programs for mentally ill offenders leaving departments of correction.



IV. General Comments

Only three respondents provided “general comments.” Each of the comments varied considerably and will be summarized here.

The respondent from Alberta noted that a provincial Quality Management Committee is being implemented in Alberta. Terms of reference for the committee, which will work in the area of mental disorder and prevention among people in the criminal justice system, will include:

- 1/** Quality Assessment: analyze trend and performance indicators in order to identify areas for improvement.
- 2/** Quality Improvement: identify gaps in service, prioritize improvements and facilitate the implementation of provincial quality improvement initiatives.
- 3/** Research and Education: facilitate the establishment and dissemination of leading/best practices, implement programs and cross-ministerial education and training, and identify research priorities and advocate for research funding.

A Nova Scotia respondent raised a very important point: there is some question about the fairness of providing special attention to offenders with substance abuse problems and/or mental health issues. The respondent stated that that governments need to demonstrate cost effectiveness and efficiency. Furthermore, there needs to be sufficient incentive for individuals to participate in the programs, as many apparently prefer to go to jail over participating in intensive treatment programs.

The respondent from Newfoundland community corrections made the prescient statement that MDO’s often arrive in the justice system simply due to other agencies’ lack of resources for treatment, intervention and service provision. In many cases, they do not have justice issues, but do have more specific needs. As such, by meeting the special needs in the first instance (i.e., early identification and prevention), there will be less need for creative solutions once people reach the criminal justice system.



Appendix A

MENTALLY DISORDERED OFFENDER SERVICES SURVEY

Dear Colleague,

The enclosed survey is being implemented as part of a project to address the needs of mentally disordered people within or at risk of entering the justice system in British Columbia, Canada. We are seeking information from key informants across Canada and in select jurisdictions internationally regarding challenges and strengths in different jurisdictions. The project is being overseen by an inter-ministerial committee comprised of the Ministry of Health and Services (MHS), the Ministry of Public Safety and Solicitor General (MPSSG), the Ministry of Children and Family Development (MCFD), the Ministry of the Attorney General (MAG), and the Forensic Psychiatric Services Commission.

The project mandate is quite broad and “Mentally Disordered Offender” is defined as those people with a mental disorder and/or substance use disorder (other than anti-social personality disorder), developmental disabilities (IQ below 70), low functioning (IQ above 70 with limited adaptive abilities), brain injury (organic or acquired) and fetal alcohol effects/syndrome who are currently involved in the justice system or who are at high risk of involvement in the justice system.

We would be very grateful if you could compile the information requested and return the questionnaire to us at your earliest possible convenience, but no later than 7 February. The information submitted will be used to help identify needs and possible solutions in our own jurisdiction. Please indicate below if you would like to receive a summary of the survey findings, and we will be happy to provide you with a copy of our report.

Please check this box if you would like to receive a summary of the results.

Jurisdiction (State/Province/Country): _____

Name and Address of the Person completing the questionnaire:

Email _____



Appendix A

I. SERVICE MODEL DESCRIPTION

We would appreciate receiving a brief overview of the service model for mentally disordered offenders in your jurisdiction. In particular, we are interested in learning whether you have specialized services, such as early intervention programs, diversionary practices, or forensic mental health services, and whether such services are centrally or regionally administered. What ministries or departments are responsible for the services? Which agencies (if any) are responsible for coordinating services between different departments or ministries? Any other relevant information you wish to provide her would also be appreciated. If you have any prepared documentation explaining these matters, we would be grateful to review them. **(Please continue on the reverse or attach additional pages as necessary.)**

Appendix A

II. CHALLENGES

We would like to obtain information about the most pressing challenges your jurisdiction faces with respect to the population of mentally disordered offenders, as defined above.

1/ What are your most urgent Mentally Disordered Offender service/ program needs?

- a. _____
- b. _____
- c. _____
- d. _____
- e. _____

2/

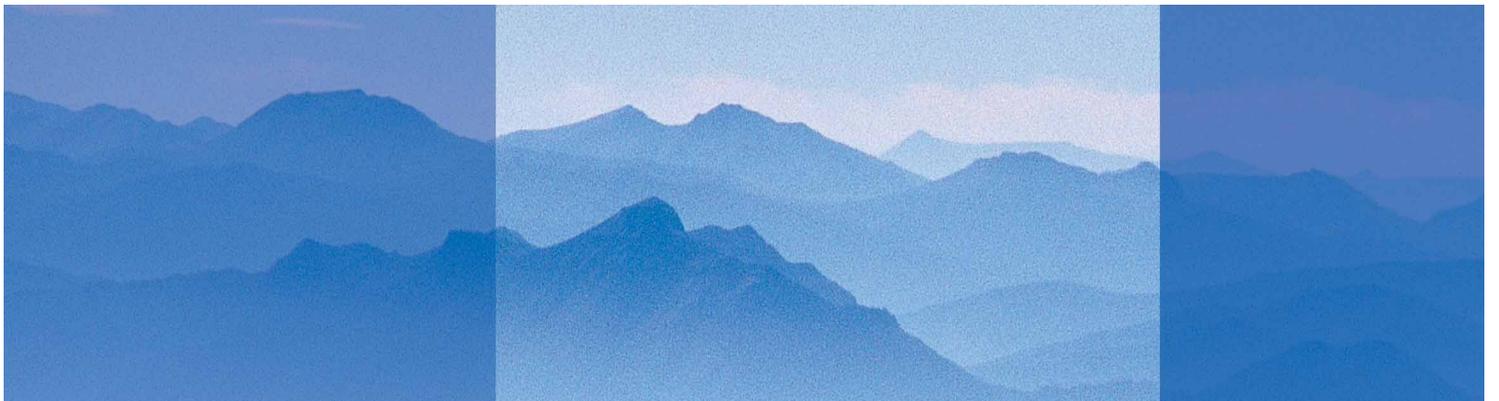
To what extent do those with the following illnesses or disabilities require specialist services to prevent them from entering the criminal justice system or to help them become reintegrated into existing or developing service systems upon release from the criminal justice system:	Do you provide services for the populations in your jurisdiction at present?
Mental illness/disorder _____ Not at all Somewhat Completely	___ Yes ___ No
Substance use disorder _____ Not at all Somewhat Completely	___ Yes ___ No
Personality Disorder (not antisocial personality disorder) _____ Not at all Somewhat Completely	___ Yes ___ No
Developmental disabilities (IQ below 70) _____ Not at all Somewhat Completely	___ Yes ___ No
Low functioning (IQ above 70 with limited abilities) _____ Not at all Somewhat Completely	___ Yes ___ No
Brain injury (organic or acquired) _____ Not at all Somewhat Completely	___ Yes ___ No
Fetal alcohol effects/syndrome _____ Not at all Somewhat Completely	___ Yes ___ No



Appendix A

II. CHALLENGES, continued

- 3/ Are there any other areas of illness or disability that we have not considered above that you feel are important for consideration? If so, please note them below.





Members of the Project Steering Committee

Irene Clarkson (Co-Chair),
Executive Director,
Mental Health and Addictions,
Ministry of Health Services;

Robert Watts (Co-Chair),
Provincial Director,
Community Corrections Division,
Ministry of Public Safety and Solicitor General;

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Peter Insley
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Ministry of the Attorney General;

Alan Markwart
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Ministry of Children and Family Development;

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Planning and Innovation,
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Ministry of the Attorney General.

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